A Healthy 2015!

How practical is a Practical Plan to achieve the Millenium Goals?

Congres organized by NVTG/Netherlands Society of Tropical Medicine and International Health and KIT/Royal Tropical Insitute

Wednesday, 12 October 2005

Netherlands Society of Tropical Medicine and International Health (NVTG, www.nvtg.org)

The NVTG promotes research, training and practice in tropical medicine and international health of people in developing countries. The NVTG has about 900 members, all working in the field of international health.

Royal Tropical Institute (KIT, www.kit.nl)

KIT is an independent centre of knowledge and expertise in the areas of international and intercultural cooperation. KIT conducts research and organizes training activities in international health and in the field of tropical infectious diseases, and aims at strengthening research in health systems and capacity building.

Eijkman Medal Foundation

Part of the congress programme is the awarding of the Eijkman Medal 2005. The Eijkman Medal Foundation promotes scientific research in tropical medicine and international health. The foundation was established to commemorate Professor C.Eijkman, a dutch researcher in tropical diseases and winner of the 1929 Nobel Prize for Physiology and Medicine. The Eijkman Medal is awarded every other year to someone who has made a significant contribution to tropical and international health research.

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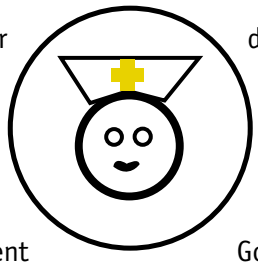
Introduction

The Millennium Development Goals were subject to a lot of debate in 2005. The launch of the UN report: *"Investing in development: A Practical Plan to Achieve the Millennium Development Goals"* challenged many to discuss, analyse, praise or criticise the eight Millennium goals. The organisers, the Netherlands Society of Tropical Medicine and International Health (NVTG) and the Royal Tropical Institute (KIT) felt encouraged to choose the MDGs as the focus for discussion at the annual NVTG Congress on October the 12th 2005 titled: ***A Healthy 2015! How Practical is A Practical Plan to Achieve the Millennium Development Goals?***

The Congress ***A Healthy 2015!*** intended to help face this challenge with regard to the MDGs related to international health: improve child and maternal health (goals 4 and 5) and combat HIV/Aids, malaria and other diseases (goal 6). The Congress reviewed the Millennium+5 Summit and focused on what is needed for the practical implementation of the MDGs at national and local levels. The guiding document was Investing in Development: A Practical Plan to Achieve the Millennium Development Goals. The UN Millennium Project (UNMP), an independent advisory commission chaired by the leading economist Jeffrey Sachs published this report in January 2005 as input for the MDG+5 Summit.

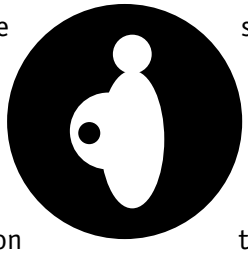


Leading questions were: How practical are the recommendations made by the UN Millennium Project? How can we put theory and plans into practice? More specifically, the Congress intended:

- To evaluate advances and constraints of the MDGs and the implementation process, five years after the formulation of the goals and one month after the MDG+5 Summit in New York;
- To evaluate the feasibility of the Quick Wins and the recommendations from the Task Force reports;
- To formulate recommendations on the reduction of maternal and child mortality, and the combat HIV/AIDS, TB, malaria and other diseases.

The organisers brought together a broad audience of professionals and experts in the field of international health who participated in rich discussions and thought-provoking debates. Among the guests were key players from the UN MP Task Force process and experts in international health. Part of the day was dedicated to formulate recommendations in the area of: Child Health

and Nutrition; Safe Motherhood and Sexual and Reproductive Health; HIV/AIDS and TB; malaria; and Management and Finance. These sessions were organised by the working groups of the NVTG. Jeffrey Sach's Practical Plan and the reports of the Millennium Project Task Forces served as background documents for these sessions, as well as the list of so called Quick Wins, the priority interventions for short term action.



The Congress ***A Healthy 2015!*** forms part of NVTG's ambition to place issues related to international health on the agenda of Dutch policy makers, and to bring together professionals and researchers in international health on specific topics. For almost 100 years -in 2007 the NVTG celebrates its centennial- the Dutch Society represents Dutch professionals with a background in international health. The NVTG 2005 Congress formed part of a congress cycle that is inspired on the four pillars of the NVTG: Platform; Education; Research; and Advocacy. Previous congresses in 2003 and 2004 dealt respectively with research (Global Health Research – the Dutch contribution) and education (Brain Gain in international health). In 2006 the Congress will investigate the role and the position of the tropical doctor. In 2007, the centennial year, the Society organises the annual Congress in collaboration with FESTMIH: *the Federation of the European Societies for Tropical Medicine and International Health*. This 5th European Congress on Tropical Medicine and International health takes place in Amsterdam, on May 25/29-2007. The conference theme is ***Partnership and Innovation in Global He@lth.*** For more information on the NVTG, FESTMIH and the 5th European Congress: www.NVTG.org and www.FESTMIH.net.
With pleasure we present this report which reflects the spirit of the 2005 NVTG Congress. We anticipate that the content and the discussions will inspire you to continue working towards improvements in international health, especially in low-income countries around the globe.

Wageningen, January 2006
Albert Mantingh, *chair*
Louis Niessen, *president NVTG*

Organising committee
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Halving hunger to multiply the effect of medical treatment

Hans Eenhoorn

Hans Eenhoorn, former CEO Unilever, formed part of the Task Force Hunger of the UN Millennium Project. The Task Force Hunger presented in January its report 'Halving Hunger: It can be done'. The following is an abstract of his presentation on the 12th of October 2005.

The Task Force plan for fighting hunger is part of the UN Millennium Project, which was commissioned by the UN Secretary-General in 2002 to develop a practical plan of action for enabling developing countries to meet the Millennium Development Goals and reverse the grinding poverty, hunger and disease affecting billions of people. As an independent advisory body directed by Professor Jeffrey D. Sachs, the UN Millennium Project submitted its final recommendations in January 2005. The Hunger Task Force is one of the UN Millennium Project Task Forces that together comprise some 265 experts from around the world, including members of parliament; researchers and scientists; policymakers; representatives of civil society; UN agencies; the World Bank; International Monetary Fund; and the private sector. The UN Millennium Project Task Force teams were challenged to diagnose the key constraints to meeting the Millennium Development Goals and present recommendations for overcoming the obstacles. Thus providing a detailed, global action plan for fighting hunger, poverty, disease and environmental degradation in developing countries and to get nations on track to achieve the MDG's by 2015.

Hunger hotspots

The Hunger Task Force was led by Dr. Pedro Sanchez, a winner of the 2002 World Food Prize, and pioneer in the field of tropical soils and agroforestry; and Prof. M. S. Swaminathan, winner of the 1987 World Food Prize, leader of India's Green Revolution movement, and world leader in the field of sustainable food security. They coordinated an unprecedented assemblage of experts from governments, the private sector, non-governmental organizations and academia who over the last three years have travelled the world to observe and discuss precisely what is being done to fight hunger and how solutions that are succeeding can be used in regions that are still struggling. The Hunger Task Force took a transdisciplinary approach, holistic and multicultural and started with mapping the hunger throughout the world: not only at the country level, but also at the regional level and came up with *hunger hotspots*.

The Hunger Taskforce gives concrete evidence that: "The Millennium Development Goal of cutting hunger in half by 2015 can be met if industrialized countries increase and improve their development assistance". "Halving hunger is well within our means. What has been lacking is action to implement and scale up known solutions."
The Hunger Task Force developed a wide variety of recommendations in the belief that each country, region or community can select the right mix of interventions best suited to its needs and circumstances.

It has crafted 40 specific, proven solutions for fighting hunger and a plan for implementing them at international, national and community levels. Africa was given specific emphasis, as it is the only region in the world where malnutrition is rising. The recommendations include:

- Move from political commitment to action through increased advocacy, increased resources, greater public awareness, and increased monitoring and awareness.
- Reform policies and create an enabling environment, through strategies such as an integrated policy covering agriculture, nutrition and rural development, increased budgetary support, empowering women and girls, increased access to land, strengthening research, removing barriers to trade and developing capacity to implement programmes to reduce hunger.
- Increase agricultural productivity of poor farmers who struggle to produce even enough food for subsistence by improving soil health, water management methods, seeds and livestock, and agricultural extension services.
- Improve nutrition for chronically hungry vulnerable groups through proven nutrition programmes focused on pregnant and nursing mothers, infants, young children and adolescents, and by supporting programmes that reduce vitamin and mineral deficiencies and infectious diseases that contribute to malnutrition.
- Reduce vulnerability of the acutely hungry through productive safety nets. Techniques include preparing for food crises in advance through early warning and emergency response systems and the development of social safety nets.
- Make markets work for the poor to boost incomes for those who struggle to pay for food. Strategies include investing in market-related infrastructure, developing networks of small rural input traders, improving access to financial services and market information for the poor, strengthening community associations and promoting alternative sources of income.
- Restore and conserve the natural resources essential for food security. Interventions include helping communities to restore natural resources, securing local access, ownership, and management rights to forests, fisheries and rangelands, developing natural resource-based “green enterprises”, and paying poor rural communities for environmental services.

5

Improve maternal health

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Free school meals

Quick Wins

One of the Quick Wins is the pre-School feeding programme - school meals with locally produced food- that addresses various MDGs: stimulate local productivity, stimulate school enrolment and increases the learning capacity. The Dutch government announced their willingness to spent at least 25 million a year (for a period over 10 years) in collaboration with the Ghanese government for a school feeding programme.

The relation between disease and malnutrition is clear, but it is widely acknowledged that the knowledge of most medical practitioners on nutrition is very weak. It is therefore imperative that Tropical Medicine starts with nutrition**.** The worst disease in the poor regions of the world is HUNGER. The medical profession cannot go on to ignore this. The effect of medical interventions, how beneficial they may be for the individual at a given moment, are ineffective at a larger scale, when the patients are malnourished and hungry. It will be a major challenge for the medical profession to include the fight against malnutrition as a priority in the practice of Tropical Medicine.

The challenge to the medical profession, in the light of the Millennium Development goals is also to develop treatment, technology and medicine that the poor can understand, apply and afford, without constant supervision of highly skilled, Western trained professionals. If the Millennium target of *halving hunger by 2015* is achieved, the effect of medical treatment in the poor regions of the world will be multiplied

This blueprint for action on hunger is crucial to meeting commitments forged in 2000 at the Millennium Summit, where world leaders agreed to make the fight against poverty -and all of its faces- in developing countries their priority. The summit inspired the *Millennium Development Goals*, which are built on the recognition that, from health to the environment, from education to gender equality, a growing list of development issues can no longer be managed solely within the boundaries of a single nation.
The UN general Assembly in September 2005, confirmed the commitment of achieving the MDGs and endorsed the action plans, including the financial means to achieve them.

QW Introduce pre-school

QW feeding programme

Meeting the MDGs: reversing the global incidence of tuberculosis

Jaap Broekmans

Jaap Broekmans is former director KNCV Tuberculosis Foundation and coordinated the Task Force on Tuberculosis (part of the UN Millennium Project). In January 2005, the Task Force presented their report *'Investing in strategies to reverse the global incidence of tuberculosis'*. The following is a summary of his presentation delivered on the 12th of October.

The recent outbreaks of TB in the Netherlands demonstrated that TB is like a wolf in sheep clothes. The infection is easy transmittable, a major killing disease and labour intensive to monitor. In order to manage TB control locally, we have to work globally. In 2004, the global burden of TB counted with two million deaths each year, eighty-nine percent of which occurred in the developing world. Over a quarter million deaths are due to TB/HIV infections. Nine million new cases are detected each year. Multi-drug-resistant TB (MDRTB) is on the rise and is present in 102 of the 109 countries surveyed from 1994 to 2003.

Work globally

The global TB control targets (WHA 2005) are the detecting of at least seventy percent of infectious TB cases and successfully treat at least eighty-five of the detected cases. The MDG related to TB: to reduce TB prevalence and deaths with fifty percent, by the year 2015. The Taskforce on TB concluded that it is possible to reach these targets, but we must remain alert on the rise of TB in Eastern Europe and the multi-drug-resistant tuberculosis. The way to reach global targets is by applying the DOTS strategy; a strategy developed under the leadership of dr. Karel Styblo in Tanzania. He found that under a strict management approach it was possible to double the cure rate, even within the existing health system. Anchors of the WHO-recommended Stop TB Strategy include:

- Pursuing quality DOTS expansion and enhancement;
- Political commitment with long-term planning, adequate human resources, expanded and sustainable financing to reach WHA and MDG targets;
- Case detection through bacteriology (microscopy first, culture/DST) and strengthening of the laboratory network to facilitate detection of SS+, SS-, DR- and MDR-TB cases;
- Standardized treatment, under proper case management conditions, including D.O.T. to reduce the risk of acquiring drug resistance, and patient support to increase adherence and chance of cure;
- An effective and regular drug supply system, including improvement of drug management capacity;
- Efficient monitoring system for programme supervision and evaluation including measurement of impact.

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Combat HIV/AIDS TB Malaria

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Distribute cost-effective treatment of TB (DOTS)

Additional components

Addressing TB-HIV, MDR-TB and other special challenges, by scaling up TB/HIV joint activities, DOTS Plus, and other relevant approaches;

Contributing to health system strengthening by collaborating with other health programmes and general services in, e.g., mobilizing the necessary human and financial resources for implementation and impact evaluation, and by sharing and applying achievements of TB control;

Engaging all care providers, public, non-governmental and private, by scaling up public-private mix (PPM) approaches to ensure adherence to the International Standards of TB Care, with a focus on the providers of the poorest;

Empowering patients and communities by scaling up community TB care and creating demand through context-specific advocacy, communication and social mobilization;

Enabling and promoting research to improve programme performance and for developing new drugs, diagnostics and vaccines.

DOTS

We have the interventions: the DOTS Strategy remains the cornerstone in modern TB control. It is a powerful intervention in diagnosis and control despite the negative treats such as MDRTB and HIV/Aids. The DOTS Strategy is the accepted approach in the public sector but at the same time we need to extend to the private sector and look for a new mix, under public stewardship. To face the new challenges the DOTS strategy was revised in earlier this year in the Stop TB Strategy.

The Global Plan to Stop TB 2006-2015 (Consultation Draft, 26 September 2005, Stop TB Partnership) outlines what can be achieved by 2015.

MDG target

We will have met the MDG goal target to have halted and begun to reverse the incidence of TB by 2015;

Partnership target

In addition, the Partnership's own ambitious targets to halve prevalence and death rates from a 1990 baseline will have been met globally with enormous progress in all regions;

Lives saved

Over the ten years of this Plan, some 14 million lives will be saved. About 50 million people will be treated for TB under a new WHO- recommended stop TB strategy based on the foundation of DOTS. About 800.000 patients with multi-drug-resistant TB will be treated, and more than 3 million people with both TB and HIV will be enrolled on antiretroviral therapy;

Quality of care

Implementation of the stop TB strategy will expand access to quality TB diagnosis and treatment - for patients with all types of TB, for patients of all age-groups, for men and women equally, and for patients from all socioeconomic strata;

New diagnostic tests

By 2008 new diagnostic tests for more rapid detection of smear negative TB will be available for use in referral laboratories. By 2010 simple, robust, affordable technologies for use at peripheral levels of the health system will enable rapid, sensitive detection for active TB at the first point of care. BY 2015 we will have diagnostic tests capable not only of identifying people with latent TB infection but also pinpointing those who are at the greatest risk of progression to active disease;

New drugs

The first new TB drug for 40 years will be introduced in 2010 and by 2015 we will be on the verge of a new TB regimen that will achieve cure in 1-2 months, compared with the 6-8 months now. This treatment will be effective against multi-resistant TB and will be compatible with the antiretroviral treatment. By then, clinical costs for new treatment of latent TB infection will be underway;

New vaccines

By 2015 we will have the first series of new, safe, effective TB vaccines available at reasonable costs, with potential for a major impact on TB control in later years;

Meaningful involvement of patients and communities: Mechanisms will have been developed so that: patients and communities can be involved productively in relevant aspects of TB care and control;

Development contribution

TB control will feature strongly on the development and political agendas, and investments in TB control will have contributed to poverty reduction and health system development in poor countries. The Stop TB Partnership commits itself to being an active player in collaborative efforts to strengthen health systems and to improve the harmonisation and alignments of its efforts.

QW QW

Eleminate user fees for basic health services

Eliminate school and uniform fees

TITANIC: The way forward to MDGs

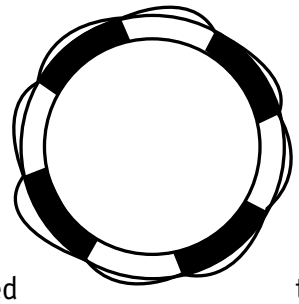
Esther Scheers

Esther Scheers is a resident gynaecologist at the University Medical Groningen and a former medical officer in Zambia. The following presentation is the integral text of her presentation during the congress *A Healthy 2015!*

What can a clinician possibly say about a practical plan to achieve health? Not being a specialist in Development Cooperation, neither being a Public Health consultant. And also this world's economy was never a subject of study to me. But, when we studied Medicine in Nijmegen in 1984 'Health for All by the year 2000' was something 'hot and debated' amongst students. In the curriculum we were given chance to learn more about the relation between poverty and health through participative research and exposure to Primary Health Care systems in South and Central America. Later I was privileged to work as a Medical Officer and Health Advisor to the District Health Services of Luwingu in the Northern Province of Zambia in an extremely resource constrained environment within the changing process of Health Reforms.

The story of TITANIC

Ladies and gentlemen. On the morning of April 15th 1912, Titanic sank in the Northern Atlantic Ocean with the loss of nearly 1500 lives. It is known that the chances of surviving the sinking were not equally distributed between all travellers. Results of analysis of survival published in 1986 by Hall showed that females were more likely to survive than males and the chances of survival declined from first to third class passengers. Amongst both women and men, the rates of survival in first class were twice as high as in third class. Overall, women and children were more likely to survive as the result of policy of giving preference in positions in the lifeboats. The official inquiry only concluded that the class differences in survival could be explained by the fact that the passengers who were in third class or steerage were predominantly emigrants who were reluctant to leave their belongings. Secondly it explained that many of these third class passengers were 'foreigners' and that their lack of English prevented them from following the crew's instructions. So, their chances of survival were reduced by their own behaviour! Indeed, the inquiry claimed that 'there was not an 'atom' of evidence that there was any discrimination practised'.



From the statements taken by the survivors it becomes clear that this is not the whole or even the biggest part of the truth. First of all, the third class passengers were

disadvantaged by the layout of the ship: the lifeboat deck was in the first class area of the ship, which was separated from the third class area below decks, by a maze of stairways and passageways. Secondly, reports were telling that not only priority was given to first class passengers but also second and third class passengers were actively being denied entry to the boats. Why were there not enough lifeboats on a ship so full of luxury and modern techniques?

Under the British Board of Trade regulations, the Titanic was not required to carry sufficient lifeboat accommodation for every passenger on board. Taken that there was no explicit discrimination between the classes in the allocation of positions in the lifeboats; are the differences in survival just a reflection of the natural order, where the winner takes it all? Was it just assumed that the price of a first class passage included an increased chance of surviving a sinking? Were women and children also going to be included if there was no such maritime practice of giving them priority to the lifeboats?

Metaphor

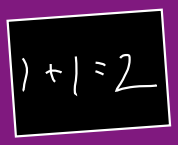
The story of Titanic clearly serves as a metaphor for the systematic differences in chances on health, disease and death between people with higher or lower socio-economic status within and between countries. Material circumstances in which people live are the most important factors that determine health inequalities: directly by living conditions, work and income but also indirectly by behaviour and psycho-social circumstances. Also the health care system itself can contribute to poverty, for example when medical fees push people into destitution, or when lack of access to care creates lifelong disability and limiting earning power. As the story of Titanic learns, differences in chances result from choices and decisions. Even for us who work in the field of health and development, it is worth reminding ourselves who the third class passengers of today's globe are.

They will be presented on the wall behind me, to illustrate whom we are talking about:

- Almost 11 million children under 5 dying every year, 6 million of them of malaria, diarrhoea and respiratory tract diseases.
- Half a million of women dying from complications during pregnancy and childbirth every year, 70.000 of them from unsafe abortion.
- Three million deaths of HIV/AIDS yearly in those countries without the basic health and education services to stop it.

2

Achieve universal primary education



QW

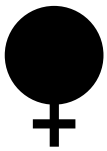
INTERNET access 4 all

These data are not just a reflection of the natural order; they have resulted from past and today's political choices. There is also nothing inevitable about poverty. It is man made. Poverty is not about economic growth, but about the fair chances to reach the lifeboats!

The Millennium Development Goals must give the third class passengers of today's globe a substantial advantage to reach those lifeboats. Its strategy has been criticized by some as being too ambitious and by others as being Minimum Development Goals. One major criticism is that they are not legally binding and without precise commitments and timeframes. Women have criticized them for gender not being a cross cutting issue. Another concern is that the Goals are not political by nature and are donor-driven with yet another set of donor conditionalities. Even with nobody being against the Millennium Goals, these critiques make sense. The disease or condition specific targets (4) to reduce child mortality by two-thirds, (5) to reduce maternal mortality by three-quarters and (6) to reduce the incidence of HIV/AIDS, malaria and other major diseases, have been criticized for being technocratic, too quantitative and not being comprehensive. Indeed, formulating goals and targets invites a top-down approach, whereby incidence and prevalence of the disease/condition are defined and cost-effective interventions to prevent or to treat are identified and implemented, on the condition that the political climate favours the process. Millennium-indicator-statistics do the rest and show where we are making progress. They will tell us about the numbers who survived. Will they also tell us the story of the structures of oppression and deprivation?
Will they tell us about discrimination and inequality as the main causes of persistent poverty?

Women

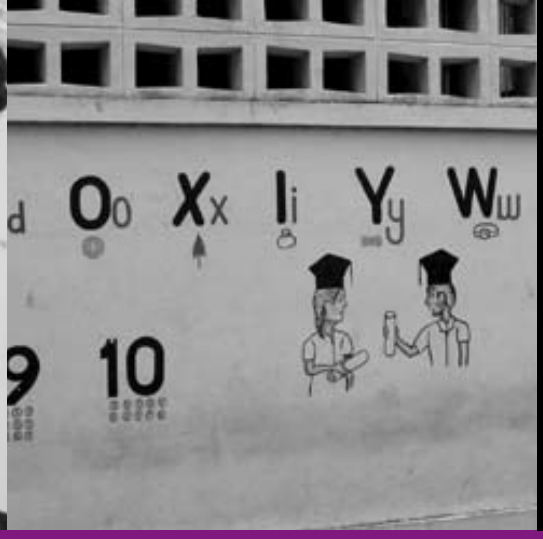
Last year Zambia's minister of health boasted that 6000 out of a targeted 10.000 people living with AIDS have accessed the government's cheap anti-retroviral drugs since the programme began. What he did not mention was that out of about 2 million people who have HIV/AIDS in Zambia, 70% are women. But only 800 women – a mere 19 % - were on treatment in 2004. The Director of The National AIDS Council, which monitors the provision of the drugs, commented



he had no idea why women are not accessing them because they are available to both men and women. Zarina Geloo -a Zambian freelance journalist- tells us more from interviews she took. For example with a man who is on ARV's who says: it is too expensive to have his wife on treatment too, even though he is unemployed and his wife is the bread winner as a tomato seller at the market. Care givers will explain further: "A women is a being of sacrifice. To be considered a model wife and mother she must put the well being of her husband and children first. That is the tradition." The wife herself will explain: I was scared of being accused that I killed my husband if I would go on ARV's and my husband did not. Moreover the income from her business is used to feed the family. The treatment regime requires a patient to eat three balanced meals a day. Women are not specifically targeted in this program. Actually, has any programme come up with the policy of testing and treating wives of infected men, like what we demand when a client shows up with a Sexually Transmitted Disease? Do we only treat the 'better' half?

Equitable health outcomes

Being practical, you might say that at least we have started and we just have to start from somewhere. That is how one might be tempted to go for Quick Wins and set priority programmes such as HIV/AIDS or reproductive health, distribution of bed nets or vaccination campaigns. The drive to produce results for the MDGs has led many stakeholders to focus on their own disease priority first with an assumption that through the implementation of specific interventions the whole system will benefit. But efforts to combat communicable disease, to reduce child and maternal mortality and to increase access to HIV/AIDS treatment all face the same constraint: provision of quality services cannot be scaled up while the health system remains fragmented, weak and inequitable.



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Promote gender equality and empower women

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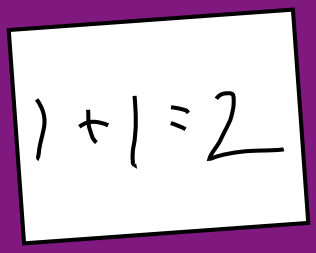
Train community workers

Also selected programmes undermine existing health services and have a detrimental effect on the quality of health service delivery; especially in highly understaffed and under funded settings. Even when additional resources are being targeted for certain selective programmes they have the undesirable effect of diverting time and attention from health workers away from other 'routine' programmes. Take for example the so called vitamin-A weeks in Zambia, whereby all transport, logistics and staffs were demanded, to give thousands of drops of vitamin A in the remotest areas of the district. While enormous efforts were made to reach the 100% coverage, all other activities collapsed with immediate effect. It can not be emphasised enough that such programmes, although they might be successful in their own, are not sustainable. Equitable health outcomes will require looking beyond technical solutions for specific interventions and address political, organizational and managerial constraints.



The example of ZAMBIA

Poor Health indicators and a centralized, inefficient health care system were among the reasons why the Zambian government initiated radical health sector reforms in the early nineties. The major thrust of the reforms was to strengthen District Health Services in order "to provide equitable access to cost effective quality health care as close to the family as possible". A group of donors -including the Netherlands- supported the health reforms and became actively engaged in this development policy and partnership framework which is known as a sector wide approach. Although achievements have been made in the areas of decentralized planning, management and actual delivery of district health services, exemplary health outputs have not yet been materialized.

Persistent shortages of drugs have been one of the most prominent complaints in recent years. Human resource constraints and failing staff morale has adversely affected service delivery. The major problem continues to be equitable access. Accessibility to health services and the level of poverty as the most influential factors determining health seeking behaviour is one aspect. The level and quality of health care that is actually provided at the health facilities is another matter. The overall health performance according to the 2000 WHO report ranks Zambia, after more than 10 years of Health reforms, at the low position of number 182 from its 191 member states.

TITANIC

Have the health reforms failed? Should disease prevention and control programmes be revived? According to health workers in Zambia: No, the Health reforms have not failed! But: How bare footed can you go, when the referral hospital is so understaffed that you can not even deliver minimum standards of care? How much Home Based Care can you offer, when your essential drugs – amongst those for TB - are out of stock during a period of 6 months? How many Trained Skilled Birth-Attendants do you want to train if you can not supply them with gloves to protect them selves? Or to quote the former Dutch first secretary health in Zambia: "For the 5 to 0 dollar expenditure per capita on health that is presently available, you can only dream of quality health service." The World Health Organization MDG 20005 report concludes that only fully functioning, strong and sustainable health systems are the means of achieving better health outcomes, including the health MDGs. And the achievement of the other MDGs is, in turn, dependent on the capacity of the health sector to deliver. If the time is now, and this is the strategy: T.I.T.A.N.I.C. – the way forward to MDGs: To Invest Towards Approaches Non-vertical Integrated & Comprehensive. All hands on deck! Women and children first!

MDG for child health: a bottom-up approach

Bernard Brabin

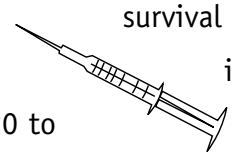
Bernard Brabin is professor of tropical child health at the University of Amsterdam and in tropical paediatrics at the University of Liverpool. The following is a summary of his presentation delivered at the NVTG Congress on MDGs.

The Millennium Development Goal on child health aims to reduce the under-five child mortality rate by two-thirds between the years 2000 and 2015. Although under-five mortality has been falling since 1990, the MDG will require that there is a three-fold increased rate of mortality reduction in the next 10 years. Some countries show improving trends but others are in reversal, partly due to drug resistance in malaria parasites and the problem of HIV infection. In general there is good knowledge on the causes of child mortality and these are expected to remain largely the same in the next decade.

Over the past 15 years we gained a lot of knowledge about the causes of deaths in children. This knowledge is not likely going to change: children will continue to die of the same causes over the next ten years as they are now. The 5 main killers of children are ARI, diarrhoea, measles, malaria and malnutrition.

Bottom-up

Besides knowledge on the causes of death, we also have a good knowledge on the scope of interventions that are effective like immunisation and child malnutrition interventions (1960s), Primary Health Care, Maternal and Child Health, GOBI (1970s); Vitamin A supplementation, Respiratory and Diarrhoeal disease control (1980s); Impregnated bednets, Integrated Management of Childhood Illness (IMCI) Poliomyelitis elimination (1990s) and in 2000 the HIV survival interventions and Newborn health initiatives. Due to massive immunisation campaigns, the amount of child deaths was reduced with 20 to 30 per cent since their introduction in the 60s and 70s). The use of impregnated bed nets in the 1990s caused a reduction of child deaths by a quarter, almost the same as the effects from immunisation. Despite the fact that we saw dramatic results from technical interventions, the problem is that all interventions have to occur at the same time in order to reach the target. And despite the good knowledge concerning effective existing interventions, which if appropriately used could theoretically prevent about 45 % of child deaths if they were to reach all children, poor coverage and competing interventions limit their effectiveness. Neonatal tetanus is used as an example to illustrate this.



4

Reduce childmortality

QW

Distribute treated bednets to children

The status of the intervention related to neonatal tetanus:

- 63 developing countries have still to eliminate neonatal tetanus in all districts;
- 40 developing countries have still to reduce nationwide neonatal tetanus incidence to under 1 case per 1,000 livebirths;
- 450,000 neonatal tetanus deaths in infants have still to be prevented yearly;
- 40,000 maternal deaths from neonatal tetanus have still to be prevented yearly;
- at least 2 doses of tetanus toxoid vaccine have still to be administered to 80 million women living in high-risk areas of the world.

A bottom up approach to the MDGs means moving away from the technical interventions and look at cost free and culturally appropriate practices. This includes cost free approaches, like as exclusive breastfeeding (breastfeeding up to six months). Yet, despite many efforts over the past 30 years to stimulate exclusive breastfeeding at present only 20% of the mothers breastfeed their babies. Other cost free approaches include 'late cord clamping', a successful intervention, as the latest analysis from some Dutch colleagues indicate. The implementation of improved child care and referral practices for sick children in both hospitals and health centres can also contribute dramatically towards mortality reductions. Most children die 's death occurs in the hospital, which calls for a closer analysis of the current diagnostic and treatment practices within hospitals and health centres. Timely and right diagnosis is a critical aspect that we need to address in order to advance on the goal to reduce child mortality. There is also a need for improved referral systems. However, despite the problem of effective referral and hospital management of childhood diseases, there are other issues that also ask our attention among others: human resources, increasing drug resistance; scarcity of resources and limited funds. Also, we need to take stock of a shift towards private health care, away from public services, especially in Asia.

Education

Some emphasis should be given to prioritising health literacy activities, in particular for adolescent girls. If you invest in girls and maternal education, the benefits for children are enormous. The Malawi Adolescent Girls Literacy Programme (AGLIT) illustrates how this practical programme reaches out to out of school adolescent girls, and aims to increase knowledge about their health and seeks to address community needs on health seeking behaviour. Education, one of the Quick Wins, is seen as crucial in young people's growth and development; the challenge is to use ways to reach the excluded. We can all play a role in achieving the Millennium Development Goals for child health through combined efforts and concerted action.

7

Access to safe drinking water

QW

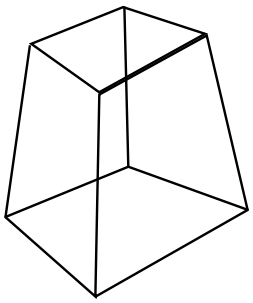
Plant trees

MDGs, the road ahead

Lynn Freedman

Lynn Freedman is Associate Professor of Clinical Public Health at the Mailman School of Public Health at Columbia University New York and is co-author of the Task Force report *'Who's got the power? Transforming Health Systems to Improve the Lives of Women and Children'*. Lynn Freedman, coordinator and author of the Task Force on Maternal Health and Child Health was asked to look ahead and illustrate the scenario for the years to come.

Virtually every report on achieving the MDGs begins and ends by expressing the sentiment that "business as usual" – even a lot more of business conducted in the same well-worn way -- will not work. We in the MDG Task Force on Maternal Health and Child Health, we certainly put forward that sentiment that business as usual will not get us there. For some people business as usual is about money. We certainly don't have enough money to meet the MDGs and we will need more money. So it can't be business as usual when it comes to money. For some people business as usual refers to political will. But I think that we need to go beyond political will. Every field has its own version of business as usual and health is no exception. So how does it look like, business as usual in public health? The more and less standard way the business of usual way to approach a problem in public health is usually this: first you choose a priority disease, and certainly the MDGs did that for us in a way; you document the causes of death; then identify the interventions for each of those causes of death; you prove the efficacy and safety of those interventions; you do demonstration projects to prove effectiveness of the intervention and to identify so called best practices; you disseminate best practices; and then you call for scale-up and for pro-poor interventions. And I think that is kind of business as usual in public health, that is how we usually approach a problem. Of course not everyone has such an epidemiological approach, and there is a good deal of important work being done on social and economic dimensions of health. So we kind of have a second line on business as usual, and I would say it is this: it is to recognize that health does indeed has roots outside of the health sector. And so we push for economic growth and for general development, with the basic explanation that wealth is associated with good health. And of course it is. We do see that association. But there is the assumption that public health will follow economic growth, almost automatically. The main argument that we made in the Task Force on Maternal Health and Child Health was that in addition to these kinds of business as usual, we actually need a major transformation in our vision about how change happens in public health; especially if that change is supposed to address issues of poor people. So we begin with the understanding that while health is a technical issue, it is also always a deeply and profoundly political

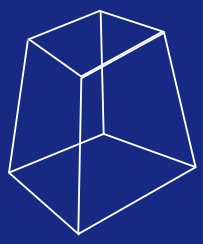


QW

Provide ARVs

6

Stop malaria



issue. And it always relates to the distribution of resources and power in a society. So as important as the scientific evidence is, as important as that business as usual way of analyzing the health problem is, we need to accept that simply putting forward the scientific case is not going to change things dramatically. I don't think it is the case that just by the powerful rationality by the good evidence base we will get dramatic change of the kind we need to meet the MDGs. Similarly there is a very good historical evidence that although ultimately wealthier countries do have better health it is not automatic that economic growth will have an automatic result of better public health. In fact we could argue, and I argue here, that real change of the kind we need for the MDGs to happen is when a sound technical evidence-based plan – A Practical Plan – is part of a broader vision of change and transformation, backed by a strong locally grounded social and political movement. The achievement of the MDGs requires true transformation in how we think, how we act, and how we invest. We need both an inspired vision and a "practical" – i.e., a doable – plan that includes concrete actions to take in the short-, medium-, and long-term. The road ahead has 3 lanes.

A social and political movement

We need to build a social and political movement; a movement that essentially can challenge the status quo – and also the standard critiques of it from both "left" and "right". By definition, this is not easy or "practical", because the status quo is the status quo precisely because it supports certain vested interests. So developing a "practical plan" is not just a question of doing research on "best practices" and then publicizing them or educating policymakers about them on the assumption that the rationality

QW Health programmes in rural communities

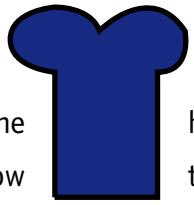
QW Agricultural programmes in rural communities

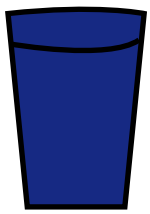
of such measures, their grounding in scientific evidence, will, by itself, ensure their adoption. So to challenge the status quo really requires a social and political movement. A movement that needs to happen not just in the School of Tropical Medicine or Columbia University, or the floor of the UN General Assembly. It needs to happen at the local level as well. That activists and social and political movement has to have a strong evidence base, but I think it can also use principles such as the rights principles to do its job which is to demand change and accountability. We need about what are the mechanisms to make them accountable. History tells us that big changes in public health require a social and political movement that advances them. The road ahead must ask and answer the question of what steps will help create and sustain such a movement in the short, medium and long-term.

Health and poverty

A conceptual shift in understanding of the relationship between health and poverty. The second lane, to go beyond business as usual we need to generate a basic conceptual shift in our understanding of the relationship between health and poverty. Basically we know the technical interventions that can address most of the causes of death in children under five and women in pregnancy and childbirth (MDG 4 and 5). This issue is how to make them accessible, utilized and equitable. And for that we need a dramatically different focus on health system; which was also the recommendation of our Task Force. We need think differently about it, we need to act differently, we need to invest differently. And that argument is built on a transformed idea about the role of health systems. So let's take health and poverty. There is sort of a standard way of talking about this relationship. One is to say that health is intrinsically valuable, that just being healthy is really part

of development and valuable in itself. The second way, very familiar in the millennium project, is that health is instrumentally valuable: that health is useful for other goals. Sometimes that is explained at the population level. Jeffrey Sachs chaired the Commission on Macro-economics and Health which in 2000 came out with a report that basically said that you need to have a healthy population in order to have economic growth. Or you can look at this at the individual level. We know that today the cost of health care for individual people can be catastrophic, the WHO estimates that 100 million people each year are pushed below the poverty line by health care expenses. There are some startling numbers for example the World Bank says that of all the people that go into the hospital above the poverty line, fully 25% of them leave the hospital below the poverty line. So indeed, the costs of health care are very critical when it comes to poverty. But I think we need a need way in thinking about health and its relationship to poverty. And in view of health systems this includes viewing health systems not just as a mechanical system for delivering technical interventions, but rather as core social institutions. When we talk about poverty we talk about it as a condition of deficit, not enough money, resources. But in fact poverty is also fundamentally, relational. The World Bank Voices of the Poor Study (in 60 different countries) clearly indicated that poverty is not just need and deficit. It is about people's relationships, their interactions with structures of power; and key among those is the health system. So what studies keep illustrating is that abuse, exclusion, neglect by the health system has now become part of the very experience of what it means to be poor. And that is not limited to the poor countries, it is also true in the US now. We need to take the fact seriously that there is actual exclusion and abuse in the interaction with health systems. At the same time the converse is also true: the health system can be a place for the assertion of rights, really as an asset of citizenship. This is what we mean by building a democratic society; it doesn't mean just elections, it means having social structures that do respond.

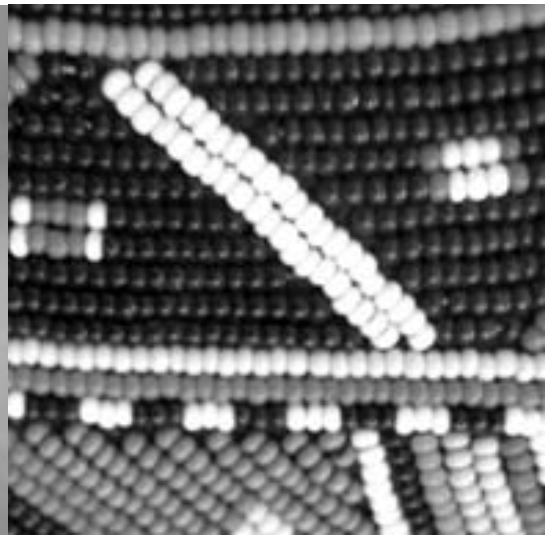




With equity and human rights as critical lenses, we need to pay new attention to the multiple interactions between citizens, the state, and providers. The road ahead includes short, medium and long-term steps for ensuring that the health system fulfils its positive role in democratic development and minimizes the extent to which it is the locus of abuse and marginalization.

A new focus on the *how* and not only the *what*

We can have the best policies, we can have the best designed programmes, we can call for implementation and scale-up, we can call for equity, but all this won't work unless we start paying a different kind of attention to the 'back office' operations, to use Lola Dare's words to describe the operations that make a health system function. Health systems consist of "key, discretionary, transaction-intensive" operations. Making health systems work for people is therefore not only a question of the right policies and programs, but of practices taken by millions of front-line providers engaged with the people they are meant to serve. Because the context that shapes such practices is always political, social and cultural, there is no blueprint, no single solution. This sentiment of no single solution is fast becoming a mantra of MDG achievement. It is true, but what does it really mean? Ultimately what it means is that there must be a qualitatively different investment in 'back office' operations, in the local capacity-building, in all forms of infrastructure, and invest in country based problem-solving with a huge emphasis on functionality, and not just on getting the right policy there. Many of our business as usual approaches to health, to funding, to development aid, don't really leave room for that kind of capacity building and country based problem-solving. But I think there is no road ahead without it. So let me finish by saying: yes, we have A Practical Plan, a technically sound and evidence based plan, but unless we commit ourselves to a dramatically different approach to implementing that plan, I think 2015 and the MDGs will really remain a distant vision.



Goals, targets and declarations:MDGs in Africa

Lola Dare

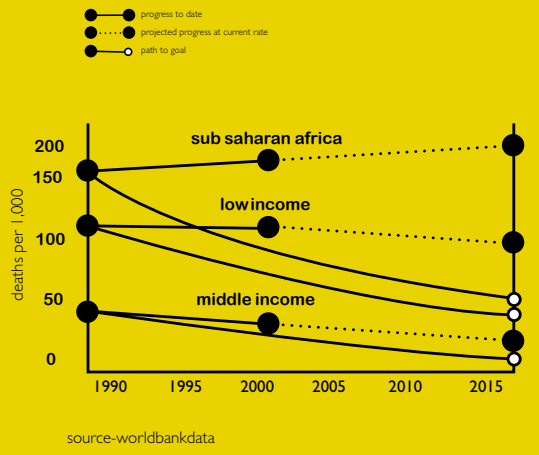
Lola Dare is the Executive Secretary of Acoshed, the African Council for Sustainable Health. She is the author of *Expanding the Frontiers of Partnership for Health Systems Strengthening in Africa*.

The health care system in Africa is strongly rooted in the systems that were developed in response to colonial needs. They had a strong service delivery focus with curative hospital based care. Independent states adopted historically grown strategies of vaccination and targeted health care delivery. The interventions were easy to deliver and had a 'campaign approach' to disease control: epidemiological and with a focus on the parasite and vector. Proposed interventions were mainly biomedical and drug related. There was commitment at the technical, financial and political level and the resources met these commitments. Effective multi-sector approaches and interventions were implemented. Successes, such as in Guinea worm and polio eradication, encouraged our governments and partners to continue with formulating declarations, the Alma Ata Declaration, Health for All by the year 2000 and now we have the MDGs. So we had the declarations, but what was the progress on attaining these targets?

Selected initiatives and programs since ALMA ATA

Initiative/program	Target
Bamako initiative	[not attained]
Guinea worm eradication	[almost attained]
Polio eradication	[on the way but hotspots remain]
Safe motherhood initiative	[not attained]
Bamako initiative	[not attained]
Trachoma initiative	[not attained]
Expanded program on immunization	[not attained]
Eradication of leprosy	[not attained]
Unated nations special initiative on Africa	[not attained]
Eradication of malaria and the RBM	[not attained]
Poverty eradication (alleviation/reduction)	[moving target]

Path to goal
- under 5 mortality rate



source-worldbankdata

Financial resources

The Bamako Initiative, Safe Motherhood, EPI were not attained. Goals on Guinea worm: attained, but not on track. And as we progress down the decade it appears that the situation has worsened in Africa. Evidence shows that Africa is increasing its share of childhood mortality globally and unstable immunization rates.

In general it can be said that Africa's health systems lack financial capacity. The average amount spent on health in Nigeria is thirteen dollar, but in some places in the country this

is less than a dollar per capita. This lack of financial capacity is not only of governments, it is also of the people. We asked our governments to allocate fifteen percent of the annual state budget to health. But we weren't the only ones: UNESCO asked them to allocate twenty-six percent to education, FAO wants a twenty percent for agriculture, and by the time you add the other sectors it exceeds the hundred percent!

Human resources

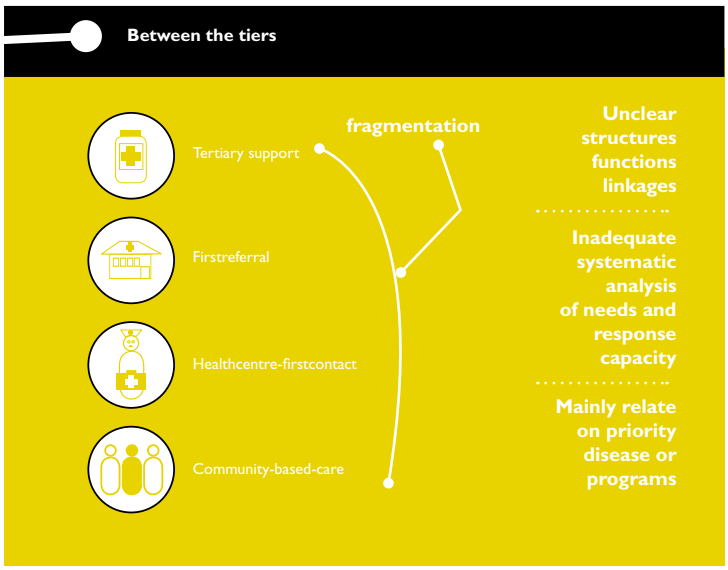
Besides lack of financial resources, African health systems also fail human resources. It comes to no surprise that the Joint Learning Initiative concluded that African systems are short of the human resources that need to function effectively. And ironically, it is in this environment that we formulate more declarations, more new instruments, approaches and strategies in spite of the fact that the ones we know that work have not been delivered. Global partnerships are multiplying and besides the acronyms on approaches we have now a number of acronyms on partnerships: Three by Five (for AIDS), Stop TB, President's Initiative on HIV/AIDS; Roll Back Malaria (RBM), Global Alliance for Vaccines & Immunization (GAVI); Global Alliance for Improved Nutrition (GAIN); Clinton Fund for AIDS; Global Fund to Fight AIDS, Malaria & TB; Polio Eradication, Millennium Challenge Account for AIDS... What a challenge it must be for African Ministers in Health: a challenge to understand the meaning of the acronyms, a challenge to respond to the many needs, and a major challenge to prioritize among them!

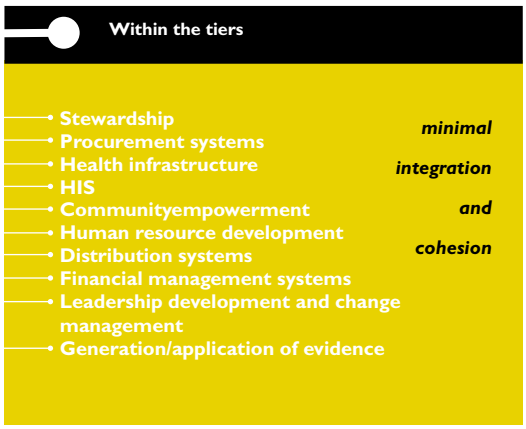
Fragmentation within and between the tiers

In an ideal situation there is an intertied approach to health care delivery and systems development: between home (community) based care; the health centre; the first referral; and tertiary support. In Africa, most systems lack structure and linkages between the tiers.

Fragmentation occurs also at the funding level, for example the funding on malaria in Nigeria: DFID funds malaria interventions at the primary care level; USAID the delivering of ITN's through home based care programmes; WB the strengthening of the referral care at the tertiary level and ADB the expansion of diagnostic capacity. Resulting that in the end not one intervention being sustainable or properly implemented at any level.

There is also fragmentation and lack of coherence within the tiers: infrastructure, procurement, financial and health information systems, community empowerment, stewardship, human resource development, and leadership development and change management.





Some progress, many frustrations

On the positive side, there is progress. We can see some increases in the number of skilled attendance at births; the use of ITNs; and the coverage for effective TB treatment. There is increased political positioning and commitment. And definitely we can establish an increase in the number of partnerships and global initiatives for health. But despite this progress the observed trends of the 90s continue. Indicators are difficult to estimate and track, especially in the case of maternal mortality. Financial resources remain difficult to mobilize and sustain, except in the context of a global partnership and a vertical programme. Health workers are migrating, de-motivated and human resources are inequitable distributed over the country. And as indicated earlier: health systems remain fragmented and weak. So we ask ourselves: are goals and targets becoming another magic bullet? The first law of improvement says: "Every system is perfectly designed to achieve exactly the results it gets". So we really need to look at African health systems and say we are achieving poor indicators in health because the systems are not designed to achieve

anything better than that. Determinants of this limited progress are caused by the major variations in epidemiology, the complexity of the interventions, and of course the human factor which is a significant element of intervention efforts.

Meeting the global targets

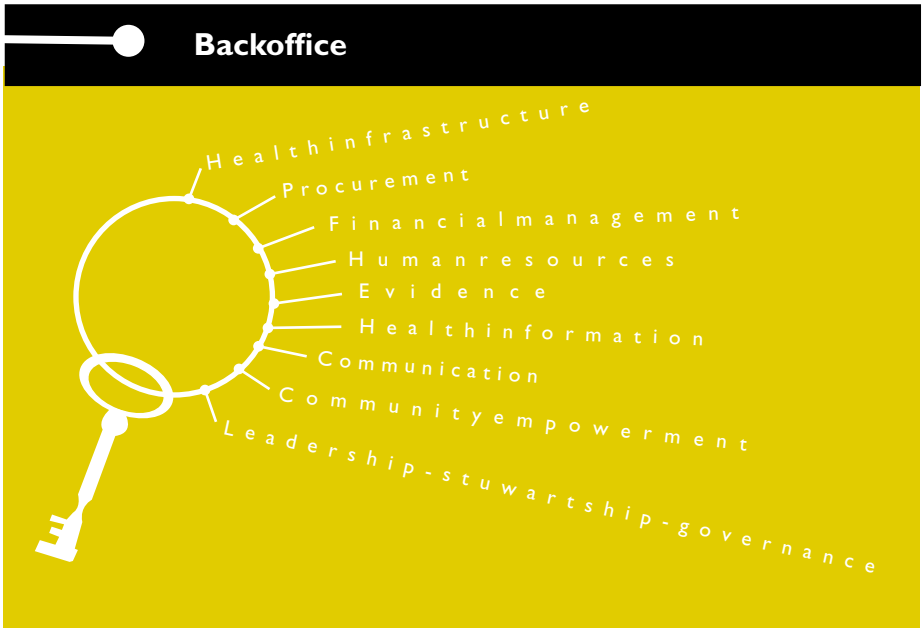
As the Practical Plan and the Task Force reports also conclude, reaching the MDGs is possible because we know what to do and we have the tools: DOTS and EOC strategy, ATC, ITNs, ARV, ABCs, vaccines. Though we are lacking the robust and efficient health care systems to deliver these interventions, and we are lacking sufficient human resources for health. Meeting these global targets is also a fiscal dilemma, especially with regards to human resources. The Millennium Project is proposing 110 dollars per capita annually to achieve the goals related to health, which would be cost shared with our governments and the people: 70 dollars paid by donors, 30 dollars by governments and 10 dollar per capita by our people. The Nigerian government would require 67 million dollar for the health sector alone! There is a large financing gap between 'needs' and current resources to meet the needs in most LICS. This financing gap is not going to be met, even if all trade barriers would be removed, even if all debt of Africa would be forgiven, and all the conditionalities in debt relief were removed.

Why do we set targets we can not meet?

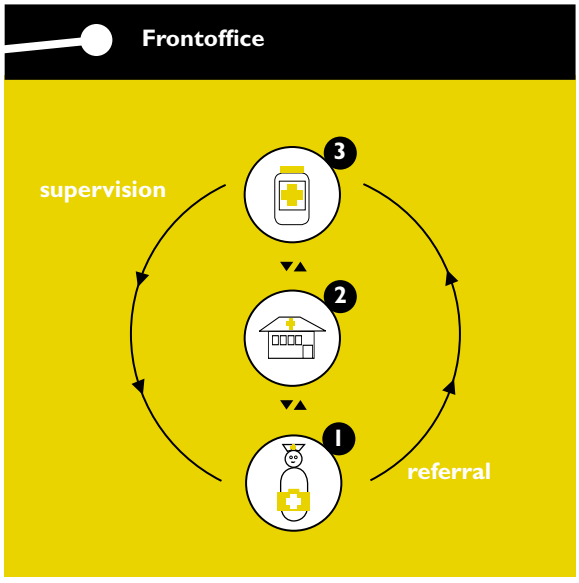
The experience from the various initiatives show that very little of these standards are being attained. These standards often are set without understanding the capacity constraints to deliver these interventions. Other issues with regards to the MDGs include: increasing cost to treat malaria; fiscal implications inadequately understood; limited managerial capacity; investments and programs remain fragmented; we face data challenges, both availability and measurements. And perhaps more important are the long term commitments, in time and money required to achieve these targets. Targets seem to have become advocacy sign posts and appear not to be intended for achievement.

Cleaning up the back office

We need to clean up the back office and strive for more cohesion within and between the tiers, looking at the referral, supervisory and support system. We need balancing investments and good practice and stewardship from national governments and partners. From the side of national governments this entails more accountability, less corruption. And from the side of our partners and donors we ask them to respect local systems and institutions when they arrive at country and local level.



Cleaning up the back office is essential, but at the same time it is important to look at the front office which, as indicated earlier, is currently fragmented.



QW

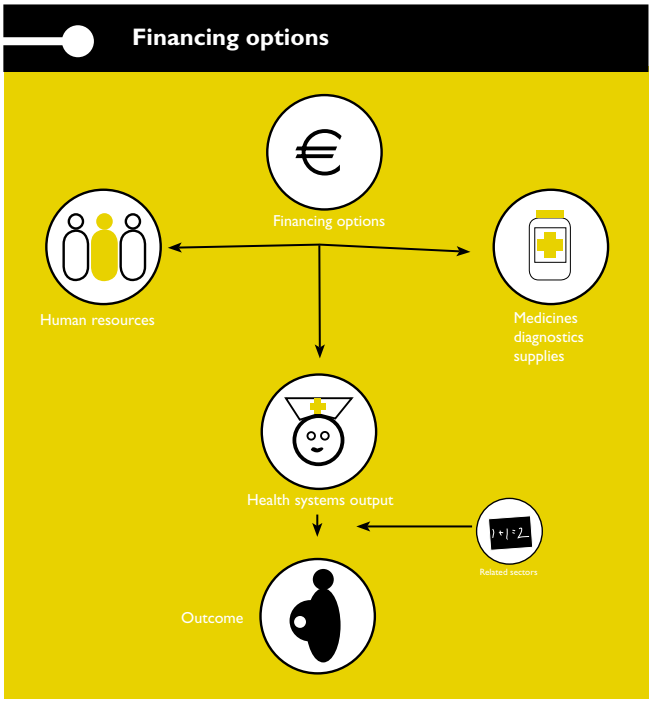
Provide ARVs

7

Environmental sustainability

This is of course going to require significant partnerships and balancing between the financial options: budget allocations, grants and loans and from evolving community financing schemes, which are the African strategies for taking away the user fees). Often these financial options are not effectively used because of the imbalance between the central assets (human resources, equipment and infrastructure) and the supportive assets (medicines, diagnostic supplies). Effective balance between these two results in health systems output: equity, efficiency and quality; and health outcome: increased health status and reduced morbidity and mortality.

Unless there is intersectoral action for health -particularly involving education, financing and public administration- health outcomes are unlikely to be achieved.



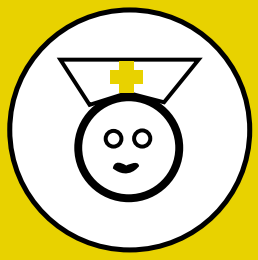
Conclusions

Health systems are critical to health outcomes, we need to promote inter-dependence and strengthen referrals: it is the combined effort of the back office and the front office that make health systems functional and efficient. Improving health systems require a broad range of actors and actions, such as broadening of partnerships. As Lynn Freedman states in the three lane road, we need to promote social and political will. Health Investments need to be increased, but I am one of these people who believe that even with the current levels of expenditure and investments we can do better than we are doing. Increasing investments rapidly would be like pouring water into a leaking basket. It is time to change baskets to solid buckets that can contain the water. And as we expand the fiscal space we need to expand the capacity of African government to manage the fiscal space efficiently and transparently.

A paradigm shift is needed: governments and partners, researchers and donors are all used to work in a set way. That direction is not necessarily the right way to achieve the goals. This requires moral and social responsibility, leadership and democratic governance.

Furthermore, it is important to move from targets to guidelines that offer countries guidance to develop their own targets based on their own realities. We are looking for what in ACOSHED we call the 'ivermectin commitment': invest in health systems for as long as it takes and stay on the target for as long as it takes. Good practices and lessons are emerging. It is useful to invest in scientific documentation, but also in capturing the tacit knowledge of implementers in Africa. It is time to document learning histories that can complement and give content to the statistics and that help people to understand experiences and the lessons they are learning.

Civil society organizations are crucial in this; they have a role which goes beyond the distribution of interventions. We need to work with civil society organisations and strengthen their institutional capacities. They need to be incorporated in changing the status quo, changing policies and advocate for interventions based on evidence.

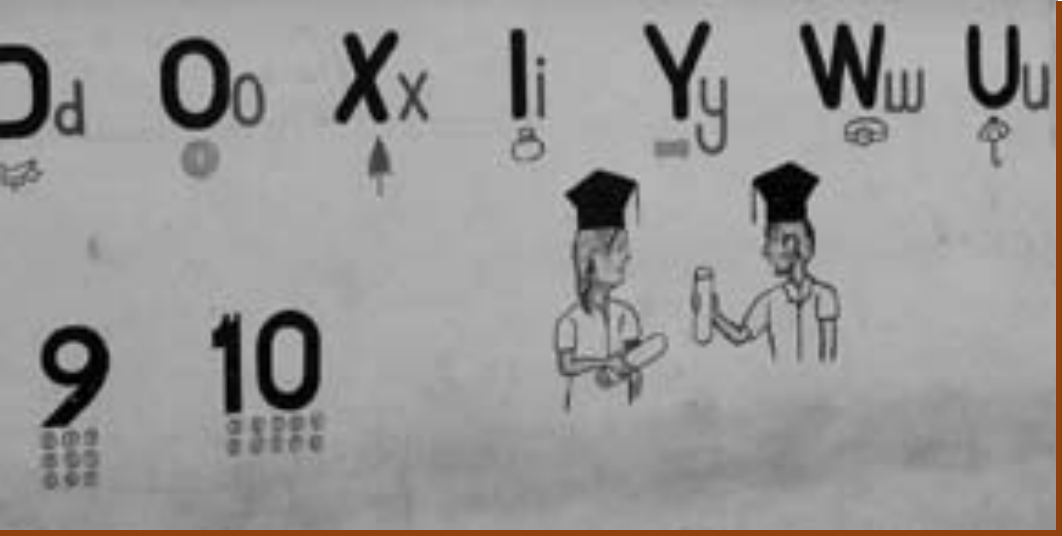


Advisory group 1

Child health and nutrition

The Millennium Development Goals on Poverty, Child Health and Malnutrition (including micronutrients) - *How are they interlinked?*

Chaired by M. Nubé (SOW-VU), B. Brabin (LSTM) and A. Hoogendoorn (KIT).



After a short introduction by the chairman of the workshop, the actual workshop started with a general discussion on the way in which child health and nutrition are incorporated in the MDG's. In the first place, reduction of undernutrition is a development goal in itself. In the second place, and highly relevant within the context of monitoring the achievement of the MDG's, nutritional data (and in particular anthropometrics) are probably one of the best and most readily available indicators on levels and trends in poverty prevalence.

In the remaining time, the main issue discussed related to current child health and nutrition intervention strategies, as promoted, among others, in the Millennium Project, and to what extent current strategies are considered appropriate and satisfactory.

Workshop report on Child health and nutrition

First, it was observed that the morning programme had brought a mixture of both very positive views (eg. presentation by Hans Eenhoorn) and more critical notes (eg presentation by Esther Scheers) with respect to the MDG's and its associated projects and programmes. Within the workshop group, it was expressed that current MDG approaches tend to have top-down characteristics, and there is a serious concern that there is insufficient ownership at the level of implementation and at the level of those directly involved.

In the same line, concern was expressed whether within the context of the MDG's, targeting is always satisfactory. As an example, with the planned large-scale school

feeding project in northern Ghana, there is a serious risk that a highly vulnerable group, adolescent girls, will not or insufficiently be reached, as in poor communities school enrollment of adolescent girls tends to be low. Without addressing nutritional conditions of adolescent girls and young adult women, the problems of poor birth outcomes, such as maternal mortality and low birth weight, will not easily be resolved.

Horizontal versus vertical approaches

These discussions were followed by a more general discussion on respective merits of horizontal versus vertical approaches in health programmes, on the differences between single cross-sectional interventions vis-à-vis long-term structural programmes, with also some specific reference to the so-called Quick Win interventions of the Millennium Project. A typical example are vitamin or mineral supplementation programmes. While *vitamin A* supplementation appears to be almost universally accepted, there is now increasing evidence on the occurrence of zinc deficiency, which may well lead to new supplementation schemes, and finally perhaps a perceived need for multiple micronutrient supplementation programmes. While such programmes might indeed result in further reductions in child morbidity and mortality, for many professionals in the field of development cooperation there would still be a feeling that with such approaches the real problems of poverty and poor health are not being addressed. Similarly, large scale cross-sectional vaccination programs are of course most valuable, but in the end the most important issues are the level of coverage achieved and the sustainability of such programmes. Also, with respect to the various Quick Win approaches, as formulated in the Millennium project, there are concerns that such programmes might compete (in terms of funds, human resources) with other more institutionalized activities. In the end, the workshop participants expressed support for the MDG Quick Win approaches, but only as long as long as such activities are not at the expense of long-term structural development programmes.

Advisory group 2

Safe motherhood, sexual and reproductive health

Chaired by Working group on International Safe Motherhood and Reproductive Health: ***Evidence-based interventions for reducing maternal and child mortality (MDG 4 & 5).***

This advisory group consisted of 6 presentations, each focusing on different aspects of how to reduce mother- and child mortality.

Introduction

(Jelle Stekelenburg, chair; tropical doctor and medical assistant at the University Medical Centre Groningen)

The year 2005 is seen as the breakthrough year in the achievement of the Millennium Development Goals. All presentations focus on important aspects for the reduction of mother- and child mortality which include:

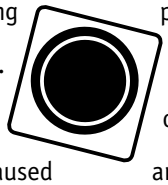
- The reduction of the number of (unwanted) pregnancies;
- World-wide access to a chain of quality prenatal and care during and after delivery;
- The improvement of referral systems.

Cold figures illustrate the need for better mother and child care: more than 10 million children die every year before their fifth birthday, of which three million within the first 7 days. Every year there are 2,7 million stillborns, an event that is closely linked to the quality of obstetric care. Every year 529,000 women die before, during or after delivery. Lifetime risk of maternal death is 1:10 in some areas, and maternal mortality rate in some areas is as high as 1,000 per 100,000 livebirths. Almost all maternal and perinatal deaths (99%) occur in low-income countries. What can we do?

Contraception, family planning and safe abortion

(Douwe Verkuyl, gynaecologist at the Bethesda Hospital, Hoogeveen)

Successful use of contraception will reduce the world-wide maternal deaths of 529,000 a year. No country in the world can handle a doubling of their population over a period of twenty years. The huge population growth in Africa from 200 million in 1960 to 700 million in 2005 is mainly caused by lacking information on, and access to contraception (services). Only in countries with high AIDS prevalence the population growth is halted, however the number of economic dependents rises enormously: 11 million children under the age of 15 in Africa lost at least one parent due to the epidemic. In these countries the need for contraceptive methods exist, but for other reasons than demographic control. There are an estimated 2 million pregnancies of HIV-positive women in Africa per year. This causes the infection of around 600,000 children due to lack of means to prevent vertical transmission.



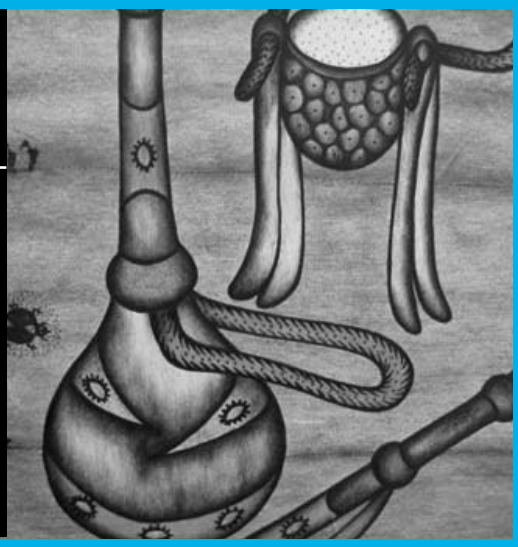
One of the most frequent operations in an African hospital is the emptying of the uterus after an induced, incomplete, septic abortion. Most often the women leave the clinic without proper information about birth control. Sex education and information on schools is a rarity in many African countries. The church directs this responsibility to the parents, while for most parents giving sex education to their children is unheard of. The international community lobbied in Cairo (1994) to declare access to contraception and good medical care after 'back street abortion' as fundamental rights. Unfortunately this failed, not in the last place because of oppression from religious groups (Catholics and Muslims). Thousand of lives could be saved annually and induced abortions prevented, contributing to the Millennium Development Goals, if the Roman Catholic Church hanged her position on the use of modern methods of contraception. It would have a direct effect because most of the dedicated health workers in catholic health facilities would be happy to provide family planning services if so authorised, and catholic schools would be in the position to include some form of sex education in their curricula. Indirectly the change of attitude would remove the association of contraception with sin, prostitution, cancer, racism and HIV which the church managed to generate in people's minds. Policy makers would no longer be worried about their careers or embarrassed when facilitating access to family planning. It is even possible to change the heart will influence policies in Muslim countries like in Somalia, Niger, Northern Nigeria and Yemen where sustainable population increases result in much suffering.

8

Global partnership for development

QW

Health programmes in rural communities



Solitary birth in rural Niger: *a different perspective on Safe Motherhood*

(Gertie Janssen, medical anthropologist), the summary is a short background to the research.

A majority of the women in the villages of south-western Niger give birth without any assistance or attendance. Niger ranks as one of the highest on the world list of maternal mortality, with a ratio of approximately 920 per 100,000 live births. Life expectance at birth is about 44 years and the infant and child mortality rates were 136 and 210 per 1000 live births respectively in 2003. These figures have about doubled due to the drought last year and the locust plague, which followed and consequently led to malnutrition, diseases and famine.

From late 1994 until mid-1996, Gertie Janssen was working in a basic health care project in the districts of Téra and Filingué in the southwest of Niger. The project, by SNV, was supporting and complementing the government health services. I conducted research in 6 villages of the 2 districts, into local perceptions of and behaviour regarding health and illness, in order to see and recommend how the formal health care could best be integrated into this. After subsequently having worked in Eritrea and Botswana for the UNFPA in similar sectors, but very different circumstances, she started further research into solitary births in Niger in 2003 and returned several times to the Téra district for more specific data.

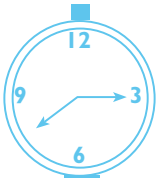
The central question to this medical anthropological research is "Why do women in Téra, Niger, opt for giving birth without assistance and do they fall short of "safe motherhood" for themselves?". In the village of Tondigoungo interviews have been held with more than 40 women and 15 men and a quarter of them have been subject to in-depth interviews. The research is also aimed at the closest clinic in a neighbouring village and the district hospital in Téra. In those settings health care personnel are interviewed and observed in their work and so are TBAs, marabous and healers in the village of Tondigoungo. Pregnant women and mothers are the focus of the research. Their own role in pregnancy and birth is analysed as well as their perspective on safety and motherhood, in which naturally the cultural context and influential people in this context are taken into account. The analysis below is based on the interviews, participant observation and health care data. Following theories of Olivier de Sardan (1982; 1984; 2001), Chapman (2003), Koster (2003), Lock & Kaufert (1998), Biesele (1997), Davis Floyd and Sargent (1997; 1989) factors of influence on solitary birth considered here are: supernatural dangers; the ideal of the courageous and strong woman; dependency and poverty.

Interventions to reduce time to reach the skilled provider

(Luc van Lonkhuijzen, tropical doctor, medical assistant at the University Medical Centre Groningen)

When complication arises during a delivery the success rate of the partum will depend to a great extend on the time that is needed to reach a clinic. There are a number of ways to diminish or reduce the delays in reaching a health facility include:

Maternity waiting homes: these facilities for pregnant women have been recommended since the 1970s. During their pregnancy, women with high risk pregnancies would be selected and referred to a maternity waiting home. Evidence exists on the success of this intervention. Though it can only be useful if support from the family and the community is provided, access to the house is guaranteed, trust in the provided facility exists and indirect costs are taken care of.



Geographical distribution: research on the effect of the location of a clinic is often seen as a given fact. It may also be true that better spreading of clinics results in better access for many. In Nigeria, the access to a number of clinics in a certain district would increase with more that 10% through better geographical distribution. Delay in reaching a clinic is often caused by unequal distribution of the facilities over the country or within districts.

Road improvement: though it might seem logical, ample evidence exists on the effect of road improvement on the positive outcome of deliveries. In Kenya there was only a slight increase in hospital admittance after paving of a road in a certain area. The construction of the road did lead to a reduction of costs, because of increased competition in public transport, though these were considered neglectable compared to the admission rate.

Improving transportation includes the availability and the affordability of means of transport. In Malawi bicycle ambulances were introduced, however did not reap the expected result because of cultural beliefs; in Nigeria taxi drivers participated in an experiment whereby pregnant women could use their services in times of need. Despite this successful programme there was no evidence for an increased admittance of women with complications to the health clinic. In Sierra Leone, a relatively expensive method was introduced: the stationing of ambulances at the referral site and a radio system in the periphery clinics. This resulted in a substantial increase in admittance of women with obstetric complications.

In circumstances where the means of transport are at (relatively) long distance, communication is crucial. A radio system in Malawi resulted in shortening of delay between referral and availability of transport from 3 to 2 hours.

All these methods require sound financing mechanism

and strategies, such as community insurance systems (like in Kenya where more than 25% of the households contributed to such a fund). In Nigeria a loan fund was implemented, with donations from the community. The fund proved to be successful, not documented is whether the fund is sustainable and if the loans are being paid back.

Based on the available literature it is hard to conclude which of the above mentioned interventions is the most effective when it comes in reducing the delay to reach a hospital at the time of an emergency. Measuring the effect of a single intervention is not easy, though very important when it comes to determine which intervention is sustainable, culturally accepted and appropriate, as well as cost-effective.

The influence of HIV and AIDS

(Jeroen van Dillen, tropical doctor, medical assistant at the University Medical Centre Groningen)

Reducing child and maternal mortality are important Millennium Development Goals of the United Nations. In his article the influence of the AIDS-epidemic, which is targeted in MDG 6, on child and maternal mortality is discussed with special reference to Sub-Saharan Africa. In addition, prevention strategies are discussed illustrating the differences between high- and low-income countries.

In 2004 an estimated 3,1 million people died of AIDS, of which 500,000 children under the age of 15. At the end of 2004 more than 39 million people were HIV-infected, of which two-third is living in Africa south of the Sahara. Maternal mortality and HIV/Aids show the same prevalence patterns world-wide. Much research has been done on the influence of pregnancy on the progress of the disease among HIV-positive women. Bad survival rates of pregnant HIV-positive women in low income countries where there no antiretroviral medication (ART) is at hand, is most likely more related to factors beyond the pregnancy itself, like poverty, malnutrition and co-morbidity like parasite infections, anaemia, malaria and tuberculosis.

Most of the estimated 590,000 to 810,000 HIV infections among children are caused by vertical transmission. An estimated 3 tot 10% of the child deaths are AIDS-related; the majority of which (90%) occur in Africa. In southern Africa these figures are as high as 15%. Without ART, about one fifth of the infected children will develop AIDS; in stark contrast to Europe where because of early treatment with ART only in rare cases the progresses to AIDS or results deaths.

Besides mortality and morbidity, the social impact of

AIDS is enormously: an estimated 15 million children below the age of 15 has lost one or both parents to the disease (2003 data), a figure that is expected to be twice as much by the year 2010!.

The best prevention of maternal deaths is good birth control and the prevention of (unwanted) pregnancy. Advice on family planning for HIV-positive women is an important strategy for the reduction of AIDS related maternal and child mortality. Unfortunately, for many women in low-income countries the first contact with health care is during their pregnancy. Important strategies to reduce maternal deaths, and to a lesser extend child deaths, is the promotion of condom use, information campaigns in communities and schools and the introduction of protocols to reduce Mother to Child Transmission. Multivitamin supplements during pregnancy reduce the progression of the disease, which also has an effect on the health status of children (during the period of breastfeeding). A study in 1999 showed that one single dose of ART can result in a reduction of vertical transmission of 47%. One of the main obstacles for the introduction of a sound PMTCT in countries with the highest needs is the poor state of the health system, often worsened by the human resource shortages because of the AIDS epidemic. Thailand and Uganda have successfully reduced the prevalence of AIDS partly because of political will, and extremely important, the allocation of funds towards the introduction of ART. Locally produced ART, like in Brazil and Thailand has been important for the introduction of affordable national PMTCT programmes.

Phase 3 - delay: Audit as a tool to improve quality of obstetric care

(Jos van Roosmalen, Leiden University Medical Centre\ brief summary of the presentation)

Medical or clinical audit? There are many approaches to audit. Almost as many views on how audit should be conducted as there are authors! The audit cycle includes:

1. Observe current practice;
2. Set standards of care (eg. No caesarean section when the fetus already died in the uterus, unless...);
3. Compare practice with standards;
4. Implement change.

There are possible constraints to the successful implementation of audit.

- The scale of resource constraints or inefficiency in resource allocation in the health sector;
- The strong hierarchical structure of the medical profession;
- Poor quality of medical case notes;
- Limited resources to support audit activities.

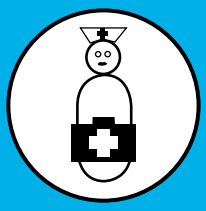
Audit is about improvement of care. Audit is never the sole stimulus to change. The more substandard care, the more need for a audit. “Audit and feedback can be effective in improving professional practice” (Cochrane), “When audit is effective, the effects are generally small to moderate” (Cochrane).

Post partum care

(Marieke Lagro, tropical doctor and medical assistant at the University Medical Centre Groningen)

Postpartum care is an important element in reducing maternal and perinatal mortality.

The postpartum period starts one hour after delivery of the placenta and ends six weeks after delivery. In many countries the recovery period for mother and child includes 40 days which corresponds with these six weeks. The early neonatal period includes the first 28 days of the newborn. The post partum is an important period in the live of the mother and her newborn, not only physically, but also emotionally and socially. The goal of postpartum care is to promote maternal and child health, as well as to prevent and diagnose diseases and complications. Research indicates that few women return for postpartum check-ups, among others because of distance, lack of transport, and lack of knowledge. Postpartum care should be an integral part of mother and child care and family planning. Health workers should be trained in the detection of postpartum complications. Most pregnant women in developing countries visit at least one time a prenatal clinic. This visit can also be used to inform women on the importance of postpartum care. Under ideal circumstances a woman who just gave birth should be monitored for at least 24 hours in a clinic. In many developing countries this is not possible. The WHO recommends a post partum schedule of "6 hours, 6 days, 6 weeks and 6 months". Postpartum care should be an integral part of the care for mother and child after delivery. It should be appropriate to the needs of the woman and should be given by health workers who are trained to detect and treat complications of mother and child. Knowledge alone is not enough: they also need to have the means to treat mother and child. Simple and relatively cheap methods like a clean delivery kit, oxytocine, misoprostol, vaccines and antibiotics can prevent many unnecessary deaths.



Advisory group 3

HIV, AIDS and Tuberculosis

Aids and TB from double trouble to single health in 2015. Coordination by Martin Boeree *(University Medical Centre Nijmegen)* and Lucy Blok *(Royal Tropical Institute)*. Presenters, Kitty Slieker *(Trainee internal Medicine Radboud University, Nijmegen)* and Jan van den Hombergh *(Royal Tropical Institute)*.

Over the past years, we witnessed a philosophy-change from emphasis on sustainable forms of development, capacity building, and allowing countries to develop in their own pace, to a more practical entrepreneurial type of thinking and acting. Old questions remain, such as the question of lacking human resources for health and the absorption capacity of a weak health system with regards to an influx of funds for vertical programmes. How can we reach the unreachable? How can we progress towards the achievement of MDG 6 (to combat HIV/AIDS, malaria and other major diseases, including tuberculosis) and the two supporting targets 7 and 8 (to have halted by 2015 and begun to reverse the spread of HIV/AIDS, and to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases). Two presentations elaborated on the road ahead: the first presentation on HIV/AIDS in Tanzania, delivered by Kitty Slieker, who worked as a medical doctor in Tanzania. The second presentation by Jan van den Hombergh, who focused on his experience in Ethiopia with TB, as it relates to the achievement of the MDG.

How realistic is the achievement of the MDG on HIV and AIDS in *Tanzania*? *(Kitty Slieker)*

Combating HIV/AIDS and to halt the spread of the disease by 2015 is an immense task, and maybe not really realistic. The targets are clear, for tuberculosis this includes the reduction of prevalence in the most affected countries, and for HIV/AIDS to provide ART to at least 75% of the infected. The reality is challenging. Almost an estimated 40 million people (adults and children) worldwide to be living with HIV as of end 2004, of which 25.4 million in Sub-Saharan Africa.

Number of people living with HIV (2004)

North America	1.0 million (540.00-1.6 million)
Caribbean	440.000 (270.000- 780.000)
Latin America	1.7 million (1.3-2.2 million)
Western & Central Europe	610.000 (480.000-760.000)
North Africa & Middle East	540.000 (230.000-1.5 million)
Sub-Saharan Africa	25.4 million (23.4 – 28.4 million)
Eastern Europe & Central Asia	1.4 million (920.000 – 2.1. million)
East Asia	1.1 million (560.000 – 1.8 million)
South and South East Asia	7.1 million (4.4 – 10.6 million)
Oceania	35.000 (25.000 – 48.000)
TOTAL	**39.4 million** (35.9 – 44.3 million)

Estimated number of people newly infected with HIV during 2004

North America	44.000 (16.000-12-.000))
Caribbean	53.000 (27.000-140.000)
Latin America	240.000 (170.000-430.000)
Western & Central Europe	21.000 (14.000-33.000)
North Africa & Middle East	92.000 (34.000-350.000)
Sub-Saharan Africa	3.1 million (2.7-3.3 million)
Eastern Europe & Central Asia	210.000 (110.000-430.000)
East Asia	290.000 (84.000-830.000)
South and South East Asia	890.000 (480.000-2 million)
Oceania	5.000 (2.100-13.000)
TOTAL	**4.9 million (4.3-6.4 million)**

The reality of HIV/AIDS in Tanzania

At the end of 2003 Tanzania had an estimated 1.6 million people living with HIV/AIDS. The HIV/AIDS prevalence rate in Tanzania is 8.8%, which is higher than the prevalence rate of the sub-Saharan African region (7.5%) and the global rate (1.1%). In 2003, an estimated 160,000 Tanzanians died of HIV/AIDS, which is estimated to be the leading cause of death among adults in Tanzania. And the problem is increasing.

The challenge of combating HIV/AIDS in Tanzania is a big challenge. Access to antiretroviral therapy (ART) is quite limited in Tanzania. With over 300,000 people in need of ART, Tanzania is among the 20 countries identified by the World Health Organization (WHO) as having the highest unmet need for ART.

As of June 2005, an estimated 5,500–9,500 people were receiving ART, which represent only 2 to 3% of those in need.

In order to solve the problem, a lot of donor money is needed. And a lot of donors are involved: a large number of donor governments and NGO's provide funding and other support to address Tanzania's HIV/AIDS epidemic. U.S. bilateral aid for Tanzania was $70.7 million (FY2004), an amount which is expected to increase to $108.8 million for the next year (FY2005) a figure that is almost as much as the total budget for health.

An experience from the reality in Igogwe (Tanzania) in the Mbeya region illustrates the reality of a small mission hospital. The hospital was one of the few that could start with HAART, in mid 2005. Through a Home Based Care-programme 1000 people received treatment, but funds are uncertain after 2005.

Problems and challenges

Role of prevention versus HAART: prevention does work but the scale is small, and all money now is targeted to ART. Where does this leave prevention? Is there still room (and funds) available for prevention interventions?

The MDG is mainly targeted towards the spreading of the disease, which clearly indicates the need for prevention.

AIDS = politics, donors = power. Donors have influence, ie on the discussion of the use of condoms. Not always is the role of the donor clear and act according to hidden agenda's.

Different countries, different strategies? Countries differ, therefore we need to be aware of these differences.

Different regions / areas, different strategies? As much as countries differ, within countries there are huge regional and local differences.

What is the effect of vertical programmes and a huge influx of donor money for HIV/AIDS programmes on the rest of the health system? The risk of setting up a parallel system is on the rise and must be faced.

Concluding statement: within the current structure (donors and lack of coordination) the achievement of the MDG will be unlikely.

AIDS and TB, from double trouble to single health in 2015, the MDG effort in *Ethiopia* *(Jan van den Hombergh)*

The Millennium Project's report "Investing in Development" provides recommendations on how the world must immediately and massively increase the investment in health programmes to achieve the Millennium Development Goals (MDGs). This includes AIDS treatment, to improve maternal and child health, to control and treat tuberculosis and malaria, and to make more medicines affordable.

For the health sector, both the Millennium Project and the Director-General of the WHO conclude that investing in proven solutions will turn the tide to help achieve the goals: "We have the means to achieve those goals. We have the technology. What we need are the resources and the political will. We cannot wait any longer to do what we have promised to achieve in the coming decade," (J.W.Lee, DG WHO).

Both the WHO MDG Status Report and *"Investing in Development"* call for:

- A massive scale-up of existing health programmes, and significant new investment

in public health, strengthening health systems and human resources;

- Health strategies to be at the heart of national poverty reduction and development strategies;
- High-income countries to their increase official development aid to 0.7 % by 2015;
- Coordination be strengthened between UN agencies, funds and programmes to support the MDGs;
- Gender, equity and environmental factors to under-pin all health issues, strategies and policies, and special attention to be given to women's and girls health.

The background of TB in Ethiopia (2005)

Ethiopia has 70 million inhabitants; the health service coverage is 61%; 44% of population lives on less than 1$ a day; 3.6% of the GNP is spent on health; WHO-estimated incidence of new cases, all forms = 367 per 100,000; 119,000 new patients were notified in 2004, of whom 40,000 (34%) were AFB smear +.

Ethiopia is among the eight countries identified as pilot countries for the implementation of MDGs and is committed to achieve the MDGs with international assistance. The process started in 2003 with the preparation of the MDGs report, which was launched July 2004 in the presence of high-ranking Government officials and Prof. Jeffrey Sachs, who is a special MDGs Advisor to the UN. Ethiopia is commencing the plan for the third five-year Health Sector Development Programme (HSDP III). It is timely for HSDP to respond to the MDG challenges for the next 5 years in a comprehensive way.

Results of the MDG process in Ethiopia

An MDG Sectoral Needs Assessment Report on Education, Health, Water and Sanitation, Rural Development, Urban Development, Trade, Private Sector and cross-cutting areas such as HIV/AIDS population, and Gender. The many Government initiatives to tackle the health problems of the country, SDPRP, HSDP and strategies such as roll back malaria, prevention of TB, child survival Initiative Strategy, improving maternal health and others have been captured.

The investment plan and the cost estimates (including costing assumptions) to meet the health components of the MDGs are summarized:

- The expenditure at the end of 2015 is estimated at 21,000 billion $ of which USD 8,000 billion is for HIV/AIDS.
- Incremental cost per capita will be raised to 34.6$, while the current per capita* expenditure is 5.60$. The population of Ethiopia is estimated at 70,000,000.

Five steps to reach the MDGs in Ethiopia

1

Information and Social Mobilization for Behaviour change

Decrease in child mortality due to HIV, malaria, diarrhoea diseases

Reduced HIV transmission

Reduced malaria morbidity and mortality

Reversed in HIV incidence and stabilized trend in prevalence

2

Health Services Extension Program

Decrease in child mortality

Reduction in HIV MTCT

40% Reduction of death due to pregnancy

Reduce malaria mortality/ morbidity

Reduce Child malnutrition

Reduced infant and child mortality by two third

First level clinical upgrade

3

Further decrease of:

Child mortality, Maternal mortality

Malaria, morbidity & mortality TB

Reduced malaria mortality by 50%

Increase TB DOTS coverage

Upgrade Emergency Obstetrical Care

4

Further decrease of : Child mortality, maternal mortality and HIV MTCT

Reduced maternal mortality by 75%

Expansion and Upgrade of Referral Care

5

Further decrease of: Child mortality Maternal mortality, HIV MTCT

Provision of HAART, and Management of MDR TB and severe malaria

Goal 6 calls for stopping and reversing the spread of HIV/AIDS, malaria and other major diseases, including tuberculosis. Not surprisingly, all three of these diseases are concentrated in the poorest countries. They could be largely controlled through education, prevention and when illness strikes, for intervention.
Progress on target 7 (have halted by 2015 and begun to reverse the spread of HIV/AIDS) and target 8 (have halted by 2015 and begun to reverse the incidence of malaria and other major diseases) are measured with indicator 23 (prevalence and death rates associated with tuberculosis) and indicator 24 (proportion of tuberculosis cases detected and cured under DOTS (internationally recommended tuberculosis control strategy).

Recommended tuberculosis control target is: to halve prevalence of tuberculosis diseaseand deaths between 1990 and 2015. Progress in TB control is assessed on trends in the prevalence (the number of cases of TB per 100,000 population) and the mortality (number of deaths due to tuberculosis each year per 100,000 population). The implementation of TB control is assessed on the basis of the proportion of estimated

smear-positive cases (those responsible for most transmission) treated under the control strategy known as "DOTS", and the proportion of these cases that are successfully treated.

The 2005 World Summit in New York (September 14-16), marking the 60th anniversary of the United Nations, was the largest gatherings of Heads of State and Government to date, who reaffirmed their pledge to achieving the Millennium Development Goals for 2015. Within their attention to health and development, they made a commitment to:

"Stressing the need to urgently address malaria and tuberculosis, in particular in the most affected countries, and welcoming the scaling up of all efforts in this regard of bilateral and multilateral initiatives"

What do we still need to know? The UN Millennium Project Working Group on TB recommends the following priorities for action in order to achieve this target: 1) Ensure access for all to TB care; 2) Address the TB/HIV emergency now; 3) Engage all primary care providers; 4) Partner with communities to stop TB; 5) Stop the spread of MDR-TB; 6) Accelerate development of new tools; 7) Support the Global Plan to Stop TB.

Questions for discussion

Are the MDGs for health realistically attainable for countries dangling at the bottom of development or poverty indices?

What does adoption of - and focusing on the MDGs change for countries that already implement a SDPRP (sustainable development and poverty reduction programme) and/or a Health Sector Development Plan (HSDP). How large is the potential overlap?

MDGs work with targets and indicators. This implies robust base line data. These are not always sufficiently available. How can then progress, let alone impact be measured?

MDGs do focus on nutrition and infectious diseases but do not address non-communicable diseases, which increasingly affect the same population. Is there a risk that these health hazards are at stake to be further neglected?

There appears to be much emphasis on "more money" if it comes to achieving MDGs.

The attention for complex issues such as absorption capacity, good governance, management capacity development, human resources etcetera seems to be overshadowed or dealt with in vague terms.

MDGs assume that somehow countries manage to receive the required financial inputs, not only through the 0.7%, but also with debt relief, UN funds, WB loans and grants and the Global Fund. However, the flow of these often large amounts of cash, is not at all guaranteed (ref. Global Fund).

TB specific points for discussion

"Prevalence" and "incidence" of TB are difficult to measure. One rather works with estimates, which are varying in preciseness from country to country. Countries with highest TB problems have often least reliable data.

WHO forecasts that in any given scenario the MDGs for TB will not be met in Africa, by and large due to the HIV epidemic.

TB and HIV programmes are overburdened, there is limited staff available for routine tasks, let alone additional tasks. No supportive climate for new hiring or contracting out. How to take up all this scaling up and rolling out?

The TB monitoring and supervision system, though one of the best M& E systems in Ethiopia is deficient. How to accurately document progress, achievements and eventually impact

The Community awareness is lagging far behind, how to catch up?

How to address the absence of an incentive structure, poor remuneration vis a vis large amounts of funding pouring in (WB, GFATM, PEPFAR, WHO)

Interventions are (public) Health Facility based. NGOs are hardly involved and seen with distrust. The same counts for the private sector. How to turn the tide here?

How to ensure adequate central coordination and planning

Questions for the Ethiopian context

Is the existing health policy sufficient and/ or adequate to address all that is needed to achieve the MDGs? If there is a gap, how should it be addressed?

It seems that currently no sector owns Nutrition. In addition, there is no Nutrition Policy.

What should be the human resources for health strategy to achieve the health components of the MDGs?

What are the challenges for the Health Extension Package?

How should health services during emergencies be handled in a way that would not jeopardize the achievement of the MDGs targets.?

What is the role of the various voluntary community health worker/promoters?

What would be the role of the Informal Social Associations such as Idir with regard to social mobilization for behaviour change?

How is the remuneration of health workers to be implemented? Who are included?

Advisory group 4

Malaria

Coordinator: Matthew McCall *(University Medical Centre Nijmegen)* Presenters are Jan Peter Verhave *(University of Nijmegen)* and Ingrid van den Broek *(MSF London)*.

7

Environmental sustainability

QW

Decrease shortage of medical doctors & engineers

Main initiatives in New Guinea, with new emphasis on public health, during the time that WHO considered malaria eradication possible. Young doctors were sent to international courses on tropical medicine and public health.

Lessons of malaria prevention in New Guinea 1952-1962

(Jan-Peter Verhave)

DDT/dieldrin spraying of walls in houses interrupts transmission.

In the euphoric mood of the time trials with DDT were considered superfluous. Dick Metselaar started a trial in a holoendemic area, anyway.

Simultaneously, the behaviour of the exophylic Anopheles was studied, using experimental huts. One needs to know the vector and its behaviour to conduct specific intervention. Mosquitoes were much less exophylic than thought; only then the spraying trial went ahead.

Result was 90% reduction of positive bloodslides and child mortality. Thereafter large scale project, resulting in 58% protection. Dieldrin was much less effective and was abandoned. DDT alone appeared not sufficient to protect the whole population!

Was this due to the vector or to the spraying method? (Rudi Slooff)

It appeared that the necessary lethal contact was not achievable for 100% of the mosquitoes.

Mass drug administration

Prophylaxis needs to reach everybody: medicated salt (Joep Meuwissen), first with pyrimethamine. Reduction of 66%, but followed by increase: resistence! Daarna CQ. Trial in area with enough salt consumption: from 26% to 4%, but small children kept high parasitaemias. Local habits determined relative succes, particularly among people with low salt consumption. Advantage is the uninterrupted development of immunity.
A combination of development, salt consumption, spraying and case detection might have been successful, but international politics prevented the proof of the pudding.

Combination

DDT and CQ prophylaxis (Wim van Dijk) caused a reduction of parasite index from 11 to 2 %. Why not 0%? Problems with total coverage of all buildings, particularly in remote areas, and with continuing maintenance!!

Lessons

- Eradication is not possible in highly endemic areas, and certainly not with one method. Moreover, it should not be aimed at, because of loss of herd immunity.

- Malaria differs from place to place. Behaviour of people and of mosquitoes determine the methods of control. Trials with new methods, before embarking on large scale.

- Young doctors/researchers in the tropics need access to modern literature and exposure to accumulated experience of their predecessors. A new method may sound promising, but will not change the world.

- Trials are scientific; campaigns are less efficacious and require a vision on health care.

- Campaigns require efficient organisation, education, quality and multidisciplinarity, as was done in Papua (New Guinea)

Ref.: J.P. Verhave & H.W.A. Voorhoeve (2005), De Dienst van Gezondheidszorg in Papoea 1950-2000. Uitg. Werkgroep Geschiedenis NVTG & IH

Implementing ACT in the field: Médicins Sans Frontières' experience *(Ingrid van den Broek)*

Malaria remains a major problem. The magnitude is: 300-500 million cases/year; 2 million deaths of which 90% are African children). Malaria accounts for 30 to 50% of the hospital admissions in Africa.

Death is one of the consequences of malaria, other health related results include serious episodes of disease, anaemia, brain damage, developmental delay in children, low (birth) weight, increase in infant deaths. Besides, malaria causes loss of school and work, which in turn have a major macroeconomic in a country.

The best current treatment is ACT (Artemisinin-based Combination Therapy), a combination of drugs that includes artemisinin derivates and extracts of a Chinese plant. ACT proves to be very effective in many places with resistance to the 'old' drugs (Chloroquine, Sulfadoxine-pyrimethamine, Amodiaquine); it is fast-acting, and reduces transmission.

Malaria is the main cause of morbidity in MSF health care projects. In 2004, MSF treated over 1 million cases of P.falciparum malaria patients. MSF started in 2002 the 'Access campaign 2002–2004. Act Now: to get malaria treatment that works to Africa', with the main goal of increasing access to ACT and influence country policies on malaria treatment.

MSF introducing ACT

- Implementation in MSF projects
- Since more than 5 years
- In >30 malaria endemic countries
- Based on biological confirmation of malaria
- Influencing process to change treatment policies of countries and of other NGO's
- Antimalarial drug trials, compliance studies

Example 1

MSF-H embarked on an ACT project in Nchelenge, N-Zambia (a PHC + HIV-project in 6 health centres). The ACT implementation included (from the start 2002): a workshop; provision of drug and RDT supply; supervision and on-the-job training and data monitoring. The evaluation in 2004 showed low use of ACT and low use of RDTs; as well as gave insights on the possible causes for this low use:

Acceptance of new protocol proved difficult, the prescription was irregular and in many instances the monotherapy (SP) was used

There is a need to change the 'mind-set' of healthworkers: malaria needs specific treatment + diagnosis

There is a need for: continuous supervision and training and clear guidelines

Example 2

ACT implementation in Sierra Leone

2000 - End of 10 years of armed conflict

2001- MSF efficacy study (CQ, SP)

2002 - Multi-centric efficacy study (CQ, SP, AQ)

2003 - Study validation, reporting

Timeline ACT Sierra Leone

2004 - Consensus meeting : ACT adopted (AS+AQ)

2005 - Implementation ACT in MSF projects

Global Fund money

2006 - Phasing in of ACT?

Issues related to ACT implementation in Sierra Leone:

- Not only ACT issue, but need to set-up/improve entire health service system.
- Long process to reach consensus on protocol, and now waiting for country-wide implementation.
- Implementation/supply/follow-up depends on NGO's and external funding.
- Treatment efficacy should be monitored: 16% failures at day 28 after AS+AQ (2005).

Example 3

ACT implementation in Burundi (in the rural area of Makamba).

AS + AQ from November 2003 \ Patient-fee 0.15

The study focused on access to AS + AQ, 8 months after implementation, and looked at:

- Health-seeking behaviour and treatment
- House-to-house survey to find recent suspected malaria cases (clinical diagnosis):

Children <5 yrs with history of febrile illness in the last 2 weeks.

Results: the access to healthcare was very low; the cost of treatment 3x higher than advised (in the health centre the average cost AS+AQ was 0.50); and low rate of prescription of ACT.

Issues related to the implementation of ACT

Cost

One of the main issues in addressing to facilitate proper ACT implementation is the issue of cost. It takes less than 1 dollar to CURE malaria.

The MDG Task Force recommended free concluded: "Essential medicines, along with other essential health services, should be provided at no cost to the end user in developing countries".

Recommendations from:

- Global Fund - no further support for failing drugs \ financial support
- WHO/RBM - strongly promoting ACT
- Unicef - committed to ACT
- INGO's - implementing and financing

1

Access

Good drugs available near to the homes, sufficient supply at al levels, production capacity;

Proper healthcare, infrastructure, trained staff, diagnostics.

When working towards the reduction of child mortality, a rapid implementation of ACT needs our commitment to:

- Financing the ACT's that countries demand;
- Improving access to health care;
- Supporting training programmes;
- Supporting development of diagnostics;
- Supporting production of artemisinins.

2

And ensuring that the highly effective drugs that cure malaria are available to the people who need them free of charge.

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3 by 5

Guarateeing women inheritance rights

Advisory group 5

Management & Finance

The Advisory Group was chaired by Jos Dusseljee (ETC Crystal). Presentations were given by Ellen Verheul (Wemos) and Albert Beekes (Public Health Consultants/GEO).

The Millennium Project recommends donors to scale up and improve their financial support to developing countries working to achieve the Millennium Development Goals. The Advisory Group on Management and Finance looked at the practical obstacles for scaling-up and identified what necessary conditions should be met.

Presentation on finance issues: *budget ceilings*

Ellen Verheul explained that the International Monetary Fund (IMF) has for long been criticised for imposing tight fiscal conditions on low-income countries. These conditions include extremely low targets for inflation and budget deficits. Main instrument for achieving these targets are restrictions on government expenditures (budget ceilings), for example on national wage bills and health budgets.

She also explained that the supposed advantages of the fiscal targets promoted by the IMF are controversial. The IMF claims they are necessary to limit inflation and debt accumulation, and thus help achieve economic growth and maintain macroeconomic stability. However, non-governmental organisations such as Oxfam, ActionAid and Eurodad and the United Nations Development Programme (UNDP) point to the negative consequences, not only for the social sectors including health, but also for economic growth. Instead, they argue for more expansionary public policies. Their concerns are increasingly echoed by national Ministries of Health, bilateral donors and the World Health Organization (WHO).

Budget ceilings for the health sector make it difficult to accommodate the inflow of additional funding, while wage bill ceilings leave little room to employ new nurses and doctors or offer higher salaries. Both extra funds and health workers are needed to achieve the Millennium Development Goals (MDGs).

In 2004, responding to the criticism, the IMF announced that it would become more flexible on fiscal targets and help accommodate higher inflows of aid money – provided that donors would commit to long-term, reliable aid and increased spending would not endanger macroeconomic stability. The situation in some African countries suggests,

8

Dept relief

QW

National campaings to reduce violence against women

however, that the IMF is maintaining its conservative fiscal approach. Wemos is documenting the experiences of four countries in which problems with budget ceilings came up in recent years: Uganda, Kenya, Zambia and Ghana. Together with civil society organisations in these countries, Wemos wants to open up the debate on budget ceilings and make decision-making processes more transparent and participatory. Ellen Verheul shared some of the outcomes of the case study in Kenya.

Regarding the report of the UN Millennium Project and the extent to which it is practical, Ellen Verheul concluded that the report recognises the need to "fix" the international aid system in order to make more resources available. Relevant recommendations from the report are:

- Countries should develop MDG-based Poverty Reduction Plans;
- Donor support should be coordinated, harmonised and aligned around these MDG-based plans;
- Donors should increase Official Development Assistance (ODA) to fill the MDG-financing gap;
- Donors should provide long-term ODA commitments;
- Donors should give more debt relief and grants (rather than loans).

Wemos broadly agrees with these recommendations. However, there is a need for further technical and political action. Ellen Verheul gave some specific suggestions for how NVTG-members can be involved, e.g.:

- Helping countries to develop ambitious plans. This can be done by NVTG-members

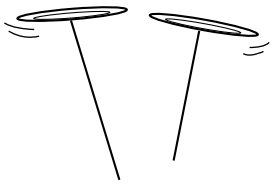
who work as public health consultants and assist national governments in the development of strategic health sector plans;

- Helping countries, more specifically Ministries of Health, to challenge Ministries of Finance and the IMF (instead of taking budget ceilings for granted);
- Supporting calls for further debt relief.

Presentation on management issues: *technical capacity to manage*

But (more) money alone is not the issue. Several countries struggle with limited absorption capacity, i.e. the ability of a country (or an organisation) to use additional funds effectively and efficiently. Consequently, the second obstacle discussed in the Advisory Group were limitations in the technical capacity to manage projects.

Albert Beekes explained shortly the planning and financing structures in Uganda, as example. The explanation stressed that the MDGs had to be fitted into planning and budgeting processes for which the direction was already set.



He explained several consequences of the grants of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for the health sector: re-introduction of verticalisation, adding to the already existing human resource crisis, adding to the administrative burden of health care organisations and weakening systems of decentralisation. In all: threatening the regular system.

Albert Beekes discussed the shift away of the donors from strengthening the public private partnership. Mid-September 2005, the Global Fund-grants to Uganda have been suspended, because of "corruption, mismanagement and incompetence". These problems occurred at the national level as well as at the implementation level.

The related recommendations in *"Investing in Development; a Practical Plan to Achieve the Millennium Development Goals"* presented under *"Fixing the Aid System"* are in fact long-term improvements: improve coordination of donor agencies, develop country-specific

programmes, incorporate new plans into long-term programmes and aim at long–term capacity building.

hhv

The language used in the Practical Plan is optimistic, but the vision is shallow, with a focus on public administration at the national level. The actual goals need to be achieved with the help of the private sector at implementation level.

Albert Beekes ended with recommendations at system level:

- Sufficient adjustment of the Medium-Term Expenditure Framework;
- Discuss sectoral ceilings;
- Integration of Global Fund-activities in the regular health system and at the implementation level;
- Strengthening regular health care organisations with a specific focus on the management capacity of health care organisations.

Assignments for the small groups: Finance

How realistic are the Millennium Project's recommendations for scaling up? That is the question that we should answer today.

Why should NVTG members be concerned about health budgets? Do you see the relevance for your daily work?

The presentation by Wemos resulted in a list of 'conditions to be fulfilled' or recommendations that should be implemented for effective scaling-up. Do you agree with this list? Can you think of any additional conditions or recommendations?

Do you see any linkages to the issues addressed in the presentation on 'management' by Albert Beekes?

What can NVTG members do to put the recommendations into practice? What role do you see for yourself, for example in your daily work?

Which of the recommendations should get priority? Which ones do we want to present to the plenary meeting later today?

Statements for discussion

There is insufficient attention for the impact of international policies, such as economic and trade policies, on health. To achieve good health, MDG 8 (more development assistance, more debt relief and fair trade) is equally important as MDGs 4 and 5 (reduce child and maternal mortality) and MDG 6 (fight AIDS, malaria and tuberculosis).

There is nothing I can contribute to the issues captured in MDG 8. I am a medical doctor and my job is to treat sick people.

The MDGs are achievable and affordable. What is needed now is political will, commitment and concrete action.

Assignments for the small groups: Management

Do you agree with the recommendations given at the end of the presentation? Do you want to Confirm, Reformulate, Remove?

Do you want to make additional recommendations?

Which of the recommendation should get the highest priority?

Statements for discussion

I think that only countries with adequate governance capability should be supported. It is better to focus on "fast-track countries" where good governance systems have been established, than to waste resources on countries that are not yet ready.

I expect the MDGs to be achieved by the year …

The whole idea of specific goals to be achieved by a certain year is wrong. It distracts attention from the long-term efforts to build more sustainable systems in health, and in other sectors as well.

Donor countries should evaluate their development, finance, foreign, and trade policies for coherence with respect to supporting the MDGs. Donors should subject themselves to at least the same standards of transparency as they expect of developing countries, with independent technical reviews.

Resources

Powerpoint presentation: 'Scaling Up for Better Health'. Ellen Verheul, Wemos. October 12, 2005.

Powerpoint presentation: 'From Finance to Management Issues'. Albert Beekes, PHC/GEO. October 12, 2005.

Brochure with an overview of selected reading material on finance and management.

For more information, please contact Albert Beekes (a.beekes@phc-amsterdam.nl) or Leontien Laterveer (leontien.laterveer@wemos.nl).

Recommendations

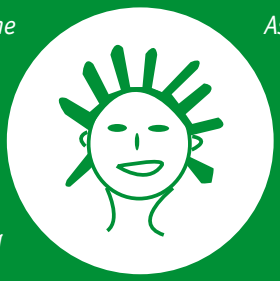
Advisory groups

This last chapter brings together the recommendations from all advisory groups. The discussions were a follow-up of the morning programme, and started with a reflection on the positive and more critical approaches towards the feasibility of achieving the MDGs and ways how to get there.

Recommendations Advisory group on Child Health and Nutrition

The advisory group discussed three issues. The first one related to the place of nutrition in the millennium development goals in a more general way. The group agreed that prevention and reduction of malnutrition is a target in itself. And in relationship to poverty, malnutrition is also a very useful indicator of poverty (e.g. by using anthropometric information on the prevalence of malnutrition in children).

Two other issues were discussed, a somewhat technical discussion on micronutrients in child health; and the third issue related to a possible conflict between population wide approaches (sometimes Quick Win approaches, or sometimes the vertical approaches) on one hand, and approaches which are much more structural in improving the health system on the other.



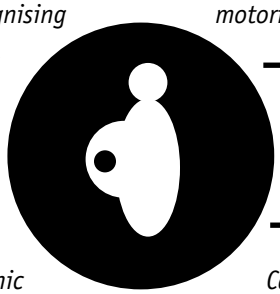
The discussions were a follow-up of the morning programme, and started with a reflection on the positive and more critical approaches towards the feasibility of the achieving the MDGs and ways how to get there. The advisory group was inclined to believe that the MDGs still have a somewhat top-down approach; and emphasises not enough on the need for ownership at all levels. A simple example to illustrate this was given by Dr Brabin who commented on a research he was involved with, a research that included nutritional anthropometry. People of the community objected to the research: they themselves expressed interest in conducting the measurements and become involved. The research was adapted and might not have proceeded as planned, however did result in something more powerful and important: the ownership of the local community in achieving improvement of the nutritional status. Another concern which was expressed by the group was the issue of reaching the most in need. The focus may well be to reach selected groups, be it geographical or a certain age group, however in the end it might show that that this particular group is not being reached. For example the school feeding programmes which are good initiatives, in some cases run the risk of leaving out for example adolescent girls simply because they are not going to school. This ultimately means that we are missing out an important opportunity to reach specific target groups, especially young girls, a group very crucial in getting across information about nutrition and pregnancy.

As said the groups felt that there is some tension between the so called 'one-shot' approaches (magic bullet approaches), e.g. micronutrient supplementation and structural approaches. With respect to micronutrients, Vitamin A is an excepted intervention, but more and more information on benefits of other nutrients (eg Zinc) is available: we even may end up with one multi-micronutrient pill for everybody. In itself this is a good thing to happen, and although it does result in improvements, it seems like we are not really solving the underlying problem. Maybe in a slightly similar way this counts also for a large vaccination campaign, though undoubtedly beneficial, its ultimate success is measured by its coverage and sustainability of the interventions, issues that depend much more on the whole structure of the health system.

Therefore, quick approaches, Quick Wins, maybe be beneficial in many ways, but should not be implemented at the expense of other, more long-term investments. Not at the expense in terms of funds, and not at the expense in terms of human or other resources.

Recommendations Advisory group on Safe Motherhood and Reproductive and Sexual Health

The objective of the advisory group was to list evidence-based interventions for reducing maternal and child mortality (MDG 4&5). The group did include the MDG on child mortality because about 30% of under five mortality is caused by neo-natal mortality which in many cases can be prevented by proper obstetric care. Recognising the complexity, the advisory group intended to keep the discussion simple and therefore did not talk about the need to strengthen health systems, human resources development, poverty reduction strategies, economic development, debt relief, hunger and nutrition, but did focus on a few interventions that more or less, to varying degrees, can help preventing maternal and child deaths. These interventions are:



- *Prevention of unwanted pregnancy and unsafe abortion by universal access to FP services;*
- *Reduce 1st phase of delay (delay that is caused during the decision-making process to seek care in a health institution) by implementing culturally sensitive interventions, closely related to experiences of women in order to have services meaningful so that use will increase;*
- *Antenatal care (WHO-new ANC model);*
- *tTBAs active at community level: a conflictive intervention maybe, but the group concluded that there is there is enough evidence (in literature) to support this statement;*
- *Reduce 2nd phase delay by birth preparedness, motorised transport and communication systems;*
- *Prevention of HIV, short course ARVs, prevention of vertical transmission from mother to their babies (PMTCT);*
- *Universal access to Emergency Obstetric Care (EmOC);*
- *Continuous support to labour;*
- *Clinical audit to improve clinical practice;*
- *Post partum care: clean delivery, active management of 3rd stage , Kangaroo-method, exclusive breastfeeding.*

You might think this is just another business as usual, that might be correct, but on the other hand the list includes many simple interventions that still are not being implemented fully. Last remark on the need for evidence: from going through the literature we learnt that true evidence is scarce and that are still many more opportunities for research on the issue.

Recommendations Advisory group on HIV/Aids and TB

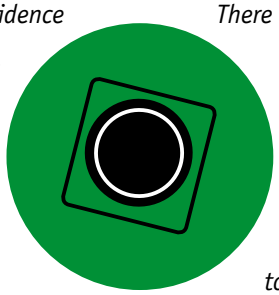
The advisory group focused on HIV/AIDS and Tuberculosis under the theme: HIV/AIDS and Tuberculosis: from double trouble to single health by 2015. The presentations focused mainly on the situation in Africa, where in many countries the goals are probably not being reached. Leading questions were: what does that mean and what can we learn in order to advance on the MDGs.

The double burden was discussed, and among the recommendations we formulated the need for combined efforts. The group wanted specifically to place emphasis on the 'how', at this moment perhaps a more important issue than to focus on the 'what'. Many countries still lack a good strategic plan on how to implement all the evidence based interventions which clearly illustrates this need to focus and support countries with ways to forward on the MDGs. Recommendations:

- *TB cannot be controlled without HIV control and vice versa*
- *Good strategic masterplan combining TB and HIV;*
- *Use of each other's resources and knowledge;*
- *Willingness to learn from each other;*
- *Willingness to come to common approach;*
- *Combine vertical and horizontal approaches.*

The group discussed the risk of just concentrating on these technical issues for HIV/AIDS and TB and therefore there was a call for the general strengthening of the health system. The recommendations also include:

- *General strengthening of the health system;*
- *Linking up with other systems such as education;*
- *Human resources;*
- *Make inventory of the problem;*
- *Continuous training (increase numbers);*
- *Adequate staffing (more staff salaries, tools, supervision);*
- *Multi-task Human Resources.*
- *Involvement private sector, including private health care involvement and corporate involvement.*

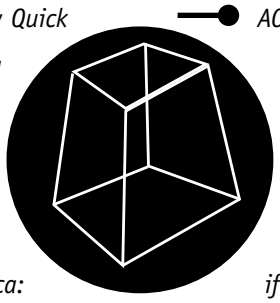


There seems to be a lot of misunderstanding between the public and the private sector. A lot needs to be done when it comes to understanding each other, in order to eventually work together. Both sectors need to find ways on how to work together.

The last recommendation includes the empowerment of community (demand from the population), creating the demand from below so that the top-down funds are being translated into bottom-up decisions on where are the priorities, what approaches can be taken etc.

Recommendations advisory group on Malaria

The advisory group started off with a historical perspective looking at malaria eradication campaigns in Papua New Guinea in the early 1950s and one of the lesions from this is that single approaches may not work on their own. Eg. Just DDT spraying or just treatment failed in both cases, but as combined approaches this worked much better. Despite this important lesson, the discussion in the group focused on just one intervention, the potentially Quick Win of implementation of Artemisinin-based Combination Therapy (ACT) as main line treatment to fight malaria, at least in Africa.



The presentation of MSF illustrated their efforts to implement ACT in various countries in Africa: the trails and tribulations it had in doing so. The discussion afterwards went onto the problems of implementation and came up with the statement that scaling up of the implementation of ACT would be a Quick Win in the reduction of malaria, unless:

- *ACT will be supplied for free. The issue of user fees was discussed and although the current thinking recommends the abolition of fees, one must be careful in doing so, in some cases it was reported that people didn't trust the system because it was for free;*
- *ACT only be supplied after (free) laboratory confirmation of the diagnosis (e.g. rapid test), as preventative means to avoid drug-resistance and unnecessary treatment;*
- *The combination treatment is chosen on the basis of local sensitivity spectra.*

The advisory group was undecided on the issue of the distribution: through official government channels only; or also through NGOs and the private sector. In any case, the local community has to be involved in the implementation of ACT.

It is crucial that ACT has to be implemented as soon as possible; it appears that the sense of urgency is felt more on paper than in practice. Besides, African countries need to be supported in the implementation process: financially and practical.

- *ACT has to be implemented at all levels: hospital, health centres, village health workers; because the effect of the treatment on morbidity and mortality will depend on accessibility (free of costs and with involvement of communities and if necessary private of commercial providers).*
- *Laboratory diagnosis is needed in order to prevent expensive medicines and possible resistance, though it should not become another barrier in the provision of ACT.*
- *The Combination therapy has been chosen based on its effectivity: is important to carefully monitor the effects.*

Finally the group discussed whether ACT can be implemented through the current health channels or not by-pass these and add a vertical system and bring it straight to the people.

Although not all agreed on all aspects of the discussion, the majority concluded that ACT is a good thing and it should be provided free of user charges. It should indeed be given after laboratory diagnosis. What it boils down to is whether you want to use your Quick Win and then in the end lose it due to multi-resistance or other problems or whether you want to invest in longer term solutions as well.

The second main conclusion was that specific ACT for a country should be chosen depending on what the resistance patterns are to the combination medicine to be used.

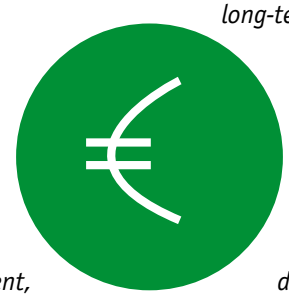
Recommendations advisory group on Management and Finance

General_1

There is insufficient attention for the impact of international (such as economic) policies on health. To achieve good health and strong health systems, MDG 8 (more development assistance, more debt relief and fair trade) is also important, and not just MDGs 4 and 5 (reduce child and maternal mortality) and MDG 6 (fight AIDS, Malaria and Tuberculosis).

To accommodate the inflow of additional funds into developing countries' health systems, both the international aid system (i.e. the way donors do business) and the national level (i.e. absorption capacity) must be improved.

Finance



There is a need to improve fiscal policy and decision-making processes in order to achieve economic policies that respect the right to health. We call for independent, transparent analyses of different economic policy options and a public debate on the economic and social trade-offs of these options. Civil society organizations should be able to participate and give inputs.

There is a role for the World Health Organization (WHO) to advocate for increased health resources and initiate a discussion with the IMF on macroeconomic policies and health. WHO should be strengthened to take-up this role. Donors, including the Dutch government, should maintain their support to this area of work in WHO (instead of cutting back).

Developing countries should develop health plans that indicate what resources are needed as well as existing financing gaps. But money alone is not the issue. Increased donors inflows should be accompanied by efforts to strengthen management capacity at all levels.

In addition to increased development assistance, there is a need for donors to change the way in which they provide aid. Their support should become more long-term en predictable.

Management

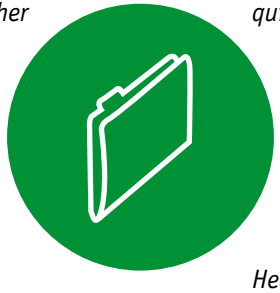
To ensure that country programs are the basis of all donor initiatives, developing countries could establish a donor coordination authority or unit in the Ministry of Health. This unit could report and assess all incoming donor support to see whether it is in line with existing national plans and priorities (e.g. an agreed action framework). We recognise, however, that it may be difficult for countries to say 'no' when huge amounts of donors money are involved.

Related to the previous point: Growing maturity

needed of donors in accepting country programmes as the basis for development activities.

Disease-specific (vertical) programmes and funds tend to put disease-specific targets first, and health system goals next. This should be the other way around.

'Quick Wins' will have to take into account their impact on the regular health system.



General_2

We think that the relevance of the report of the UN Millennium Project lies mainly in the sense of urgency that it communicates (and less in its alleged practical character). The report is a good tool for raising awareness, including on tropical medicine and international health issues.

We think that investing in long-term solutions (including health systems strengthening) is more sustainable than making 'Quick Wins'. But we recognise that there is a trade-off: sick people need quick solutions.

There is a role for NVTG to take up some of the issues that we raised. First of all, we call on the NVTG Board to co-sign a letter to the High-Level Forum on the Health MDGs, November 14-16. The letter is an initiative of Wemos and will be signed by many other (international) health organisations. Secondly, NVTG can initiate health research, for example on the development of a 'health systems checklist' by which we can assess feasibility and expected outcomes of 'Quick Win' proposals, or a study on the 'costs' of uncoordinated donor support.

Epilogue

...the road ahead and the route to take

"The road ahead towards achievement of the Millennium Goals has three lanes", according to Lynn Freedman– coordinator and co-author of the Task Force Report 'Transforming health systems to improve the lives of women and children'. In her presentation she illustrated the importance of social and political movements in bringing about big changes in public health. Furthermore, she emphasises that a conceptual shift is needed which allows us to analyse health systems from the human rights and equity perspective. In that way we can start understanding the relationship between health and poverty. Not only do we need to understand causes, we need to go further and come up with concrete plans for the short-, medium and long-term.

The Congress A Healthy 2015! intended to explore the challenges and the feasibility of the recommendations from the Task Force reports and the Quick Wins. "Our generation can choose to end poverty", says Jeffrey Sachs, chairman of the UN Millennium Project. "...to do it, we need to adopt a new method, which I call clinical economics, to underscore the similarities between good development economics and good clinical medicine. In the past quarter-century, the development economics imposed by rich countries on the poorest countries has been too much like medicine in the eighteenth century, when doctors used leeches to draw blood from their patients, often killing them in the process. Development economics needs an overhaul in order to be much more like modern medicine, a profession of rigor, insight and practicality" (Sachs, The End of Poverty). But how feasible are the Quick Wins and the Practical Plan when looking in detail at the implications of these plans for the improvement of maternal and child health, the reduction of killer diseases like HIV/AIDS, TB and malaria? What is needed in the countries themselves; should they adapt new strategies or adjust national health

plans or programmes? And on the donor side: do they need to invest differently?

1 First of all, the goals are not new: many international and United Nations conferences during the eighties and nineties came up with similar goals and interventions. Many years of experience show us which interventions work; numerous (innovative) technologies are at hand. The only new element perhaps is renewed political commitment, increased interests from the business community and a more business-type approach to development. As one representative from the business community, former CEO of Unilever Hans Eenhoorn puts it: "With less than 150 dollar per person it is possible to achieve the eight Millennium goals. It is our duty as citizens of the world to combat hunger worldwide. We do have the technologies, international will and the financial means. What are we waiting for? The time to act is NOW!"

2 Secondly, increasingly we reach the boundaries of what it means to live in a globalised world. Diseases that were scarce in the developed world do not stop at national borders, illustrated by the recent outbreaks of tuberculosis in the Netherlands. And there we see that we can learn from strategies that were developed and proved to work in developing countries, like the DOTS strategy in the case of preventing and treating TB.

3 Thirdly, with the introduction of any strategy it is important to look at the appropriateness of the proposed intervention. Are we careful enough in examining local practices, traditions and national structures? Is the proposed technology appropriate in a given situation? And additionally, with the introduction of a programme it is crucial to assess the viability of these actions within the health system. Are they strong enough to implement and to sustain interventions?

Lola Dare, drawing from experiences from twenty-four African countries, plead to put human development at the forefront, and to invest in the back-office. "Investing in health and investing in actions that can progress the achievement of the goals requires that we clean up the back office. Which entails striving for more cohesion within and between the tires: looking at the referral, supervisory and support system. A solid health system is needed in order to achieve any of the health targets. In many low income countries it is like pouring water into a leaking basket. It is time to change the basket to solid buckets!" Almost all recommendations from the advisory groups emphasised in their recommendations the same aspect: investing in health

calls for human resource development, calls for strengthening health systems. Fourthly, meeting the global targets has financial implications. If donor countries hold their promises made at the Monterrey 'Financing for development' Conference the amount for international cooperation would mount up to 220 billion dollar. In that case financing of the Millennium Goals would be no problem. Unfortunately the reality is differently; in 2003 contributions summed up to a meagre 69 billion dollar. For the achievement of the Millennium Goals all donor countries should be held to their promise of allocating at least 0.7 percent of the GDP for international development. Furthermore, developing countries need to be put in the situation to deal comprehensively with the debt problems through national and international measures in order to make debt sustainable in the long term. In that way, developing countries can start with narrowing financing gaps between needs and current resources. In conclusion, a few words on the initial question: how practical are the Practical Plan and the Task Force Reports on health? Practical enough was the conclusion of a vast majority of the participants and the main spirit that came out of the advisory group discussions. However, as some of the more critical notes indicated: we must not take the goals as blue-prints, but rather as guidelines that need to be translated locally and nationally. Yet again, most Quick Wins are well-known and proven interventions, like the free distribution of treated bednets for all children in areas with high prevalence of malaria and the abolition of user fees for basic health care. However they can only reap positive health outcome unless we address at the same time underlying causes of poor health and inequity. Some interventions are innovative and some are remarkably simple and cheap: like late-cord clamping, exclusively breastfeeding and kangaroo babies. Some are more complicated such is the case with the qualitative and quantitative shortages of doctors, especially in the rural areas. This underlines the need to work equally and simultaneously on the short-term and the long-term targets. Or to cite Lynn Freedman: "Virtually every report on achieving the MDGs begins and ends by expressing the sentiment that business as usual - even a lot more of business conducted in the same well-worn way – is not enough. The achievement of the MDGs requires true transformation in how we think, how we act, and how we invest. We need both an inspired vision and a practical, a doable plan that includes concrete actions to take in the short-, medium-, and long-term."

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