

Committee for Development Policy

Policy Note

**Implementing the Millennium Development
Goals: Health Inequality and the Role of
Global Health Partnerships**



United Nations
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DESA

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Foreword

Many developing countries have recently made significant strides towards achieving the health-related Millennium Development Goals. The international community has played an active role and new approaches for development cooperation—the global health partnerships—have emerged, bringing in new actors and additional resources.

But developing countries continue to suffer from their fragile national health systems, undeveloped capacity and insufficient financial resources. There are still large gaps between what has been achieved and what is still to be achieved. The gap must be filled quickly.

The Committee's focus on the persisting inequalities in health is very timely. It is not acceptable that a child has a significantly higher probability of dying before reaching the age of 5 simply because she was born to a poorer family or in a poor country. This Note argues that inequalities, which are severe within and among countries, are of fundamental importance. Inequalities in health have far-reaching effects that determine the health of the poorest and disadvantaged. Furthermore, the prevalence of poor health leads to poor outcomes in most other dimensions of wellbeing, including education and income levels.

Tackling inequalities in health has important implications for the international cooperation for achieving the MDGs in health. Progress in achieving health goals cannot be accelerated and will not be met if the poor and other disadvantaged groups are not reached. The best approach requires that recipient and donor governments take an integrated approach to the health system, giving priority to primary care and the strengthening of the institutional and technical capacities of the system. Global health partnerships (GHPs) should adopt this logic and ensure that their actions do not unintentionally weaken or fragment the national health system. Additionally, relevant development partners should further facilitate and create more flexible legal procedures to allow greater access to low cost medicines and treatments by developing countries.

It is hoped that this Note contributes not only to moving forward the debate on the implementation of the internationally agreed goals on global public health, but also to new insights and directions for international cooperation in a way that maximizes its positive impact on public health.



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Executive summary

This Note examines the extent of health inequalities within and between countries and analyses ways in which global health partnerships (GHPs)—an innovative and important vehicle for international cooperation—can alleviate health inequality so as to support developing countries in achieving internationally agreed goals in health, including the health-related Millennium Development Goals (MDGs).

Health inequalities affect the implementation of the health MDGs directly and that of other MDGs indirectly. Where inequalities are wide and increasing, it is more difficult to achieve the MDGs. In many situations, efforts to achieve the MDGs may increase inequalities, with the better-off in a society benefiting disproportionately.

Although aimed at eradicating specific diseases and mitigating their negative impact in developing countries, GHPs' approaches in recipient countries may not address—and can even worsen—existing inequalities in health. Most GHPs claim to be “pro-poor”, but they do not appear to have specific indicators for their equity aims. In fact, there are concerns about whether anti-poverty and gender-equality approaches are sufficiently integrated into the GHP practices.

International assistance, including GHPs, should be designed to promote equitable progress in health because assuring equitable health outcomes is an effective way of achieving progress in public health at the national and global levels. The main diseases targeted by GHPs are among those suffered primarily by the less well-off, but the impact of the interventions on the disadvantaged depends on the way the GHPs operate and on the social and economic context.

To ensure that benefits reach all, interventions should strengthen the healthcare system and be appropriate to the specific social and cultural conditions of each group. Corrective action needs to be taken with respect to the social factors which determine people's health conditions, as emphasized in the report by the WHO Commission on the Social Determinants of

Health. To measure progress, the aggregate health goal for each country should include explicit health goals in terms of health outcomes for groups defined by income group, region, ethnicity/race, age and gender.

At the same time, GHPs should not ignore the main “killer diseases” in most poor countries—that is, respiratory and intestinal diseases leading to millions of child deaths. It is thus essential that GHPs do not divert resources from other urgent needs, but do bring additional resources to combat neglected diseases.

The international community, including the traditional official donors as well as non-traditional donors, has an important role to play in assisting developing countries in improving the health status of their populations. In this regard, international cooperation for development should, among other things: (i) further facilitate essential access to low-cost medicines and treatments in developing countries, and (ii) improve coordination between disease-specific interventions and general health services to reduce conflicts over human and financial resources.

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Explanatory notes

The following abbreviations have been used in the present publication:

ARI(s)	Acute respiratory infection(s)
ALRI(s)	Acute lower respiratory infection(s)
CIS	Commonwealth of Independent States
COPD	Chronic obstructive pulmonary disease
CSDH	Commission on Social Determinants of Health
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DOTS	Directly observed treatment, short-course
DPT	Diphtheria, pertussis and tetanus
GAVI	Global Alliance for Vaccines and Immunization (or GAVI Alliance)
GHP(s)	Global health partnership(s)
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross national income
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
IFFIm	International Financial Facility for Immunisations
LDC(s)	Least developed country/countries
MDGs	Millennium Development Goals
NGO(s)	Non-governmental organization(s)
ODA	Official development assistance

OECD/DAC	Organisation for Economic Co-operation and Development—Development Assistance Committee
PEPFAR	President’s Emergency Plan for AIDS Relief (USA)
PRSP(s)	Poverty Reduction Strategy Paper(s)
RBM	Roll Back Malaria Partnership
SAP(s)	Structural adjustment programme(s)
SWAp(s)	Sector-wide approach(es)
TB	Tuberculosis
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
U5MR	Under-five mortality rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children’s Fund
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WTO	World Trade Organization

Implementing the Millennium Development Goals: Health Inequality and the Role of Global Health Partnerships

Introduction

Despite progress made over recent decades, health conditions in many developing countries are still unsatisfactory and, in many instances, the health status of their populations remains below that enjoyed by people in developed countries. Global inequalities in health status reflect, to a large extent, the socio-economic disparities that exist between rich and poor countries. Equally, health inequalities are prevalent between or among different socio-economic, ethnic, racial and cultural groups within countries. At the same time, many people in developing countries, particularly in low-income countries, suffer from preventable or easily treatable diseases.

Health inequalities exist not only in terms of health outcomes, but also in relation to the availability of and access to health inputs such as the number of doctors or nurses per unit of population, relevant information, and the quality and types of medical treatment available, among others. More generally, however, inequalities in health status and inputs reflect, among other factors, the levels of income and education that individuals and families command. Simply put, health inequalities are both manifestations and determinants of existing inequalities in various other economic and social dimensions.

Accordingly, and as indicated by the Commission on the Social Determinants of Health, there is an urgent need to improve daily living and working conditions for better health outcomes, and this requires tackling the inequitable distribution of power, money and resources. Inequity in health is shaped by social structure and by processes that need to be changed. “In order to address health inequities, and inequitable conditions

of daily living, it is necessary to address inequities...in the way society is organized.”¹

A relatively recent approach to international cooperation, global health partnerships (GHPs)—alliances among public and private entities—have multiplied recently and become an important presence in implementing internationally agreed goals on public health. Accordingly, actions by GHPs have an impact on health inequalities. Yet there are concerns about whether anti-poverty and gender-equality approaches are sufficiently integrated into GHP practices.

After indicating how inequalities affect the implementation of internationally agreed development goals, and briefly discussing the conceptual considerations taken into account in the analysis, this Note will identify the factors underlining the persistence of inequalities in health. It will then assess the impact of health policies on the internationally agreed health-related goals, including the Millennium Development Goals (MDGs), through the “inequality lens”. Then it will examine whether and how new approaches to development cooperation embodied in the GHPs may have an impact on health inequalities. Finally, it will recommend ways in which GHPs or other approaches of international cooperation can help reduce health inequalities and further assist developing countries to improve the health status of their populations.

Why do health inequalities matter for achieving the internationally agreed health-related goals?

First, good health is arguably the most important precondition of all other capabilities; consequently, health inequalities matter more than most other inequalities: where health inequalities are large, the poor are likely to experience other types of inequalities—for example, low labour productivity and

¹ Commission on the Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (Geneva: World Health Organization, 2008), p. 2 (available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf).

income, low educational attainment and poor access to safe drinking water. Moreover, good health is an intrinsic component of human security.

Secondly, the inequalities in health that exist between the developing and developed worlds demonstrate that health attainments in developing countries remain unsatisfactory, despite successes in terms of national averages. Even in those developing countries with mortality and morbidity patterns similar to those of developed countries, health outcomes remain below those attained in the developed world. A significant share of the population in many developing countries suffers from preventable and/or easily treatable diseases. Gaps in health outcomes also indicate how far the international community still has to go to provide adequate health services for all.

Thirdly, it will be much more difficult to achieve the health MDGs (reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases) without reducing health inequalities—and in some cases it may not be possible to do so, since it is among poorer groups that there is the most need and greatest potential for improvements. Health inequalities within nations—in developing and developed countries alike—are often as great as, or even greater than, inequalities across countries.² In the absence of well-targeted efforts to provide necessary health care services for worse-off groups (such as the poor, people living in remote areas, or a particular gender or ethnic group), achieving a particular average target does not necessarily indicate that living conditions of *all* have improved. It should be recalled that investing in the health of children has life-long significance for production and incomes. Early interventions can also prevent permanent disabilities, providing major social and economic advantages for individuals and society over the long term.

Finally, health inequalities reflect an interplay of cultural, political and economic forces, including the frequency, length and depth of conflicts as well as other severe adverse shocks (natural disasters, for instance) that a country or a region experiences. Development partners need to ensure that

² For example, life expectancy in a part of Glasgow, Scotland, at 54, is below the average life expectancy in India; in the United States, equalizing deaths between African-Americans and white Americans in the 1990s would have averted five times more deaths in the United States than were achieved by medical advances over that period.

their programmes take account of and address existing inequalities. When aggravated, inequalities—not only in health, but also on other fronts—can become a source of social unrest or conflict, which can, in turn, have a serious adverse impact on health. Such considerations go beyond the narrowly focused “efficiency” or “effectiveness” objectives of aid policies.

Conceptual considerations

Health incorporates many aspects of the life of the individual and the structure of society. People and communities have diverse ideas and aspirations about what desirable health outcomes should be at the societal level. Health-related and other relevant concepts and definitions employed in this Note are discussed below.

Equality or equity?

Although sometimes used interchangeably, *inequality* and *inequity* are different concepts. Inequality implies disparities in status, opportunity or treatment, while inequity incorporates an assessment of fairness. This distinction is particularly important in health, where equality among individuals or groups does not necessarily mean achieving the same state of health. There are natural inequalities in health that may not be considered unfair. For example, as people age—both males and females—their health tends to deteriorate, and it would be unreasonable to expect individuals of all ages to have equal health. Additionally, some people are prone to specific diseases, while other illnesses are particular to a specific gender (haemophilia in males, for instance). There are a variety of genetic advantages or disadvantages that need to be taken into account when deciding what an equitable distribution of health is. Equity is, thus, the most relevant concept for determining health policies, rather than equality *per se*.

Achieving complete *equality* of outcomes in health, therefore, may not be a possible or desirable policy objective: *equity* in health seems to be a more relevant objective. Equity in health could be interpreted as consisting of equality in outcomes among groups or individuals who are similar

from a genetic/age/sex perspective. Yet, this is not a sufficient requirement for achieving health equity in a given society, because it can allow large disparities in health outcomes between different groups. For instance, after controlling for certain idiosyncratic individual genetic determinants (such as a higher propensity to having cancer in some families than in others) one could end up with all women equally having poor health, while all men equally have good health. Thus it may be considered desirable to take into account the particular factors pertaining to some people or some groups—by designing and implementing the necessary policies to facilitate better health outcomes in groups that are disadvantaged, so as to reduce the disadvantage. In this regard, it is up to each society or nation to define what it considers as desirable with respect to the distribution of health and what people expect from their governments in terms of achieving those goals. Further examination of these issues is beyond the scope of this Note. Simply put, this Note argues that large inequalities in health outcomes, such as exist in many countries and across countries, are generally undesirable.

Health is multidimensional

A second point of clarification relates to the outcomes with which the Note is concerned. Health is a multidimensional concept incorporating many aspects which may be differently affected by structures and policy. Dimensions of health may include the *quantity* of life (i.e., life expectancy and mortality rates at different ages), as well as factors related to the *quality* of life, such as morbidity, nutrition, and psychological and social well-being. Common measures of health outcomes include mortality rates; the prevalence or incidence of particular diseases; anthropometry; indicators of self-rated health; process indicators such as child immunization coverage; data on the availability or accessibility of healthcare services; measures of health behaviours such as smoking, diet and physical activity, and measures of mental health.

The presence of inequities in one dimension does not necessarily correspond to the existence of inequities in another. For example, a community may have an inequitable prevalence of heart disease across different

ethnic groups, despite equitable access to healthcare services. Depending on which aspect of health is being examined, one may reach different conclusions. It is thus important to be explicit about what outcomes or processes are (or are not) being assessed.

Horizontal inequalities

Thirdly, there is the question of the unit among which inequality is being measured, e.g., among individuals or groups within nations, or among nations. The most common measures of inequality with respect to health are of *vertical* inequality, or inequality among individuals or households, while *horizontal* inequality is concerned with inequalities that may exist among groups—with the relevant groupings depending on the historical, social and economic context. The literature on health inequalities spans inequalities between racial/ethnic groups, or by class (as determined by occupational type), education, income, religion, or geographic area (rural/urban, nations, North/South, etc.). There are often considerable overlaps between these classifications since individuals generally belong to more than one group at any one time. There are also “natural” (as opposed to social) groupings, such as gender and age, which may be associated with differential biological characteristics. Of most concern are those systematic disparities in health outcomes among socially constructed groups which do not have any biological basis and imply inequity as well as inequality.

Evidence of health inequalities

The current state of data collection on health, particularly in developing countries, is not adequate. Analysis, therefore, faces severe limitations. Many countries do not have adequate capacity for collecting data on health. Owing to financial and administrative constraints, only a few low-income countries are able to maintain death, birth and disease registries. Censuses and vital registration systems are non-existent in many countries. Even when survey data are available, their validity—i.e., measuring what they are

supposed to measure—is sometimes questionable, due to the crude tools and methodological approaches employed.³

Because of the problem of the lack of availability and reliability of data on health, the data presented here should be considered preliminary. Despite these limitations, the available data do provide enough information on the health status of the population. Monitoring changes in health status and inequalities within a population over time allows policy makers to devise health policies to advance public health status and to enhance equity.

Defining the appropriate groups within a given country is an important consideration when examining health inequalities. Groups should be established according to the objectives of the analysis being made. Yet, as mentioned before, groupings interact and overlap with each other, making it difficult to single out the impact of a given intervention on the health status of a particular group. Geographic location is a case in point. Geography is often considered as a factor underlining inequality, but it can also be a proxy for differences across ethnic or religious groups in some countries. In such cases, the concentration of people sharing the same ethnic or religious background in a given region may be a factor contributing to inequality (between that region and the rest of the country), besides location and/or difficulty of access. Additional information is thus needed to distinguish the effect of each factor on the outcome, in order to identify what additional policies or interventions should be introduced to increase equality.

The health status of the population reflects many aspects of the social and natural environment in which “people grow, live, work and age”⁴. Some aspects can be local, such as traditional social norms and hierarchy, while others are global. In general, socio-economic inequalities, such as in economic status and educational achievements, are critical determinants of health inequalities. Climate change—changes in atmospheric environment at the global level—has also recently been recognized as a significant and

³ Attaran, A, “An Immeasurable Crisis? A Criticism of the Millennium Development Goals and Why They Cannot Be Measured”, *Plos Medicine*, vol. 2, issue 10 (October 2005), pp. 955-961. (PLoS Med 2(10): e318. doi:10.1371/journal.pmed.0020318).

⁴ Commission on Social Determinants of Health (2008), op. cit., p. 42.

emerging threat to health.⁵ Equity (or inequity) in health is fundamentally determined by the global and national structures of social and economic hierarchy and the socially created conditions that dictate health as well as geographic factors.

As mentioned in the previous section, a single indicator cannot capture the multi-dimensionality of health, and an array of information about health status and health system inputs must be analysed carefully to assess health inequalities and their trends over time. Moreover, different indicators often lead to different—even contradictory—assessments when monitoring changes in inequality status over time.

In addition, it is important to select appropriate statistical methods to measure the extent of inequality and to assess changes over time. The magnitude of health inequality across different social groups can be summarized by, for example, calculating ratios or rate differences (e.g., between the average or top quintile and lowest quintile), or more complex numerical manipulation of data to characterize the degree of inequality of health status (e.g., the Gini coefficient⁶ and generalized entropy). Choices are numerous, and there may not be an objective criterion *a priori* that can be used to select a particular approach or a specific indicator for a specific purpose.

Health inequalities across countries

Large inequalities in health exist between the developing and developed countries, not only in health outcomes, but also in the supply of healthcare services and how such services are financed by public and private agents (*see table 1*). It is well known that disparities in health outcomes, such as differences in under-five mortality rates and life expectancy at birth, are wide between these two groups of countries. Disparities are also considerable in the amount of resources devoted to health—both in absolute and relative terms

⁵ Confalonieri, Ulisses et al., “Human Health”, in M. L. Parry et al. (eds.), *Climate Change 2007: Impacts, Adaptation and Vulnerability: Working Group II Contribution to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change*, Cambridge, UK, Cambridge University Press, 2007, pp. 391–431.

⁶ The Gini coefficient is a measure of statistical dispersion, commonly used as a measure of inequality of income or wealth distribution. See box 1, below.

Table 1
Health disparities among countries

Country groups by income level	Life expectancy at birth in years (2006)	Under-5 mortality rate per 1,000 live births (2006)	Total expenditure on health as percentage of GDP (2005)	Private expenditure on health as percentage of total expenditure on health (2005)
Low income	59	110	4.6	74.1
Lower middle income	71	35	4.8	55.1
Middle income	69	26	6.6	46.8
High income	80	7	11.2	39.9
World	65	71	8.60	44.0

Source: United Nations, Department of Social and Economic Affairs (UN/DESA), based on World Health Organization, *World Health Statistics 2008*, WHO, Geneva, 2008.

as well as in terms of the share of health expenditures that are financed by individuals. Low-income countries can only afford to spend a small portion of their total income on health, and their populations have to cover a large share of their medical expenses out of their own pockets. These facts demonstrate that health attainments and services in developing countries remain unsatisfactory, despite successes achieved on many fronts.

Inequalities within countries are considerable, and are frequently associated with inequalities in income (*see box 1*). Table 2 shows the range of inequalities in under-five mortality rates in developing countries. In virtually every country, children born in poorer families are facing a higher probability of dying before reaching age 5. Not surprisingly, a similar pattern is observed across different levels of educational attainment of the mother because wealth and education levels are positively correlated. Children whose mothers have lower educational attainment are less likely to survive to age 5.

Developed countries also show health inequalities across different levels of educational attainment. In Europe, health inequalities vary considerably across educational attainments; in all countries education levels are statistically significant in explaining health inequalities. For example, in the Czech Republic, Hungary and Poland, the ratio of death rate (i.e., the ratio of total deaths to total population in a group or community) between

Box 1

Linkage between health and income inequalities

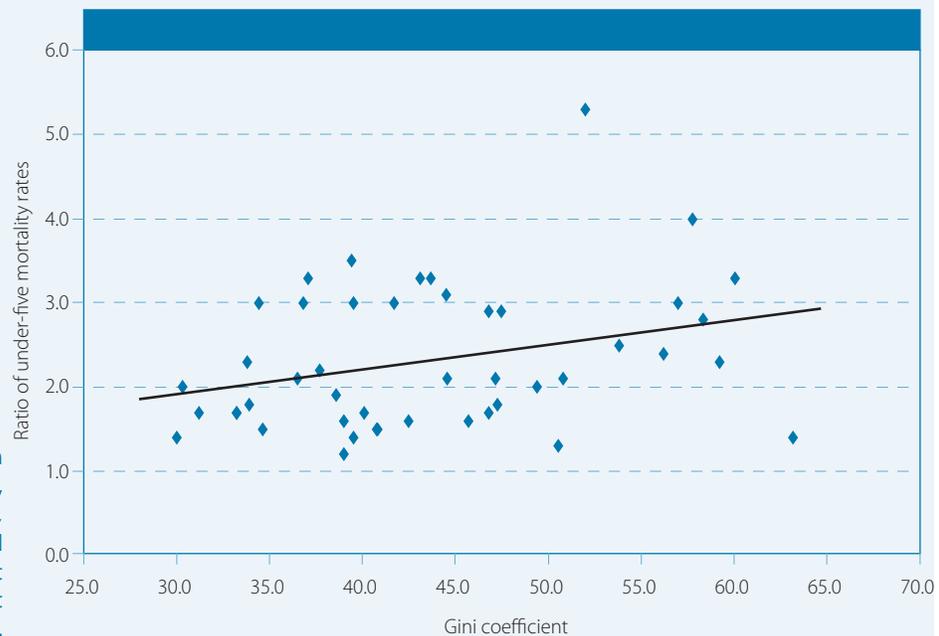
The scattered diagram below depicts relationships between the Gini coefficient of income distribution (the horizontal axis) and the ratio of under-five mortality rates (U5MRs) between lowest and highest wealth quintile (the vertical axis). The higher the Gini coefficient, the more unequal the income distribution becomes, while the higher the ratio of the two U5MRs, the more unequal the health outcomes are.

The diagram shows a weak positive correlation between the two measures, indicating that when income distribution becomes more unequal, health inequality worsens.^a A similar relationship between income and health inequality can be observed when employing other measures of income inequality, such as the share of income held by the bottom deciles in total income. In this case, however, the correlation is negative: the lower the share the higher the U5MR.

The existence of a correlation between income and health outcomes indicates—to some extent—that, on the one hand, reducing the income gap cannot

a Correlation coefficient is -0.203. If Peru, an outlier, is removed from the sample, it becomes -0.166.

Gini coefficient and ratio of under-5 mortality rates between lowest and highest wealth quintile



Sources: UN/DESA, based on World Health Organization, *World Health Statistics 2008*, (Geneva: WHO, 2008); and World Bank, World Development Indicators Online (available at <http://web.worldbank.org>).

Box 1 (cont'd)

be achieved without improved distribution of (and better) health outcomes, and, on the other hand, that health inequality relates to income inequality. Lower disposable income restricts discretionary (and sometimes necessary) spending on health care (and other social items), leading to ill health or disability for various durations of time and, consequently, lower labour income.

This correlation between income and health suggests the need for a comprehensive socio-economic policy package to reduce inequalities. Investment in human capital through education, and healthcare provision by government can help to enable people, particularly the poor lacking adequate access to services, to realize their full productive potential.

Table 2
Distribution of ratio of under-5 mortality rate between two different socio-economic groups in developing countries

Number of countries		
<i>Ratio of the lowest to the highest quintile</i>	<i>According to wealth</i>	<i>According to education of the mother</i>
1-2	26	23
2-3	15	33
3-4	12	5
4+	2	0
Total (number of countries)	55	61

Source: World Health Organization, *World Health Statistics 2008*, WHO, Geneva, 2008.

the lowest and highest quintiles of educational attainment of the mother is more than 4, while in Belgium, Denmark, Norway, Spain and Sweden the ratio is under 2.

Health inequalities are also present between males and females across countries. It is well known that females have a higher life expectancy at birth, irrespective of income levels (*see table 3*). Nevertheless, differences of life expectancy between the sexes become less pronounced when health-adjusted life expectancy is estimated, because women are prone to be unhealthy for longer periods of time before they die. However, gender-based health gaps can also be observed owing to the strong preference for sons in some countries (*see table 4*). The preference for sons is deeply rooted in

Table 3
Life expectancy and healthy life expectancy at birth

Years						
Income group countries	Life expectancy (2006)			Healthy life expectancy (2002)		
	Male	Female	Difference	Male	Female	Difference
Low income	58	60	2	50	50	0
Lower middle income	69	73	4	60	63	3
Upper middle income	66	73	7	60	66	6
High income	77	82	5	69	73	4

Source: World Health Organization, *World Health Statistics 2008*, WHO, Geneva, 2008.

Table 4
Infant mortality rate, 2006

Deaths per 1,000 live births			
Region ^a	Male	Female	Both sexes
African region ^b	100	87	94
Region of the Americas ^c	19	16	18
South-Eastern Asia region ^d	52	51	52
of which:			
India	57	58	57
Europe ^e	15	12	14
Eastern Mediterranean region ^f	66	57	62
Western Pacific region ^g	18	22	20
of which:			
China	17	24	20

Source: World Health Organization, *World Health Statistics 2008*, WHO, Geneva, 2008.

a According to WHO regions.

b Excluding the countries in Africa listed in note f/ below.

c Countries in Latin America and the Caribbean plus Canada and the United States of America.

d Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

e Eastern and Western Europe and CIS.

f Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen.

g Countries in Asia and the Pacific, excluding countries in Asia listed in note d.

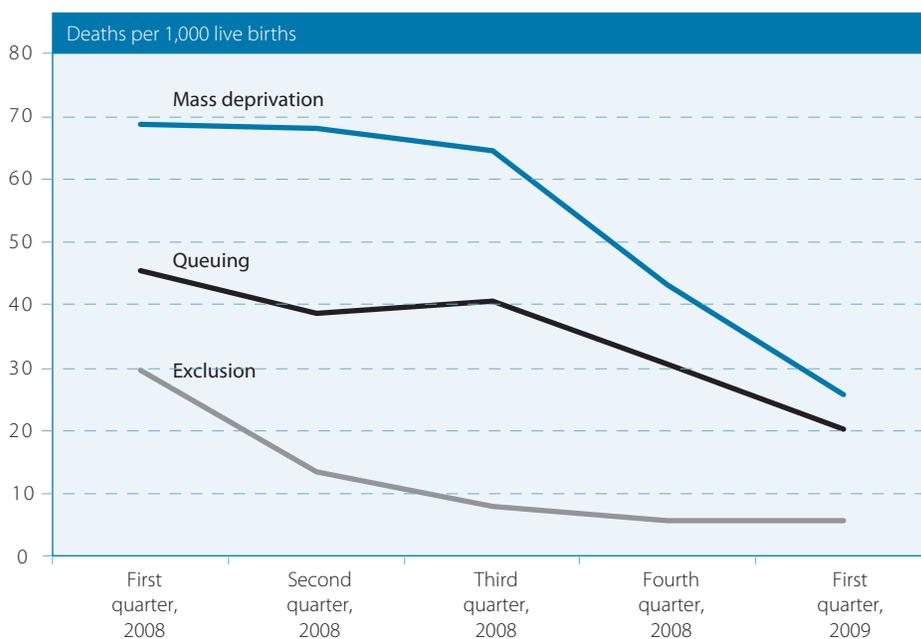
a few Asian countries, notably China and India, both of which have lower infant mortality rates among males than among females. Females generally have a lower infant mortality rate than males in other parts of the world and the rest of Asia.

Patterns of inequality

One useful way to assess inequalities is by visually plotting data. Health distribution trends are varied, but could be grouped into three main patterns, as illustrated in figure 1:

- (i) “mass deprivation” is when the majority of the population has broadly equal but very limited access to healthcare services, while a small privileged class finds ways to obtain high levels of care;
- (ii) “queuing” is where general access to health services is better than in case of mass deprivation, but middle-income and upper-income groups benefit most, while poorer groups still suffer; and,

Figure 1
Under-5 mortality rates across wealth quintiles



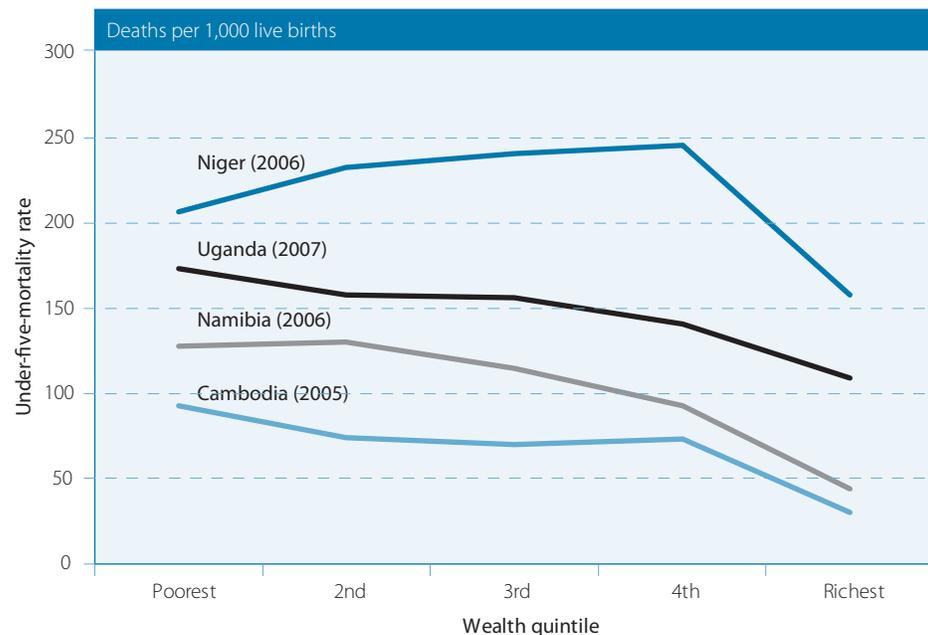
Source: UN/DESA.

(iii) “exclusion” is where the majority of the population has reasonable access to services, but a poor minority of the population is deprived, relative to other groups.⁷

Figure 2 shows patterns in the distribution of under-five mortality (U5M) rates in four developing countries. Niger appears to fit the mass deprivation pattern. Queuing characterizes patterns in Namibia and Uganda (although at different levels of overall U5M), while Cambodia’s pattern is mixed, showing that richer groups enjoy lower mortality rates, but the rates among poorer groups are not as extremely high as those observed in Niger.

Admittedly, these are simplistic characterizations of the distribution of health outcomes in a given country and may not exhaust patterns existing in all countries. When such graphic representation is available over

Figure 2
Under-5 mortality rates by wealth quintile, selected developing countries



Source: UN/DESA, based on the Demographic and Health Survey (available at <http://www.measuredhs.com/accesssurveys/start.cfm>).

⁷ Van de Poel, E., et al., “Socioeconomic inequality in malnutrition in developing countries”, *Bulletin of the World Health Organization*, vol. 86, no. 4, WHO, Geneva, April 2008, pp. 241-320.

time, it does provide useful information on how health interventions affect different socio-economic groups differently, and points out the effectiveness of certain interventions on the health of the poor and disadvantaged.

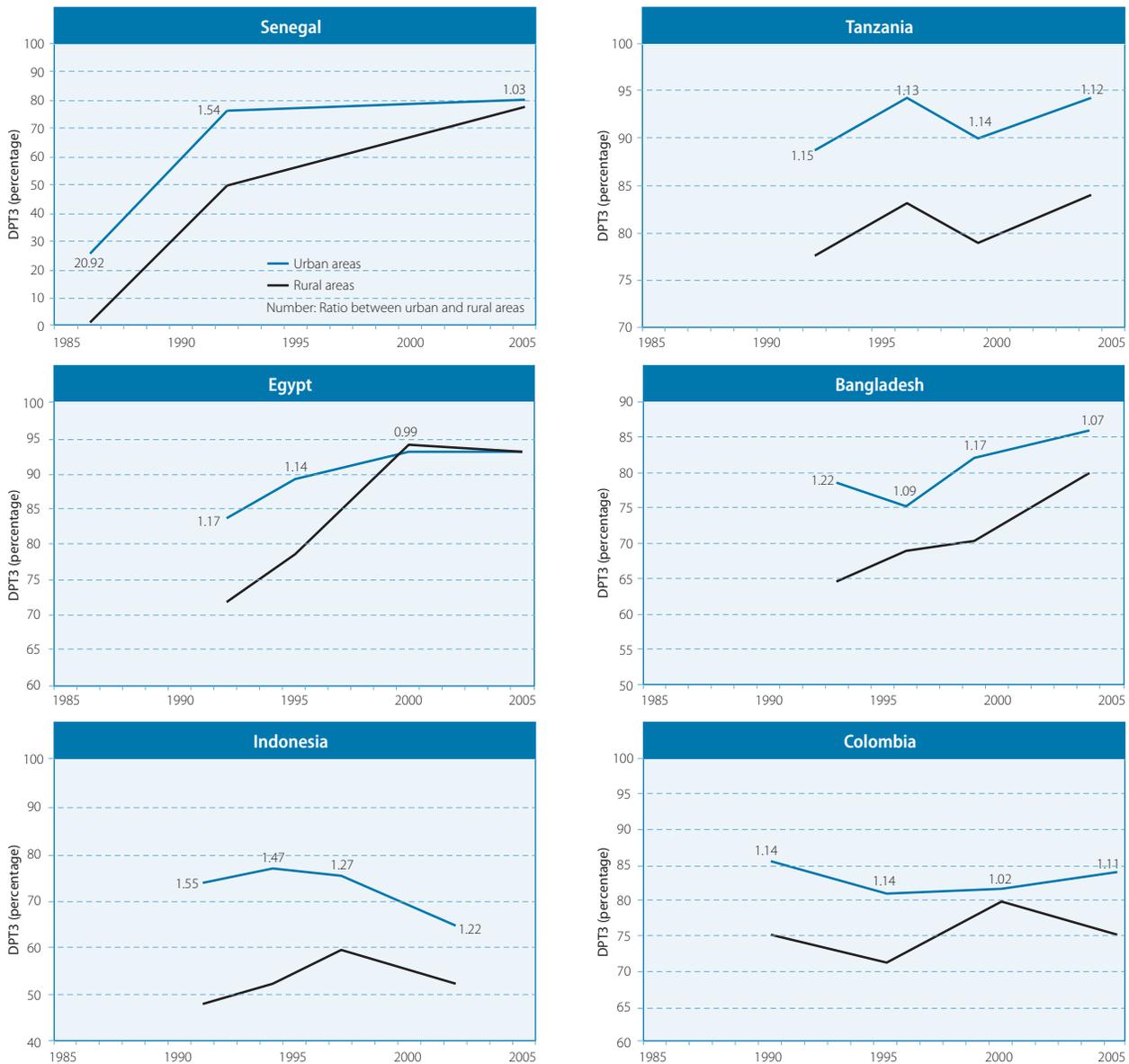
Thus far, aspects of health inequalities across countries at a given point in time have been discussed. What about the trends in health inequalities over time? Trend analysis requires at least two different data points, and only a handful of developing countries have conducted health surveys whose results are comparable at two or more different points in time.

Figure 3 shows the coverage of three doses of vaccine against diphtheria, pertussis and tetanus (DPT3) in urban and rural areas for the period 1985–2005 in six developing countries. Overall DPT3 coverage improved in four out of the six countries, while inequality trends varied across countries. Countries such as Bangladesh, Egypt and Senegal not only improved immunization levels in both urban and rural areas, but also narrowed the urban-rural gap, with the latter two countries having achieved parity between the two areas. Tanzania appears to have shown positive trends, improving levels in both urban and rural areas, but the gap between the areas remained. In Colombia, immunization levels remained flat over time, with no obvious trends in the urban-rural gap. While the coverage declined in both urban and rural areas in Indonesia between 2000 and 2005, the urban-rural gap improved slightly simply because the rate of decline in the urban area was larger.

Figure 4, in turn, depicts trends in the nutritional measure of stunting, comparing families whose mothers have no education and those with secondary education. While stunting ratios declined for both groups in four of the six countries, only the Dominican Republic has been successful in significantly narrowing the health gap associated with educational attainment. Overall, however, comparing stunting ratios between the two groups in these countries shows mixed results. In two countries, the ratio widened; three countries experienced improvement, and one country presented no clear trend. Disparity between the two groups has been more persistent in the case of stunting.

In fact, stunting is considered to be a comprehensive indicator of health outcomes because it measures the combined effects of different

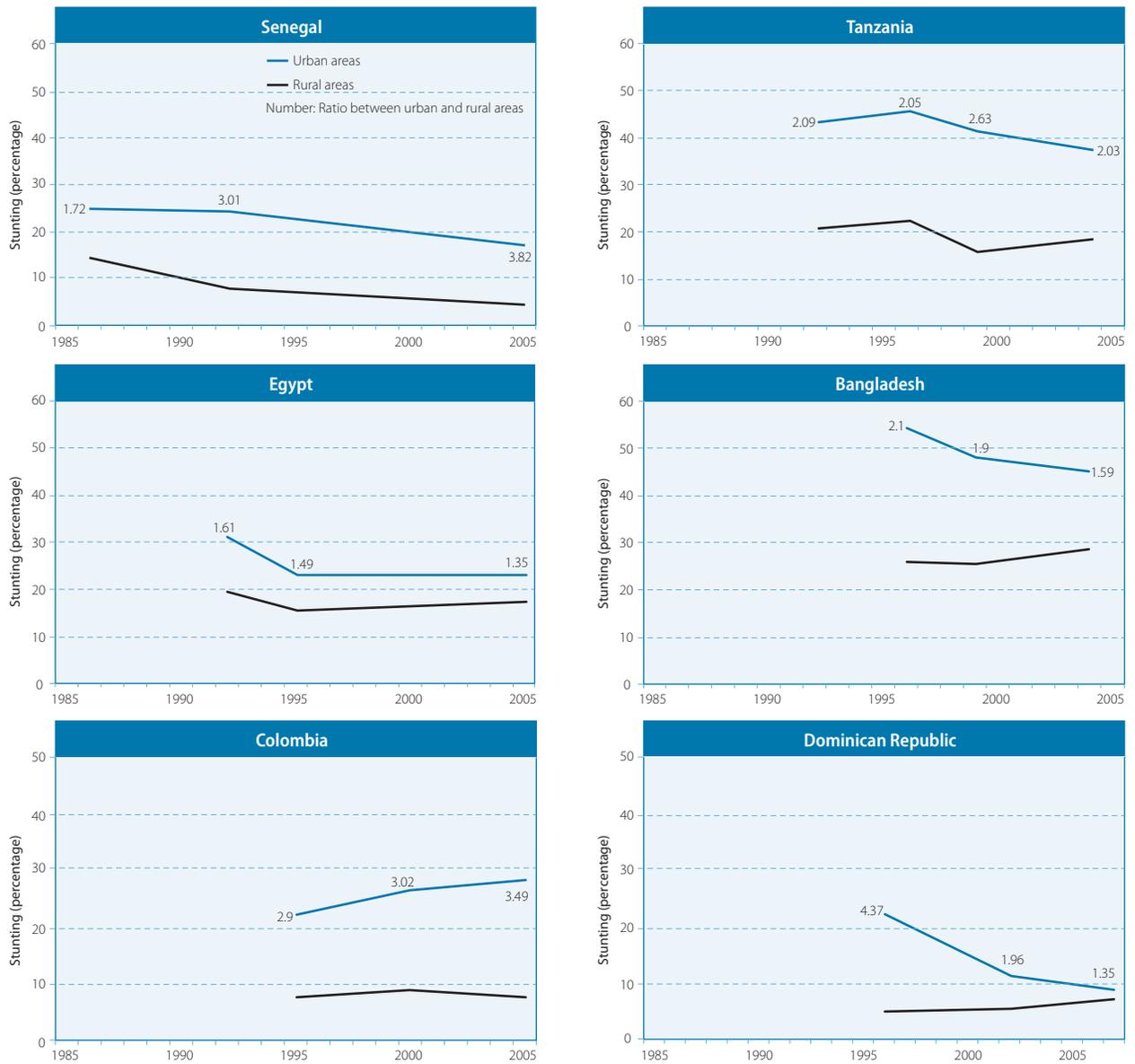
Figure 3
Trends of DPT3 immunization levels in urban and rural areas,
selected developing countries, 1985-2005^a (percentage)



Source: UN/DESA, based on the Demographic and Health Survey (available at <http://www.measuredhs.com/accesssurveys/start.cfm>).

^a Percentage of living children aged 12-23 months who received 3 doses of the vaccine.

Figure 4
Stunting in households where mother has no education and in households where mothers have secondary education, selected developing countries, 1985-2005^a
 (percentage of children aged 5 and younger)



Source: UN/DESA, based on the Demographic and Health Survey (available at <http://www.measuredhs.com/accesssurveys/start.cfm>).

^a Stunting is defined as having a height-for-age more than 2 standard deviations below the median of the National Centre for Health Statistics/World Health Organization growth reference.

parameters in the health systems. Malnutrition, one factor in stunting, reflects chronic problems and hence the deficiency of ongoing efforts related to health systems. Nutrition is not only about food intake, but also reflects health care, life styles and the environment in which people live and work. Immunization coverage, on the other hand, can be improved by discrete interventions. Overall improvement in immunization coverage in the sample countries in figure 3, on the other hand, can be attributed to some extent to the implementation of global health programmes and partnerships (discussed below) introduced to achieve the health-related goals and targets of the Millennium Development Goals.

Health inequalities and the Millennium Development Goals

How do changes in health inequalities among different socio-economic groups relate to progress towards achieving the health-related goals and targets in the MDGs? Health-related targets are generally linked to the overall achievement of a nation, thus reflecting only the national average. Overall progress towards the health-related targets can be made even while health inequalities among different socio-economic groups persist, or deteriorate, as some groups may be left behind or may not necessarily benefit to the same extent as the relatively more affluent or privileged.

As an illustration, table 5 presents data on U5MR for 22 developing countries according to an index of household assets. The countries encompass high and low mortality situations and account for about 27 per cent of the world's population.⁸ Despite the wide variation in U5MR across countries, mortality is always higher in the poorest quintile than in the richest. The ratio of the U5MR in the poorest to richest quartiles of wealth distribution varies between 1.18 (Tanzania, 1999) and 5.26 (Peru, 2000), and most ratios are within 1.5 and 3.0, meaning that a child born in the poorest family is 50 to 200 per cent more likely to die before reaching age 5 than a child born in a better off family.

⁸ Moser, Kath A., et al., "How does progress towards the child mortality millennium development goal affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data", *British Medical Journal*, vol. 331, 19 November 2005, pp. 1180-1182.

Table 5
Trend in level and inequalities in under-5 mortality in 22 developing countries

Country (years) ^a	Overall under-5 mortality			Ratio of mortality on the bottom and top quintiles		
	Level of under-5 mortality per 1,000 births		Percentage change in level of under-5 mortality	Rate ratio		Change in rate ratio ^c
	Earlier year	Later year		Earlier year	Later year	
Countries with declining under-5 mortality^b						
Bangladesh (1996-1997; 2000)	127.8	110.0	-13.9	1.86	1.93	..
Benin (1996; 2001)	183.9	162.7	-11.5	1.89	2.13	Increase
Colombia (1995; 2000)	37.4	28.0	-25.1	2.21	1.94	Decrease
Egypt (1995; 2000)	95.9	69.2	-27.8	3.76	2.91	Decrease
Ghana (1993; 1998)	132.8	110.4	-16.9	2.08	2.66	Increase
Guatemala (1995; 1998-1999)	79.2	64.6	-18.4	2.35	1.97	Decrease
India (1992-1993; 1998-1999)	118.8	101.3	-14.7	2.85	3.11	..
Malawi (1992; 2000)	239.7	202.7	-15.4	1.47	1.55	..
Namibia (1992; 2000)	91.8	60.2	-34.4	1.46	1.76	Increase
Nepal (1996; 2001)	139.2	108.4	-22.1	1.89	1.92	..
Nicaragua (1997-1998; 2001)	56.0	44.6	-20.4	2.32	3.35	Increase
Turkey (1993; 1998)	80.5	59.7	-25.8	4.60	2.61	Decrease
Zambia (1996; 2001-2002)	192.1	167.9	-12.6	1.57	2.07	Increase
Remaining countries						
Cameroon (1991; 1998)	144.0	146.3	1.6	2.46	2.29	..
Haiti (1994-1995; 2000)	140.6	137.7	-2.1	1.55	1.51	..
Kazakhstan (1995; 1999)	47.9	63.0	31.5	1.21	1.83	Increase
Mali (1995-1996; 2001)	252.2	238.2	-5.6	1.76	1.67	..
Peru (1996; 2000)	68.4	60.4	-11.7	4.98	5.26	..
Tanzania (1996; 1999)	144.8	161.1	11.3	1.44	1.18	Decrease
Uganda (1995; 2000-2001)	156.2	156.5	0.2	1.69	1.80	..
Vietnam (1997; 2000)	45.9	32.9	-28.3	2.75	3.35	Increase
Zimbabwe (1994; 1999)	75.9	90.3	19.0	1.50	1.60	..

Source: Moser, Kath A. et al. (2005). "How does progress towards the child mortality millennium development goals affect inequalities between the poorest and least poor? Analysis of Demographic and Health Survey data", *British Medical Journal*, vol. 331 (19 November 2005), pp. 1180-1182.

a Years that Demographic and Health Surveys were conducted.

b Statistically significant declines.

c Rate ratio increase or decrease of at least 10 per cent. Change less than 10 per cent is indicated by "..."

Among the 22 countries, 13 reduced overall U5MRs between the two surveys in a statistically significant way, but in only four countries (Colombia, Egypt, Guatemala and Turkey), did the gap between the richest and poorest quintiles decline (although not statistically significantly). In five countries the gap widened.⁹ In the remaining four countries out of the 13, reductions in the national U5MR had a neutral impact on health distribution.

As Moser, et al. (2005) noted, "...improvements in national under 5 mortality, in line with the MDG[s], do not necessarily bring about decreasing inequalities in mortality between the poorest and least poor in society. Indeed, such society-wide improvements seem as likely to be accompanied by increasing as decreasing inequalities."¹⁰ In fact, it has been suggested that efforts to achieve the MDGs are likely to *increase* inequalities, with the better-off benefiting disproportionately more than their disadvantaged counterparts, in the absence of a concerted effort to ensure that disadvantaged groups benefit from health service delivery.¹¹ This is in part because it is often more difficult for the health authorities to extend services to the worse-off, who more likely live in distant or hard-to-reach areas. Moreover, reaching some groups requires efforts in other areas such as improving communications between local authorities and targeted groups, facilitating increased participation by local communities, and greater access to education and information so as to increase people's awareness of health issues, among others.

Evidence of the linkage between policies to achieve the health-related goals in the MDGs and their impact on health inequalities is admittedly scarce. But where available, it indicates the importance of paying attention to health inequalities and their social determinants, as well as the need for additional concerted efforts in the implementation of health interventions and other social policies so as to reach the poor and

⁹ In the case of Tanzania, where overall mortality increased, the increment was not statistically significant.

¹⁰ Moser, et al., op. cit., p. 1181.

¹¹ Gwatkin, D. R., et al., "Making health systems more equitable", *Lancet*, vol. 364, issue 9441, October 2, 2004, pp. 1273-1280 (<http://www.ncbi.nlm.nih.gov/pubmed/15464189>).

the disadvantaged. Accordingly, efforts by official donors and global health partnerships to transfer resources to improve health in developing countries would be more efficient and better attuned to the spirit of the Millennium Declaration if programmes and projects explicitly incorporated into their objectives the reduction of inequalities in health and other pertinent areas.

Determinants of health inequalities

The poor health conditions of the worse-off or the socially disadvantaged are, in a broad sense, “caused by the unequal distribution of power, income, goods and services, globally and nationally... This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon...”.¹² Social (dis-)advantages are associated with differences in socio-economic status, gender, ethnicity and geographical area. Social advantages are often the result of socio-economic development, and are related to cultural, political and historical factors, natural and “built-in” environments as well as public policies. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequalities between and within countries.¹³

Health and socio-economic status, ethnicity and geography

Socio-economic status reflects economic resources (income and wealth), education and occupation. Household wealth is a significant measure of economic resources available for health care and, as seen in figure 2, there is a correlation between greater household assets and better health outcomes. Similarly, *education* is also positively correlated with health outcomes. As

¹² Commission on Social Determinants of Health (2008), op. cit., p. 1.

¹³ The Commission on Social Determinants of Health (CSDH), for instance, considers four sets of issues in examining the production of health inequalities in a framework designed to facilitate the description, analysis and monitoring of social determinants of health, and the consideration of entry points for action: (i) socio-economic political context, (ii) social stratification, (iii) differential exposures, vulnerabilities, and consequences; and (iv) differential outcomes in health. See CSDH, op. cit., p. 175.

seen above, the likelihood of stunting in childhood is higher among children whose parents have limited educational attainment.

The type of *occupation* is another factor affecting health outcomes (and is itself the result of access to education, wealth of parents, gender considerations, among other factors). Occupational hazards vary, and health outcomes also differ according to employment grade or rank. For example, in the United Kingdom civil service, the higher the hierarchical grade the lower the mortality rate.¹⁴ Furthermore, there is a strong inverse relationship between the grade of employment and absenteeism due to health issues. The type and quality of jobs can have direct effects on health through occupational hazards, or may affect health indirectly through income security or through psychological and social mechanisms. In the Russian Federation, the increase in mortality among working age adults between 1980 and 2001 has been attributed to “unemployment, alcohol consumption and social stress”.¹⁵

Discrimination against specific racial, ethnic or religious groups is also known to have serious health and social consequences. In Central and Eastern Europe, the Roma people routinely suffer deprivation.¹⁶ In Bulgaria, for example, their life expectancy at any age is five to six years below the rest of the population, while their infant mortality rate is six times the national average. In Hungary, infant mortality among the Roma is nearly four times the average for the country, while in Romania it is two and a half times greater.¹⁷ In Indonesia in 1995, mortality among non-Javanese children was 36 per cent higher than among Javanese, while non-Chinese children had mortality rates nearly four times higher than the rate observed among Chinese children (whose parents are likely to be wealthier). Child

¹⁴ Marmot, Michael G., “The importance of psychosocial factors in the workplace to the development of disease”, in M. G. Marmot and R. G. Wilkinson (eds.), *Social Determinants of Health*, New York, Oxford University Press, 1999.

¹⁵ Murphy, Michael et al., “The widening gap in mortality by educational level in the Russian Federation, 1980–2001”, *American Journal of Public Health*, vol. 96, no. 7, 2006, pp. 1293–1299.

¹⁶ See United Nations Development Programme (UNDP), *Roma: Human Development Challenges and Opportunities, 2005* (available at <http://roma.undp.sk/>) for hidden impediments to social services in Romania.

¹⁷ *Ibid.*

mortality rates among the non-Tagalog speaking population of the Philippines were 33 per cent above those of Tagalog speakers, and the rates for non-Christians were 47 per cent above those of Christians (who are, again, more likely to be wealthier). In Latin America, the prevalence of child diarrhoea and maternal mortality is significantly higher among indigenous people than among non-indigenous.

Discrimination is also often observed in developed countries. In the case of the United States, there is abundant evidence of health disparities along racial lines, while such factors as place of residence, occupation, education, and income are considered to be secondary to ethnicity. The life expectancy of African-Americans in the District of Columbia is 63 years, compared with 80 years for whites in neighbouring Montgomery County (Maryland). A life expectancy of 63 years is below the average found in a large number of developing countries, including the Philippines, Egypt and all Latin American countries. In the United Kingdom of Great Britain and Northern Ireland, the ratio of people of Bangladeshi and Pakistani origin who reported “not good” health in a survey was around 1.8 times higher than the average for all of England and Wales. Moreover, official statistics show that infant mortality rates for Pakistani and Caribbean groups in the United Kingdom were 9.6 and 9.8 per 1,000 live births, respectively in 2005, compared with a U5MR rate of 4.5 for “white British” and 6 for the United Kingdom as a whole.¹⁸

Health inequalities also occur across *geographical area*, partly owing to natural differences in the risks and exposures in different geographic contexts, as well as to differences in the availability and quality of healthcare services. In South Africa, the Eastern Cape and the Northern Province have the highest prevalence of stunting; these are also the two provinces with the highest rates of incidence of poverty in the country.¹⁹ In the Chandigarh

18 UK Office of National Statistics, “Large differences in infant mortality by ethnic group”, news release, 24 June 2008 (<http://www.statistics.gov.uk/pdfdir/imeth0608.pdf>); UK national statistics from United Nations Children’s Fund, *The State of the World’s Children 2009*, UNICEF, New York, 2008.

19 Zere, Eyob and Diane McIntyre, “Inequities in under-five child malnutrition in South Africa”, *International Journal for Equity in Health*, no. 2:7, BioMed Central Ltd., 2003 (available at <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=201028&blobtype=pdf>), quoting South African Government statistics.

Union Territory in India, about 68 per cent of birth deliveries were not assisted by a skilled attendant (such as a nurse, midwife or doctor) in the slums, compared with 21 per cent and 7 per cent in rural and non-slum urban areas, respectively.

Health inequalities between women and men

Although females generally have a genetic advantage manifested in higher life expectancy, they frequently face disadvantages in access to health care, in health research and in the quality and kinds of health services provided. Moreover, gender inequities work in a manner that interacts with other types of inequalities arising from the factors examined above (education, income, etc.). These elements persist in the more affluent societies. The costs of not attending to the effects of gender are immense. They include:

- Neglect of diseases and health problems facing women, e.g. numerous physical and emotional ill-health problems arising from socially normalized gender-related practices such as sexual abuse and violence against women and girls, female genital mutilation, illicit abortions, child marriage, sex trafficking, etc.
- Slow diagnoses and treatment of diseases and conditions that specifically affect women, e.g. breast and cervical cancer, sexually transmitted diseases, endometriosis and others.
- Inattention to social factors causing women's ill health—occupational hazards in the various places where women work, overwork and stress, inequalities in remuneration and economic insecurity, as well as insecurity arising from sexual harassment, etc.

Apart from the fact that men generally have a lower life expectancy, gender inequities are also noticeable for men in some particular circumstances. For example, the decline in average life expectancy in the Russian Federation in the 1990s was sharper among men than women. Between 1990 and 1994, life expectancy for Russian men declined from 63.8 to 57.7 years (a decline of 6.1 years) and for Russian women from

74.4 to 71.2 years (3.2 years).²⁰ Tobacco and alcohol abuse and psychological depression—probably related to job losses—were among the many factors that accounted for the disparities in life expectancy between men and women during that period.

Gender inequalities in health reflect a complex interaction of social and biological variables. Yet because they tend to be dismissed as “biological differences”, social responsibility is denied, and gender differences in health are therefore often not treated seriously in social policy.²¹ A gender approach to health distinguishes between biological and social factors, and examines their interactions. When it comes to social factors, a gender approach to health does not just address the ascribed “gender roles” of women, but also addresses the structural inequalities between women and men in access to money, education, resources, jobs, and services—including health services.

Gender-related health inequalities and the MDGs

The international development agenda pays particular attention to issues of gender inequality and empowerment of women. MDG 3 specifically commits to achieving gender equality in many socio-economic, political and cultural areas. Reflecting the linkages among these elements, other of the MDGs have specific gender-related targets—in education and health, for instance. But much more needs to be done to mainstream gender into global health policy. For example, reducing infant mortality requires attending to the factors that lead to significantly higher mortality rates among girls than among boys in some countries, despite the greater biological vulnerability of boys at birth. Meeting MDG 5 (improving maternal health), which addresses one particular aspect of women’s health, also has significant implications for MDG 3. Maternal mortality is strongly correlated with women’s unequal access to adequate education and nutrition, as well as inadequate health facilities, exacerbated by curbs on women’s mobility that limit access

²⁰ Notzon, Francis C., et al., “Causes of declining life expectancy in Russia”, *Journal of the American Medical Association*, vol. 279, no. 10, March 11, 1998, pp. 793-800.

²¹ Sen, G., A. George and P. Östlin, eds., *Engendering International Health: The Challenge of Equity*, Cambridge, Massachusetts, MIT Press, 2002.

Box 2

Spousal violence: a serious health concern

One of the most hidden, pernicious, and yet widely prevalent health risks women face globally stems from violence within the home from spouses and other intimate partners. Although it is still underreported, estimates show that worldwide 10 to 50 per cent of ever-married women, cutting across countries and economic groups, face physical violence from husbands.^a Marital violence is found to devastate the women who suffer it, scar the children who witness it, and dehumanize the men who perpetrate it. It adversely affects not only individuals but their families, future generations and entire societies. Indeed, the World Health Organization has identified marital violence as a major health concern.^b

Marital violence is found to cause serious physical and mental injury to women. Violence during pregnancy is linked to miscarriages, low birth weight infants, maternal morbidity, and even foetal and maternal deaths.^c The term “battered woman syndrome” describes a situation where a woman’s sense of self is so damaged that she believes she deserves to be abused.

Physical or mental injury can adversely affect a woman’s job prospects, productivity, work regularity, and upward mobility. Even the fear of injury can undermine a woman’s ability to earn a living, by making her fearful of reprisal if she goes to work, or to upgrade her skills, or to explore job options. A woman’s inability to obtain or hold a job due to marital violence reduces her income. This can reduce not only her own healthcare prospects but also her children’s, given that mothers’ incomes tend to benefit child nutrition and health care more than fathers’ incomes.^d Moreover, it erodes her social relationships by keeping away neighbours and friends and by making her withdraw from social contact. Accordingly, it reduces women’s ability to seek help during ill-health or pregnancy, and can even affect their life expectancy.

Marital violence also carries direct intergenerational costs, such as foetus damage and psychological damage to children witnessing violence. Such children tend to have greater emotional and behavioural problems than other children and carry-over effects into adulthood.^e Having seen their fathers beat their mothers, girls in adulthood are more likely to accept a husband’s abuse and boys are more likely to beat their wives. Marital violence thus undermines the physical and mental capabilities of all family members.

Policies require a multi-pronged approach, including stringent protective laws; promoting legal awareness; sensitizing the legal machinery and police force for effective implementation; safe short-stay homes for women and children; social

Box 2 (cont'd)

security systems as economic cushions that battered women can draw upon; preferential job options for the long term; and most importantly subsidized housing, given the findings of recent research that women who own or have access to secure alternative housing or land of their own are at substantially lower risk from spousal violence than property-less women.^f

- a** "Ending Violence Against Women", *Issues in World Health*, vol. 27, no.4, The Johns Hopkins School of Public Health, Baltimore, Maryland USA, December 1999, pp.1-43.
- b** "World Health Organization, *Women's Mental Health: An Evidence Based Review*, WHO, Geneva, 2000, and *World Report on Violence and Health*, WHO, Geneva, 2002.
- c** Dannenberg, A.L., et al., "Homicide and other injuries as causes of maternal death in New York City, 1987 through 1991", *American Journal of Obstetrics and Gynecology*, vol. 172, no. 5, May 1995, pp.1557-1564, and Jejeebhoy, S.J., "Associations between wife-beating and fetal and infant death: impressions from a survey in rural India", *Studies in Family Planning*, vol. 29, no. 3, September 1998, pp. 300-308.
- d** Thomas, D., "Intra-Household Resource Allocation: An Inferential Approach", *The Journal of Human Resources*, vol. 25, no. 4, 1990, pp. 635-664.
- e** Edleson, J.L., "Children's Witnessing of Adult Domestic Violence", *Journal of Interpersonal Violence*, vol. 14, no. 8, 1999, pp. 839-870, and McCloskey, L.A., et al., "The Effects of Systemic Family Violence on Children's Mental Health", *Child Development*, vol. 66, no. 5, October 1995, pp.1239-1261.
- f** Agarwal, B. and P. Panda, "Toward Freedom from Domestic Violence: The Neglected Obvious", *Journal of Human Development and Capabilities*, vol. 8, issue 3, November 2007, pp.359-388.

to antenatal and obstetric emergency treatment. WHO further observes that vulnerability to gender-based violence by partners during pregnancy is a causal factor in maternal mortality²² (see box 2).

MDG 6 (combating HIV and AIDS, malaria and other diseases) demands particular attention to the extent that gender inequalities are implicated in the epidemiology of HIV/AIDS and to policy responses and services, in addition to the burden on women and girls generated by widespread sickness and fatalities brought on by the pandemic. The gender dynamics of HIV/AIDS mean that women are often unable to exercise choice and control their physical integrity in the context of war and conflict, and of extreme poverty in many societies. In such situations, the "abstain, be faithful, condomise" (ABC) approach has little practical value.

²² World Health Organization, *World Health Report 2002*, WHO, Geneva, 2002.

Overall the global health policy context is one in which the mainstream remains largely inattentive to gender as a major determinant of health. Moreover, women inherit the care burden when public services are eroded, as happened when economic structural reforms were introduced in the 1980s.

Health inequalities and environmental factors

In addition, environmental factors can also contribute to health risks for women, thus widening health disparities between women and men. A case in point is the health implications for women of widespread dependence on traditional biomass fuels for domestic energy.²³

Women are found to suffer disproportionately more than men from acute respiratory infections (ARI) and acute lower respiratory infections (ALRI), in addition to chronic obstructive pulmonary disease (COPD). They also face greater risk of lung cancer and cataracts leading to blindness. The mortality risk to women from smoke-related infections is assessed to be 50 per cent higher than for men. Sixty per cent of the 1.6 million deaths reported annually due to inhaling fuel smoke from cooking indoors are of women.²⁴ Pregnant women also risk having still births and low birth weight babies, with associated intergenerational effects on the child's life chances and future health²⁵ (see box 3). In addition, fuel collection is primarily women's responsibility in many countries, and fuel shortages—besides having negative implications for good nutrition—add to women's already long working days. This again can have adverse health

23 Most traditional biofuels are unprocessed organic material used in their natural, primary form. The term "solid fuel" is used to include both unprocessed biofuels and coal.

24 Modi, V., et al., *Energy services for the Millennium Development Goals*, United Nations Development Programme, UN Millennium Project, and the World Bank, UNDP, New York, 2005.

25 One study in India found a 50 per cent adjusted excess risk of stillbirth among women using biomass fuels during pregnancy (cited in Smith, K.R., S. Mehta and M. Maeusezahl-Feuz, "Indoor air pollution from household use of solid fuels", in M. Ezzati, A. Lopez, A. Rodgers and C. Murray (eds.), *Comparative Quantification of Health Risks*, vol. 2, WHO, Geneva, 2004, p. 1453).

Box 3

Women's health and the environment: indoor air pollution

Half the population of the developing world—about 2.4 billion households—still depend on conventional biofuels for cooking and heating. These traditional biofuels—in particular firewood, charcoal, cattle dung and crop waste—are used by over 90 per cent of rural households in sub-Saharan Africa, 80-90 per cent in India, and 50-70 per cent in China, and the numbers relying on such fuels is projected to increase to 2.6 billion by 2030 (*see table below*), with the highest numbers and percentages living in Africa and South Asia. Although this reliance is greatest among the poorest households, many well-off households also use traditional biofuels to a substantial extent, even as they move to modern fuels for additional energy needs.^a

Cooking with traditional biofuels using inefficient stoves in poorly ventilated conditions is found to produce serious health ill effects. The smoke produced during the combustion of traditional biofuels contains pollutants such as particulates, carbon monoxide, nitrogen and sulphur oxide, formaldehyde, and benzopyrene. In Africa and South Asia, around 70 to 80 per cent of the population is exposed to such smoke from the fuels they use domestically. Indoor smoke from solid fuels (unprocessed biofuels plus coal) is globally responsible for 35.7 per cent of lower

^a In an analysis of 2,366 rural households in Pakistan, even the richest quintile of households used wood and dung to a substantial degree. See Chaudhuri, S. and A. Pfaff, "Does Indoor Air Quality Fall or Rise as Household Incomes Increase?", Working paper no. 1, School of International and Public Affairs, Columbia University, New York, USA, 1998.

Population relying on traditional biomass for cooking and heating, 2002-2030 (millions)

Region	Actual	Projections	
	2002	2015	2030
Africa	646	805	996
South Asia	746	844	883
India	595	665	693
East Asia (excluding China)	221	211	188
China	704	618	505
Latin America	79	68	60
Developing countries	2 398	2 549	2 634

Source: International Energy Agency, World Energy Outlook (2004).

Note: Middle East not included as the numbers are negligible.

Box 3 (cont'd)

b World Health Organization, *World Health Report*, WHO, Geneva, 2002, p. 70.

c World Health Organization, "Indoor Air Pollution and Health", Fact sheet no. 292, WHO, Geneva, 2005.

d Modi, V., et al., *Energy services for the Millennium Development Goals*, United Nations Development Programme, UN Millennium Project, and the World Bank, UNDP, New York, 2005.

e WHO (2002), *op. cit.*

f Mishra, V., K.R. Smith, and R.D. Retherford, "Effects of Cooking Smoke and Environmental Tobacco Smoke on Acute Respiratory Infections in Young Indian Children", *Population and Environment*, vol. 26, no. 5, May 2005.

respiratory infections, 22 per cent of chronic obstructive pulmonary disease and 2.5 per cent of trachea, bronchus and lung cancer.^b It is also linked with a higher incidence of tuberculosis, cataracts and asthma. The WHO notes that indoor air pollution is responsible for 2.7 per cent of the global burden of disease.^c An estimated 1.6 million deaths a year in developing countries are associated with inhaling smoke from indoor cooking from such fuels, making indoor air pollution the fourth leading cause of premature deaths in developing countries.^d Those at greatest risk from these diseases are women who do most of the cooking, and young children playing near or in their mother's laps or carried on their backs.

Children are even more at risk directly. The WHO estimates that acute respiratory infections account for 20 per cent of child deaths each year (2.2 million out of 11 million).^e Of these, a very large percentage is due to cooking-fuel-related indoor air pollution. In India alone almost two thirds of the children under 36 months live in households using only unprocessed biomass fuels for cooking and an estimated 200,000 to 300,000 Indian children died due to acute lower respiratory infection mortality linked with biomass fuels in 2001.^f Children being carried on the mother's back while she is cooking (as is common in rural Africa) are often at greatest risk, and this can have gender implications according to which gender tends to be carried more. Similarly, in South Asia, girls inducted at a very early age to help their mothers cook are at higher risk than boys who are sent out to play.

The provision of clean, adequate and affordable domestic energy thus needs priority attention by governments. The solutions will need to be not only technical but also financial and institutional in nature. Improved stoves with chimneys and greater fuel efficiency can also help. Policies in these directions can, however, complement but not substitute for cleaner fuels. A shift to cleaner fuels is possible in the short and medium term, and at a fairly low cost, even with known technologies. A case in point is biogas plants which produce methane gas by anaerobic fermentation of biomass.

Short- and long-term solutions will require not just adaptation of technology to local needs and appropriate pricing and credit support policies, but also additional institutional inputs. In particular, more participatory and collective approaches are needed for ensuring community involvement—especially women's participation—in the process of adapting and adopting the cleaner fuels and associated technologies.

effects directly for women, but also indirectly for children left behind for long periods without the main caregiver. Domestic energy shortages are not confined to poor households, since in many regions much of the cooking fuel is gathered, even among the well-off.²⁶

Culture and gender inequality in health

Specific groups may face additional health risks because the particular socio-economic environments they face are often in part determined by dominant cultural values, which in turn can contribute to the perpetuation of conditions such as marginalization, stigmatization and lack of access to culturally appropriate health care and services. The cultural environment can strongly constrain the behaviour of men and women through powerful cultural components that closely regulate the lives of both men and women.

For example, in traditional Moroccan society, there are specific social norms and roles assigned to men and women, and these tend to shape the structure and functioning of society. The father is traditionally the absolute head of the family, and his authority over his wife (or wives) and children is culturally sanctioned. As a result, a gender hierarchy, whereby males have authority over females, is established at the level of the basic cell of society: the family.

There is a direct relationship between how a culture manifests itself in its norms and legal instruments and in unequal access to goods and services, opportunities and rights. This can contribute to inequalities in health care and health outcomes. For example, the male-dominated culture influences male and female behaviours alike with regard to reproductive health education and services, and this can translate to resistance to government family planning initiatives.

²⁶ In rural India in the mid-1990s, 85 per cent of cooking fuel was gathered and not purchased.

The macroeconomic environment: adjustment and health inequalities

The provision of healthcare services for all is a goal shared by the international community.²⁷ But common problems may prevent realization of this goal in many of developing countries. These include the inadequacy of available human and financial resources and the inequitable allocation of such resources among different groups of the population—not only in health but also in other sectors such as education and economic and social infrastructure. The poor and other disadvantaged groups are most likely to be adversely affected by these shortcomings, despite their greater need.

Many developing countries faced significant reversals in social welfare policies during the 1980s when implementing internationally mandated structural adjustment programmes (SAPs). SAPs consisted of a set of components, such as balance of payments adjustments, trade liberalization, privatization, monetary discipline and fiscal austerity. The last component, in many cases, led to reductions in public spending on social services and subsidies, accompanied by cost-recovery measures such as the introduction of user fees (officially charged fees) for services.

Because of the complex relationships between the macroeconomic environment and health outcomes, no outright conclusion on the impact of SAPs on health is possible. The WHO Commission on Macroeconomics and Health, which reviewed 72 articles on the impact of macroeconomic adjustment policies, including SAPs, found both positive and negative consequences on health outcomes. In sub-Saharan Africa, however, it found mostly negative consequences. Largely owing to the lack of data, particularly across different socio-economic groups, the report failed to analyse the impact of SAPs on health inequalities.²⁸

²⁷ WHO, *World Health Report 2008*, op. cit.

²⁸ Breman, A. and C. Shelton, "Structural adjustment and health: a literature review of the debate, its role-players and presented empirical evidence", Commission on Macroeconomics and Health (CMH), Working Paper Series, no. WG6:6, World Health Organization, 2001.

More recently, the greater availability of health indicators has made it possible to come to a broad consensus. Accordingly user fees, many of which were introduced during the 1980s, have been found to be a barrier to access to health services, particularly for the poor, thus exacerbating health inequalities between poor and rich. But user fees appear to be only one of the several barriers that the poor face. Other direct costs have been identified as preventing the poor from accessing healthcare services—such as informal fees (including in-kind transactions) and the costs of drugs and other health supplies, often imported in low-income countries and made more expensive by the currency devaluations that also often result from structural adjustment programmes. To be sure, other types of indirect costs and non-monetary factors can influence health service access and outcomes: these include travel costs; the quality of health services for the poor; the supply of properly trained health workers; the availability of essential drugs on a daily basis; and lack of information on health services.²⁹

Several countries, however, have recently introduced health policy initiatives to address the problems mentioned above, largely within the framework of two international development initiatives—the MDGs and the World Bank-led Reaching the Poor Program.³⁰ One such initiative was to remove user fees as in the case of Uganda (see box 4).

The current global economic crisis threatens to stymie progress for many developing countries. Any shortfall in fiscal revenues (including donor grants) due to the economic slowdown could have major repercussions on health through pressures on health budgets, thus limiting the

²⁹ New WHO research carried out in 12 countries in Africa shows a critical shortage of health workers: in 10 of the 12 countries studied, current pre-service training is insufficient to maintain the existing density of health workers once all causes of attrition are taken into account. It estimates that with current training patterns and only involuntary attrition, it would take 36 years for doctors and 29 years for nurses to reach the WHO target of 2.28 health workers per 1,000 of the population, and some countries would never reach it. Kinfu, Yohannes, et al., "The health worker shortage in Africa: are enough physicians and nurses being trained?", *Bulletin of the World Health Organization*, vol. 87, no. 3, 2009, pp. 225-230.

³⁰ Gwatkin, Davidson R., et al. (eds.), *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why*, World Bank, Washington, D.C., 2005.

Box 4

Abolition of user fees in Uganda

a The case reported here is based on Burnham, Gilbert M., et al., “Discontinuation of cost sharing in Uganda”, *Bulletin of the World Health Organization*, vol. 82, no. 3, March 2004, pp. 187-195.

b It should be noted that at the beginning of the present century, a little less than 50 per cent of the population earned less than US\$1 a day, and 60 per cent US\$50 per month.

c Nabyonga, J., et al., “Abolition of cost-sharing is pro-poor: evidence from Uganda”, *Health Policy and Planning*, vol. 20, no. 2, 2005, pp. 100-108.

d The outpatient utilization rate is calculated as the ratio between the total number of visits in all health centres in the region and the number of people living in the region.

e Utilization rates by wealth group are not reported in the paper.

After two decades of upheaval, at the end of the 1980s Uganda emerged with an under-equipped and under-staffed health care system.^a Cost sharing—in the form of user fees—was introduced to cover public health workers’ salaries, alleviate drug shortages and strengthen community management of facilities. User fees and managed revenues were determined at the local level, but often were in the range of US\$0.25–0.45 per visit.^b After the introduction of the user fees, outpatient attendance dropped by more than 20 per cent in some districts, while the opposite happened in some remote areas. For health employees and community-level health facilities, revenues from user fees became a relatively secure source of income, and provided for purchases of medical and other supplies.

In March 2001, as there was some evidence that they were leading to unnecessary suffering and even death, user fees were abolished. The major objective of this policy change was to improve access to health services for the poor. The Ministry of Health introduced a supplemental fund of US\$5.5 million to buffer the loss of revenue and to counter a potential shortage of drugs. The fund was financed by the World Bank-sponsored district health services project.

Utilization rates increased. In public referral facilities—heads of the sub-district healthcare systems, typically larger hospitals with doctors available and relatively well equipped medical facilities—utilization rates increased by 26 per cent in 2001 when the fees were abolished and 55 per cent in 2002. The equivalent rates in public centres (lower level than the referral facilities) were 44 and 77 per cent, respectively.^c When examining outpatient utilization at health centres among different wealth groups, the poorest (defined as a group of households below the bottom quartile in a wealth ranking) recorded the highest rate at 0.8 in 2001 (i.e., an average person in the poorest category visited centres 0.8 times a year) and almost 1.0 in 2002.^d The other groups reached around 0.6 in 2001 and between 0.8 and 0.9 in 2002 showing that the abolition of fees induced other groups who also benefited from the measure. Females consistently utilized health facilities more than males before and after the abolition of user fees in 2001, and there is no evidence of a change in this pattern after the elimination of the fees.^e

The abolition of user fees did not seem to have implied deterioration in the quality of services rendered—one of the reasons commonly evoked in support of user fees. For example, there was no significant increase in average stock-out days—days when a health centre is out of stock of drugs—per month after the

Box 4 (cont'd)

abolition; average drug stock-out appeared to increase in 2001 immediately after the abolition, but it declined in 2002. Other quality aspects of health services, such as staff attitude and availability and health unit cleanliness and maintenance, reported no deterioration.

The debate on whether abolishing user fees is “pro-poor” will continue. For countries like Uganda, where the significant portion of the population is poor, the imposition of user fees, however small, puts even basic healthcare services out of reach.

availability of publicly supplied health services. This was well documented in the cases of Central and Eastern Europe and the Commonwealth of Independent States (CIS) during the 1990s, when economic difficulties led to a reduction of employment in the health sector and a shrinking of government expenditure for health. Partly as a result of this, some CIS countries experienced declines in life expectancy at birth, and Armenia, Moldova and some Central Asian countries saw increased incidence of tuberculosis.³¹ (Other causes included rising stress due to unemployment and greater general insecurities.)

In developing countries, much of the population, including the poor, rely on public provision or assistance for essential health services such as primary health care and immunizations. Recession and falling tax revenues may reduce funding for these services. In addition, falling remittances, increasing unemployment and lower wages imply fewer resources available to cover health costs, while formal sector employees may lose access to health insurance provided through employment. As reported in table 1, a large share of health costs is covered by out-of-pocket private expenditure in low-income countries. Countries which depend on foreign assistance for the delivery of basic health care are likely to suffer if official development assistance (ODA) flows are not sustained.

Public health may also be expected to be affected by the consequences of rising food prices, which reduce incomes as well as imperilling nutrition. From 2006 to 2008, between 109 and 126 million people are

³¹ Golinowska, Stanisława and Agnieszka Sowa, “Inequalities of access to health care services and health status in CEE and CIS countries” (draft), a paper prepared for the CDP Expert Group Meeting on global public health, November 2008.

estimated to have fallen below the \$1-a-day poverty line due to increased food prices.³² Moreover, recent declines in food prices alone do not seem to be fully reversing the trend, as the current level of food prices is still historically high. In view of the current global crisis, health interventions should be complemented by strengthening development financing in the agricultural sector to secure resources for food, as a contribution to health for all.

Global health partnerships

Global health partnerships have been designed to assist recipient countries to advance public health in general and to achieve the MDGs in particular. The emergence of GHPs has had both positive and negative effects on the capacity of developing countries to make effective advances in tackling health problems. This section examines the role of international cooperation, with particular emphasis on GHPs, in advancing public health in developing countries and reducing health inequalities. The impact of the GHPs on the international aid framework is examined in detail in the Appendix.

International development assistance for health has accelerated since the launching of the Millennium Development Goals in 2000 and amounted to a total of \$12.6 billion worth of commitments in 2006 by both bilateral and multilateral donors of the Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD/DAC). Disbursements reached \$10 billion, on average, in the period 2005-2006 and corresponded to 17 per cent of donors' total disbursements—up from 9 per cent in 1996-1999. Sub-Saharan Africa is the largest recipient region of health aid.

There have been significant changes in the pattern of resource allocation within the health sector. While HIV/AIDS and infectious disease control absorbed about 20 per cent of ODA commitments in the 1990s (12 and 8 per cent, respectively), these programmes accounted for 51 per cent of all commitments in 2005-2006 (35 and 16 per cent, respectively).

³² United Nations Department of Social and Economic Affairs, "Don't forget the food crisis: New policy directions needed", *UN-DESA Policy Brief*, no. 8 (October 2008).

On the other hand, the share of general health (health policy, training and research) declined from 36 to 18 per cent during the period.³³

The health sector has also witnessed a proliferation of new actors and new institutional arrangements: between 80 and 100 international alliances, also called GHPs, have been created to attain the international development goals and to enhance the efficiency of aid and its traditional channels of allocation and management. According to WHO, public-private alliances are understood as those partnerships which “bring together a set of actors for the common goal of improving the health of a population through mutually agreed roles and principles” and are a key for achieving significant improvements in health on an international scale.³⁴

There are four main reasons that justify the creation of GHPs. Firstly, fighting against certain diseases (especially contagious diseases) is a global public good, and it therefore requires global and effective responses. Secondly, focusing on a specific disease can mobilize public opinion and resources in a more effective way. Thirdly, there are reasonable doubts about the levels of efficiency and effectiveness of traditional aid channels. And finally, certain diseases have high externalities that demand a concentrated and massive effort to fight them.

Available assessments suggest that the partnerships function acceptably well, especially in terms of overall improved access to treatments, therapies and medicines.³⁵ At the same time, there are concerns about the role of GHPs in addressing health inequality, their impact on national health systems and on the coherence of the international aid architecture. It seems that approaches adopted by the GHPs in their country operations can have implications for national health care systems by affecting the delivery of services and the allocation of resources among socio-economic groups and geographical areas.

³³ OECD papers: “Measuring aid to health”, October 2008 (<http://www.oecd.org/dataoecd/18/35/42242018.pdf>); and “Recent trends in official development assistance to health”, 2006 (<http://www.oecd.org/dataoecd/1/11/37461859.pdf>).

³⁴ Kickbusch, I. and J. Quick, “Partnerships for health in the 21st century”, *World Health Statistics Quarterly*, vol. 51, no. 1, WHO, Geneva, 1998, pp. 68-74.

³⁵ See Maciocco, G., “From Alma Ata to the Global Fund: The History of International Health Policy”, *Social Medicine*, vol. 3, no. 1, Bronx, New York, 2008, pp. 36-48, and Appendix of this present Note.

Scope of GHPs

In terms of the scope of their activities, GHPs generally focus on at least one of the following areas and, in many cases, target some of them simultaneously:

- (i) *Research and development*: Dedicating resources to the discovery and development of new treatments, products and vaccines.
- (ii) *Technical assistance and service support*: Directing resources and technical support towards the definition of policies and the improvement of access to pharmaceutical products and medical services.
- (iii) *Advocacy*: Improving the response capacity (both national and international response) to specific diseases, promoting the participation and resources to tackle them.
- (iv) *Financing/funding*: Promoting resources for specific programmes.

GHPs that aim at research and development are designed to increase investment and research efforts in new medicines, vaccines or diagnostic tests for diseases which disproportionately affect the developing world. This type of partnership typically involves the pharmaceutical industry as well as philanthropic foundations. The Global Alliance for TB Drug Development, which involves Glaxo Smith Kline, among others, and the Medicines for Malaria Venture, which brings together Hoffmann La Roche, Basilea Pharmaceutica and Fulcrum Pharma, are cases in point.

Multilateral organizations are frequent participants in GHPs. As expected, the WHO takes part in most initiatives (43 out of around 80 studied), followed by UNICEF (21) and the World Bank (18). Well-known financing partnerships that have the largest funding and international impact are the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) and the Global Alliance for Vaccines and Immunization (GAVI).

Most GHPs have multiple objectives. They aim at the development of new products and treatments through research and development, as well as at increasing access of the poorest people to products and treatments. Additionally, most of them take a disease-specific or condition-specific approach in their health programmes. In fact, around 60 per cent of GHPs

target three diseases—namely HIV/AIDS, tuberculosis and malaria. There are also GHPs devoted to the eradication of diseases that affect a smaller share of the population, and to infections which are less well known and about which the general public is less aware, such as dengue fever, Chagas, Guinea worm, and others.³⁶ Only a small number of GHPs are designed to strengthen national health services.

GHPs and the promotion of equality

The objectives of global health partnerships are, among other things, to eradicate specific diseases and mitigate their adverse impact in developing countries, as well as to expand actions and resources with the aim of attaining the internationally agreed development goals in health. Despite most GHPs' claim to be “pro-poor”, their workings in recipient countries may in fact worsen existing inequalities in health. Indeed there are concerns about whether issues of inequalities in health, including gender inequality and poverty reduction, are sufficiently integrated into GHP practices. The United Kingdom Department for International Development (DFID) concluded in 2004 that “GHPs are in practice only as pro-poor or gender-sensitive as the policy environment and health systems they operate within”.³⁷

In principle, there are four channels through which the relationship between GHPs and the issue of equality may be considered. Firstly, through the relationship between poverty and diseases; secondly, through the selection of beneficiary countries; thirdly, through the impact on national health services; and, fourthly, through the working procedures followed by GHPs in the countries in which they operate.

³⁶ Ito, B., “Global Health Partnership and Funding System”, in H. Uchimura (ed.), *Health Service and Poverty: Making Health Services more Accessible to the Poor*, Institute of Developing Economies, Japan External Trade Organization, no. 142, chapter 3, Chiba, Japan, 2007.

³⁷ Caines, K., et al., *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre, London, 2004.

Tackling the poverty-disease nexus

Poor people tend to suffer higher rates of mortality and morbidity than those who have a higher income; and, despite the fact that their needs are greater, they attend to health services less frequently than better-off people. These inequalities are not the consequence of differing preferences among social groups, but rather of unequal restrictions faced by them. Improving the access to health services is an important aspect of reducing social and gender inequalities. Thus, it is important to analyse the specific barriers that affect poor and vulnerable people in each situation and country. Furthermore, it is necessary to go beyond having a disease-specific focus. For instance, AIDS treatment cannot be provided in isolation from national health systems, and it is impossible to fight malaria without the support of primary health care.

There are clear interlinkages among the incidence of poverty, other types of inequalities and a large share of the diseases and areas targeted by GHPs. For example, it is recognized that social and gender inequality increases the risk of HIV infection and, once a person is infected, the same inequality acts as a barrier against proper treatment. In this case, then, the action of the GHP on *diseases* should have a positive effect on the *living conditions* of the poorest sectors. This conclusion could be generalized to a large part of the diseases that the GHPs target, especially the so-called “neglected diseases” that devastate the most marginalized sectors of society in the developing world. However, this positive effect is limited by the small amount of attention which GHPs have dedicated to strengthening national health systems, and by the unintended adverse impact that they may have on those systems, as discussed below.

Health specialists recognize that individuals have different capacities for benefiting from health care, even if services are provided equitably. In addition, the provision of services does not reflect the actual use of those services by different sectors of society. There is ample evidence that improvements in access to antiretroviral treatments in Africa, for example, do not necessarily lead to the actual use of those treatments by many people, especially among the poor. In order to ensure that provision benefits all, it is necessary to address the social conditions within which people live and

work. To achieve this requires strengthening national structures of primary health care, aiming at providing rational, evidence-based and anticipatory responses to health needs and to social expectations. By starting with the existing health structures, the treatments can also be adapted to the specific conditions (both social and cultural) of each group. As has been pointed out, attaining good health “cannot therefore be effectively promoted through partnerships that focus narrowly on improving drug access; rather, it must to be pursued as part of a broader reform to strengthen health systems”.³⁸

Additionally, there is no guarantee that the investment in health care is targeted to poor people, even if the intervention is focused on the diseases that mainly affect poor people. In fact, there is evidence that the rates of use of standard primary healthcare interventions for immunization, oral rehydration therapy, medical treatment of diarrhoea and acute respiratory infection and attended deliveries are higher in upper socioeconomic groups than in lower groups.³⁹ It requires great effort to reach disadvantaged groups, due to their limited resources and limited ability to use even heavily subsidized health services.

Allocation of resources: poor countries, diseases of the poor

GHPs can also promote equity and reduce the inequality of health outcomes across countries by focusing on the poorest countries. GHPs are oriented mainly to fight against infectious diseases, 90 per cent of which are reported in developing countries, whereas these countries account for only 12 per cent of global expenditure on health. In fact, the activities and resources of GHPs are mainly oriented to poorer areas or groupings, especially sub-Saharan countries. For example, 60 per cent of approved funds in Rounds 1-8 of the Global Fund are for sub-Saharan Africa. Eligibility for GAVI funds is restricted to countries whose per capita gross national income (GNI) was below US\$1,000 in 2003.

³⁸ Asante, A. D. and A. Zwi, “Public-private partnerships and global health equity: prospects and challenges”, *Indian Journal of Medical Ethics*, Forum for Medical Ethics Society, Mumbai, October-December 2007.

³⁹ Gwatkin, Davidson R., et al. (eds.), *Reaching the Poor with Health, Nutrition, and Population Services: What Works, What Doesn't, and Why*, World Bank, Washington, D.C., 2005.

In this regard, GHP aid allocation seems to be in line with the objectives of reducing international inequalities. While this is encouraging and can contribute to reducing gaps across countries, it does not guarantee—except in the case of massive campaigns reaching a significantly large share of the population—that inequality within given countries will be reduced and that the most disadvantaged groups will be reached.

As highlighted in the Appendix, many poor countries need proper technical assistance in order to access fully the benefits of GHPs, and here, too, significant shortcomings have been found. This is largely due to the limited attention which GHPs have given to support activities and technical assistance in beneficiary countries, which has made it difficult for the poorest countries to maximize benefits from the GHPs' programmes.

More important, however, is whether these initiatives are addressing the major diseases that affect the poor and other disadvantaged groups in particular. In spite of the important achievements accomplished on HIV/AIDS, it should be recalled that today the top killer diseases in most poor countries are respiratory and intestinal diseases leading to child deaths from pulmonary failure or diarrhoea (*see table 6*). Yet there is very little advocacy for addressing these problems, and there is no GHP to support them.

Table 6
Leading causes of death in low-income countries, 2004

<i>Disease or injury</i>	<i>Deaths (millions)</i>	<i>Percentage of total deaths</i>
Lower respiratory infections	2.9	11.2
Ischaemic heart disease	2.5	9.4
Diarrhoeal diseases	1.8	6.9
HIV/AIDS	1.5	5.7
Cerebrovascular disease	1.5	5.6
Chronic obstructive pulmonary disease	0.9	3.6
Tuberculosis	0.9	3.5
Neonatal infections	0.9	3.4
Malaria	0.9	3.2
Prematurity and low birth weight	0.8	3.2

Source: World Health Organization, *The Global Burden of Disease: 2004 Update*, WHO, Geneva, 2008.

In some countries, very large GHPs emphasizing a single disease (such as those focusing on HIV/AIDS) may unintentionally be addressing the needs of small groups to the detriment of the majority. For instance, the World Bank reports that in Mozambique the epidemic and endemic risks for malaria are high (21 and 57 per cent respectively), while child mortality is also high at 118 per 1,000 live births. Meanwhile, the AIDS prevalence rate reaches 3 per cent but funds allocated for the disease are 2.5 times larger than for malaria and 46 times the allocation for the integrated management of childhood illness. In Uganda, the very rapid increase in allocations to address HIV/AIDS has pulled medical personnel from other parts of the health sector, compromising delivery of services.⁴⁰

Impact on national health services

GHPs have often channelled resources towards the support of a particular disease programme. Problems emerge from this vertical approach. The first problem is related to the potential conflict between the “horizontal approach” of national health systems and the “vertical approach” of the GHPs. The horizontal approach seeks to tackle overall health problems on a wide front and on a long-term basis, while the vertical approach calls for solution of a given health problem by means of single-purpose machinery.

General health services, based on the horizontal approach, have the advantage of being more comprehensive and more embedded in the community. In that sense, they are more likely to reach the deeper causes of an illness (frequently conditioned by social factors). On the other hand, vertical approaches can be justified when trying to combat a disease that affects a high proportion of a population. When the treatment has important dynamic externalities and the disease has specific causes, making a big investment effort through a vertical approach is recommended in order to produce irreversible achievements. Nevertheless, it is clear that in the long run, organized and efficient health-service systems are what countries need most.

⁴⁰ Kirkby-Zaki, Jane, et al., “Global Program Funds at the Country Level: What have we learned?”, paper prepared by The Global Programs and Partnership Group, Concessional Finance and Global Partnerships Vice Presidency, World Bank, July 2008 (http://www.gavialliance.org/resources/Global_Program_Funds_Synthesis_Paper_Final.pdf).

Therefore, it is not a question of making a mutually exclusive choice between these two approaches, but rather of carefully defining the circumstances in which a massive effort is the best answer against a disease, and striving to achieve adequate coordination between general health services and vertical funds. More precisely, it is necessary to use explicit intervention priorities to drive the required improvements into the health system. It is best to avoid both undesirable extremes: creating isolated islands of sufficiency in a sea of under-provision on the one hand (if only a vertical approach is supported), and maintaining a generalized insufficiency, without improvements in severe diseases on the other (if only a horizontal approach is supported). It would be better to build certain areas of sufficiency amidst a system in the process of improvement, and trying to connect these areas gradually. This calls for greater integration and coordination between disease-specific initiatives and the underlying healthcare delivery system.

Improved coordination will, however, require that the number of vertical initiatives is limited. In fact, the present situation seems to be characterized by runaway proliferation of vertical funds. As a consequence, it is very difficult for the fragile national health systems of poor countries to coordinate the activities of the GHPs. Nevertheless, the efficient treatment of any of the diseases targeted by GHPs seems conditioned by the capacity of the national health system to integrate preventive, diagnostic and therapeutic measures in a holistic, comprehensive approach.

In general, GHPs do not place sufficient attention on strengthening national health systems. Moreover, GHP operations have severe implications for existing local capacities, both in terms of human and technical resources, with important consequences for the provision of primary health care and the health of those that depend on it the most: the poor and disadvantaged.

While some GHPs have committed resources to strengthening local health services, resources are often earmarked for services and institutions related to a specific disease targeted by the GHP.⁴¹ From an

⁴¹ See for example, The Global Fund, Fact Sheet: "The Global Fund's approach to health systems strengthening", Global Fund Fact Sheet Series, 5 of 5, 1 March 2008 (http://www.theglobalfund.org/documents/rounds/8/r8hss_factsheet_en.pdf).

operational perspective, a government may receive funds from GHPs to support a specific programme, but may have limited financial capacity to deliver basic health care outside the scope of the GHPs.

In other instances, GHPs have affected national health services and the supply of basic healthcare services by attracting health professionals away from the public sector—already facing considerable shortages of skills—to higher-paid positions within the GHPs. The vertical nature of their approach creates a new type of front-line healthcare worker with very specific skills, which may not correspond to the overall needs of the country. In general, people living in remote areas, urban slums or particular geographical areas with high concentrations of ethnic minorities depend heavily on such basic primary care services. As observed elsewhere, “there is a serious risk that weak human resource and systems capacity at central and local levels can be overwhelmed by the growing proliferation of GHP—and other HIV/AIDS initiatives—with separate demands”.⁴² Even if vertical funds invest resources in strengthening national capacities or improving their harmonization and alignment, difficulties will persist because each initiative has its own governance structures and decision-making process.

Adjusting working procedures

Progress on health equity is only possible when achieving health equity is incorporated as an explicit objective into the definition and design of interventions. The United States President’s Emergency Plan for AIDS Relief (PEPFAR), for instance, has indicated that it targets children and orphans particularly. The share of children receiving PEPFAR-supported treatment grew from 3 per cent of total beneficiaries in fiscal year (FY) 2004 to 8 per cent in FY2008. Through FY2013, PEPFAR plans to work with host nations to support care for 12 million people, 5 million of whom are orphans and vulnerable children.⁴³ PEPFAR acknowledges inequalities between gen-

⁴² Caines, K., et al., *Assessing the Impact of Global Health Partnerships*, DFID Health Resource Centre, London, 2004.

⁴³ U.S. President’s Emergency Plan for AIDS Relief, fact sheet: “Celebrating Life: Latest PEPFAR Results” (<http://www.pepfar.gov/documents/organization/115411.pdf>), 2008.

ders which “perpetuate women’s vulnerability to HIV”⁴⁴ and 61 per cent of those receiving antiretroviral treatment in its programmes are women (HIV/AIDS prevalence is higher among women than men in targeted countries). Meanwhile, the Global Fund’s guidelines are seen as encouraging countries to consider social and gender inequalities in their applications.⁴⁵ Yet, it is not clear whether or not this recommendation has been followed in all cases, or how such considerations address existing inequities.

Notwithstanding the above, the use by GHPs of generalized procedures—the “one size fits all” approach—with no particular consideration given to the institutional and cultural environment of diverse communities, has not helped to develop grassroots approaches that are sensitive to the conditions of the poorest. In this regard, GHPs should analyse the specific factors that limit the access of poor people to health services, and ensure that their interventions help to overcome these limits. As Hanefeld (2008) points out: “GHIs [global health initiatives] need to consider social inequities, including gender inequities, in designing context-specific programmes, to ensure that these are equally accessible to women and men”.⁴⁶ GHP policies and programmes should be checked for their potential long-term impact on social and gender inequities before they are implemented.

Moreover, there are inconsistencies in the approaches of GHPs that affect their potential contribution to addressing equity issues effectively. For instance, the participation of pharmaceutical companies may have negative implications for equity, as there may be conflicts of interest. A case in point is the constraints facing developing countries in making use of

⁴⁴ “Chapter 4—Gender and HIV/AIDS: Responding to Critical Issues”, The President’s Emergency Plan for AIDS Relief: Second Annual Report to Congress (February 2006), available at <http://www.state.gov/s/gac/rl/61286.htm>.

⁴⁵ Hanefeld, J., et al., “How have global health initiatives impacted on health equity? What strategies can be put in place to enhance their positive impact and mitigate negative impacts? A literature review commissioned by the Health Systems Knowledge Network, January 2007. (http://www.who.int/social_determinants/resources/csdh_media/global_health_initiatives_2007_en.pdf).

⁴⁶ Hanefeld, J., “How have Global Health Initiatives impacted on health equity?”, in *Promotion and Education* 15, on behalf of International Union for Health promotion and Education, SAGE, 2008 (<http://ped.sagepub.com/cgi/content/abstract/15/1/19>).

the flexibilities allowed under the World Trade Organization's international agreement of 2003 on "trade-related aspects of intellectual property rights and public health", known as "TRIPS". These constraints affect the ability of countries to improve the access of their populations to essential medicines through the supply of generic products or by overriding patent rights (see box 5). Some partnerships (PEPFAR, for example) may insist on the use of specific drugs, bypassing the less expensive generic alternatives. Additionally, although national governments participate in the partnerships, objectives need to be clearly established and shared among stakeholders, so as to prevent public funds from being used to benefit any companies involved, instead of improving health outcomes of a given population.

Box 5**TRIPS and public health: improving access to cheaper medicines for the poor?**

Access to essential medicines and treatments is fundamental for better health. Despite progress, partly owing to the involvement of GHPs, access to essential medicines by the poor and other disadvantaged groups in developing countries is not yet adequate. This has become a major public health concern, as patented drugs are often very costly, making treatments unaffordable and therefore unreachable for the poor.^a A patent grants "the right to exclude others from making, using, offering for sale or selling" a product or invention^b, allowing its holder to control the price of, say, a medicine or treatment for a specific period of time. For example, the cost of HIV/AIDS treatment with patented medicines is between \$10,000 and \$15,000 per patient per year in developed countries, compared to \$300 if generic drugs by producers in developing countries are used.^c

The World Intellectual Property Organization (WIPO) has been the main forum where international intellectual property negotiations and standard setting took place before the creation of the World Trade Organization (WTO). The Trade-Related Intellectual Property Rights (TRIPS) Agreement of the WTO, which went into effect in 1995, introduced significant changes in the overall framework of the international intellectual property system.^d WIPO presided over an international intellectual property régime of rule diversity, which permitted developing countries to tailor their intellectual property régimes to meet their development objectives. In contrast, TRIPS introduced the principle of minimum intellectual property standards.

Box 5 (cont'd)

In this regard, the TRIPS agreement represents “an attempt to narrow the gaps in the ways these [intellectual property] rights are protected around the world, and to bring them under common international rules.”^e Moreover, the approach implies that, in practice, any international intellectual property agreement negotiated thereafter can only create higher standards (often known as TRIPS-plus). At the same time, shifting the regulatory focus from WIPO to the WTO permits the use of trade remedies to enforce property standards.

However, WTO members are allowed to use exemptions and amendments—called flexibilities—to some of the provisions in the Agreement. For instance, if patented medicines are unaffordable and essential for public health, a government can take remedial measures, such as compulsory licensing and parallel imports.^f

Compulsory licensing is the granting of permission to an agency or a company to produce the patented product or to reproduce a patented process without the consent of the patent owner. A licence may be granted in an “unusual” situation (for example, a public health emergency) but that requires domestic manufacturing capacity. Alternatively, a country may, without the consent of the patent owner, import cheaper drugs from a manufacturer that holds a parallel patent. It can also import the generic version of the drug (patent-expired or voluntarily licensed). It may not, however, import from a manufacturer that was issued a compulsory licence by its government. In the latter case, production shall be predominantly for the supply of the domestic market and thus there is a *de facto* restriction on exports.

By recognizing the public health aspects of this problem, particularly concerning drugs for use against HIV/AIDS, malaria, tuberculosis and other diseases, WTO member States adopted the Doha Declaration of the TRIPS Agreement and Public Health in November 2001 (and later revised in 2002) to clarify the existing flexibilities. Since the adoption of the Doha Declaration, there have been cases of compulsory licensing and parallel imports incorporated in the TRIPS Agreement at the country level, including for Brazil, Ghana, Indonesia, Malaysia, Mozambique, Thailand, Zambia and Zimbabwe.^g At the same time, the WTO dispute settlement mechanism has confirmed these flexibilities.^h

Exporting generic medicines produced under compulsory licence to countries without manufacturing capacity became legally possible with the adoption of the 2003 Decision on Implementation of Paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health (often called the Paragraph 6 System), an interim waiver which is supposed to last until the WTO agreement is amended. Under the System, total production of a country may be exported to meet health needs of importing countries.

Box 5 (cont'd)

A series of requirements have to be fulfilled. Importing countries, among other things, have to notify the TRIPS Council of the name and quantities of medicines to be imported, and confirm eligibility to import; that is to say, if the country is not a least developed country (LDC), it has to establish that it has insufficient or no manufacturing capacity. Notifications are also required from the exporting countries on details of the compulsory licence being issued besides specific labelling and marketing requirements.ⁱ

In 2005, The WTO General Council adopted a decision to amend the TRIPS Agreement so that the waiver on the export restriction could become a permanent feature of the agreement. That however requires two thirds of the WTO's members to accept the change. The originally deadline (1 December 2007) had been extended to 31 December 2009. As of early May 2009, 21 out of the 153 WTO members have accepted the amendment. The régime has been criticized for being cumbersome, challenging for the limited administrative and technical capacities of many developing countries, and providing limited flexibility for the countries concerned. In fact, the System was used for the first time (and the single time to date) only in September 2008 by Rwanda (an LDC) to import from Canada, after the latter changed its national intellectual property laws accordingly.

The Paragraph 6 System is a step forward towards creating more flexible legal procedures within the TRIPS Agreement to allow better access to essential medicines by developing countries. But it is certainly not enough. The overall framework of the TRIPS Agreement needs to be reviewed and made more "development friendly" so as to contribute further to improved access to medicines and better health for all.

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- a** It should be noted that price is only one of the factors influencing access to medicines. Access to medicines is defined as having medicines continuously available and affordable at public or private health facilities or medicine outlets that are within one hour's walk from the homes of the population. See United Nations Development Group, *Indicators for Monitoring the Millennium Development Goals: Definitions, Rationale, Concepts and Sources*, United Nations, New York, sales publication E.03.XVII.18, 2003, p. 89.
 - b** See United States Patent and Trademark Office at <http://www.uspto.gov/web/offices/pac/doc/general/>.
 - c** Khor, Martin, "Patents, Compulsory License and Access to Medicines: Some Recent Experiences"; Policy Innovations, Carnegie Council for Ethics in International Affairs, New York, February 2007.

Box 5 (cont'd)

- d** Musungu, Sisule and Graham Dutfield, "Multilateral agreements and a TRIPS-plus world: The World Intellectual Property Organization (WIPO)", TRIPS Issues Papers, no. 3, Quaker United Nations Office, Geneva and Quaker International Affairs Programme, Ottawa, Canada, 2003.
- e** World Trade Organization, "Intellectual property: protection and enforcement", Understanding the WTO: The Agreements, available at http://www.wto.org/english/thewto_e/whatis_e/tif_e/agrm7_e.htm (accessed on 24 April 2009).
- f** Leevy, Tara, "Intellectual property and access to medicine for the poor", *Virtual Mentor, American Medical Association Journal of Ethics*, vol. 8, no. 12, December 2006, pp. 834-838.
- g** This is not an exhaustive list of countries which used the flexibilities in the TRIPS agreement. For details, see Khor (2007).
- h** Lamy, Pascal, "Access to medicines has been improved", *WTO News: Speeches* (9 December 2008), available at http://www.wto.org/english/news_e/sppl_e/sppllll_e.htm (accessed on 24 April 2009).
- i** For additional information on "TRIPS and public health" see the WTO website: http://www.wto.org/english/tratop_e/trips_e/pharmpatent_e.htm.

Without strong links to poverty-reduction processes (and adherence to the Paris principles of aid effectiveness), scaling up aid may not have strong positive impacts on health equality. This applies to GHPs as well. One approach would be for GHPs to be more explicitly linked to the Poverty Reduction Strategy Papers (PRSPs) and funds to be channelled through government budgets (*see Appendix*). At the same time, the PRSPs should also take into account the need to create additional "fiscal space" for health—i.e., space in the public budget to scale up health. In the case of Rwanda, for example, where the government is accountable for delivering the goals in its PRSP, much of the assistance in the health sector was channelled through GHPs and other vertical programmes. Only 14 per cent of the aid for health that the government received passed through the budget. The difficulty for a government is that if it misses the PRSP goals, it may face aid suspension and other negative reactions from donors, even though it does not exercise much control over the financial resources received. Additionally, macroeconomic stability still dominates PRSPs' concerns, which constrains expenditure increases in health and in other social sectors.

Conclusions and recommendations

The health status of a given population is the result of the complex interaction of a wide range of factors which go beyond the jurisdiction of health authorities. Inequalities in socio-economic status in particular tend to influence health inequalities. Addressing health challenges requires policy makers to have a comprehensive approach. Improving health outcomes in a sustained and equitable manner goes beyond the simple provision of treatments and medicines.

Inequality matters for achieving goals of global public health: numerical targets can be mechanically met while many are left behind, thus affecting overall health achievement. Without specific effort and targets, the less privileged members of society can be often bypassed.

While health needs to be mainstreamed into overall development strategies, it is also necessary to integrate social and gender considerations and to address existing inequities in making health care available and accessed by those who need it. It demands corrective action to be taken towards the social factors which determine people's health conditions, as emphasized in the report by the WHO Commission on the Social Determinants of Health. In this regard, the Commission puts forward three main recommendations, which CDP fully supports:

1. *Improve living conditions*, emphasizing especially the well-being of girls and women, the circumstances in which children are born, improving living and working conditions, providing social protection for all.
2. *Tackle the inequitable distribution of power, money and resources*. This fundamental requirement assumes a strong public sector and commitment to governance for equity at all levels, from community to national to global.
3. *Measure and understand the problem and assess the impact of action*. The Commission notes the need for surveillance systems to report on equity.

In order to ensure that the development partners and international cooperation in particular addresses existing health inequality, the

Committee further recommends that monitoring activities on performance on the MDG health goals be enhanced by including an indicator on achieving the targets among the poor and disadvantaged.

In this regard, the aggregate health goal for each country should be adjusted to include explicit health goals in terms of health outcomes for groups defined by income group, region, ethnic/race, age and gender, so as to advance the promotion of health for all.⁴⁷ At the global level, a small set of key indicators of health inequalities for monitoring should be selected: for example, healthy life expectancy (male, female), under-five mortality (urban, rural), and infant mortality ratios (by wealth quintiles), among others. Additionally, inequality impact assessments for interventions in the health sector need to be introduced. This would draw attention to the inequality implications of proposed actions by local authorities and through international cooperation, including those of GHPs.

The international community, including the traditional official donors as well as non-traditional donors, has an important role to play in assisting developing countries in improving the health status of their populations. To promote the achievement of the MDG health goals and to reduce health inequalities, the Committee also recommends the following international actions:

- Essential access to low-cost medicines and treatments should be further facilitated by allowing more flexibility and less complex legal procedures to grant exemptions to intellectual property rights with regard to medicines and medical treatments. Access, particularly under the Paragraph 6 System, should be further reviewed and amended so that the current patent and property rights régime is truly “development friendly” and, more importantly, improves access to essential medicines for the poor. Since agreement on and implementation of reforms is likely to be protracted, in the meantime, the provision of technical assistance to improve countries’ capacities to comply with the provisions of the TRIPS amendment is recommended.

⁴⁷ Gwatkin, D. R., et al., “Making health systems more equitable”, *Lancet*, vol. 364, issue 9441 (October 2, 2004), pp. 1273-1280.

- Adjustment policies in reaction to the global financial crisis should be designed so as to sustain expenditure on health and education, especially basic services benefiting disadvantaged groups. In this regard, the international community should sustain development assistance specifically supporting health and education.
- The effectiveness of interventions by GHPs needs to be improved. Better coordination is required to reduce conflicts between disease-specific interventions and general health services. Recipients and donors need to keep an integral view of the health system, giving priority to primary attention and the strengthening the institutional and technical capacities of the system. GHPs should adhere to that logic, mainly local, taking care that their action does not weaken (or fragment) the national health system.
- GHPs need to go beyond having a disease-specific focus and to ensure that the causes of social and gender inequities that determine access to health are accurately addressed. Furthermore, GHPs should include measures sensitive to social and gender inequities when establishing their own operational targets. It is essential to ensure that access to health services does not become less equitable as a result of GHP interventions. New GHPs should be introduced only where they support these objectives.
- GHPs should implement the following actions: (a) adoption of the principles of the Paris Declaration (especially the ones related to alignment and coordination); (b) subordination to the recipient countries' health system, preserving the leadership of host governments in addressing health issues at the local level; (c) enhancing their structures of governance, and (c) increased technical assistance, as a means to correct the existing inequalities within countries and improve the efficiency of their own programmes.
- Regarding bilateral official development assistance delivered in the “traditional way”, donors need to review their criteria of resource allocation to guarantee that recipient countries are able

to integrate GHP efforts in a coordinated way with their own actions in the field of health. In this way, GHP interventions can respond to the specific characteristics of domestic health systems and their respective needs. In some cases, this could mean a review of the contributions donor countries give to GHPs in the benefit of a greater support of recipient countries' budgets, thus reinforcing sector-wide approaches (SWAs, see box A.1, below) and/or poverty-reduction strategies.

The responsibility for improving the health of the population and reducing inequalities lies primarily with national governments. The CDP recommends that national governments take the following measures in the health sector, supported by aid:

- Assure universal access to health services of a satisfactory quality, including:
 - ♦ Eliminating all sources of discrimination within the health service itself and in relevant sectors of society, including racial, ethnic, gender and age discrimination.
 - ♦ Redesigning training and task allocation to improve the supply and distribution of health personnel and services across regions and groups. The critical shortage of health-care workers needs to be addressed. Securing a sufficient number of medical doctors and nurses, together with physical infrastructure, requires not only long-term solutions but also shorter-term responses. One such measure is to provide incentives to existing and potential health workers by offering better remuneration and working conditions.
 - ♦ Removing user charges for basic health facilities. This measure would contribute to lowering barriers to access for the poor. As noted above, however, this is only the first step. Providing financial support to cover other costs of using health services (such as transport and related opportunity costs) is also necessary. Cash transfers to households whose members attend health centres/clinics or health education

programmes at school appears to encourage attendance at clinics and to benefit the poor, although the very poorest are sometimes excluded.

- Improve the balance between primary and secondary health care, as the poor benefit more from the supply of primary health care than from care extended by hospitals and/or made available through expensive treatments. Achieving an improved balance may also involve restructuring the education and training of medical personnel as suggested above.
- Emphasize the provision of preventive health education and health services. Health education should become a major component of the educational curriculum. Additionally, female education should be promoted not only for advancing gender equality but also to promote better health outcomes for women and their families.
- Promote a healthier physical environment, including the use of less polluting and damaging cooking stoves and fuels.
- Tax and regulate items that cause ill health, and use the revenue to support the health sector. Taxing and regulation should extend to tobacco, alcohol, “junk food” and soft drinks and “luxury” health services, such as cosmetic surgery.

Finally, the Committee recommends that efforts should be directed towards improving the availability and quality of the existing data on health indicators. Action against social inequity in general, and health inequality in particular, will be more effective if the systems, including vital registration and regular monitoring of health outcomes and inequality, are in place. In this regard, there is a need to measure a smaller number of indicators that bear direct relevance to decision-making and high-priority health issues as those suggested above. Inter-agency activities on the MDGs are a good basis for providing guidance and building databases of indicators on health inequalities. Strengthening statistical capacity in low-income countries will need a concerted effort from governments, from donors, and from multilateral institutions.

Appendix

Assessing global health partnerships: additional considerations

The proliferation of GHPs has had both positive and negative effects on the capacities of developing countries in tackling health problems. One of the most visible contributions of the GHPs has been the integration of agents and resources from various spheres (public and private) into a common and discrete goal. The GHPs thus set a framework within which different perspectives come together to establish formulas for consensus based on the experience and knowledge of all participants. On the negative side, the partnerships have imposed a toll on the coherence of the overall international aid system.

I. Positive aspects

The positive contribution of GHPs to advance health goals can be expressed in terms of:

Operative efficiency

The GHPs have functioned acceptably well, especially in terms of improved access to treatments, therapies and medicines. For instance, by December 2008, the Global Fund to Fight AIDS, Tuberculosis and Malaria had provided AIDS treatment for 2 million people and TB treatment for 4.6 million people under directly observed treatment, short-course (DOTS), and distributed 70 million insecticide-treated mosquito nets to protect families from malaria. These initiatives are estimated to have contributed to saving the lives of some 2.5 million people.

GHPs have stimulated the research and development of new markets and new products and helped to reduce the production costs and

risks associated with new product development. Due to increased demand, additional markets have been secured for the eventual products coming from innovation and research efforts.¹ At the same time, a significant reduction in the price of some pharmaceutical products has been achieved in developing countries. For example, HIV treatment in the poorest countries now costs close to a tenth of what it costs in developed countries.

Additionally, there are indications that the GHPs have promoted better policies for the treatment of the diseases concerned in the beneficiary countries by giving national systems better means of planning their goals and determining their future needs. Improvements have also been noted in monitoring practices, transparency in procedures and, even, in some cases, the participation of many agents, including NGOs, in defining health policies. Nevertheless, these results coexist, in some cases, with inefficiencies in access to less costly medicines such as generic drugs, delays in the release of payments, and in the implementation of programmes, or even the limited capacity of funds to impact on certain types of diseases.

Increased resource mobilization

The emergence of GHPs has led to a significant mobilization of efforts and resources to tackle goals in the field of health. This increased capacity to mobilize funds is largely owing to the fact that in this type of framework, private agents—such as foundations and companies—have found a suitable means of joining these initiatives. Yet, the availability of resources is still below what is needed to achieve the MDGs in health.

It is important to note, however, that official donors have frequently redirected a part of their international aid in health to new activities related to supporting GHPs. For instance, during the period 2001-2008, official bilateral donors provided \$1.5 billion to GAVI, which corresponds to 40 per cent of all resources donated to that partnership. Additionally \$1.2 billion has been raised through the International Financial Facility for Immunisations (IFFIm), a financing mechanism that aims at

¹ The approach of the Global Fund to Fight AIDS, Tuberculosis and Malaria to international health financing is discussed on the Global Fund website, at <http://www.theglobalfund.org/en/partnership/?lang=en> (accessed on 19 June 2009).

accelerating the availability and predictability of funds for immunizations used in GAVI. Official bilateral donors also take part in the financing of the Global Fund, contributing over \$8 billion—or 80 per cent of total funds contributed—over the period 2001-2007. Thus, only part of the resources mobilized by the GHPs is actually new money for health.

II. Risks and inefficiencies

The proliferation of GHPs is not without problems and risks. Most of those risks come from the effect that GHPs have on national health systems (discussed in the main text of this chapter), on the one hand, and on the coherence and efficiency of the international framework for cooperation for development, on the other.

The sustainability of interventions, resource predictability and effects on financial stability

The way in which GHPs operate can have undesirable effects on the recipient countries' ability to manage their budgets. The problems are diverse. First, there may be problems regarding *absorption* of the funds and initiatives in the recipient countries, especially when national administrations—often facing severe technical and institutional constraints—have to be involved in the management of such funds and programmes. Second, the limited *predictability* of activities and funds to be released is a cause of concern. The fact that part of the funding is sometimes made outside the budget and with the participation of other agents outside the public system (such as NGOs) only compounds the problem. The dynamics of decision making and resource management is thus superimposed on the budgetary cycle of the recipient country, making it difficult to integrate these resources properly into the country's budgetary processes. Third, *financial stability* can be compromised as, in some cases, the sums involved amount to an injection of resources large enough to affect macroeconomic stability. A fourth problem refers to the *sustainability* of interventions, since the GHPs may increase the level of operations far above the administrative capacity of the government.

With respect to aid predictability, there is increasing concern at present about the implications of the current economic crisis for health outcomes in recipient countries. Past economic crises, such as those in Norway and Sweden in the early 1990s, have shown declines in aid in the subsequent years with their eventual return. In the case of Finland and Japan, which also faced economic crises in the 1990s, their aid flows have not yet returned to their peak values. A decrease in aid for these already poor countries would have devastating effects on the progress that has already been made in matters of immunization and access to treatment and care against deadly infectious diseases if partnerships are forced to lower their support for these countries.

System coherence and transaction costs

Another type of risk associated with the proliferation of GHPs concerns their impact on the functioning of the entire international aid architecture, on one hand, and on the effectiveness of interventions on the other. Due to the support granted by the new agents involved in global initiatives, the social sectors have absorbed a larger share of aid, to the detriment of the productive sectors. However, these latter sectors are crucial for development, not only because the living conditions of the poor depend on them, but also because they constitute the basis on which achievements made in social issues (including those related to health) can be made sustainable.

The proliferation of vertical initiatives, when uncoordinated, creates a serious problem in terms of harmonization among donors and the alignment of those initiatives with the priorities and procedures of the recipient country, as discussed earlier. There is a need to clearly define roles and responsibilities of the partners to avoid duplication among the different programmes, as well as minimize possible competition between the different programmes. One recurrent problem is the lack of country presence of some partners, who operate with little administrative staff or do not have in-country workers at all, complicating communication and coordination efforts.

Additionally, a high burden is placed on the recipient's national administration as it deals with numerous agents with diversified procedures, demands and work dynamics. This problem is exacerbated if the GHPs'

vertical nature is taken into account—that is, their highly specialized areas of action (*issue-specific*) aiming to accomplish immediate results (*quick-results oriented*). This approach implies that the partnerships have tended to consider each activity (disease or task) as issue-specific, with its own international response, thereby presenting a more global or wide-ranging vision of the components of health.

Integration of the GHPs in the sector-wide approach (*see box A.1*), which strictly adheres to a working application of the Paris Declaration, could correct some of these shortcomings. The principles of the Declaration are entirely pertinent to GHPs, but it has to be said that the degree to which those principles have been implemented by these funds is very low (*see box A.2*). Neither one of these alternatives is generalized practice among GHPs.

Box A.1

SWAp: sector-wide approach

The sector-wide approach (SWAp) initiative emerged from the Sector Investment Programme (SIP), a concept promoted by the World Bank in the mid-1990s and now utilized by bilateral and UN agencies.^a The SWAp has as its purpose to foster ownership, “improve donor harmonization and aid predictability and align policy behind a health-reform program agreed between government and donors”.^b The approach has contributed to increasing health-sector coordination, enhancing national leadership and ownership and strengthening management in the countries as well as the delivery systems.

The approach implies that the ministry of health takes leadership in the coordination of aid and the direction of activities. Donors are also to be responsible for synchronizing their planning, review and monitoring systems with those of the government, as well as providing long-term projections of their contributions.^c

The SWAp programme requires consensus among stakeholders in the direction of health system strategy, as well as the responsibility of the partners for carefully monitoring of programme implementation. The World Bank participates in approximately 30 health-related SWAps in 20 countries.

There can be a number of main constraints to the implementation of a SWAp: the limited capacity of the health ministry to direct the programmes due to lack of experience; poor relationships or coordination with the other sectors, and a slow

^a Larsen, Bjarne, “Sector Wide Approach—history and some theoretical considerations”, paper presented for Chief Advisors at Danida Seminar, June 2003 (<http://www.dev-ass.dk/uploads/pub-sector-wide-approach.pdf>).

^b Working Party on Aid Effectiveness and Donor Practice, World Health Organization, World Bank and the OECD/DAC, Proposal to use health as a “tracer sector” for tracking progress on the Paris Declaration, 2007.

^c Hutton, G. and M. Tanner, “The sector-wide approach: a blessing for public health?”, *Bulletin of the World Health Organization*, vol. 82, no. 12, WHO, Washington, D.C., December 2004, pp. 891-970.

Box A.1 (cont'd)

shift of ownership to the ministry. Furthermore, donors may not adequately take into account the national development framework and national particularities when implementing programmes or setting targets. Additionally, implementing a SWAp depends on concrete agreement on a single strategy among all of the partners—including the government, funding agencies and other stakeholders. If these conditions are not in place, then the SWAp is not likely to be successful. But if they are, SWAps can contribute to improving the health of the population in a country, while strengthening the national health system.

Box A.2**The Paris Declaration and global health partnerships**

a Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability, adopted at the High Level Forum, held in Paris, 28 February-2 March 2005, available at <http://www.oecd.org/dataoecd/11/41/34428351.pdf> (accessed on 19 June 2009).

The principles of the Paris Declaration on Aid Effectiveness^a are highly relevant for aid in health:

Ownership should be applied to the health system, at least on two counts. First, a strategy on health should be originated and developed from national foundations. The GHPs, like other donors, should integrate themselves into these strategies, strengthen their design and facilitate their implementation. Second, health ministries should engage in framing “upstream” development strategies, improving the budgetary conditions in which the sector operates.

Health aid should be *aligned* with national systems, including systems which provide health-related services, the mechanisms related to information, monitoring and evaluation of public policies, and the national procurement systems. In this regard, it is necessary to operate through a multi-annual plan so as to allow for increased predictability of resources and for the country to develop its institutional capability.

Enhanced *harmonization* of GHPs' procedures is needed to reduce operational costs. There are many different kinds of agents operating in the health sector (bilateral and multilateral, public and private), and their activities are very diverse (different diseases, research, treatment, strengthening of institutions, etc.) Harmonization is also a prerequisite for engaging in better coordination between agents.

It is necessary to *manage the programme* by results. This requires reaching a consensus among stakeholders on the procedures for monitoring and evaluating interventions. Additionally, improved information systems should be in place.

Box A.2 (cont'd)

Finally, it is necessary to implement systems of *mutual accountability* between donors and recipients. In this regard, the GHPs must adopt more flexible stances and maintain open dialogue with national authorities and improve their systems of governance in health.

Necessity to combine resources and technical assistance

Many studies point out that GHPs do not have adequate technical support components in their programmes aimed at helping the recipient countries access the funds, adequately absorb resources and manage health interventions or aid programmes. Recipient countries, especially the poorest ones, have limited capacity to judge which of the many available funds is the most appropriate for their needs, or which programmes they can participate in with some certainty of success.

Technical assistance is necessary to allow recipient countries to benefit fully from a GHP. Assistance is especially relevant in the areas of planning, budgeting, and monitoring and evaluation, in training and in the implementation of initiatives. Although there are initiatives to finance technical assistance within the GHP framework, the majority of them are *ad hoc* proposals, granted on request.

Systems of governance

GHPs also suffer from governance issues. Some GHPs (such as the Global Fund, for example) have their own, independent, legal frameworks, while others are hosted by another institution (for instance WHO in the case of GAVI, the Stop TB Partnership and the Roll Back Malaria Partnership). Independent institutions carry higher operating costs. Meanwhile, when hosted by other organizations, a GHP and its host may face coordination issues with regard to the governing structures and operating procedures of both. It is difficult for a partnership to take place if the roles and responsibilities of the partners involved are not agreed and properly aligned.

Issues of representation in GHPs arise when one partner overly dominates the other partners, when some partners have only a limited

presence (as with NGOs) or when developing countries are not adequately represented.² Problems of accountability for GHPs may arise not only with their partners, but also with beneficiaries and with public opinion in general. In fact, recipient countries may feel that decisions come from the top to the bottom in a large proportion of GHPs, and that there is limited transparency in decision-making processes. As Asante and Zwi (2007) point out, referring to the operative procedures of the GHPs, “the process of selecting private partners, the setting of targets to be achieved and the formulation of management guidelines are anything but transparent.”³

2 For instance, as Buse and Harmer (2007) stated, the representation of low and medium income countries barely reached 17 per cent in the governing structures of a wide section of GHPs, and that of NGOs scarcely reached 5 per cent, while the representation of companies reached 23 per cent. Buse, K. and A. M. Harmer, “Seven habits of highly effective global public-private health partnerships: Practice and potential”, *Social Science & Medicine*, vol. 64, issue 2, January 2007, pp. 259-271.

3 Asante, A. D. and A. Zwi, “Public-private partnerships and global health equity: prospects and challenges”, *Indian Journal of Medical Ethics*, Forum for Medical Ethics Society, Mumbai, October-December 2007.

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