# INSTITUTIONAL CHANGE IN THE HEALTH SECTOR AND THE MILLENNIUM DEVELOPMENT GOALS[1]

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***Abstract***

This paper first shows that progress in the achievement of the MDGs in general, have been poor, especially in the health sector. Most regions and countries have made some progress but not fast enough to reach the goals by 2015, and even others like the countries in Sub-Saharan Africa are stagnated in several of them, especially in child and maternal mortality. In that sense, it is urgent to try something drastic at global and national levels if we want to reach the agreed goals by 2015.

Second, the revision of the vast MDGs literature developed over the past two years shows that the main constraint for speeding progress is not the money or the availability of technologies or specific interventions in favor of the health MDGs. The key limitation seems to lie on the institutional weaknesses that developing countries show in their public sectors as a whole, and especially in their health sectors. Public health sectors need to step up to show they can make significant progress if more money is allocated to them. They also need to improve their communication with other areas of the public sector because many of the proven successful pro-health MDGs interventions lie beyond the health sector.

Developed and developing countries need to identify institutional strategies that allows the latter to quickly scale up proven successful interventions while at the same time promote the long run development of their health systems. Many important efforts are being developed by international initiatives, but they have been limited precisely by the weaknesses of public sectors in worse performing countries. Institutional strengthening strategies have been developed but they are likely to take time to give results. In this paper I propose a complementary *learning by doing* approach that can strengthen public health sectors while already implementing promising pro-health MDGs interventions. The strategy is based on an intensive use of the power shown by randomized trials to scale up once the interventions have robustly proven to be successful.

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## 1) Introduction

The international community agreed to use the year 2005 as an opportunity to evaluate progress and to reinvigorate the commitment to achieve the MDGs, considering the poor performance shown in the first 15 years. At the current pace, for instance, only South America and the Caribbean would reach the goal of reducing hunger by half[2]. The progress in the health MDGs is also far from encouraging, with health inequalities between and within countries widening[3]. In that sense, many global institutions prepared special reports about the current issues surrounding the MDGs. Among the UN organizations, we have WHO, FAO, UNICEF, the UN Population Fund, among others. In addition, these and other multilateral organizations formed special groups to assess progress and identify global and local policy alternatives to assure reaching the goals in time, such as the Millennium Project. Within the health sector, we have the High Level Forum on Health MDGs that has been meeting once a year since 2003[4].

The general consensus is that, although progress has been lagging in the first fifteen years (since 1990), the MDGs are still achievable, but a much more decisive effort is required from all global, regional and local stakeholders. Moreover, for the health MDGs, there is a consensus that technologies are already available and they are indeed affordable considering the commitments already made by rich countries[5]. The challenge is to identify institutional innovations that can quickly help developing countries implement many of the already identified technologies in favor of the health MDGs at a large scale in a sustainable manner. We need to understand that most of the countries with the worst performance in terms of progress in the MDGs are the ones with weaker institutions, especially those in

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[2] FAO (2005).

[3] See WHO (2005).

[4] The term health MDGs refers to goals 4-6, namely the reduction of child mortality by two thirds relative to the situation in 1990; the improvements in maternal health and the reduction in maternal mortality by two thirds; and the control of the spread of HIV/AIDS, malaria and other diseases.

[5] See, for instance, Vandemoortele (2002).

Africa and others in what has been called *fragile states*, although the issue is actually relevant in most developing countries of all regions.

The document I present here benefits from the contributions of all these documents, but attempts to contribute with a more in-depth discussion of the institutional challenges associated to three aspects of the MDGs challenge: (i) the need to scale up of specific health interventions, (ii) the need for the health sector to assume some leadership for the coordination of interventions beyond the health sector, and (iii) the need to strengthen national health monitoring systems in a way that successful innovations are quickly identified and understood, so they can be replicated in other areas and contexts.

Before proceeding, it would be important to clarify that, although the title suggests a focus on the institutional innovations required in the health sector, the approach followed here is more consistent with a search for the institutional innovations required to achieve the health MDGs. The difference may look subtle considering that all MDGs are clearly related and progress in one contributes to the achievement of the others, but there are some important differences. One of the points that I want to stress in this document is the need to recognize that much of what is important for the health MDGs lies outside the health sector, as is the case of improvements in access to clean water and sanitation, or the empowerment of women. In that sense, what may be required is that the health sector be more capable to lead or coordinate efforts with other sectors to effectively favor the achievement of the health MDGs[6]. On the other hand, we do not stress here about the implications of health improvements upon the achievement of other MDGs such as those associated to poverty and education, for instance, understanding it is not necessary at this juncture to argue in favor of the economic returns or the urgency in health investments.

This document is organized in 4 sections, including this introduction. Section 2 presents a brief overview of the progress made in the achievement of the MDGs, with some especial emphasis on the health MDGs, and also summarizes much of the consensus in the literature around the factors that have explained the slow pace and what is required in

[6] Actually, this is an avenue that the WHO is already following with the formation of a high-level Commission on Social Determinants of Health (CSDH). See CSDH (2005).

general to reach them in time by 2015. Section 3 discusses more deeply two specific topics that relate to the key challenges that should be assumed by the global and national health sectors and related stakeholders to make the MDGs feasible. Section 4 argues for the need of a learning *by doing* type of strategy, that is based on the extensive use of randomized trials, to strengthen public health sectors while implementing promising interventions in favor of achieving the health MDGs. Finally, section 5 presents some concluding remarks.

## 2) How are we doing with respect to the health MDGs?

### 2.1) Progress by developing countries: 1990-2005

Progress in the MDGs has been poor so far with many countries and regions out of track, while others with no change or even worsening conditions, especially in Sub-Saharan Africa. In Figure A. **1**, I reproduce a diagrammatic picture of the progress made by developing countries in the MDGs up to 2004 prepared by the UN Statistics Division, based on data and estimates from different international organizations[7]. Figure A. **1** shows, for instance, that Latin America is the region that has made most progress in most indicators as it is reflected in the number of green boxes. Still, it has shown problems to make progress in certain areas such as the preservation of forests, reduction of extreme poverty, maternal mortality and in providing access to water and sanitation in rural areas. In the other extreme, Sub-Saharan Africa shows by far the worst performance of the eight regions identified in Figure A. 1. For most indicators, the original situation was already the worst and progress has been absent over the past 15 years. Some progress was observed in providing universal access to primary schooling, in equalizing the access to education and literacy by girls, or in controlling HIV but at a rate slower than the one needed to achieve the corresponding Millennium goals.

[7] For more detailed information on the progress in MDGs, review the following UN webpage: http://unstats.un.org/unsd/mi/mi_goals.asp. The reader could also find useful to review FAO (2005), WHO (2005).

Also, some indicators have shown to be more difficult to make progress, especially the provision of water and sanitation in rural areas for which no region has shown positive progress. On the other hand, measles immunization shows the largest number of regions with a positive performance (goal already met, or on track) and only the Sub-Saharan Africa remains stagnant. South Asia has made some progress but is still lagging in immunization. In the case of infant mortality, the performance is most heterogeneous, with regions such as Northern Africa, Southwestern Asia and Latin America and the Caribbean for which progress is on track to meet the Millennium goal while the Sub-Saharan Africa shows no change and the CIS countries have experienced a reversal. The rest of Asia, have shown some progress but largely insufficient.

Concentrating in the health MDGs, Figure 1 shows that progress is particularly negative, especially in maternal mortality and the control of HIV and malaria, and in comparison to the MDGs associated to education and gender equality. Incidence of HIV and malaria remain high and no much progress has been seen over the past decade in most affected areas, especially in Sub-Saharan Africa. In this region, progress in the control of HIV has been important but still far from enough. As indicated above, progress in child mortality has been very heterogeneous across regions. Most countries in Northern Africa, Southeastern Asia and Latin America and the Caribbean seem to be on track but the evolution in the rest of Africa and Asia remain lagging behind. On the other hand, progress in access to health services has been more positive, in immunizations and reproductive health services. In a sense, such patterns are not surprising knowing that health services is only one of the determinants of health and health inequalities for these variables, and that other factors such as monetary poverty and access to sanitary infrastructure play an even more important role.

The analysis with Figure 1 allows us to see regional trends based on the 10 regions defined by the UN, but omits the discussion of heterogeneity of performance within regions. When using country-level data on infant mortality, we can define the relative performance by each country by the ratio of change in the infant mortality between 1990 and 2003 divided by the initial level. With such indicator, I estimate that only 30% of the variability in country performance is explained by these groups, while the remaining 70%

Figure 1: Progress in the Health Millennium Development Goals by 2004

| | Africa 840 million (Population 2002) | | Asia 3,738 million | | | | Oceania 8 million | Latin America & Caribbean 536 million | Commonwealth of Independent States (formerly republics of the Soviet Union) | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Goals and Targets** | **Northern** | **sub-Saharan** | **Eastern** | **Southeastern** | **Southern** | **Western** | | | **Europe** | **Asia** |
| **CHILD MORTALITY** | | | | | | | | | | |
| **Reduce mortality of under-five-years old by two thirds** | on track | very high, no change | progress but lagging | on track | progress but lagging | moderate, no change | progress but lagging | on track | decline | decline |
| **Measles immunization (85% of the population at risk)** | met | low, no change | xxx | on track | progress but lagging | on track | moderate, no change | met | met | met |
| **MATERNAL HEALTH** | | | | | | | | | | |
| **Reduce maternal mortality by three quarters** | moderate level | very high level | low level | high level | very high level | high level | very high level | high level | xxx | xxx |
| **HIV/AIDS, MALARIA & OTHER DISEASES** | | | | | | | | | | |
| **Halt and reverse spread of HIV/AIDS** | threatened | some progress | some progress | some progress | significant increase | threatened | threatened | some progress | significant increase | threatened |
| **Halt and reverse spread of malaria** | continuing threat | pandemic | met | low level | low level | continuing threat | low level | met | low | low |

Source: UN Statistics Division, based on data and estimates provided by World Bank, FAO, UNESCO, UNICEF, WHO, UNAIDS.

of the variability occurs within the regions[8]. Clearly, then, it would be helpful to explore further the trends about which countries were able to do better in terms of the child mortality goal during the past decade. Figure 2 shows that, in general, inequality seems to be rising, as richer countries and those with lower initial levels of child mortality were the ones that showed better performance in the reduction of infant mortality. A similar path is likely reproduced for other MDGs. FAO (2005), for instance, reports the same kind of trend for progress in undernourishment.

The remaining of this section is dedicated to summarize the factors that have been raised in the literature to explain this worrying performance in the achievement of the Health MDGs.

### 2.2) The current global context and perspectives

The challenge to reach the health MDGs clearly demands working on improving national health systems, not only to become more efficient but also to be more sensitive to health inequities against most vulnerable groups such as the poor, women in reproductive age or traditionally marginalized ethnic populations. But the challenge to the health sector does not stop there. The achievement of the MDGs likely requires the health sector to step up and assume some leadership so that more funds are assigned to the achievement of the health MDGs, and that many other anti-poverty and rights-based interventions are coordinated with them to maximize equitable impact.

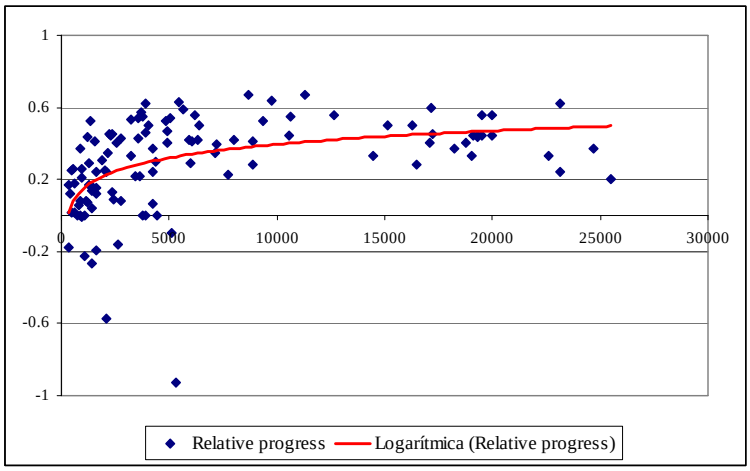
Improvements in health systems are crucial because countries that have shown less or no progress also have very weak institutions in general, and in the health sector. The development of health systems requires work in several areas: stewardship, human resources, health facilities, equipment and drugs, financial resources and management systems (see HLF, 2005). Many proposals have been developed for this purpose[9], but the

[8] I use the decomposition of the general entropy class of inequality indices (GE(a)), for a=2. This specific indicator is equivalent to half the square of the coefficient of variation for the chosen measure.

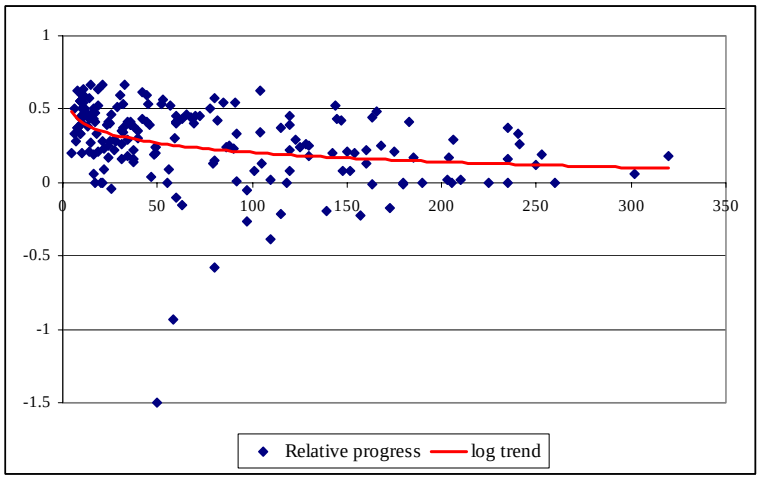
[9] See, for instance, World Bank (2004), chapter 8.

Figure 2: Trends in the relative progress in child mortality

a. per capita GDP (PPA-1993) – 114 observations




b. Child mortality 1990 – 190 observations




Source: UN Statistics Division and WDR, several years.

problem is that most of them take more time, energy and patience than what can be afforded for the MDGs. In that sense, a key challenge for achieving the health MDGs is to identify strategies to implement specific large-scale health interventions that do not conflict with, or even contribute to, the development of an efficient and equitable national health system. Most global MDGs stakeholders agree that current health technologies are sufficient to prevent and cure much of the MDG-related burden of disease, as well as

affordable, but what is withholding progress in the achievement of the MDGs is that poorest countries have ill-formed health systems[10].

The affordability of the available technologies refers to estimates of the costs made by the Millennium Project and the Commission on Macroeconomics and Health (CMH). The Millennium Project have recently estimated that US $ 135 billion a year of Official Development Assistance (ODA) is required annually to achieve the MDGs, a number that would increase to US $ 195 billion by 2015[11]. The most important point is that this amount represent about 0.44% of rich countries' GNP, so that it falls under their commitment to allocate 0.7% of their GNP to development aid. Although affordable, these numbers imply a huge increase in spending by poor countries, something that would be traumatic to most national public sectors and even monetary systems. Within health, the CMH estimated in 2001 that the provision of a minimum adequate set of services would cost between US $ 30-40 per capita, which is huge compared to the current average level of just US $ 8-10 per capita[12].

As already mentioned, the need to increase the funding for the achievement of the MDGs is not minor, but most estimates suggest that the costs are globally affordable, considering the commitments already made by rich countries. The challenge is to find ways to coordinate the efforts of donors, multilateral organizations, governments and other global and national stakeholders so that some positive effect can be reasonably expected (see HLF, 2005.b). This is particularly relevant for countries with fragile states as a result of armed conflict, or some other natural or political disaster, but it also works for many other countries that face political constraints to adopt a decisive strategy in favor of the MDGs.

Clearly, the development of national strategies to achieve the MDGs need to be context specific, based on the alignment with local priorities and health systems[13]. Nevertheless, it is also important to consider several global or regional threats when

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[10] See WHO (2005), Jones et. al. (2003), among others.

[11] See Sachs and McArthur (2005).

[12] See WHO (2005), chapter 5.

defining these strategies. The most important ones refer to: (i) the shortages of health personnel in the poorest countries, and in rural and remotest areas within countries, especially in Sub-Saharan Africa, where the shortage of health personnel is increasingly acute[14], (ii) the issue of drugs patent rights in the context of World Trade Organization (WTO) negotiations and the proliferation of bilateral trade agreements through which poor countries are being persuaded to offer pharmaceutical firms benefits beyond the Doha declaration on the Trade Related Aspect of Intellectual Property Rights (TRIPS) agreement and Public Health[15].

With respect to the shortage of health personnel, it is clear that no health system reform would work without the contribution of doctors, nurses, etc in the areas where infant and maternal mortality, HIV/AIDS, malaria or tuberculosis are most acute. In that sense, it is urgent to work on a global initiative to identify and implement strategies to reduce the shortages of health personnel in Sub-Saharan Africa, a region that is at the same time the one most lagged in progress for the MDGs and also the most affected by the human resources crisis in health. HLF (2004.b) estimates that countries in this region have a doctor/population ratio of 1:5,000-30,000. In comparison, other developing countries have an average ratio of 1:1,400 while the developed world has a ratio of 1:300. The Sub-Saharan Africa region is particularly affected by the high incidence of malaria and HIV/AIDS, which not only affects the health workers but also increase significantly the workload these workers have to assume. Besides this important "push" factor, there are also "pull" factors associated to better economic incentives in the private health sector or even other sectors, as well as the possibility of the most qualified ones to migrate to more developed countries within Africa and even developed countries.

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[13] This aspect is particularly important in not-so-poor countries like many in Latin America, where the MDG agenda seems insufficient, especially with respect to health and education.

[14] See HLF (2004.b). They identify three dimensions of the crisis in human resources in the health sector: (i) shortage of health workers in some countries, especially in Sub-saharan Africa; (ii) maldistribution of human resources affecting poorest remote areas, (iii) low productivity. The shortages are associated to a combination of both "push" and "pull" factors.

[15] See Lanjouw (2003).

Although individual freedom to migrate cannot be limited, it is clear that international coordinated action is required to deal with the health workforce in Sub-Saharan Africa, including identifying mechanisms to compensate countries of origin for their contribution to the health workforce in richer countries. But it is also important to keep in mind that there are important shortages of health personnel within many developing countries outside the Sub-Saharan Africa, especially in remote rural areas[16]. In those areas, the same kind of "push" factors plays a role so it is crucial to work on the innovation of monetary and non-monetary mechanisms to attract health workers to rural remote areas where many poor people live. In that sense, it is important to find ways to equip better the health facilities in these rural areas, not only to increase productivity, but also as a way to improve working conditions of the workers posted in those areas.

The other important global process for the health MDGs is the very active negotiations that are taking place in the WTO and in many free trade agreements that are being negotiated between mainly the US and developing countries. The pharmaceutical industry is pushing hard to make the case that worldwide protection of intellectual property rights is crucial to sustain research for new drugs. At the same time, developing countries have been equally adamant in that those patent rights should not limit their ability to produce or buy lower cost generic versions for local markets (Lanjouw, 2003). Drug prices are one of the major barriers for poor people to access the medicines they need, as they account for 60-90% of household health expenditures[17]. Even though the MDGs are supposed to have resources available given the commitments made by rich countries, it is crucial to deal with the price of drugs as it is always true that more drugs could be purchased the lower the prices.

The dispute started to pay off in the last few years as rich countries, for example, started to earmark funds to finance the purchase of anti-retrovirals drugs for treating AIDs

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[16] The FAO (2005) makes a valid point that the battle for the MDGs will be won or lost in rural areas where most poor people live and where it is most difficult for basic public services to reach. I would say that this statement is especially valid for the health MDGs.

[17] See UK Working Group on Increasing Access to Essential Medicines in the Developing World (2002).

patients in developing countries. Also, an agreement was reached at the WTO meeting in Cancún on the rules to export drugs under compulsory licenses for serving countries that are unable to produce them. These steps, and others, have been positive but the problem has not been really solved yet. Tension will remain as current general rules for compulsory licensing or parallel imports remain complex and uncertain[18]. Another source of tension is the pressure rich countries, are making for developing countries to adopt provisions beyond the WTO minimum standards, in exchange for the negotiation of bilateral free trade agreements. In that regard, for example, countries like Cambodia and Nepal decided not to use the option to have until 2016 to implement TRIPS standards, instead agreeing for a 2007 date. Also, US negotiators are instructed by law to ask for accelerated implementation of TRIPS and to obtain standards of protection similar to those found in US law[19].

In general, there is a consensus that we need to find ways to control the share of the research financing to be covered by poor countries, considering that in many cases their weight in the incentives is small. The UK Working Group on Increasing Access to Essential Medicines in the Developing World also found consensus that some form of differential pricing is required. Lanjouw (2003) offers an interesting proposal based on the reality that pharmaceutical markets are extremely different depending on the disease they are treating. The key difference is between global diseases such as cancer or heart disease, and the set of diseases that affect primarily the poor, such as malaria. For the first group, research incentives appear to be well set based on the demand from rich countries. For the second group of diseases, though, research incentives are weak given the lack of or limited patent protection and the low purchasing power by the poor, and there is an urgent need to increase research in search for new and better drugs. These differences allow for

[18] The current situation is marked by the Doha Declaration on the Trade Related Aspects of Intellectual Property Rights (TRIPS) agreement and Public Health. Under TRIPS countries have to effectively implement a system of patents, although most developing countries have until 2016 to do it. TRIPS also includes a clause under which countries can issue "compulsory licensing" and "parallel imports" to allow poor countries access the drugs they need under certain circumstances and rules. These are the rules that are still complex.

[19] See Lanjouw (2003). It is important to mention that at the same time, these negotiators are told to respect the Doha declaration.

segmentation of markets and different rules for patent protection. For the so called global diseases, Lanjouw proposes to facilitate immediate competition from generic drugs in poor countries, as long as they represent a small portion of global demand. In the case of the diseases of the poor, the idea is to gradually move towards fullest protection as already agreed with TRIPS in order to generate the incentives to increase research. The proposal is very interesting, although it may require further work on the details of the role of increased financing from rich countries for the purchase of drugs for the so called diseases of the poor, especially those associated to the health MDGs. Clearly, some global innovative action is required to lead these or other type of efforts to guarantee access to low-price drugs.

## 3) The Agenda for the next decade: The institutional challenges

The recent MDG literature shows consensus about the availability of technologies and specific preventive and treatment interventions to help achieve the health MDGs. Wagstaff y Claeson (2004) show a list of these interventions identifying the level of evidence supporting their effectiveness for the reduction of child and maternal mortality, improved nutrition, and for the prevention and treatment of HIV/AIDS, malaria and tuberculosis in low-income settings. For diarrhea, the second-leading cause of child deaths, effective preventive treatment interventions include breastfeeding, complementary feeding, zinc and vitamin A supplementation, and access to water and sanitation. For treatment, we can include oral rehydration therapy, antibiotics for dysentery and zinc supplementation. Jones et. al. (2003) estimated that about two-thirds of child deaths could be prevented by achieving universal coverage of proven interventions in an integrated manner[20].

For maternal mortality, Wagstaff and Claeson estimate that about three quarters of current maternal deaths could be averted if universal coverage could be achieved. In this case, key interventions include access to essential obstetric care and safe abortion services,

[20] Integrated strategies include systems such as the Integrated Management of Childhood Illness (IMCI) and the Integrated Management of Pregnancy and Childbirth (IMPAC), which have already been implemented in many countries.

active rather than expectant management in the third stage of labor, and the use of magnesium sulphate and other anticonvulsants for women with pre-eclampsia. Similar situation is expected for treatment of specific MDG diseases with anti-retroviral therapy for HIV/AIDS patients, BCG immunization, or insecticide-treated bednets to prevent malaria.

Clearly, the universal coverage assumption implies significant increases in public health spending, although it is also clear that money is not the only issue and that we need the national health sectors of developing countries to drastically adjust their ways so that these interventions can be applied at a large scale. Wagstaff and Claeson op. cit. show estimates that make it clear that increasing government health spending have impacts only on countries with good governance. One of the explanations for the poor performance of government health spending is the poor targeting that usually characterizes large public health interventions (Gwatkin, 2005). The issue then is that current health systems are not reliable in the poorest neediest countries to handle the substantial increases in health spending required to achieve the health MDGs. Something needs to be done to improve these health systems, but much of the identified reforms take a long time, so the real MDG institutional challenge is to find ways to rapidly scale up specific interventions for the achievement of health MDGs, while favoring, or at least being consistent with the long-run development of health systems.

Finding the required institutional innovations demand a good diagnosis of what is wrong with the current health systems. Lack of access to health services in poor countries is associated to the lack of good infrastructure and well-trained health personnel, especially in rural remote areas. Besides the bad distribution of health facilities, it is always hard to get doctors to work in remote rural areas, and even for filled positions, absence rates are often extremely high. Also, lack of adequate provision of equipment and drugs make it difficult to offer quality health services. But material resources is not the only limitation, as the social distance between health care providers and patients is also a very important factor affecting the quality of services received by the poor. Health systems and personnel are not responsive to the special needs of patients according to their socio-economic status (SES), gender, religion, ethnicity or age.

These failures in health systems have been clear for a while at global and often national levels too, and many solutions have been proposed and tried out along the developing world with different results, none showing to be a panacea. Institutional solutions have included civil service reform, privatization, democratization, decentralization, contracting out, empowerment, participatory methods, user associations, etc. Results have varied and seem to be very context-dependent so that there is not one solution. The World Bank (2004) focuses precisely on finding alternatives for services to work for the poor, with special emphasis on health and education. The general framework is based on the idea that accountability among all actors, citizens/clients, politicians/policy makers, organizational providers and professionals, is crucial for building a successful provision system for the poor.

In the health sector, building accountability is particularly complicated due to informational asymmetries between patient and professional and institutional providers, as well as between providers and insurers. In general, the complexity of the services and the heterogeneity of health needs make it very difficult to standardize the provision of health services in such a way that monitoring by policymakers or patients becomes feasible. Clinical services, for example, demand individually tailored diagnostics and treatment so that monitoring by insurers or policy makers is very difficult. In the case of poor patients, lack of purchasing power is another factor that limits the possibility to base accountability systems on the population.

But not all health interventions are as discretionary as general clinical services, and more importantly, many of the key health MDG interventions have developed into technologies that can now be classified as standardized. Services such as vector control, child immunization, micronutrient supplementation, antenatal screening etc. are pretty standardized now, so that monitoring by policymakers, or directly by the population, is feasible[21]. On the other hand, information and mobilization campaigns for nutrition and sexual behavior and other specific diseases are very discretionary as they need to adjust to specific needs of the population but would still be easily monitored because they do not

[21] See World Bank (2004), figure 8.8.

depend as much of the participation of health professionals. In that sense, accountability for many of the health MDG interventions is potentially achievable provided enough commitment by policymakers or empowerment of the population around the health MDGs. Still, relevant information about the way public money is spent in local areas and connected to health outputs and outcomes would be necessary to make accountable systems prosper.

### 3.1) Innovations for Scaling up: Contracting health services

The relative standardization of health MDG interventions has lead many to propose the use of contracts with non-state agencies as a way to quickly scale up these interventions[22]. Governments can issue management or service delivery contracts to non-state agencies such as NGOs, universities, or even individual practitioners or for-profit firms. Loevinsohn and Harding (2005) identify at least six potential advantages of this contracting for health service delivery strategy:

(i) ensures greater focus on the achievement of measurable results as the contract can include incentives to contractors based on objective an verifiable outputs and outcomes,

(ii) helps overcome constraints that prevent governments from effectively using the resources made available for specific purposes,

(iii) use the private sector's greater flexibility and often better morale to improve services,

(iv) increases managerial autonomy and decentralizing decision-making to managers on the ground,

(v) use competition to increase effectiveness and efficiency,

(vi) allows governments to focus on planning, standard-setting, financing, regulation, etc.

These authors review the results of 10 studies based on different contracting experiences in different settings, and find that contracting with NGOs to deliver primary health care or nutrition seem to be very effective in generating rapid and impressive improvements, significantly more so than equivalent public providers. Their findings are

[22] See, for instance, Loevinsohn and Harding (2005), WHO (2005), Wagstaff and Claeson (2004), among others.

especially interesting because five of the cases studied involved large-scale operations, with million of beneficiaries of health and nutrition interventions in Bangladesh. Also, their findings suggest that contracting can increase coverage in poor remote areas, especially when specific targets are included in the contract[23], and even when contract management appears to have problems (Bangladesh and Guatemala). These results make a good case for contracting-out, despite the limitations of the analysis, which are recognized by the authors themselves.

Although promising, the contracting option should still be treated with care. First, the equity concerns remain as there is evidence that many NGOs tend to work in less remote areas within developing countries. Contracting is also more complicated in the remotest localities as governments have lower monitoring capacity and competition between bidding non-state providers is more difficult to promote. In such contexts, contracts would need to rely more on the organized population for the planning and monitoring of health services, but there is still a lot to learn about what works to promote such participation where it has not existed before and there is a history of social exclusion of important groups of the population.

Second, it is still not well understood what are the political conditions that are required for this alternative to be feasible in a specific country. In many spaces, contracting with non-state providers is fiercely opposed, as it is perceived as a hidden strategy by the government to limit their involvement in the financing of health care. The analysis of the political economy within the health sector, and in general, would help to define the convenience of this strategy. In that regard, starting small with rigorous transparent evaluation strategies could be crucial for giving a chance to this option. Actually, the rigorous evaluation of this alternative would be advisable also on the grounds of resolving the remaining uncertainties about what works best in terms of size, price schedules, etc.

A third aspect that needs to be considered when evaluating the contracting option refers to its implications for the development of national health systems. There is a consensus that any scaling-up strategy better promotes, or at least be consistent, with such

[23] See Bhushan et. al. (2005) for a more in-depth description of the Cambodian case.

objective in the long-run and some have raised the issue that the expansion of contracting-out carry the danger of further weakening health systems by diverting staff and resources to vertical programs[24]. Also, more careful evaluation is needed on the differentiated performance of non-state contractors when the global public financing scheme of health services points towards universal health insurance as opposed to a scheme that relies more on the collection of user fees. The review by Loevinsohn and Harding cannot help us on these questions because the cases studied were too young and none of them considered this specific question. This would be another reason for which the implementation of the contracting-out option should be accompanied with a rigorous evaluation strategy.

Finally, in this idea of scaling up health services, we often see donor money as a rapid solution as it is agreed that the re-allocation of domestic resources implies a complicated long process. Nevertheless, it is clear that such source would often not be available after a few decades. In that sense, the scaling up strategy needs to take donor money as a temporary solution, and needs to define ways for domestic resources to come in as economic growth allows. This would be the only way vertical programs could be inserted in the national health system in a more structural way after a while.

### 3.2) Going beyond the health sector

The literature on the social determinants of health and health equity has made a good case to convince us that health interventions alone would not be able to improve significantly health outcomes unless we also address the other socio-economic and political factors that affects them[25]. Actually the MDG approach clearly recognizes that situation so that it is not by chance that many of them are directly associated to the other five MDGs such as those associated to gender equity, access to clean water and sanitation, nutrition, or education. In that sense, the achievement of the health MDGs requires involvement of all actors of a society and not only of those in the health sector, so that if they want to promote the

[24] See, for instance, WHO (2005).

[25] See CSDH (2005), or WHO (2005), chapter 3.

achievement of health MDGs, health sectors need.to significantly improve their skills for intersectoral dialogue.

First, the health sectors need to negotiate for extra resources for health with the ministries of Public Finance. Sometimes the issue is not only about getting a larger share of public expenditures, as countries need to increase tax collection as a percentage of GDP to afford increases in public health spending[26]. Health sectors need to talk to them in their own language about the urgent health needs, the available solutions, and even the social and economic benefits of public health investments.

But a more active dialogue is also required with other sectors that run programs that affect significantly improvements in health outputs and outcomes. The increasing evidence that interventions that promote gender equity, improve basic infrastructure, education, etc. also affect health has reached the health sector so that many of the interventions run by the health sector now incorporate women empowerment strategies, nutrition, information and education components, etc. In this sub-section, I present evidence that interventions and policies outside the health sector that relate to these issues may have even larger impact on health outputs and outcomes than their health sector counterparts[27]. This evidence is often overlooked by the health literature but stresses the need for the health sector to coordinate with other non-financial sectors if we want to make fast progress with the health MDGs. The list of interventions or policies includes urban land titling in Peru and its effect on fertility, privatization of water companies in Buenos Aires and its effect on child mortality, and conditional cash transfers in rural Mexico and its effect on child health and nutrition.

The idea that promoting gender equity is not only one of the MDGs, but also crucial for the other seven, and especially for reducing child and maternal mortality as well as controlling HIV/AIDS, has long been recognized at different levels[28]. The promotion of gender equity is related to access to some health services, but not exclusively. UNFPA

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[26] See Wagstaff and Claeson (2004), chapter 9.

[27] Given my background and my areas of work, these examples are mostly from Latin Amercian experiences, but I am sure there are many similar ones in other regions of the world.

[28] See, for instance, UNFPA (2005) or United Nations (2005).

(2005), for instance, identifies three key areas of intervention: education for girls and women, reproductive health information and services and women's economic rights[29]. With respect to the latter, in many parts of the world, women are prevented from owning property or even inherit from deceased husbands, acquiring credit or controlling income. In that sense, some of the interventions have inserted features that try to overcome discrimination of women in these regards. One of them is the titling program of urban dwellings implemented in Peru by the late nineties, which incorporated a clause for female partners to be included in the titles issued by the national program, COFOPRI, as a way to empower women and increase their bargaining power within the household[30].

Field (2003) uses a natural experiment that result from the temporal sequencing in the beneficiary areas to identify the effect of the program upon several variables such as the participation of women in the labor market, access to credit and fertility. With respect to the fertility rate, a variable closely connected to the health MDGs although it was not explicitly included as a goal, she finds a very large effect, as beneficiary communities show a fertility rate 22% smaller than control communities. This effect in such a short period is arguably very difficult to imagine for any specific family planning intervention. Field identifies the higher bargaining power of women as one of the key mechanisms that explain this effect together with the improved security of the dwelling which make parents less dependent of their children to guarantee the property of the dwelling.

Another set of interventions that have been widely recognized for its impact on child health and mortality is the improved access to clear water and sanitation. WHO-UNICEF (2005) argues that the effects of clean water and sanitation not only reduce infant mortality but also increase the performance of children in school and of adults in the labor market, as well as allowing people to live longer. The *Water for Life* report presents that the last

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[29] Launching national campaigns on violence against women, promoting women's property and inheritance rights; expanding access to reproductive health care, and ensuring that women participate in policies to promote achievement of MDGs are also among high-impact "quick -wins" identified by the UN Millennium Development project (UNFPA, 2005).

[30] The acronym COFOPRI stands for its name in spanish, Comisión de Formalización de la Propiedad Individual.

decade showed important progress in the access to these basic services but a much stronger effort would be required to achieve the corresponding MDG. It also argues that there are many technologies and interventions available to increase access at a low cost and to promote good practices for its use to improve child health and reduce child mortality.

Experiences in Bolivia and Brazil, for instance, suggest that the use of condominial water and sewerage systems have great potential to improve access to these services in urban settings at a lower cost than traditional systems. Despite this positive experience, the system has not been replicated in other countries. One key factor in the success of this technology is the participation of the community to share the responsibilities of the financing and functioning of the system. For rural areas, many water treatment technologies are available including chlorination, solar disinfection, filters, etc. Information and education about good hygiene practices also play an important role to guarantee positive effects on child mortality and health.

A different alternative for marginal urban settings is the privatization of water companies. Although this option has been widely opposed precisely for its potentially negative health equity implications, Galiani et. al. (2005) uses a robust identification strategy to show quite opposite results for the wide privatization process implemented in Argentina in the early nineties. Indeed, they find not only that the privatization brought about a significant reduction in child mortality, but a clear pro-poor bias as the poorest were the ones that benefited the most from thee improvements in service quality. Indeed, privatization of water provision reduced infant mortality by 8 percent on average, but the effect was of 26% en the poorest localities. The authors argue that the estimated difference is indeed a causal effect since mortality reasons that dropped the most were those related to infectious and parasitic diseases. This result may suggest that we need to keep an open mind about the true effect of this type of intervention, although much more needs to be studied about the conditions required for the privatization process to have this kind of effect. In particular, it is important to analyze the role of the regulatory system and of the incentives for the private firm to increase access and quality of the service to those that were not being served prior to the privatization.

These two examples are very clear in showing that it is possible that interventions outside the health sector can have very large contributions to the achievement of the health MDGs, and there should be many more other examples around the world. Another very successful and publicized type of intervention is the conditional cash transfers programs, which were initially implemented in Mexico with a randomized design that allowed for a rigorous evaluation of its impact on the health and education of the Mexican children in rural areas. This PROGRESA intervention is characterized by the issuance of monthly money transfers to the women of families with children with the condition that they attend certain training sessions on health information, take their children to periodic growth and health check-ups and that they attend school regularly[31].

The studies have shown convincingly that the program increase the use of health services and reduced child morbidity and increase child height among children of the rural areas of Mexico, variables that are directly connected to the health MDGs. Indeed, PROGRESA children 0-5 had a 12% lower incidence of illness as a result of the program, while prime-age adults reported a 19% decrease in sick or disability days. The program also had an effect of the growth of children under five, especially the poorest with more educated mothers, reducing the probability of stunting. An important issue is that the rigorous design of the impact evaluation was crucial not only for the survival of the program to the change of presidential regime, but also for its expansion to urban areas, and latter to other countries such as Nicaragua and Honduras[32]. Nevertheless, with so many components, it is not clear which of them are responsible for these effects. One thing is the contribution of the money transfer, but we do not know to what extent the conditionalities played a role, or the fact that the money was given to the women in the household.

The same way there are interventions outside the health sector that affect child health, the lack of them have also proven to have devastated effects. One example is provided by Paxson and Schady (2005) who present evidence that the macroeconomic crisis of the late eighties in Peru increased the infant mortality rate by 25 per thousand born babies, a 50%

[31] The intervention is now called *Oportunidades*, and has now been expanded to urban areas.
[32] See Villatoro (2005).

increase from the levels of the years prior to the crisis and right after. This huge negative effect was even more dramatic the lower the level of education of the mother, showing that the higher health vulnerability faced by the poor can overturn the impact of any public health intervention if no appropriate public safety net is available.

All these examples surely show the need for the health sector to step up and assume some institutional changes to allow them to improve its communication with the other areas of the public sector, in many cases with a leading role. They need to be more in touch with this type of interventions outside the health sector if the health MDGs are to be achieved. Global efforts such as the WHO Commission on Macroeconomics and Health (CMH) could provide good insights on how to promote inter-sectoral interactions. Also, the new Commission on the Social Determinants of Health may well be a good starting point to prepare the health sector for such a task, although it needs to have an impact at the local levels very soon. Saying it is several times easier than doing it. So, without attempting to cover all aspects, the next section discusses some basic features of a strategy that can complement current efforts of institutional strengthening, while already working on pro-health MDGs innovations.

## 4) Time to move: *Learning by doing* to strengthen public health sectors and improve inter-sectoral dialogue

The discussion in section 3 makes it clear that health MDGs are technologically and financially feasible, with the key limitation being the institutional weaknesses of national health sectors, especially in poorer countries. The revision in sub-section 3.1 showed the consensus that health technologies are already available for significant improvements in child mortality, child malnutrition, maternal mortality, and the control of HIV/AIDS, malaria and TB in poorer countries. Also, the discussion in sub-section 3.2 showed several examples that suggest that there are already proven interventions outside the health sector that can also significantly contribute to the achievement of the health MDGs. Thirdly, commitments already made by developed countries have shown to be in excess of the estimated costs of achieving the MDGs.

With this scenario, and within less than a decade before the key deadline, it is urgent to get even deeper in the international effort to strengthen national health systems, especially those from poorer countries, and with worst performance regarding the health MDGs. Specific measures required vary by region and country, but the international effort can help in at least three aspects: (i) facilitating tools to raise local awareness on the importance and feasibility of the health MDGs, (ii) raise local knowledge of the health technologies available for each health MDG, and (iii) help national health sectors have a stronger voice when talking to the rest of national public sectors.

The United Nations Development Program (UNDP), with the help of other multilateral organizations, has been leading a wide international effort to raise awareness on the MDGs among rich countries and within domestic agendas. The UN Secretary General commissioned the Millennium project that has been working on different aspects of the MDGs. Another example, most pertinent for the objectives of this paper, is the joint WHO-World Bank effort named the High Level Forum on the Health MDGs[33]. However, success to lead towards action has been limited. In less poor countries, such as those in Latin America, the MDGs do not easily match with domestic agendas. In the specific case of the health MDGs, the absence of an explicit goal regarding fertility and the use of modern contraceptives has often times limited the capacity of multilateral organizations to insert the MDGs into the domestic health sector agendas[34]. In the case of the poorer countries, as mentioned before, the key limitation is the weakness of the public sectors, in general, and the health sector in particular. Only strong public health sectors would be able to increase budgets for proven successful pro-health MDGs interventions.

Efforts such as those generated by public health observatories can help institutional strengthening of public health sectors in developing countries. Public health observatories (PHO) started in England as a key strategy to reduce and eliminate broadening health

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[33] Actually, many of the documents reviewed here have been commissioned or sponsored by these kind of initiatives. Similar efforts are sponsored by FAO, IADB, among others.

[34] See, for instance, Benavides y Valdivia (2004) for a discussion of the extent in which public officials and other stakeholders of the Peruvian health sector take into consideration the MDGs when defining their policies and actions.

inequities, and have expanded to other European and some developing countries like Bolivia[35]. PHOs are independent organizations that monitor health and disease trends, evaluate progress by public health agencies, and highlight key areas of action for improving health and reducing health inequalities. Although independent, they usually work closely with policy makers and representatives of the civil society and local communities. As stated in PAHO (2001), this would be a very positive setting for evidence-based policy making, and in that sense also positive for the promotion of national efforts to reach the health MDGs. Unfortunately, strong PHOs are not that common in developing countries, but pro-MDG efforts should coordinate with such networks if they are indeed present.

Although, a sound strategy in normal times would be to first strengthen public health sectors so that they can in turn promote harder the health MDGs within each country, less than a decade from 2015, the urgency of the moment demands some *learning by doing* type of strategy. One in which we strengthen public health sectors while and by getting them into action in favor of the health MDGs. An inspirational example is the way the Mexican PROGRESA program was handled not only to survive a change of political regime but also to scale up, both, within the country and in many other neighboring countries. The PROGRESA program implied an innovation from traditional nutrition, health and education programs based on in-kind transfers towards a conditional cash transfer programs, an option that had significant resistance among different stakeholders within the developing world[36]. Once the program showed positive results on nutrition, health and educational outcomes, it became very popular so that it survive in Mexico the political switch from the regime of the traditional PRI, that had stayed in power for over seventy years since the Mexican revolution, to one led by the conservative PAN. The program also received full support from international agencies and the IADB recently granted its largest

[35] See PAHO (2001).

[36] See Morley and Coady (2003) for a detailed description of the characteristics of the design and implementation of this type of programs, as well as an account of the impact of the program upon the nutrition, health and education of children of children of several countries where they have been implemented.

loan ever to expand the program to urban areas[37]. Moreover, the program has been replicated in other countries of the region such as Honduras, Jamaica, Nicaragua, among others. How did Mexico do it? The answer to this question is of significant relevance for the rest of the developing world to achieve the health MDGs.

A key characteristic of the PROGRESA experience is that it involved from the design a rigorous experimental methodology to evaluate its impact. Selection of beneficiary and control communities was done randomly so that the comparison of the changes in the behavior of treatment and control groups can be attributed to the program. The use of this methodology was very powerful because randomized trials are the best known strategy to avoid common selection biases raised with non-experimental methods[38]. When comparing non-experimental treatment and control groups, we can always suspect that the estimated differences can be affected not only by the features of the intervention but also by observable and unobservable differences in the actors involved in each group. Often times those biases affect substantially the evaluation of the impact of the program making a good intervention look bad or a bad program look better.

Another important feature of the PROGRESA case was that the evaluation of the first round was done by an external institutional evaluator[39]. That decision sent an unprecedented signal of transparency in the way public programs work in developing countries, increasing trust in the results from the different domestic and international agents involved and affected by the program.

Another health-related example of the power of randomized trials to improve service delivery and mobilize resources for scaling up health services is the Cambodian

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[37] See Parker and Teruel (2005). The name of the program was changed to OPORTUNIDADES with the change of regime and the expansion to urban areas.

[38] See, for instante, Duflo et. al. (2004) for a detailed non-technical discussion of the advantages of randomized experiments to evaluate the impact of social programs. It also presents several cases where randomized evaluations have been useful in guiding social service delivery.

[39] The evaluation of PROGRESA was led by the International Food Policy Research Institute (IFPRI) and included researchers from prestigious universities and multilateral organizations such as FAO, the World Bank and the IADB. See http://www.ifpri.org/themes/progresa.htm for a detailed list of the institutions and personnel involved in the evaluation of the first cycle of the program.

experiment. Within a large program to increase coverage of primary health care (PHC), the Cambodian Ministry of Health and the Asian Development Bank (ADB) manage in 1999 to design and implement an experimental evaluation of the impact of different options for contracting private providers for the provision of PHC in rural areas[40]. As discussed in section 3.1, the contracting option has become for many MDG advocates a key element of a strategy to scale up the provision of basic health services. At the same time, though, it does face significant opposition from different social and political groups that fear its negative effects on inequality, especially in environments where proper contract supervision is not feasible. In that context, it is particularly useful to use a randomized trial to evaluate the impact of this innovation over the access to PHC and the health status in a specific environment.

Although the contracting experiment in Cambodia was not designed as cleanly as the PROGRESA one, recent studies have started to show important positive effects. Bloom et. al. (2006) show that contracting led to significant improvements in targeted outcomes such as access to antenatal care by pregnant women, institutional births, vitamin A supplementation of children, among others, and only small, in excess of those observed in government-run health facilities. At the same time, only small differences were observed on important non-targeted outcomes suggesting that improvements in targeted outcomes were not obtained taking advantage of holes in the contracts regarding other important outcomes. Nevertheless, it is troubling to find that contracting also led to lower quality of health care in the perception of those that used the corresponding health facilities. These positive effects are larger than those obtained in other experiences in the developing world[41], and

[40] Two contracting options were analyzed. One was basically a management contract that allowed the private contractor limited flexibility associated to an incentive package (contracting in). The second one was a fully flexible system that allowed the private contractor to hire and fire personnel as well as define providers of goods and services (contracting out). The control group was run under the regular government rules but received the same increment in resources for incentives as the contracting in option. Targets in line with the health MDGs were established for all treatment and control groups.

[41] See Loehvinsohn and Harding (2005). It must be said that such literature review did not find other contracting experience with a randomized experiment.

the government of Cambodia has already expanded the experience beyond the 12 districts considered in the initial pilot phase[42].

Beyond the nature of the two specific interventions discussed here, these two examples show the power that randomized experiments can have these days on strengthening the public sectors and on scaling up interventions that prove to be successful in helping reach the health MDGs in developing countries. For one thing, it shows that robust evidence on the positive effects of a particular carefully designed innovation can take one a long way into the effort of convincing Ministries of Finance to allocate the additional funds required to achieve the health MDGs. With that step solved, funding can come from the Treasury itself or from multilateral organizations. There are several other ways in which randomized pilots can help empower the health sectors of developing countries. The idea of starting with a small pilot rather than a large program may help overcome the opposition of different political and social groups to the proposed innovation[43]. Also, the implementation of the trial with specific goals and incentives does not go unnoticed in the rest of the public sector and also generates a process of alignment around some goals that can help the institution. That was clear, for example, in the Cambodian experiment where the regular MoH personnel openly competed with the contracting options, which implied that the government-run districts also presented large improvements in PHC with respect to the pre-intervention situation, though smaller than their private counterparts.

However, one can easily wonder that if this strategy is such a good idea, why has it not been happening? Actually, it should be made clear that, obviously, I am not the first one to raise the potential of evidence-based policy making[44]. What may be new here is the stronger focus on randomized trials, which imply early involvement in the design and

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[42] The 12 districts covered a population of 1.26 million people (11% of total population in Cambodia).

[43] It may be useful to note here that we are not limiting this approach to new programs, also including changes/innovations to old programs. Clearly, the experimental design will not evaluate the impact of the old program, but of the proposed innovation.

[44] See, for instance, PAHO (2001), The World Bank (2006), Sutcliffe and Court (2006).

implementation of the innovative interventions. It is argued that such approach has an extra advantage because it can help strengthen public sectors while already implementing promising innovative interventions in a specific social environment. And it is particularly appropriate for the current situation of the health MDGs considering the urgency to make progress and the consensus that technologies to make them feasible are already available, though delivery systems need to be adjusted to each specific context. Moreover, the Cambodian experiment shows that this strategy has already started to occur in the context of the health MDGs albeit not as widely as the urgency of the health MDGs demand.

Still, it is clear that MoHs from poorer countries would benefit from getting support from some of the international efforts working now in favor of the MDGs, and in particular those working for the health MDGs. As discussed in section 3.1, initiatives such as the Millennium project and the High Level Forum on the Health MDGs have already contributed in identifying technologies that have proven to work for reducing child and maternal mortality, and the control of malaria, TBC and HIV/AIDS. Still, the implementation of this *learning by doing* strategy requires a diagnosis about which intervention is a priority in each country or region, as well as which are more feasible considering the socio-political structure. Extra work is also required in the design of delivery systems that are most appropriate in each country/region. Actually, these are the instruments that would be tested in the pilot experiments we are promoting, not the technologies as they have already proven to be successful. Finally, some active lobbying may be required to get governments into trying these innovations through an experimental pilot.

Who should be in charge of such work? Such a decision would require negotiations between the different actors already involved in the promotion of the health MDGs, but regional task forces within any of the already mentioned health MDGs initiatives could probably be a proper setting. It would also be useful to find ways for other WHO initiatives to contribute, especially the Health Metrics Network (HMN) and the Commission on the Social Determinants of Health (CSDH). The efforts of the HMN to improve health information systems worldwide would be extremely useful for the design of the data collection efforts required for the proper evaluation of the testing interventions. On the

other hand, the collaboration with the CSDH would help to keep in mind that many of the interventions required for the achievement of the health MDGs lie beyond the health sector, as discussed in section 3.2 of this document.

## 5) Summary and concluding remarks

This paper first shows that progress in the achievement of the MDGs in general, have been poor, especially in the health sector. Most regions and countries have made some progress but not fast enough to reach the goals by 2015, and even others like the countries in Sub-Saharan Africa are stagnated in several of them, especially in child and maternal mortality. In that sense, it is urgent to try something drastic at global and national levels if we want to reach the agreed goals by 2015.

Second, the revision of the vast MDGs literature developed over the past two years shows that the main constraint for speeding progress is not the money or the availability of technologies or specific interventions in favor of the health MDGs. The key limitation seems to lie on the institutional weaknesses that developing countries show in their public sectors as a whole, and especially in their health sectors. Public health sectors need to step up to show they can make significant progress if more money is allocated to them. They also need to improve their communication with other areas of the public sector because many of the proven successful pro-health MDGs interventions lie beyond the health sector.

Developed and developing countries need to identify institutional strategies that allows the latter to quickly scale up proven successful interventions while at the same time promote the long run development of their health systems. Many important efforts are being developed by international initiatives such as the Millennium project or the High Level Commission on Health MDGs, but they have been limited precisely by the weaknesses of public sectors in worse performing countries. Institutional strengthening strategies have been developed but they are likely to take time to give results.

Given the urgency to make progress for the health MDGs, in this paper I propose a complementary *learning by doing* approach that can strengthen public health sectors while already implementing promising pro-health MDGs interventions. The strategy is based on

an intensive use of the power shown by randomized trials to scale up once the interventions have robustly proven to be successful.

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Figure A. 1: Progress in the Millennium Development Goals by 2004

| | Africa 840 million (Population 2002) | | Asia 3,738 million | | | | Oceania 8 million | Latin America & Caribbean 536 million | Commonwealth of Independent States (formerly republics of the Soviet Union) | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Goals and Targets** | **Northern** | **sub-Saharan** | **Eastern** | **Southeastern** | **Southern** | **Western** | | | **Europe** | **Asia** |
| **POVERTY** | | | | | | | | | | |
| **Reduce extreme poverty by half** | on track | high, no change | met | on track | on track | increase | xxx | low, minimal improvement | increase | increase |
| **Reduce extreme hunger by half** | low, minimal improvement | very high, no change | on track | on track | progress but lagging | increase | moderate, no change | on track | xxx | xxx |
| **PRIMARY EDUCATION** | | | | | | | | | | |
| **Universal primary schooling** | met | progress but lagging | met | met | progress but lagging | relatively high, no change | progress but lagging | met | decline | met |
| **GENDER EQUALITY** | | | | | | | | | | |
| **Equal girl's enrolment in primary schools** | met | progress but lagging | met | met | on track | on track | met | met | met | met |
| **Equal girl's enrolment in secondary schools** | met | no significant change | xxx | met | no significant change | decline | on track | met | met | met |
| **Literacy parity between young women and men** | lagging | lagging | met | met | low | lagging | lagging | met | met | met |
| **Women's equal representation in national parliaments** | progress but lagging | progress but lagging | moderate, no change | progress but lagging | very low, no change | very low, no change | progress but lagging | progress but lagging | decline | decline |
| **CHILD MORTALITY** | | | | | | | | | | |
| **Reduce mortality of under-five-years old by two thirds** | on track | very high, no change | progress but lagging | on track | progress but lagging | moderate, no change | progress but lagging | on track | decline | decline |
| **Measles immunization (85% of the population at risk)** | met | low, no change | xxx | on track | progress but lagging | on track | moderate, no change | met | met | met |
| **MATERNAL HEALTH** | | | | | | | | | | |
| **Reduce maternal mortality by three quarters** | moderate level | very high level | low level | high level | very high level | high level | very high level | high level | xxx | xxx |
| **HIV/AIDS, MALARIA & OTHER DISEASES** | | | | | | | | | | |
| **Halt and reverse spread of HIV/AIDS** | threatened | some progress | some progress | some progress | significant increase | threatened | threatened | some progress | significant increase | threatened |
| **Halt and reverse spread of malaria** | continuing threat | pandemic | met | low level | low level | continuing threat | low level | met | low | low |
| **ENVIRONMENTAL SUSTAINABILITY** | | | | | | | | | | |
| **Reverse loss of forests** | | decline | met | decline | small decline | | decline | decline (exc.Caribbean) | met | met |
| **Halve proportion without clean drinking water in urban areas** | met | no change | decline | high access but no change | met | met | high access but no change | met | met | met |
| **Halve proportion without clean drinking water in rural areas** | high access but little change | progress but lagging | progress but lagging | progress but lagging | on track | progress but lagging | low access, no change | progress but lagging | high access but limited change | high access but limited change |
| **Halve proportion without sanitation in urban areas** | on track | low, no change | progress but lagging | on track | progress but lagging | met | high but no significant change | high but no significant change | high but no significant change | high but no significant change |
| **Halve proportion without sanitation in rural areas** | progress but lagging | no significant change | progress but lagging | progress but lagging | progress but lagging | no significant change | decline | progress but lagging | decline | decline |

Source: UN Statistics Division, based on data and estimates provided by World Bank, FAO, UNESCO, UNICEF, WHO, UNAIDS.