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Investing in the Health of the Poor
A Strategy for Sustainable Health Development and Poverty Reduction in the Eastern Mediterranean Region

World Health Organization
Regional Office for the Eastern Mediterranean

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Foreword

The unanimous adoption of the Millennium Development Goals (MDGs) at the special session of the United Nations General Assembly in September 2000 was recognition that development is not just a matter of investment in physical capital. On the contrary, expenditure on social services, such as health and education, particularly for the poor, far from being a burden, is an engine of national growth and welfare. The adoption of the MDGs also ensures that in future the success or failure of any country's development efforts will be measured by their impact on the poorest in society.

The regional strategy for sustainable health development and poverty reduction presents the multiple challenges being faced in the Eastern Mediterranean Region—challenges that influence progress towards the attainment of good health. The objective of the regional strategy is therefore to seek maximum gain in the health of the population, and particularly of its poorest members. The strategy articulates broad lines of action for public authorities, and suggests the need to redress the existing imbalances between policy and allocation of public resources. It proposes a far stronger focus on the wider determinants of health, with the public authorities functioning in three modes: promotive, to target directly the diseases that affect the poor more than the rich and to support the adoption of healthy lifestyles by the population; regulatory, to diminish the impact of adverse environmental and social influences on health; and participatory, where the health agencies need to advocate action by, or collaborate with, partners in other sectors of government, with enterprises and with civil society to achieve health-related goals.

Success in implementing the regional strategy will require a seriousness of purpose, a political resolve, and an adequate flow of resources from high-income to low-income countries and groups on a sustained and well-targeted basis. This process can be greatly facilitated through existing community-based initiatives that place attainment of good health at the centre of poverty reduction, environmental health and human development. Such micro-level interventions have enabled the communities in many

countries of the Region to successfully overcome some of the socioeconomic inequities between the poor and the rich.

Until recently the international community sheltered behind the assumption that the health attainments of the more affluent would eventually be disseminated across all strata, while neglecting to observe and measure the constant, and widening, chasm between the health of the rich and that of the poor. The agenda set out in the regional strategy will require national governments, specifically ministries of health, to judge their achievements by the touchstone of how the poorest within our societies experience health and disease. It is hoped that the regional strategy will inspire the leadership in each country and partner agencies to take the broadest view of its responsibilities, with a sharper focus on the health of the poor.

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Executive summary

Multiple challenges impede the efforts and progress towards the attainment of good health and sustainable development in the Eastern Mediterranean Region. Poverty has been shown to have a direct effect on the efforts of the poor to attain better quality of life. Pro-poor policies can deliver more effectively if the challenges are addressed and diseases that affect the poor more than the rich are targeted. There is no doubt that more resources are required, in addition to improved performance and efficiency of individual programmes. Multilateral and bilateral agencies, global funds and commissions, United Nations organizations and affluent countries will have to accelerate their efforts to support policies and initiatives that attack the poverty trap and enhance the social status of poor communities.

It is important to integrate at national level the different processes of implementing the international development agenda. The health sector can take the leadership, building on its cross-sectoral aspect, in demonstrating that the objectives of poverty reduction are very much consistent with improving the health outcomes of the poor and with implementing the health reforms that are required in many poor countries. Ministries of health are also called upon to play a more proactive role in influencing policies made outside the health sector. This not only requires health ministries to become advocates for good health outside their domains but also places an onus on them to support their arguments with evidence and information. It is necessary to capitalize on the existing interventions and resources. Of particular importance to the Eastern Mediterranean Region are the ongoing community-based initiatives that can be effectively used as a springboard for formulating pro-poor policies and implementing the recommended strategic directions.

1. Introduction

There has been major shift in the perception and vocabulary of development in recent years. Where once development was equated with economic growth, which was seen as the ultimate objective of development, poverty reduction is now seen as the over-arching goal of development. Where the route to economic growth was once seen as investment in physical capital, it is now recognized that many forms of capital, including human and social capital, contribute to the growth of output. Poverty itself is recognized as a multifaceted concept, not simply a matter of insufficient income, but also a matter of insufficient or inappropriate earning capacities in relation to ill-health, ignorance, and lack of power and voice. Where once it was assumed that the benefits of economic growth would eventually "trickle down" to the poor, the delivery of welfare to the poor in the forms of improved livelihoods, social services and benevolent governance is now seen as both a direct assault on those multiple deprivations and as an investment in the capacities of the poor to lift themselves out of poverty. Economic growth is still perceived as desirable, but it is for its instrumental value in enhancing the resource base to deliver social services, productive employment opportunities and better governance, not as an end in itself.

This shift in perception is reflected in the Millennium Development Goals (MDGs), adopted unanimously by all countries of the world at the United Nations in September 2000. The first goal is the halving of the proportion of the population living in extreme poverty. Three of the supporting goals are concerned with health, one each with education, gender equality, and environmental sustainability, and the last is the instrumental goal of forging a global partnership for development. These goals are not free standing, but are mutually synergistic. The implication is that achievement of the over-arching goal of poverty reduction will not occur unless the supporting goals are also met. Recent thinking has sought to bring health to the centre of the development debate by asserting that poor health is both a consequence and a cause of poverty[1]. It is therefore a challenge to

[1] Poverty and inequity: a proper focus for the new century. *Bulletin of the World Health Organization*, *2000*, 78(1).

all health authorities, national and international, to deliver the gains which will support poverty reduction and human development. National health and poverty reduction strategies should be able to demonstrate how the benefits of development reach the poor, and put in place monitoring systems and the processes by which these benefits are delivered. Ministries of health, alone, cannot play an effective role in combating the adverse effects of poverty and improving the health of the poor unless a broad-based partnership is available. This can be facilitated through a coherent process involving the development of Poverty Reduction Strategy Papers (PRSPs), the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization, and the follow-up to the report of the Commission on Macroeconomics and Health.

Appreciation of the critical relationship between health, sustainable development and poverty reduction is not sufficient. It is also essential to embark on the crucial steps to move from analysis to policy, and from policy to action. Recognizing the need to widen the scope from only health-focused goals towards the attainment of better quality of life, the WHO Regional Office for the Eastern Mediterranean has been advocating poverty reduction as one of the most effective approaches to achieve equitable development and health improvements. Community-based initiatives such as basic development needs, healthy cities and healthy villages have been promoted in the Region in pursuit of this objective.

The development of a regional strategy on sustainable health development and poverty reduction is an effort to build on the experience of community-based initiatives, aiming to move from micro-level initiatives to macro-level policies by creating partnerships of a wider spectrum. It is hoped the regional strategy will inspire Member States and partners to reshape their policies and redouble their efforts, and to look at ways and means by which WHO and others can support these endeavours.

2. Situation analysis

2.1 Linkages between health and poverty

In common with other regions, the Eastern Mediterranean Region comprises countries with variable levels of health and income. The Region includes oil-rich states which achieve a high level of well-being for the great majority of their citizens, very poor countries in which a significant proportion of the population live below the US$ 1 a day level, and a varied group of middle-income countries in which poverty and sub-optimal health is a widespread concern, albeit at less extreme levels of deprivation.

Comparing Member States of the Region at the level of national averages, there are positive correlations between per capita income, life expectancy, health expenditure and primary health care coverage. Although there is a fairly strong implication that health differences between countries of varying prosperity are reflected in differences between socioeconomic strata within each country, there is very little direct evidence bearing on this point, as the information is scanty on the poverty situation in most countries of the Region. Data[2] on the income ratio of the richest to the poorest among selected Arab countries (Table 1) show a wide disparity between the rich and the poor even in comparatively affluent countries of the Region.

Analysis of original data from the Demographic and Health Surveys of Morocco and Pakistan, using an index of household assets and dividing the survey samples into quintiles by socioeconomic status, corresponding health status and service utilization measures, permits some exploration of the relation between health status and socioeconomic status (see Table 2)[3].

[2]United Nations Development Programme, Arab Fund for Economic and Social Development, *Arab human development report, 2002.* New York, UNDP, 2002.

[3] *Demographic and health indicators for countries of the Eastern Mediterranean 2001*, Cairo, World Health Organization Regional Office for the Eastern Mediterranean, 2002.

Table 1. Income ratios of the richest to the poorest in selected Arab countries

Country	Richest 10% to poorest 10%[a]	Richest 20% to poorest 20%[a]	Gini index[b]
Jordan 1997	9.1	5.9	36.4
Tunisia 1995	13.8	8.5	41.7
Algeria 1995	9.6	6.1	35.3
Egypt 1995	5.7	4.0	28.9
Morocco 1998–99	1.7	7.2	39.5
Yemen 1998	8.6	5.6	33.4
Mauritania 1995	1.2	6.9	37.3

[a] Data show the ratio of income or consumption share of the richest group to that of the poorest
[b] The Gini index measures inequality over the entire distribution of income or consumption
A value of 0 represents perfect equality, and a value of 100, perfect inequality

Table 2. Relation between health status and socioeconomic status

	Morocco (1993)			Pakistan (1990–1991)		
	Lowest quintile	Highest quintile	Ratio	Lowest quintile	Highest quintile	Ratio
Infant mortality rate	79.7	35.1	2.27	88.7	62.5	1.42
Under 5 mortality rate	1.6	39.2	2.85	124.5	73.8	1.67
% under 5 stunted	39.2	8.1	4.84	61.1	32.9	1.86

This is the clearest evidence available of the strong relationship which exists between health status and socioeconomic status within countries. Ideally, such information should be available for all countries, and be frequently updated, as almost all the available health indicators are undifferentiated national averages. A rare exception is access to health services, which shows in some instances rural access to be substantially inferior to access in urban areas. However, even this type of data is not available for all countries in the case of the more demanding indicators, such as maternal mortality ratio.

2.2 Challenges

Like many parts of the world, widespread poverty, poor health status, environmental degradation and water scarcity are among the important challenges affecting social development in the Eastern Mediterranean Region. Challenges and issues intrinsic and specific to the region pose additional impediments to achieving sustainable poverty reduction and health development. Military conflicts and wars, sanctions and embargoes have affected many economies of the Region, causing declines in productivity and disrupting markets [4, 5]. Some countries struggling to recover from the ravages of war have emerged with substantial debts, limiting options for public expenditure. Ethnic minorities and refugees account for a sizable population in the Region. A major challenge faced at the moment is the drafting of policies that take into account the perceived health and economic needs of these populations.

Policies formulated in the social and economic sectors have started to take into account the need for gender-sensitive approaches but still these appear not to be uniformly applied and therefore do not yield the desired results. The additional factor of cultural barriers and taboos further complicates the situation. This not only impedes the implementation of economic policies but also results in the under-utilization of health care delivery systems.

Equity concerns do not always receive the attention they should. Inequitable distribution of services (be that geographical, cultural, social or economic) tends to increase the already existing imbalance in favour of the more affluent at the expense of health and development of the poor.

Globalization and the growth of new technologies have put additional strain on the already over-burdened economies of the Region. Developments in the area of genome and genetic engineering not only add to economic and scientific challenges for the less developed economies but also have strong ethical ramifications which seem to be more pronounced in poor populations since they have little or no access to evidence and information about the newer technologies.

[4] *World development indicators 2003*, New York, World Bank 2003.

[5] *Millennium Development Goals: A compact among nations to end human poverty. Human development report 2003*. New York, UNDP, 2003.

A major challenge facing WHO and countries of the Region is the deficient state of information and evidence about the magnitude of poverty, its distribution among different groups, the effect of poverty on health and development and the impact of poverty on the overall economy.

3. Strategic framework

3.1 Mission and principles

The *mission* of the regional strategy on sustainable health development and poverty reduction is to spur a commitment from the Member States to improve the health of the poor. Health refers to health status, not just the provision of health services. The health of the poor cannot be isolated from the health of the entire population. But experience also provides the lesson that, if no special attention is given to the poor, if the mission is defined as simply to optimize health in general, then the outcome is that the health of the poor remains worse than the health of the non-poor, and the health status gap may even widen. The *objective* of the regional strategy is to avoid this sub-optimum outcome and to seek the maximum gain in the health of the population, and particularly its poorest members, by the application of pro-poor national health policies. A suggested definition of a pro-poor policy is a policy which, when implemented, generates proportionately greater benefits for the poorer members of society. The reason why the objective should incorporate a distributional concern is because of the intimate connections between health and poverty (see Box 1).

It is now commonplace to observe that the association runs in both directions: from poverty to ill-health, because there are consistent observations that the poor carry a disproportionate share of the burden of ill health, and from health to poverty, because of the causal links between poor health status and income poverty. More positively stated, there are clear demonstrations of health improvement as a means of generating income growth, as the return on improved human capital. Both of these associations are important, but the one which is most open to policy intervention by the health authorities is the connection that runs from improved health status to poverty reduction. The most direct contribution that the health sector can make to poverty reduction is by improving the health status of poor households.

Box 1. Different perspectives on the relationships between poverty and health

POVERTY		HEALTH
1. Traditional epidemiological analysis		
Low incomes, poor nutrition Insanitary environment Lack of information and awareness Low use of effective health services	→	Poor health status
2. Recent poverty analysis		
Households plunged into poverty	←	Poor health leading to loss of income and high medical expenses
3. Modern development paradigm		
Human capital stock improved generating higher incomes	←	Improved population health status

Key *principles* to achieve the mission stated above include the following:

- Supporting the Member States in developing a shared vision for health and development and in formulating national strategies focusing on health of the poor based on poverty analysis and measurement;

- Creating synergy for pro-poor policies by integrating different initiatives and developing methodologies and approaches aiming at health improvement, poverty reduction, gender mainstreaming, human and social development and environmental health;

- Assisting the national authorities and civil society in reducing health inequities and poverty through dynamic intersectoral collaboration, and building and expanding existing partnerships so as to tackle challenges pertaining to globalization, human rights and emerging technologies and resource constraints;

- Helping in empowering communities and vulnerable groups, particularly women, to play the leading role in health and development;

- Assisting and motivating Member States in incorporating community development approaches and pro-poor health policies in national poverty reduction policies and programmes.

The agenda set out in the above mission and supporting principles require a more proactive role not only for WHO but for the Member States as well. The Regional Office will continue to assist the Member States and other partners towards achieving better health for the people of the Region as a means to economic prosperity and sustainable development.

3.2 Supporting sustainable health development and poverty reduction–four domains of action, five strategic directions

The regional strategy identifies five critical directions distributed over four domains of action. The first four strategic directions are intrinsic to the health sector where, although wide intersectoral collaboration is sought, it is primarily the responsibility of health sector to execute policies and programmes. The fifth strategic direction however, is extrinsic to the health sector, as it requires multisectoral efforts to attain maximum health gains by addressing the wider health determinants and risks that disproportionately affect the poor. It is therefore essential that governments, and specifically ministries of health, should take a wider view of their responsibilities than is traditional. Whereas they traditionally focus on actions mentioned in the upper left quadrant in Box 2 (public hospitals and clinics), this strategy urges them to:

- engage with nongovernment providers of medical care
- revitalize and expand public health functions
- advocate and participate in intersectoral action to promote health

Box 2. Four domains of health action

Public hospitals and clinics	Non-government hospitals, clinics and pharmacies	**Medical care**
Public health functions: environmental regulation and health promotion	Intersectoral action to promote health	**Wider determinants of health**

The modes of intervention that are available differ across these four domains. While the Ministry of Health can give direct instructions and budgetary allocations to the public provider system, including its public health component, when it engages with other sectors and nongovernment providers, it cannot give direct orders. It can influence the conduct of these providers by a mix of various forms of regulatory action, ranging from restrictive licensing to positive accreditation, subsidy, exhortation and collaborative agreement. Similarly, it cannot give direct instructions even to public agencies in other sectors, still less to other types of partners. The main tool it can deploy is advocacy by providing the evidence and arguments that health benefits are produced through action taken in other sectors, such as education, agriculture, nutrition, environment, energy, transport, water supply and sanitation, along with provision of better economic opportunities. In some cases, the Ministry of Health can offer participatory action in collaboration with other ministries and relevant governmental or nongovernmental entities, which have the prime jurisdiction in the sector concerned. For example, there are many opportunities for collaboration between the health and education sectors. The important point is that the Ministry of Health must initiate and inspire intersectoral action for health, because health is not at the top of the agenda in other jurisdictions. Without pressure from the Ministry of Health, the opportunities to work for better health outcomes through interventions in other sectors would be lost.

The strategic directions recommended by the regional strategy are summarized in Box 3.

Box 3. Five strategic directions for pro-poor health policy

1. **Reallocate resources and services by targeting poor and vulnerable people directly**
   - reallocating resources by geographic areas (e.g. population-related resource allocation formulas)
   - developing and adequately funding universally accessible systems of primary health care supported by appropriate referral hospitals
   - countering imbalanced and inequitable distribution of human resources
   - encouraging nongovernment provision in underserved areas
   - adapting services to specific needs of poor (refugees, street children)
2. **Concentrate on the diseases and conditions of the poor**
   - combating the high impact communicable diseases (tuberculosis, malaria, HIV/AIDS)
   - providing reproductive health (pregnancy and delivery care, sexually transmitted infections treatment, family planning)
   - preventing childhood diseases through immunization and integrated management of child health
   - reducing malnutrition (protein–energy, micronutrient)
   - extending support for noncommunicable diseases where supported by evidence of disease burden on the poor
3. **Reduce the burden of direct out-of-pocket payment for health services**
   - increasing budget and donor funding as share of total expenditure
   - operating graduated fees and fee exemptions
   - discouraging unofficial fees
   - encouraging collective risk sharing, pre-payment mechanisms (both formal insurance, and community schemes for the informal sector)
4. **Improve the supply and effectiveness of non-personal public health services**
   - expanding public information and promotion of healthy lifestyles
   - undertaking food fortification programmes (iodine, iron, zinc)
   - setting and applying standards for air, water and soil quality; occupational health; and food and chemical safety
5. **Advocate and participate in intersectoral action to achieve health gains**
   - expanding water supply and sanitation
   - preventing road traffic accidents (victims in many cases are poor pedestrians, bus passengers)
   - reducing tobacco consumption
   - increasing female education
   - raising incomes of poor (support livelihoods, cash and in kind transfers)
   - promoting local integrated community development (Basic Development Needs, Healthy Villages)

3.3 Potential interventions for strategic directions

The strategic framework outlined covers all four main components of WHO corporate policy by employing a broader public health approach to reduce risks to health, focusing on health problems disproportionately affecting the poor, making policy development responsive to the wider determinants of health and ensuring that health systems serve the poor more effectively. It supports the efforts so far made towards the achievement of Health for All, endeavouring to provide universal access to social, physical, economic, mental and spiritual well-being. Below, for each of the strategic directions, potential interventions are identified.

1. Reallocate resources and services by targeting poor and vulnerable people directly

Institute mechanisms to provide cost-effective health care service to the poor, eliminating both the financial as well as geographical barriers. Efforts should be made to reallocate resources to the lower tiers of the service delivery pyramid, which are generally not served by high level facilities. Supporting nongovernment service providers in underserved areas and redistribution of health personnel within the public provider system also tend to reach the poor more than the rich. Making services more geographically accessible is by nature a pro-poor policy. Strengthening the primary health care services and establishing effective community linkages are major strategies to reach the unreached. An alternative approach is to provide specifically adapted services for particular groups of the poor and vulnerable, who do not readily use conventional services. Countries and WHO need to operationalize the recommendations of the Commission on Macroeconomics and Health and develop the health component of the Poverty Reduction Strategy Papers to secure adequate assistance from the donors.

2. Concentrate on the diseases and conditions of the poor

Employ programmes and policies leading to integrated and sustainable delivery of services that effectively reach the poorest strata of the society, and within those particularly women and children, at a place and cost which they can afford. Strategies like integrated management of child health (IMCI), safe motherhood, nutritional support through food fortification and food subsidies have been shown to reach the poor more effectively. Defining a

package of essential services, giving preferential allocations to its components and ensuring a high rate of utilization will offset the burden caused by diseases affecting the poor. An important contribution to the resources available to countries is the access to the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization. Action directed at combating noncommunicable disease should also be instituted wherever evidence suggests the need.

3. Reduce the burden of direct out-of-pocket payment for health services

Financial barriers to access to health services are as important as physical barriers. In the Eastern Mediterranean Region out-of-pocket payment as a percentage of all financing resources ranges from a low of 4% to a high of 79%[66]. The recommended solution is to move to greater reliance on various forms of collective pre-payment. Social insurance is one such option, whereby the rich in effect pay for the poor. Alternatively, the state may pay premiums for the poor or otherwise disadvantaged groups, either at the normal rate or a concessional rate. Fee exemptions can be made for the poor or financial incentives provided for the services most commonly used by the poor to mitigate the negative impact of user fees. Special attention is required to address the needs of ethnic minorities and more disadvantaged groups, such as refugees.

4. Improve the supply and effectiveness of non-personal public health services

Establishing mechanisms for informing the public about risks to health and making information more readily available to the poor, sensitize them and enable them to participate in modifying lifestyles and behaviour detrimental to health. Regulation of the environment, be it control of pollution of air, water or soil, occupational health or food safety, produces benefits for all citizens, but particularly the poor, who are most exposed to the hazards of polluted environments. Caution should, however, be observed in order not to limit enforcement and application of such interventions to the major cities and the affluent suburbs. It is essential that environmental protection measures be applied also in peripheral unplanned and rural settings. Fortification of staple foods with elements like iodine, iron and zinc is not only an extremely cost-effective way of ensuring protective levels of intake

[6] *Spinning off for sustainable microfinance. Case study*. A study by the Regional Bureau for Arab States, United Nations Development Programme, in cooperation with the World Bank, Middle East and North Africa Region. UNDP, 1999.

for the entire population, but its value is particularly great for the poor whose normal diet does not guarantee the required intakes.

5. Advocate and participate in intersectoral action to achieve health gains

Ministries of health need to advocate action by, or collaborate with, partners in other sectors of government, the business sector and civil society to achieve health-related goals like provision of safe drinking-water and improved waste management, development of healthy public policies (regulation on smoking), prevention and reduction of environmental pollution and increasing opportunities for female education. Engaging poor communities in economic development schemes will not only improve their social well-being but will also improve their chances of access to better environments. Community-based initiatives are one of the approaches that can be used to implement the concept of intersectoral collaboration to generate sustainable livelihoods and improve social conditions, including health outcomes. In the long term, community mobilization will form an important ingredient for sustainability, not of only health services, but of all development benefits.

3.4 Prerequisites for success

The very considerable agenda for pro-poor health action outlined above implies the need for additional resources, specifically in the public sector, both from domestic budget allocation and donor assistance. For some of the poorer countries, additional resources might come from the debt relief offered to countries qualifying for the enhanced Heavily Indebted Poor Countries (HIPC) initiative. Debt relief *per se* does not create a new inflow of resources; what it does is allow governments to reallocate funds previously earmarked for external debt service to domestic expenditure, thus making possible higher expenditure on health and other social services among other uses. Under the new arrangements announced in 1999, debt relief has been linked to poverty reduction by making the grant of debt relief conditional on the production of a Poverty Reduction Strategy Paper (PRSP), a comprehensive document prepared by the national authorities setting out a national strategy for poverty reduction and proposed changes in resource allocation. The requirement to produce a PRSP is now extended to many countries, which sought to use the concessional finance facilities of the International Monetary Fund

and the World Bank. Under the PRSP agreements, up to 25% of the incremental resources can be applied to the health sector. It is expected that countries with well-constructed PRSPs will attract additional bilateral and multilateral funding. An important role for WHO is therefore to assist ministries of health in developing the health component of the PRSP based on evidence.

A second possible resource might be enhanced donor transfers, as recommended by the report of the Commission on Macroeconomics and Health. The report argues that countries might be expected to find an additional 1%–2% gross domestic product for health, by 2007, but acknowledges that even this daunting achievement would still leave many of the poorer countries short of the target of US $30–40 per capita annual expenditure on health. The difference could only be made up by vastly increased donor support to the health sector, from US$ 2 billion to US$ 20 billion annually. Although doubts remain that such a vast increase in donor generosity will occur, two recently introduced grant mechanisms provide sufficient hope and promise for the future. These are the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI). Similar efforts can be made in the Region, including setting up a regional fund to support pro-poor health policies and interventions.

Taking these sources together (debt relief, domestic budgetary increases and increased donor flows) there is at least the prospect that some of the resources required to implement the proposed strategy can be found. An implication of the new international arrangements is that funds will flow preferentially to those countries which can demonstrate that their policies are genuinely pro-poor, and that are able to meet donor and civil society expectations of probity, transparency and accountability in the management of resources.

Efforts towards poverty reduction employed by different institutions/organizations/countries are often plagued with bad governance when it comes to implementation of programmes. Good fiscal control, effective human resource development, meaningful management reforms, concrete accountability measures, good rapport between the community and public sector, and gender sensitive policies and plans will all add value to the resource mobilization efforts. Much can be achieved by employing simple techniques taking cognizance of the externalities, which may have, at times, more important bearing

on poverty reduction than just to making more resources available. Good health-promoting practices and designing programmes and interventions which tend to focus on cost-effectiveness and cost- efficiency are pragmatic measures for achieving desired results.

Since poverty reduction and sustainable health and development are multi-dimensional issues, wide spectrum partnerships are required with clearly outlined roles and responsibilities. Institutions (World Bank, Asian/African/Islamic Development Banks), organizations (WHO, United Nations Development Programme, UNICEF, United Nations Industrial Development Organization), funds and consortia (GAVI, Commission on Macroeconomics and Health, GFATM), countries, nongovernmental organizations and civil society have to take a more proactive role and build on the pro-poor policies and interventions to break the major barriers towards sustainable development.

It is important to recognize is that activities and interventions are integrated at macrolevel and microlevel, reinforcing actions towards sustainable health and development. Integration within the health sector and between sectors would draw out mutual strengths and would reduce the resource gap towards the attainment of national strategies. Equity issues can only be addressed when integrated action and policy formulation are instituted at the corporate and country level.

4. Rationale and contribution of existing programmes

With a view to identifying the potential for sharper policy focus or resource reallocation in the Region for the strategic framework suggested above, a review undertaken of the current (2002–2003) and prospective (2004–2005) regional programme budgets indicates that almost all programme areas remain under-funded. Over recent years, the Eastern Mediterranean Region has suffered the double squeeze of the progressive erosion through inflation of the real value of a fixed nominal regular budget, and the reallocation of resources from the region to others consequent on the passage of resolution WHA 51.31, which will have produced a cumulative reduction of 9.6% in the regional allocation by 2004. Although 50% of the Region's population live in low-income countries, the Region receives very limited access to voluntary contributions to support country level activities, particularly in the areas of poverty reduction, healthy environment and health system development. Consequently it remains the case that each programme area is under staffed at the Regional Office, and has little discretionary funding to support major initiatives.

Although the overall priorities in the Regional Office are in line with the requirements of support to a pro-poor reform strategy and these appropriate emphases are carried through to the content of individual programmes, yet there is increased recognition of the fact that these can no longer be sustained in the existing manner. The cumulative benefit to poor populations can be transferred only if contribution by different programmes is reinforced—something which can be done only with more resources. Uniform thinking across the Organization, not only at the regional level but at the headquarters level as well, needs to be developed on the issue of resource allocation so that individual programmes do not suffer at each other's expense. Any additional resources that may become available should be directed towards priority areas that support national pro-poor health reform efforts, including health financing, health service management (including relations with nongovernment providers), health promotion, health system strengthening and environmental health.

Community-based initiatives (basic development needs, healthy villages, healthy cities, women in health and development), which are an important vehicle for implementing strategic directions at local level, require, at the same time, scaling up since they are not only in line with global efforts at poverty reduction and sustainable health and development but are also an approach that contributes to the attainment of the Millennium Development Goals.

5. Capacity-building

The regional strategy proposed here assumes that national governments, and specifically their ministries of health, will need to take on a much wider range of functions than they have traditionally. This implies the need for institutional development (the creation or expansion of specialized units within the Ministry of Health and possibly within coordinating agencies such as the ministries of finance, planning, education, trade and industry, agriculture, housing) and staffing of those units with personnel who have relevant skills. It can be anticipated that the need will be identified for greater capacity in policy analysis, information systems, health advocacy and intersectoral working, negotiation and analytical skills, behaviour change, communications, environmental health, health programme planning and health financing. Moreover, building the skills and capacities of the community to respond effectively to these disciplines is critical because of the strong partnership role communities tend to exhibit.

In the light of the dearth of relevant information to support policy-making, it may be assumed that strengthening information systems will become a major component of support to countries. As we are critically highlighting the importance of wide sectoral partnerships, globalization, gender mainstreaming and human rights, evidence about the relation of these issues to health and health services is required to effectively reach informed decisions. Current capacity at the country level for searching and accumulating such evidence is weak. The challenge for WHO will be to support the development of new skills and methods of working in the Organization and in the countries. It is important to stress that it is not just the resources of the Regional Office but also those of headquarters that can be deployed in support of the national authorities. All available means for disseminating new ideas can be used including:

- consultation visits by staff of Regional Office and headquarters
- consultation visits by external consultants
- training workshops organized at local, sub-regional, regional and inter-regional levels

- exchanges of experience and distillation of best practice
- preparation and dissemination of tools, survey instruments, operational guidelines
- information exchange using web-based systems
- building alliances and partnerships with academic and research centres, civil society and international nongovernmental organizations, in and beyond the Region.

6. Monitoring and evaluation

The system for monitoring the adoption and implementation of pro-poor health reforms should be designed so as to avoid burdening national governments with excessive investigation or reporting requirements. It should focus on maximum exploitation of existing data systems, and it should not expect rigorous measurement of changes in health status to be reported at frequent intervals. Indicators of progress on an annual basis might include: adoption of formal policy positions; evidence of participation by civil society organizations in national decision-making, (re)allocation of resources in pursuit of strategic objectives; measures of activities, including utilization of services of various types; demographic indicators (where data systems of adequate reliability exist); and, periodically, the results of population-based surveys, such as the Demographic and Health Survey.

It is important to note that the Millennium Development Goals do not provide a wholly satisfactory framework for monitoring the implementation of pro-poor health policies. This is because the goals themselves are framed in terms of national averages, whereas the definition of pro-poor action proposed here is that which generates disproportionate benefits for poor people. It is therefore desirable that information on MDGs is collected by adopting the process and tools that allow for disaggregation by socioeconomic group, or by some proxy such as rural/urban or regional distribution.

The Millennium Development Goals are largely expressed in terms of health status outcomes, and so are the corresponding targets and measurable indicators. These are appropriately the ultimate test of successful policy implementation, but by their nature, population-related data are not generated by routine administrative processes (other than comprehensive vital statistics systems) and they are difficult to measure at frequent intervals. There is therefore a need to make periodic special efforts, usually involving household survey methods, in order to measure final outputs in the form of health status changes. An appropriate balance needs to be maintained between the frequent reporting of the process indicators discussed above (monitoring) and the

periodic measurement of final outputs and outcomes (evaluation).