World Health Organization

INTER-COUNTRY WORKSHOP FOR DEVELOPING PLANS OF ACTION FOR TAKING FORWARD CMH-RELATED WORK
Addis Ababa, Ethiopia, 4-8 August 2003

WORKSHOP REPORT

REGIONAL OFFICE FOR AFRICA
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List of Abbreviations

AFRO	Regional Office for Africa
AIDS	Acquired Immune Deficiency Syndrome
CBA	Cost Benefit Analysis
CEA	Cost Effectiveness Analysis
CHPS	Community Health Planning and Services
CMH	Commission for Macroeconomics and Health
COMESA	Common Market for Eastern & Southern Africa
CTC	Close to Client
ECOWAS	Economic Community of West African States
GPRS	Growth and Poverty Reduction Strategy
HIV	Human Immune Deficiency Virus
HQ	Headquarters
IMF	International Monetary Fund
LHD	Long-term Health Development
MDGs	Millennium Development Goals
MH	Macroeconomics and Health
MHS	Macroeconomics and Health Strategy
MTEF	Medium Term Expenditure Framework
NEPAD	New Partnership for Africa's Development
NHA	National Health Accounts
POA	Plan of Action
PRSP	Poverty Reduction Strategy Paper
SADC	Southern African Development Community
SWAP	Sector Wide Approach
UN	United Nations
WHO	World Health Organization

Executive Summary

Enhancing political commitment for health and planning country actions to increase health investment were the two principal objectives of the workshop organized by WHO Regional Office for Africa (AFRO) with the dynamic support of the WHO Ethiopia Office and Headquarters. The six-day workshop in Addis Ababa, Ethiopia, from 4 - 9 August 2003, contributed towards discussions on improving the implementation of poverty reduction processes and the achievement of MDGs and the New Partnership for Africa's Development (NEPAD) targets.

Fourteen countries of the African Region – the host country Ethiopia, Angola, Botswana, Congo, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Uganda and South Africa – debated the findings of the CMH Report and drew up plans of action for taking the recommendations of the Report forward. Given the limited time, countries were requested to come up with tentative plans of action prior to the workshop. This meant that participants had already initiated contacts with key stakeholders in their countries to present the Report's findings and determine interest.

Over 60 high-level representatives from the ministries of health, finance and planning from African countries, as well as WHO staff from Regional Offices, Country Offices and Headquarters, attended the workshop. The participants clearly indicated that the CMH Report contributed significantly towards changing perceptions among political leaders, from health as a consumption good to an investment providing significant socio-economic returns. Demonstrating that health is not a narrow sectoral issue, but instead involves all key sectors, partners and communities, the CMH Report has helped focus attention on health policies and investments to enable scaling up public health programmes, especially for the poor. During the workshop, country delegations discussed the objectives and preparation for the October 2003 Consultation on Macroeconomics and Health, seeing it as an important step forward.

The CMH workshop provided a unique opportunity for African countries to debate plans of action for taking forward Macroeconomics and Health work as applied to national socio-economic circumstances. In tackling the content of the plans, participants were requested to focus on objectives that were specific, measurable, achievable, realistic and time-limited

(SMART) and to state expected outcomes (specific results and tangible products) resulting from undertaking tasks or activities. The use of appropriate indicators was encouraged, as was the methodology and processes to describe what will be achieved.

Ethiopia and Ghana were among the first group of countries to start formally a plan of action on Macroeconomics and Health (MH). At the end of 2002, the two countries established a national Commission on Macroeconomics and Health to study economic and health variables. Based on the experiences of these countries AFRO drafted a framework —made available during the workshop— describing the components of the plan, including goals, objectives, expected results, activities, resources and monitoring and evaluation.

The workshop agreed that MH work within the health sector should be matched by a strong intersectoral component that places health values at the highest possible level of country priorities. The aim would also be to strongly link health with poverty reduction strategies and development goals such as MDGs and NEPAD targets. Considering that the attainment of health goals involves all key sectors, MH was described as a mechanism to rally the support of all stakeholders to achieve health goals and strengthen the health component of PRSPs.

During the workshop, countries prepared draft agendas or plans of action for developing strategic long-term Health Investment Plans. Country delegations confirmed WHO's central role in catalyzing and supporting country work to increase health investments. Critical areas for support would include analyzing the effect of targeted macroeconomic policies and creating options to strengthen public health system capacity to efficiently deliver cost-effective interventions. Within government budget and policies, this process would create an opportunity to debate the need for re-orienting resource allocations to improve health outcomes. In addition, developing further evidence on the impact of current health policies of the poor (e.g. cost sharing or risk pooling) can help improve technical and allocative efficiency within and outside the health sector.

The discussions that took place during the workshop centered on planning country efforts for the preparation of long-term Health Investment Plans. The participants appreciated the fact that this process offers the possibility for re-examining existing health programmes, developing intersectoral situation analyses, and creating macroeconomic scenarios related to

increasing investments in health. The workshop debated the need for strengthening country support in the area of macroeconomics and for dealing with issues such as health budget ceilings based upon externally-imposed artificial criteria for macroeconomic stability. Other discussions focused on the importance of supporting ongoing disease-specific programmes such as HIV/AIDS, TB, malaria and child survival for scaling up disease-specific interventions and health system capacity. The workshop unanimously agreed that the process for producing Health Investment Plans could mobilize additional resources from domestic and international sources.

Participants appreciated the added value of Macroeconomics and Health work and agreed that MH:

- Accelerates advocacy and ownership for health investment across sectors, whilst improving efficiency and transparency in sectoral planning.
- Strengthens human, institutional, managerial and governance capacities leading to increased absorptive capacity of health investments.
- Targets health investments on the needs of the poor who thus far have been marginalized, and therefore, the work provides an opportunity to reallocate available resources and better invest future resources targeting the health needs of the poor.

The following issues were clarified during the workshop:

- The relationship between MH, sectoral planning process, and related inputs to achieve the MDGs and NEPAD targets.
- The ways for supporting the health systems' component of planned work, such as strengthening national health accounts, implementing cost-effectiveness studies for prioritizing resources (given the importance of other criteria such as feasibility, political and local interests and others), and quality of care issues.
- Advocacy to mainstream MH issues into legislative organizations such as the UN General Assembly, African Union and various sub-regional initiatives.
- Making use of existing commissions or health sub-committees to move forward effectively MH work.

- The importance of coordinating mechanisms among WHO, World Bank and IMF on health development work, including Macroeconomics and Health.

Participants suggested that WHO should support countries in long-term health development and that the countries should consider how the MH process can support input in scaling up outcomes for the poor. During plenary and break-out sessions, they discussed critical country constraints and debated how to develop high-level advocacy for follow-up work. In this context, participants felt that their role in the preparation of the Global Consultation in October was important and therefore proposed that specific actions be included in country plans of action.

1. BACKGROUND

To support CMH follow-up work in Africa, AFRO has developed a generic work-plan format to assist an initial group of thirteen countries to take forward Macroeconomics and Health (MH) work. To facilitate this process, the Regional Office convened the workshop in Addis Ababa to debate the MH approaches to improving health outcomes of the poor — overcoming institutional and systemic constraints, prioritising, and improving effectiveness of health delivery systems; investing more in health from internal and external allocation of resources; and improving coordination with donors. The overall goal of the workshop was to support a consensus in developing, implementing and monitoring national Health Investment Plans, and to provide technical assistance for the preparation of MH country plans of action.

Workshop Objectives

- To discuss and build consensus on the relevance of the CMH findings and recommendations to Member States in the African Region.
- To develop country preparatory plans of action that would ultimately lead to the production of pro-poor multi-year Health Investment Plans.
- To share experiences from countries regarding the process of implementing the CMH recommendations.
- To share some analytical tools (e.g. advocacy, stakeholder analysis, LHD, planning) that could be useful moving the CMH process forward.
- To discuss the support countries can expect from WHO and partners (e.g. Columbia University).

Workshop Expected outcomes

- A consensus among the directors of planning in the ministries of health, planning and finance on the relevance of the CMH findings and recommendations to countries.
- Draft preparatory plans of action for countries (Angola, Congo, Botswana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Zanzibar and Uganda).
- A list of Macroeconomics and Health work-related lessons from the Ethiopian & Ghanian experiences.

- A consensus on steps that need to be undertaken in order to produce and implement multi-year Health Investment Plans. A consensus on expected support from WHO and its partners (e.g. Columbia University).Detailed objectives and expected outcomes of the workshop can be seen in Annex 1.

2. OPENING OF THE WORKSHOP

The workshop was structured to facilitate the sharing of experiences and expertise and to place countries in the driver's seat. As the workshop progressed, questions for group discussion were designed to address the issues arising daily. The programme was altered as necessary, so as to meet the needs expressed by the participants and the workshop objectives. In addition, CMH activities in Ethiopia and Ghana were used to illustrate best practices and lessons learned, with the aim of presenting the processes for mobilizing attention and resources for health, both at national and international levels, and to reaffirm WHO’s commitment to supporting countries and providing technical expertise per its mandate.

The WHO representative in Ethiopia, Dr Angela Benson, chaired the first day of the workshop. She welcomed participants (see Annex 2 for the List of Participants) and emphasized the need to make Macroeconomics and Health a priority, if countries in the African region are to achieve the MDGs.

This was followed by a keynote address by the Minister of Health, Dr Kebede Tadesse (see Annex 3). Supporting the findings of the CMH Report, the Minister stressed the importance of health in development and the need for all sectors to pull together to fight disease. While acknowledging the high levels of poverty in most countries of the Region, the Minister stressed that this is all the more reason for countries to put more resources in health. This would contribute towards healthy living, economic development, while at the same time provide a key input into human resources, thereby enhancing productivity.

The Minister emphasized that though the level of resource mobilization both from domestic and external resources would pose a tremendous challenge to many sub-Saharan

African countries —whose current estimated per capita expenditure is averaging around US$ 12 per year— these countries should not be discouraged to a point of inaction. With determination, firm commitment and generous support from cooperating partners, more resources could be mobilised. "What we need to do is to strive with vigor and sense of urgency," stated Dr Tadesse.

3. MACROECONOMICS AND HEALTH IN AFRICA

During the initial sessions the first two days, technical discussions focused on the relevance of the CMH recommendations in African countries and addressed the regional perspective of Macroeconomics and Health work. Key issues pertinent to the African Region were identified as the following: a massive burden of disease; cost-effective interventions not reaching the poor; low spending on health; poor management of limited resources; low spending on other sectors that impact health, e.g. sanitation, education, agriculture and industry; the need to forge links with partners (see Annex 4 for more details).

The workshop heard about current efforts to examine the CMH findings in Africa and a description of the initial planning and management tools and preparatory phases before the Health Investment Plans are put into action (see Annex 4 and 5). Participants were briefed on the support provided by collaborating international partners such as the Earth Institute at Columbia University and KIT, as well as the role of advocacy, communications and information dissemination for catalyzing commitment and government action. They heard that stakeholder analysis can help identify appropriate forms of stakeholder participation to define characteristics of target groups that will influence planned work, and also can help assess the manner in which they might affect or be affected by the work. These first "setting-the-scene" sessions concluded with animated discussions on the experiences of the two countries that have embarked on the CMH process — Ethiopia and Ghana — and from other countries planning to enter the process. Key overall areas addressed during the country presentations and the steps undertaken with Macroeconomics and Health work (see Annex 6 for more details) included:

1. The CMH process in Ethiopia has been generating awareness of the important links between health and economic development among essential target audiences. The authorities welcomed the CMH approach and the opportunity to establish a Technical Working Group under the Ministry of Health and the country's Central Joint Steering Committee of the Health Sector Development Programme (HSDP). The Ministry of Health approved the MH Plan of Action in March 2003, and the Technical Working Group has started to assess how the MH process can integrate into the established PRSP.

2. A high-profile launch of the Ghana Macroeconomics and Health Initiative (GMHI) is analysing the Ghanaian Poverty Reduction Strategy, known as the Growth and Poverty Reduction Strategy (GPRS), in the light of the CMH Report's findings. Ghana is focusing on three main issues: health insurance, access to water and sanitation, and Community Health Planning and Services (CHPS), a close-to-client health service delivery. A Technical Working Group has investigated performance and outcome gaps in the GPRS implementation, identifying cross-sectoral causes of health system deficiencies. In one outcome of the MH process, analysis has prompted new policies and strategies that aim to increase capacity of human resources delivering health services. In Ghana, the MH Strategy is positioned to sustain and heighten commitment of important ministries that influence the allocation of resources through the NDPC planning process.

The workshop heard more overview presentations on 'Three themes that provide a context for a macroeconomics and multi-sectoral approach to strategic health investments'; Monitoring, evaluating & describing progress; and Long-term Health Development Tools for CMH .

> Before the CMH Report economic wealth was taken as the driver of health: "As people get wealthier, they will get healthier". After the CMH evidence health is being understood as the driver of poverty reduction.

- The '**Three themes that provide a context for a macroeconomics and multi-sectoral approach to strategic health investments'** outlined that a well-planned strategy for health investments will accelerate social and economic growth. Building upon the CMH Report, the Macroeconomics and Health approach uses three themes: improve health outcomes, especially among poor people; strengthen commitments to increased financial investments in health; and minimize non-financial constraints to the absorption of greater investments.

- The paper on '**Monitoring, evaluating & describing progress'** pointed out the importance of monitoring progress using indicators, and evaluating the data to determine quality, efficiency, and effectiveness. Monitoring uses indicators to measure accomplishment of objectives and milestones to track the timeliness of progress towards objectives. Evaluation looks at the reasons for achievements and barriers, as a basis for making any needed changes.

Evaluation looks at the reasons for achievements and barriers
What lessons were learnt? What specifically caused problems? How can it be prevented or overcome? How can this help develop the contents of the next Phase? What was the macro - and socioeconomic context at the beginning? How many resources were devoted to health, and how successful are plans to increase them?

- **'Long-term Health Development Tools'** can be used by African countries to build compelling and shared visions for health, formulate innovative and effective national health strategies, implement a series of action plans to realize the visions, and build human and institutional capacities for strategic thinking. For Macroeconomics and Health, it was pointed out that LHD can be used in consensus building and setting of appropriate institutional arrangements, situation analysis and scenarios planning; strategy formulation and developing the national Health Investment Plan; and revising the health and health-related sectoral plans and the relevant components of PRSPs.

Following the overview sessions, participants focused on breakout sessions with countries addressing specific questions arising from the first two days.

During several moderated discussions, participants were asked to focus on the following issues: the key actions of the CMH agenda; the relevance of the CMH action agenda in individual countries; and the linkages between the ongoing processes at country level (e.g. sectoral plans, PRSPs, SWAPs) and the action agenda proposed by the CMH. Participants highlighted the following points:

1. The need for strong intersectoral collaboration when developing strategic documents on health and development. In particular, the national process for developing Health Investment Plans must be multisectoral, spanning all levels of public and voluntary

infrastructure — from ministries of finance, planning, health, other related ministries, to international partners, donors and civil society**.**

2. It was emphasized that countries must set high goals in health planning but at the same time address issues of accountability, transparency and improve internal absorptive capacity to be able to take up investment. It was agreed that the MH process can support countries in setting priorities and achievable goals.

> "It is better to jump with the aim of touching the sky, such that in case of failure, you can at least touch the roof."
>
> Ethiopian saying

3. Effective advocacy is needed to increase political commitment, carry out policy changes and increase investment in health. It is needed to win support of key constituencies to influence policies and spending and bring about desired social change.
4. The issue of donors' failure to honor their pledges (unpredictability of the pledges) must be addressed.
5. The key role of the CMH Report and the Reports of the National Commissions as a tool to mobilise interest and resources in health. Countries can establish National Commissions or use existing institutional mechanisms in order to move forward the components of the Macroeconomics and Health strategy.
6. The fragmentation that too many initiatives and different development mechanisms can create (PRSPs, sectoral planning, Health Investment Plans). However, as the Ghanaian experience demonstrates, the targets and planned work towards MDGs, CMH and NEPAD can be incorporated into the existing national poverty reduction strategy. Any initiative that is not incorporated within the PRSPs will not receive attention or funding.
7. The severe lack of human resources and how to address "brain drain".
8. The role of HIPC savings as additional input to fund social services. For example, in Ghana about 25% of HIPC savings support district social services.
9. The need to address health–related issues such as access to clean water, sanitation, and nutrition when countries plan their health investment. The Ghanaian experience was used as an example, as the country is implementing plans for improving water and sanitation and capacity of human resources at village level.
10. The lack of commitment and planning resources to pursue MH work by some countries that participated in the various CMH-related meetings.

11. The importance of the 2003 Global Consultation on Macroeconomics and Health as a means to engage dialogue between the ministries of health, finance and planning, country representatives, and donors. The purpose of the Consultation is to strengthen common action, with a focus on country activities, for appropriate integration of health investments in poverty reduction and development cooperation mechanisms, in line with, and contributing to, the achievement of the Millennium Development Goals. The expected outcomes were the following: sharing experiences based on progress and plans for action; framework for advancing in implementation clarified; inter-linkages and joint planning among initiatives promoted; and networking facilitated among committed decision makers and analysts.

The last day of the workshop was used to finalize the summary workshop report in plenary. The organizing committee provided a draft summary report. Participants were able to go through the draft together, adding issues that they felt the drafting team had not included.

4. COUNTRY PLANS OF ACTION

The country breakout sessions focused on plans of action. The questions addressed included:

Question 1: Six-month objectives; key activities; outcomes sought; timeline of activities;

Question 2: Why & Where: describe institutional arrangements: Where will the CMH process be located? (what existing or new mechanisms will be used to manage the process); Why did you make this choice?

Question 3: Who & When: Define entry point(s) for mobilizing sufficient political support; Who will be the key stakeholders, and in what order will they need to be approached? What opportunities exist to get this into the national agenda? (e.g. ministerial conferences, other initiatives that are being launched, etc.)

Question 4: How: How will you mobilise other resources? What additional stakeholders might be interested in supporting process? What other sectors could you involve, and why do you think they would be willing to commit themselves to this?

The country plans of action for Angola, Botswana, Congo, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Uganda and South Africa can be seen in Annex 7.

5. CONCLUSION: OVERVIEW OF WORKSHOP DISCUSSIONS

5.1 ADDED VALUE OF CMH WORK: PARTICIPANTS' PERSPECTIVES

In the view of the participants, the key actions of the CMH agenda are:

- Definition of essential package of health services
- Scaling up access to quality cost-effective interventions
- Coordination of multi-sectoral activities and global initiatives
- Estimation of the burden of diseases and cost-effective interventions
- Strengthening health delivery system, especially Close to Client (CTC) systems
- Advocacy of additional financing of the health sector
- Importance of undertaking research in the health sector
- Providing opportunity for various health programs to be reviewed
- Bringing out the importance of tools and instruments of analysis such as NHA, CBA, CEA.

All the delegates who participated in the workshop indicated unequivocally that the findings and recommendations of the CMH were relevant to their countries. They agreed that CMH should be country-driven.

In the view of the workshop participants, the publication of the CMH Report had the following positive spillovers:

- It provided concrete evidence on the linkages between increased investments in health, economic development and poverty reduction. By doing so it has increased awareness of health investments as inputs into economic development.

- It has helped to reinforce the fact that health is not only the concern of the Ministry of Health alone, but instead it involves all the key sectors (e.g. finance, planning, water and sanitation, education, etc), bilateral and multilateral partners and other stakeholders (e.g. civil society). Thus, it is a mechanism for rallying the support of all stakeholders (sectors, partners, communities) to achieve national socio-economic development goals, MDGs and NEPAD targets.

In addition, they were of the opinion that the implementation of the CMH work would:

- Accelerate advocacy for health investment. This is important as health is a prerequisite of social and economic development.
- Strengthen human, institutional, managerial & governance capacities leading to increased absorptive capacity.
- Target health investments on the needs of the poor who thus far have been marginalized. Thus, it provides an opportunity to reorient the allocation of currently available resources and those that will be available in the future to leverage health needs of the poor.
- Generate additional evidence on the extent to which the current health sector policies (e.g. cost-sharing mechanisms) impact on the health status of the poor.
- Provide an opportunity for improving technical and allocative efficiency (i.e. increased value for money).
- Once the strategic Health Investment Plans have been finalized, they could be used as tools for mobilizing resources from domestic and international sources; and
- Enhance ownership of health development processes.

5.2 ISSUES

Linkages between CMH Work and Ongoing Processes and Initiatives in Countries

The participants noted that there is need to:

- Clarify the relationship between CMH work and sectoral plans, Health Sector Reforms, PRSPs, MDGs, NEPAD, SWAPs, MTEF.
- Mainstream MH Health Investment Plans into the existing national socio-economic policies and strategic plans.
- Time and include CMH agenda into budgetary processes, including MTEF, Forward Budgets, and core poverty programmes.

Resource Mobilization and Utilization

Another issue raised by the participants was of resource mobilisation and utilisation. The issues raised under this included:

- Unpredictability of donor funding
- Lack of absorptive capacity in some countries
- Inadequate transparency and accountability in the use of resources
- Demonstration of results for public and donor confidence
- Need to build different scenarios for mobilizing resources for filling the financing gaps
- Need to increase technical and allocative efficiency in the use of currently available resources
- Need to mobilize local resources.

Health Systems Capacities

The issues under health systems capacities included:

- Setting highly optimistic goals vis-à-vis realistic/achievable goals
- Need to strengthen the health systems component focusing on 'Close To Client' systems
- Prioritization of health problems and interventions
- Realities of brain drain of human resources for health vis-à-vis the human resource needs for scale-up of health interventions proposed by CMH
- Need to address the quality of health care in the scale-up process
- Need to strengthen Member States' capacity to be able to use Long-term Health Development tools

- Need to develop analytical capacity to deal with constraints to moving CMH work forward
- Need to plan for support to countries taking into account that they are at different stages of implementing the CMH action agenda
- Costing and financing of the package
- Existence of competence for making allocative and technical efficiency
- Need to revise or scale up interventions
- Need to revise and scale up prevention and primary health care
- Need to address absorptive capacity issues.

Strong Advocacy

To ensure that there is strong advocacy for CMH work, the workshop expressed concern that:

- The CMH work in countries might not take root unless the support of the highest powers in countries is mobilized.The advocacy messages for scaling up investments in health might not be optimally effective unless if they strengthen the argument of health as an end in itself (since it enables people to enjoy life or to flourish) and as an investment (since it enables to enable people to be productive).
- The need to ensure intra- (within the sector) and inter-sectoral (across sectors) advocacy.
- Advocate to have Macroeconomics and Health issues mainstreamed into the legislative organizations, e.g. United Nations General Assembly, African Union, SADC, ECOWAS, COMESA.
- Trade-off between politicians' short stay in office and the pressure to demonstrate results, and the long-term Health Investment Plans proposed by the commission.
- The need for investment in other sectors so as to achieve the Millennium Development Goals, as well as the NEPAD targets, related to health.
- The need for criteria for identifying the sectors that need to be involved in the CMH work.
- Political commitment not yet sufficient.

- Sometimes political wishes override technical decisions based on cost-effective analyses.

Country-Specific Analyses

As countries face different circumstances, stress was placed on the need for country-specific analyses, in particular related to:

- the extent to which the current health sector policies (e.g. cost-sharing mechanisms) impact on the health status of the poor.
- the relationship between Macroeconomics and Health which could be used to support political and managerial decision making.
- identification of macroeconomic issues and their implications.
- understanding the relevant macroeconomic issues to policy makers.
- use of existing tools such as NHA, CBA, CEA, incidence analysis, etc.

Institutional Arrangements

With regard to institutional arrangements for implementing the CMH action agenda, the workshop participants wondered:

- Whether all the countries need to set up institutional arrangements.Whether in some Member States the CMH work had become too health sector focused instead of encompassing all the key sectors whose activities impact on populations' health.
- Whether where PRSPs institutional arrangements already exist, establishing new structures would be seen as parallel structures.
- How to bring the different stakeholders together to develop consensus on the way forward for CMH work at country level.

Coordination Between WHO and Other Major International Players in Support of Country-Level CMH Work

Concerning collaboration between WHO and Bretton Woods Institutions, the participants expressed the need for:

- Coordination between WHO, World Bank and IMF on the CMH work. WHO needs to dialogue on health development endeavors (including the CMH work) at the highest levels of the World Bank, IMF and various UN agencies to mitigate stakeholder rivalry. Clarification of how countries will be able to scale up the interventions, as advocated by the CMH, given the ceilings on public expenditure imposed by the World Bank and IMF. Bringing on board all the major bilateral partners, in particular at country level. CMH work should be country driven and be seen at the global level as a collective endeavor geared to facilitate the attainment of the MDGs.

5.3 RECOMMENDATIONS AND ACTIONS TO BE TAKEN

In the course of the workshop, the participants made the following recommendations:

- Countries implementing the CMH action agenda should first explore the possibility of using existing institutional arrangements (e.g. inter-ministerial group on PRSPs, National Steering Committee for NHA) instead of replacing them with new ones.
- Countries should include a step on resource mobilization to fill expenditure gaps in the strategic Health Investment Plans.
- Countries should use strategic Health Investment Plans as tools for accelerating the achievement of the MDGs and NEPAD targets.
- Member States should consider basing their Sector-Wide Approaches (SWAps) on costed strategic Health Investment Plans.
- Countries should make concerted efforts to enlist the support of high profile individuals (e.g. presidents, prime ministers, first ladies) in support to CMH work.
- Countries should use CMH to ensure synergy among existing health-related initiatives.
- Countries should use CMH to facilitate the achievement of combined goals and objectives of MDGs, NEPAD and PRSP targets.
- Countries should use CMH to develop Health Investment Plans to input into country PRSPs and sectoral plans.

- WHO should support countries to strengthen their capacity in Long-term Health Development, and other technical tools (NHA, CBA, CEA, Incidence analysis, etc.).
- WHO CMH-related support should be tailored to countries at different levels in the planning process of implementing the action agenda proposed by the Commission.
- WHO should provide technical support and seed funding for the initial CMH activities.

5.4 FOLLOW-UP ACTIONS AND ACTIVITIES

Countries

Countries were to immediately implement the draft plans they had drawn up during the workshop. The initial steps were seen to be briefing the ministries of health, finance and planning on the proceedings of the Addis Ababa Inter-Country CMH workshop and the need for a coordinated approach. The next step was to undertake a quick stakeholder analysis, bring all the stakeholders together and disseminate the CMH findings and recommendations. The countries, it was further agreed, were to prepare for the 2nd Consultation on Macroeconomics and Health.

WHO Country Offices

Country Offices are to continue giving the necessary support to countries. They should assess country requirements and forward them to WHO/AFRO/CMH.

WHO/AFRO

AFRO is to follow up on the draft plans by countries and provide the necessary technical support to countries.

WHO/HQ

WHO/HQ is to continue supporting AFRO to provide the necessary technical support to countries, and where possible, financial support, to move the process forward. WHO/HQ was to coordinate with other international agencies so that there is clarity on the interrelations of the different activities at the country level. The forthcoming 2nd

Consultation on Macroeconomics and Health was seen as an opportunity to continue this dialogue.

5.5 CONCLUDING REMARKS

The key concluding remark of the workshop was that MHS should be country-led. In spite of the different levels of progress made by countries, each still had something to gain from the MHS. The MHS should be seen as multi-sectoral and not only health sector. While WHO will support countries financially in the initial stages, countries should budget and mobilize resources for the process.

The workshop was brought to a close by Dr Michael Jancloes, consultant and adviser to the Director General, WHO.

- ## ANNEX 1: Workshop Program

Day / Date	Time	Activity	Chair; Presenter; Rapporteur
Sunday 3rd August, 2003	All Day	Arrival of Participants	WHO Country Office
	18.00 – 20.00	Organisers Meeting	AFRO, HQ, Consultants, Country Office, Colombia University
Monday 4th August, 2003	8.00 – 9.00	Registration of Participants	WHO Country Office Secretariat
	9.00 – 9.15	Introductions	**Chair: Dr A. Benson**
	9.15 – 9.30	Opening Remarks	**Minister of Health**
	9.30 – 9.45	**Presentation:** Workshop objectives, expected outcomes, Day's objectives	**Chair:** Dr A. Benson **Presenter:** AFRO – HEC / CMH
	9.45 – 10.00	**Presentation:** CMH findings and recommendations	**Chair:** Dr A. Benson **Presenter:** AFRO – HEC / CMH
	10.00 – 10.30	Tea Break	
	10.30 – 10.45	**Presentation:** Global perspective – (the way forward, HQ support to countries)	**Chair:** Dr A. Benson CMH/HQ – Dr Spinaci
	10.45 – 11.00	**Presentation:** Regional perspective – (the way forward / steps / phases, AFRO support to countries)	**Chair:** Dr A. Benson **Presenter:** AFRO – HEC/CMH
	11.00 – 11.15	**Presentation:** CMH Action Agenda (main elements to include in action plan)	**Chair:** Dr A. Benson **Presenter:** CMH/HQ - Dr Spinaci
	11.15 – 11.30	**Presentation:** Columbia University, support to countries	**Chair:** Dr A. Benson **Presenter:** Dr Rosenberg
	11.30 – 12.30	**Discussion:** Findings and recommendations (application of regional concepts to developing country POA; support to countries)	**Chair:** Dr A. Benson
	12.30 – 14.00	Lunch Break	
	14.00 – 14.15	**Presentation[1]:** Experiences from Ethiopia (using country progress report format)	**Chair:** Dr A. Benson **Presenter:** Ethiopia
	14.15 – 14.45	**Discussion**	
	14.45 – 15.00	**Presentation[1]:** Experiences from Ghana (using country progress report format)	**Chair:** Dr A. Benson **Presenter:** Ghana
	15.00 – 15.30	**Discussion**	**Chair:** Dr. A. Benson
	15.30 – 16.00	Tea Break	
	16.00 – 16.45	**Country briefs[2]:** five minutes each: Angola, Botswana, Malawi, Kenya, Mozambique, Nigeria	**Chair:** Dr A.. Benson **Presenter:** Countries
	16.45 – 17.30	**Country briefs[2]:** five minutes each: Rwanda, Senegal, Congo, Tanzania, Uganda, South Africa	**Chair:** Dr A. Benson **Presenter:** Countries
	17.30 – 18:00	**Discussion**	**Chair:** Dr A. Benson
	18.00	**Organisers meeting:** key emerging issues, days observations	Secretariat
Tuesday 5th August, 2003	8.30 – 8.45	**Presentation:** Summary of Day 1 main points, lessons from Ethiopia and Ghana, issues emerging from country briefs **Presentation: Day's Objectives**	**Chair:** Dr Kirigia
	08.45 – 09.30	**Moderated Discussion** – Give comment on the issues that need to be clarified and discussed in today's breakout sessions.	**Chair:** Dr Kirigia
	9.30 – 10:00	**Breakout sessions:** working groups: clarifying value added by CMH process in countries	**Chair:** Dr Kirigia
	10.00 – 10.30	*Tea Break*	
	10.30 – 11.00	**Breakout sessions continued**	
	11.00 – 12.30	**Moderated discussion:** Developing consensus on broad goals and objectives of CMH process, and how it can help countries achieve their goals	**Chair:** Dr Kirigia
	12.30 – 14.00	Lunch Break	
	14.00 – 15.00	**Presentation:** - The Advocacy perspective on implementing the Macroeconomics and Health Strategy	**Chair:** Dr Kirigia **Presenter:** Dr Agnes Leotsakos
	15.00 – 15.30	**Moderated Discussion** – Importance of advocacy	**Chair:** Dr Kirigia
	15.30 – 16.00	Tea Break	

	16.00 – 16.15	**Presentation:** Plans of action – Generic formats	**Chair:** Dr Kirigia **Presenter:** CMH-AFRO,Dr Mwikisa
	16.15 – 16.30	**Presentation:** Stakeholder analysis	**Chair:** Dr Kirigia **Presenter:** CMH/AFRO, Dr Mwikisa
	16.30 – 17.30	**Moderated Discussion** – Engaging Stakeholders, (experience of Ethiopia and Ghana?)	**Chair:** Dr Kirigia
	17.30 – 18.00	**Organisers meeting:** key emerging issues, days observations	Secretariat
Wednesday 6th August, 2003	08.30 – 09.00	**Overview:** Summary of Day 2 main points Day's Objectives	**Chair:** Dr M. Jancloes
	09.00 – 09.15	**Presentation:** Three themes that provide a context for a macroeconomic and multi-sectoral approach to strategic health investments	**Chair:** Dr M. Jancloes **Presenter:** CMH/HQ – Mr O'Connell
	09.15 – 09.30	**Presentation:** Two questions to be discussed in this morning's breakout sessions.	**Chair:** Dr .M. Jancloes **Presenter:** CMH/AFRO – Dr Kirigia
	09.30 – 10.00	**Breakout sessions:** Discuss Question 1 & 2	Same groups as Tuesday
	10.00 – 10.30	*Tea Break*	
	10.30 – 11.30	**Breakout sessions:** Continue discussing Questions 1 & 2	Same groups as Tuesday
	11.30 -12. 00	**Group presentations**: Each team briefly presents (5 minutes) responses to 2 questions	**Chair:** Dr M. Jancloes
	12.00 – 12.30	**Plenary**: open discussion on morning's work	**Chair:** Dr M. Jancloes
	12.30 – 13.30	*Lunch Break*	
	13.30 – 13.45	**Presentation:** Third question for group discussion.	**Chair:** Dr M. Jancloes **Presenter:** CMH/AFRO – Dr Kirigia
	13.45 – 15.30	**Breakout sessions:** Focus on priorities for Phase 1	Same groups as this morning
	15.30 – 16.00	*Tea Break*	
	16.00 – 16.15	**Presentation:** Monitoring, evaluating & describing progress	**Chair:** Dr M. Jancloes **Presenter:** CMH/HQ – Mr Tom O'Connell
	16.15 – 16.45	**Presentation:** - Long-term Health Development Tools for CMH	**Chair:** Dr M. Jancloes **Presenter:**WHO/AFRO Dr Mawaya
	16.45 – 17.30	**Moderated Discussion** – What are the necessary next steps needed to move forward over the next 1 month?	**Chairs:** Dr M. Jancloes & Dr Spinaci
	17.30 – 18.00	**Organisers meeting:** key emerging issues, days observations	Secretariat
Thursday 7th August, 2003	08.30 – 09.00	**Presentation:** Summary of Day 3 main points, **Presentation:** Day's Objectives	**Chair:** Dr C. Tiny
	09.00 – 09.20	**Presentation:** Country planning for the 2nd Consultation on Macroeconomics and Health	**Chair:** Dr Tiny **Presenter**: Dr Spinaci
	09.20 – 10.00	**Moderated discussion:** 2nd Consultation on Macroeconomics and Health Preparations: next steps	**Chair:** Dr C. Tiny CMH/HQ, Dr Spinaci
	10.00 – 10.30	*Tea Break*	
	10.30 – 10.45	**Presentation**: Terms of Reference for breakout sessions	**Chair:** Dr C. Tiny
	10.45 – 12.30	**Breakout sessions:** Country working groups PoA	Country Teams
	12.30 – 13.00	**Country teams:** print out draft PoAs for distribution, and finalise PowerPoint presentations	Country Teams
	12.30 – 14.00	*Lunch Break*	
	14.00 – 15.30	**Presentations of PoAs[3]:** (5 slides maximum) Angola, Botswana, Kenya, Mozambique	**Chair:** Dr Tiny **Presenter:** Country Teams
	15.30 – 16.00	*Tea Break*	
	16.00 – 16.10	**Presentation:** Terms of Reference for afternoon discussions with workshop facilitators	**Chair:** Dr C. Tiny
	16.10 – 17.30	**Country teams work individually with workshop facilitators**	**Chair:** Dr Tiny

	17.30 – 18.00	**Organisers meeting:** key emerging issues, days observations	Secretariat
Friday 8th August, 2003	8.30 –8.45	**Presentation:** Summary of Day 4 main points	**Chair:** Dr M. Jancloes
	08.45 – 10.00	**Plenary**: Brainstorming on workshop report	**Chair:** Dr M. Jancloes
	10.00 – 10.30	**Presentation / Discussion:** Next Steps & follow up (country level, AFRO, HQ)	**Chair:** Dr M. Jancloes HEC/AFRO, Dr Kirigia CMH/HQ, Dr Spinaci
	10.00 – 10.30	*Tea Break*	
	10.30 – 12.00	**Moderated Discussion** – main issues / participants point of view / other country efforts	**Chair:** Dr M. Jancloes
	12.00 – 12.30	Closing	**Chair:** Dr M. Jancloes
	12.30 – 14.00	*Lunch Break*	
Saturday 9th August, 2003	All Day	Departure of Participants	WHO Country Office
Sunday 10th August, 2003		**Last Departures**	

ANNEX 2: List of Participants

No.	Name	Country	Title
1.	Dr P.P. Balladelli	Angola	WHO Representative
2.	Dr Balbina Ventura Felix	Angola	Disease Prevention Control Officer
3.	Mr Vincent Musowe	Botswana	STP/MPN
4.	Mr Lesetedinyana Lesetedi	Botswana	Assistant Director, Primary Health Care
5.	Mr Guy Urbain Moukpokpo	Congo	Directeur des Etudes et Planification
6.	Mr Jéremie Mouyokani	Congo	MPN
7.	Mr Camille Moulene	Congo	Conseiller Technique
8.	Mr Jonas Kimbangou	Congo	Economiste
9.	Dr Kebede Tadesse	Ethiopia	Minister of Health
10.	Mr Netsanet Walelign	Ethiopia	Health Care Finance Advisor
11.	Mr Getachew Adem Tadir	Ethiopia	Health Economic Policy & Planning Department
12.	Dr Demessie Tadesse	Ethiopia	Vice Minister
13.	Dr Girma Azene	Ethiopia	Head Planning & Programme Department
14.	Mr Yohannes Tadesse	Ethiopia	Head, Health Services &Training Department
15.	Ms Frehiwot Yirsaw	Ethiopia	Expert in Welfare Monitoring Unit
16.	Mr Selassi Amah d'Almeida	Ghana	Health Economics Advisor
17.	Dr Regina O. Adutwum	Ghana	Director, National Development Planning Commission
18.	Mr Frimpong Kwarteng-Amaning	Ghana	Principal Economics Advisor
19.	Mr Stanley Kalama	Kenya	Chief Health Administrative Officer
20.	Mr Stephen C. Wainaina	Kenya	Chief Economist
21.	Mr Stephen Muchiri	Kenya	Deputy Chief Economist
22.	Mrs Turphena Mokaya	Kenya	Principal Economist
23.	Dr Dominic Mutie	Kenya	Disease Prevention Control (DPC)
24.	Dr Joyce Onsongo	Kenya	Disease Prevention Control (DPC)
25.	Mrs Kate Jane Langwe	Malawi	Economist
26.	Mrs Flanneys E. Nkata	Malawi	MPN
27.	Dr Humberto Cossa	Mozambique	National Director for Planning & Cooperation
28.	Ms Eva Pascoal	Mozambique	HEC
29.	Dr Shehu Sule	Nigeria	Director, Health Planning & Research
30.	Mr C.D. Gali	Nigeria	Director, Budget
31.	Dr Tolu Fakeye	Nigeria	Deputy Director, International Health
32.	Dr Amos Petu	Nigeria	HEC
33.	Dr Nizeyimana Vianney	Rwanda	Director Planning
34.	Mr Rugwabiza Leonard	Rwanda	Economist
35.	Mr Bigabiro Charles Louis	Rwanda	HEC
36.	Ms Celina Schocken	Rwanda	Country Director
37.	Dr Lamine Farba Sall	Senegal	HEC
38.	Mrs Dramé Ndeye Coumba Guisse	Senegal	Experte/Coordinatrice
39.	Mr Aboubakry Demba Lom	Senegal	Director, of Planning
40.	Ms Regina Kiluli	Tanzania	Head of Planning and Budget Section
41.	Mr Samuel C. Kabaja	Tanzania	Senior Finance Officer
42.	Mr Maximillian Mapunda	Tanzania	National Programming officer
43.	Dr George Bagambisa	Uganda	Ag. Commissioner Planning
44.	Dr Juliet Nabyonga	Uganda	Health Economist
45.	Ms Mwaka A. Said	Zanzibar	Director of Planning &Administration
46.	Mr Rashid S. Kibao	Zanzibar	Commissioner of Economic Management & Budgeting

No.	Name	Country	Title
47.	Dr Sergio Spinaci	WHO/HQ	Executive Secretary, CMH
48.	Mr Tom O'Connell	WHO/HQ	SDE/CMH/HQ
49.	Dr Michel Jancloes	WHO/HQ	Consultant, Advisor to the DG
50.	Dr Agnes Leotsakos	WHO/HQ	Advocacy Advisor, SDE/HQ
51.	Dr Carlos Alberto P. Tiny	WHO/HQ	WHO/Consultant
52.	Dr Maria Paalman	WHO/HQ	WHO Consultant Senior health Advisor
53.	Ms Ann Rosenberg	USA	Associate Director, Macro Health
54.	Dr Chris Ngenda Mwikisa	WHO/AFRO	CMH/des
55.	Dr Joses Kirigia	WHO/AFRO	HEC/AFRO
56.	Mrs Khoko Soumahoro	WHO/AFRO	Administrative Officer/DPM
57.	Dr Anthony Mawaya	WHO/AFRO	Technical Officer, LHD/DES
58.	Mr Dan Kraushaar	USAID(USA)	
59.	Dr Angela Benson	WCO/Ethiopia	WHO Representative a. i.
60.	Dr Teferra Wonde	WCO/Ethiopia	Senior Policy Advisor
61.	Dr Eshete Yilma	USAID/Ethiopia	Project Management Specialist

ANNEX 3: Opening speech by H.E. Dr Kebede Tadesse, Minister of Health, Federal Democratic Republic of Ethiopia

The Inter- Country Workshop On Macroeconomics and Health, August 4 – 8, 2003

Distinguished participants, Ladies and Gentlemen

On behalf of the Government of the Federal Democratic Republic of Ethiopia, Federal Ministry of Health and myself, I would like to welcome you all to this important inter-country workshop on Macroeconomics and Health. The Federal Ministry of Health takes it as a great honor to host this important gathering from 15 African countries.

As we all recall, the former Director-General of WHO Dr Gro Brundtland, has taken an important step in this direction by establishing the Commission on Macroeconomics and Health in 2000 to assess the place of health in global economic development.

The findings of the Commission, after two years of hard work, were decisive. It reported that extending the coverage for basic and crucial health services, targeted at the World's poor, not only could save millions of lives each year but also stimulate economic development, reduce poverty and promote global security.

The Commission's recommendation to improve heath and achieve the Millennium Development Goals (MDGs) revolves around two pillar implementation arrangements.

1. A significant scaling up of the resources currently spent in the health sector, and
2. Tackling the non-financial obstacles that have limited the capacity of poor countries to deliver heath services.

Accordingly, the major focus should be in the creation of a service delivery system at the local "close-to-client" level, complemented by nationwide health programmes. The estimate for the worldwide scaling up of health investments and particularly for financing essential interventions would require an average of US$ 30 to 40 per person in low-income countries. But this level of investment is beyond the reach of very many poor countries in Africa in the foreseeable near future. Realizing this, the Commission has recommended that the affluent countries support the effort by gradually increasing their assistance to the order of US$ 38 billion per year by 2015.

Such level of resource mobilization both within and outside would pose a tremendous challenge to many countries in sub-Saharan Africa whose current estimated per capita expenditure is averaging around US$ 12 per year. This of course, is a big obstacle but should not discourage us to a point of inaction. With determination and firm commitment on our side and generous support from our partners in development, I am very optimistic that it could be achieved. What we need to do is to strive with vigor and sense of urgency.

On its part, Ethiopia has greatly appreciated the initiative from the start and follows with keen interest its development. This is because it finds the Macroeconomic and Health Initiative very much compatible with its policy, the ongoing Health Sector Development Programme (HSDP) and with the recently approved Sustainable Development for Poverty Reduction Programme (SDPRP). The Health Sector Development Programme is intimately linked with our far-reaching national development initiative and is made to focus in the main on combating the major killer diseases

related to poverty - HIV/AIDS, Malaria, TB and childhood and maternal illnesses that cause high mortality and morbidity rates in our country.

We have been closely working with WHO and the Macroeconomics and Health group in Columbia University headed by Prof. Jeffrey Sachs, and as part of the preparatory phase for the implementation of the initiative we have been able to develop a plan of action. We are currently in the process of creating a Unit under the appropriate Department of the Federal Ministry of Health. We will soon align the Unit with our high level multi-sectoral health development steering committee which includes our Ministry, the Ministry of Finance and Economic Development, a number of donors and other stakeholders. We are hoping that the activities stipulated in the plan of action would be smoothly implemented and that it would be of benefit to our overall development efforts.

We are also determined to link the upcoming HSDP III more closely with the Millennium Development Goals. We are well aware that in order to reach the MDGs by the target date of 2015, both domestic and external support and effort will be needed. It is expected that the Plan of Action to be developed during this conference will show the linkages of the health sector with the MDGs, Poverty Reduction Strategies and New Partnership for Africa's Development (NEPAD), and this is a vital step towards having a coordinated, and thereby an effective, approach to our many rapid development initiatives and endeavors in the region.

DISTINGUISHED PARTICIPANTS!!

We are delighted that you are all here to attend this important inter-country workshop on Macroeconomics and Health. We very much appreciate the commitment of the participants to change and improve access to health service in their respective countries by concretizing the findings of the Commission on Macroeconomics and Health. I can assure you that Ethiopia will do its utmost to realize the importance of this initiative and to translate it into action.

Finally, I would like to take this opportunity to thank the WHO Headquarters Secretariat on Macroeconomics and Health, WHO AFRO, the WHO Ethiopia Country Officers and Columbia University for their active and continued support and guidance.

I welcome you again to Ethiopia and hope that you will find time to mix with the convivial people of Addis Ababa and enjoy our hospitality. I wish you good and successful deliberations.

Thank you for your attention!

ANNEX 4: THE REGIONAL PERSPECTIVE

1) Key health and development issues pertinent to the African Region:

- **High burden of disease:** A few conditions account for the high proportion of ill-health and premature deaths. About 70% of deaths in the African Region result from ten causes. HIV/AIDS, lower respiratory tract infection, malaria, diarrhoeal diseases and maternal and perinatal conditions account for 54% of mortality.
- **Cost-effective interventions not reaching the poor:**
  - Access to health services is only 53%
  - Less than 30% of the people have access to essential drugs
  - Cost-effective interventions including insecticide-treated materials, DOTS, condoms, vaccines against childhood diseases and many others, are not reaching most of the poor.

  Expansion of interventions addressing priority health problems can save millions of lives per year in the African Region.
- **Low spending on Health:** Most member states need to mobilize more resources for health to meet the agreed level of at least 15% of annual budget (Abuja Commitment by African Heads of State). GHE per person in 29 countries is between US$ 1 and US$ 9; US$ 11 to US$ 23 in eight countries; US$ 37 and US$ 294 per capita per year in nine countries, in 2000.
- **The financing gap:** Member States need to advocate individually and collectively at the international level for more resources. Member States need to significantly improve the management of resources and capacity to use the additional resources, prioritizing benefits to the poor.
- **Low spending on other sectors that impact health:** Currently, 47% of the population in the region do not have access to adequate sanitation facilities. On average 40.2% do not use improved water sources, on average 40% of adults in the region are illiterate, average primary school enrolment ratio is 63%, and average secondary school enrolment ratio is 21%. Health is a cross-sectoral issue and by creating links with other sectors –education, finance, planning, water and sanitation, agriculture, environment, tourism, industry– health services can be strengthened. Investment in health-related sectors needs to be increased.
- **International partners:** Establishing links with regional partners and development banks will also be of prime importance.

2) Efforts to examine the CMH findings have been initiated in Africa:

Currently, 14 countries are interested and six countries are engaged in debate and strategic planning.

- Evidence from Ghana and Ethiopia already point to the requirements of the relevant linked ministries and help clarify the role of WHO in this process. WHO is not a fund-raising agency, but works closely with countries to strengthen political processes and action. It facilitates the creation of alliances so that the necessary political and budgetary steps are taken to increase per capita investment in health as recommended by the CMH Report.
- At least 50% of health spending in African countries is out-of-pocket. This is one of the reasons why families and communities sink further into poverty. Addressing this issue as well as that of equity for health and social services is of paramount importance.
- Research and the development of public goods must receive increased funding.

3) Developing plans of action:

The process of arriving at the Health Investment Plans is important, as is to mobilize developmental partners and the civil society at the very beginning of the process. To arrive at Health Investment Plans it is recommended that countries plan activities, roughly categorized according to three phases:

Phase 1 focuses on building a consensus among the stakeholders on the relevance of the findings and recommendations of CMH at the country level, and putting in place the appropriate institutional arrangements to facilitate implementation of the CMH recommendations in countries.

Phase 2 covers the strategic Health Investment Plan development. Some envisaged contents of the Health Investment Plan include among others a situation analysis of health, macroeconomics, and other sectors; a set of priority national health problems; a package of cost-effective "essential interventions" for addressing the problems; current levels of coverage for various essential interventions; target coverage of individual essential health interventions; cost of scaling up coverage of essential interventions to the desired targets; an estimate of the current level of spending (broken-down by different sources) on the essential interventions; an estimate of the expenditure gap; and scenarios analysis of how the gap would be financed (from domestic and international sources). These will form the basis of revising the health and

health-related sectoral development plans and the relevant components of Poverty Reduction Strategy Papers (PRSPs).

Phase 3 The third and last phase will be implementation of the multi-year Health Investment Plan that may be through rolling annual or biennial plans of action. The keys to successful development and implementation of strategic Health Investment Plans were stressed. These include participation of all key stakeholders, adoption of a multi-sectoral approach, and the need for national authorities to be in the driver's seat throughout the entire process, a critical step to ensure country ownership of the process.

4). The way forward in increasing investments and improving efficiency towards achieving health outcomes for the poor:

Emphasis was placed on encouraging ownership by stakeholders; building on existing processes and integrating into existing economic planning instruments (PERs, PRSPs, MTFs); building national capacities to absorb investments; strengthening alliances with on-going donor activities; and increasing and rationalizing spending for achievement of health-related MDGs and national priority health outcomes for the poor. Further emphasis was placed on Six Actions essential to increase countries' capacity for investing in better and equitable health. These include: Alliance building and maintenance; Analyses of issues and options; Marketing and Advocacy; Policy to achieve specific outcomes; Investment plans; and Monitoring for management. In order to fulfill technical support needs, a network of local, regional, and international expert consultants, academic institutions, and NGOs will be developed. Opportunities to build partnerships and linkages with development partners, donors, and relevant ongoing projects will be explored, and high-level political commitment will be sustained through communication and media avenues. Together, there is need to leverage funds, technical support and political impetus for the system and programme changes that can accelerate achievement of health and development goals.

ANNEX 5: GENERIC PLAN OF ACTION FORMAT

GENERIC PLAN OF ACTION FORMAT
PHASES AND STEPS AT THE COUNTRY LEVEL

Macroeconomics and Health Strategy

June 2003

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Acronyms

CMH	Commission on Macroeconomics and Health
CTC	Close to Client
IEC	Information, Education and Communication
MHS	Macroeconomics and Health Strategy
MTEF	Medium Term Expenditure Framework
NSCMH	National Steering Committee on Macroeconomics and Health
PRSP	Poverty Reduction Strategy Paper
TC	Technical Committee
TOR	Terms of Reference
UN	United Nations
WHO	World Health Organization

1. BACKGROUND

In January 2000, the WHO Director-General established a Commission on Macroeconomics and Health (CMH) to study the links between increased investments in health, economic development and poverty reduction.

The Commission's analysis revealed that ill-health contributes significantly to poverty and low economic growth, a few conditions account for the high proportion of ill-health and premature deaths, and the current level of spending on health in Member States is insufficient to scale up the available essential public health interventions.

The CMH recommended enhanced political commitment, at both national and international levels, to increase investments in 'Close to Client' (CTC) health systems and expand coverage of cost-effective interventions targeting the poor. Thus, countries in the African Region are encouraged to prepare multi-year investment plans for scaling up essential health services.

This brief note suggests possible phases and steps that countries may follow to develop multi-year investment plans for scaling up essential health services. These steps are not prescriptive. Countries may adapt different approaches depending on their circumstances and requirements. The suggested steps should be carried out within the existing: (i) national policies, development plans and poverty reduction strategies; and (ii) administrative, planning, implementation and monitoring structures and processes in individual countries.

2. PHASE 1 - Steps 1 – 2: Consensus Building and Setting up Appropriate Institutional Arrangements

Step 1: Dissemination and consensus building on the relevance of the findings and recommendations of CMH at the country level.

Objective: To build consensus on the relevance of the findings and recommendations of CMH at the country level.

Expected Outcomes:

- A list of stakeholders
- A list of possible consultants
- Consensus on the relevance of the CMH findings, recommendations and action agenda to the national health situation
- Commitment by stakeholders for supporting the government to implement the relevant recommendations and action agenda.

Activities:

- Compile a list of stakeholders
- Compile a list of possible consultants to attend the workshop
- Organize a workshop with all the key stakeholders in the country to discuss the relevance of the CMH findings and action agenda.

Planned Budget: (cost each activity)

Step 2: Setting up institutional arrangements to facilitate implementation of the CMH recommendations in countries.

Objective: To establish institutional arrangements for facilitating implementation of the CMH recommendations in countries.

Expected Outcomes:

- An inter-ministerial National Steering Committee on Macroeconomics and Health (NSCMH) or its equivalent established. Its membership may consist of Ministers of Health, Economic Planning and Regional Cooperation, Finance, Local Government and Rural Development, Works and Housing, Parliamentarians, representatives of civil society, private sector, UN Agencies, Bilateral and multilateral donors.
- A Technical Committee (TC), to act as secretariat to the NSCMH, established
- Terms of reference for NSCMH developed
- Terms of reference for TC developed.

Activities:

- Organize a meeting of key stakeholders to constitute a NSCMH and a TC
- Develop terms of reference for NSCMH and TC
- Formulate a plan of action for developing a multi-year Health Investment Plan.

Planned Budget: (cost each activity)

3. PHASE 2 – Steps 3 – 5: Developing a Health Investment Plan

Step 3: Analysis and strategy development.

Objective 1: To conduct a health and health-related situation analysis.

An analysis of national health situation disaggregated by income and geography (including risk factors), national health policies including human resource policies and plans, health system performance (goals and functions), national health accounts (or health expenditure review), and macroeconomic (including poverty) indicators to facilitate development of a sound strategy for scaling up health interventions. An indication of emerging information and health systems performance gaps.

Expected Outcomes:

- A list of health related sectors
- Terms of reference for consultants to conduct health situation analysis
- A health and macroeconomics situation analysis report
- Data on burden of disease disaggregated by income, geography (e.g. rural vs. urban) and other relevant factors (migrant communities, isolated ethnic/religious communities, etc.)

- Reports of studies undertaken to bridge the information gaps.

Activities:
- Undertake a comprehensive health and macroeconomic situation analysis identifying information gaps and empirical research needed
- Undertake studies to bridge the gaps needed
- Organise a meeting to draw a list of health related sectors
- Draft terms of reference for a situation analysis
- Organise a meeting to discuss terms of reference for a situation analysis
- Advertise for consultants
- Shortlist consultants
- Hire consultants to conduct a situation analysis.

Planned Budget: (cost each activity)

Objective 2: To develop a multi-year strategic Health Investment Plan to extend the coverage of essential health and health-related services.

Expected Outcomes:
- A Health Investment Plan.

The Investment Plan will contain: (a) a set of priority national health problems; (b) a package of cost-effective "essential public health interventions" for addressing the problems; (c) current levels of coverage for various essential interventions; (d) target coverage of individual essential health interventions; (e) cost of scaling up coverage of essential interventions to the desired targets (this should include the cost of strengthening "close-to-client" health services); (f) an estimate of the current level of spending (broken-down by different sources) on the essential interventions; (g) an estimate of the expenditure gap, i.e. "e" minus "f"; (h) an indication of how the gap would be financed (from domestic and international sources); and (i) monitoring and evaluation plan. The plan should also provide the basis for filling information gaps through adequate investment in operational research.

The investment plan can be summarized in a logical framework format as illustrated in the table below:

Activities:
- Develop Terms of Reference for consultants to draw investment plan
- Organise a meeting to discuss Terms of Reference for an investment plan
- Advertise for consultants
- Shortlist consultants
- Hire consultants.

Planned Budget: (cost each activity)

Table 1: Logical Framework Format: Investment Plan

Sector	1 Priority Health Problems	2 Essential Public Health Interventions	3 Current Coverage Levels	4 Coverage Target	5 Current Expenditure Level	6 Scaling-up Cost	7 Expenditure Gap	8 Financing Expenditure Gap
1 Health	1.							
	2.							
	3							
	Etc.							
2 Water / Sanitation	1.							
	2.							
	3							
	Etc.							
3 Education	1.							
	2.							
	3							
	Etc.							
4 Other	1.							
	2.							
	3							
	Etc.							
Total								

Step 4: Filling expenditure gaps

Objective: To develop scenarios of how financing gaps could be bridged. (Scenarios should take into consideration issues of equity / burden and sustainability.)

Expected Outcomes:

- A prioritized list of scenarios for bridging the financing gap.

Activities:

- Hire consultants to examine all possible financing gap bridging scenarios
- Hold a meeting / workshop to consider / prioritize the financing scenarios.

Planned Budget: (cost each activity)

Step 5: Revise the health and health-related sectoral development plans and the relevant components of PRSPs

Objective 1: To revise the health and health-related sectoral development plans.

The health and health-related sectoral development plans (e.g. health, water and sanitation, education) will need to be revised to accommodate the scale-up plan developed in step 3. The list of related sectors would also have been determined in step 3.

Expected Outcomes:

- Revised sectoral development plans (health, water and sanitation, education, etc).

Activities:

- Develop Terms of Reference
- Hire consultants to revise sectoral development plans
- Hold a meeting / workshop to review revised sectoral plans.

Planned Budget: (cost each activity)

Objective 2: To revise the relevant components of PRSPs.

The relevant components of PRSPs will need to be revised to accommodate the scale-up plan developed in step 3. The revisions should also take into account the observations of WHO on PRSPs outlined in the document "The health component of National Poverty Reduction Strategy Papers (PRSP) for African countries", Harare, October 2002.

Expected Outcomes:

- Revised PRSPs.

Activities:

- Develop Terms of Reference for the revision of PRSP
- Hire consultants to revise relevant components of PRSP.
- Organise a workshop to review revised PRSP.

Planned Budget: (cost each activity)

Objective 3: To design an implementation plan.

Expected Outcomes:

- An implementation plan.

Activities:

- Develop Terms of Reference for consultants to design an implementation plan
- Hire consultants to design an implementation plan
- Organise a workshop to review implementation plan.

4. PHASE 3 – Steps 6 – 7: Implementing Health Investment Plan

Step 6: Implementation of the multi-year strategic plan

Step 7: Monitoring, evaluation and reporting

5. CONCLUSION

The Macroeconomics and Health strategy (MH) goal is the long-term strategic plan for health investments. The country work-plans for Phases 1 & 2 are simply operational steps to achieve this goal. Lessons from countries that have completed phase 1 have shown that a time period of six months is sufficient for completion of the first phase.

Phase 2 builds upon Phase 1 achievements to launch an MH process. Since no country has yet completed this phase, the time period for its completion is not yet certain. It is however estimated that a time period of 18 months should suffice. The primary Phase 2 objective is a specific, long-term plan for investments in health and other health related interventions that all major stakeholders agree to support. This gives the overall strategic direction, strategies and policies for resource re-allocation and resource mobilisation.

The focus of phase 1 & 2 activities is therefore the creation of a long-term plan for health and health related investments, that:

a) Addresses non-financial (system) constraints through effective reallocation of resources based on Burden of Disease studies, Cost-Effectiveness Analyses, etc;
b) Attracts more internal funds from the government by offering a local evidence base that shows how such investments improve society as a whole;
c) Creates a long-term strategic plan so thoroughly integrated into cross-sectoral national policies as to create confidence in external donors that the strategies will be implemented;
d) Systematically addresses equity, so that the poor and vulnerable groups in society have access to essential services, and that the entire health system benefits from a more reasoned and evidence-based approach to delivering health interventions;
e) Focuses on all relevant cross-sectoral determinants of health, including environmental, water & sanitation, education, etc., and change the strategic thrust of public sector polices and strategies to make health a core of any developmental planning; and
f) Permanently incorporates health into all macroeconomic development policies, and incorporates macroeconomic analysis into health policy development.

Phase 3: Starts with the long-term plan being implemented, so the country workplans come to an end. The long-term plan becomes the driver of increased health investments. How implementation will occur is the overarching Phase 2 goal. It should be country-based in design & execution. There are several options for operationalizing a plan, but all translate the long-term plan into a linked series of annual plans with clear objectives. For countries with Medium Term Expenditure Frameworks (MTEFs) the investment plan should be integrated into the process. Countries with no MTEFs can integrate the plan into a series of annual plans, assess each year’s progress, and make revisions as environmental changes occur. In both cases the ideal is to integrate this long-term Health Investment Plan into the core of the country's sustainable development and macroeconomic growth strategies.

Implementation methods also can depend on the sources of funding. A country that is reliant on internal resource allocations has a greater flexibility of choosing how to

operationalize the long-term strategic plan than one that has to negotiate for external aid flows and incorporate donor inputs into the implementation of a cross-sectoral strategic plan.

It must be emphasized that the goal of CMH/MH is neither a series of medium-term plans, nor a specification of how the long-term investment strategy is to be operationalized. These are decisions for individual countries to make. What is sought is a binding commitment by governments and all stakeholders to implement the core recommendation of the CMH Report: a long-term and sustained increase of investments in health and health-related sectors.

Finally, successful implementation of the MH will depend on a well-designed and realistic implementation plan. For purposes of ownership, it is essential that the respective sectors take the lead in the activities. Consultants should be used as and when it is essential and in supportive roles.

References

‘Macroeconomics and Health: Investing in Health for Economic Development’, Report of the Commission on Macroeconomics and Health, December 2001.

ANNEX 6: COUNTRY EXPERIENCES

ETHIOPIA:

Country Profile	
Surface Area	1.1 million km
Population	67 million (2002)
Average life expectancy	54 years (2002/03)
Per capita income	US$ 100 (2001/02)
Potential health service coverage	61% (2002/03)
Gross primary enrolment ratio	59% (1999/00)
Male 67% Female 50%	
Net Primary enrolment ratio	34% (1999/01)
Male 36% Female 50%	

Health Sector Development Program (HSDP) :20 year plan with a rolling five year programme.

Health Policy:

- Democratization and decentralization of the health service
- Development of the preventive, promotive and curative components of health care
- Assurance of accessibility for all segments of the population
- Promoting participation of the private sector and NGOs.

Vision:

- Develop the preventive, promotive and curative component of the health care delivery system
- Develop an equitable and acceptable standard of delivery
- Train and deploy motivated and adequate number of technical and managerial health workers.

HSDP II constitutes the health section and is an important component of the Sustainable Development Poverty Reduction Program (SDPRP).

- HSDP I 1997/98 – 2001/02 completed and evaluated
- HSDP II 2002/03 – 2005/06 under implementation
- HSDP III 2006/07 – 2010/2011 under preparation

SDPRP is used as a foundation for achieving the Millennium Development Goals (MDGs).

Health Care Finance Reforms:

1) Health Care and Financing Strategy: Endorsed by the Federal Democratic Government of Ethiopia (GOE) in 1998**,** and laid out the health finance reform approach for Ethiopia

Goals of the Strategy

- Identify and obtain resources for preventive, promotive, curative and rehabilitative health care

- Increase efficiency in the use of available resources
- Increase absolute resources to the sector
- Promote sustainability of health care financing and improve quality and coverage of health services.

Strategy Guiding Principles

- cost-sharing and periodic revision of user fees
- facility retention of health facility revenue
- fee waiver to reduce financial barrier for the poor
- exemption to encourage consumption of preventive, promotive, or public health services
- active involvement of the community
- privilege to appropriate referrals
- partnerships with the private and NGO sectors.

2) National Health Accounts

- two rounds- 1995/96 and 1999/00
- per capita health expenditure: 1995/96 – US$ 4.09
  1999/00 – US$ 5.60

3) Expansion of special pharmacies

Objectives:

- stabilize drug prices
- ensure continuous and consistent supply of drugs
- provide safe, efficacious, quality drugs
- cross-finance quality-improving activities
- improve staff motivation.

4) Fee waiver and expansion

- both are about free provision of health care services
- practiced since the introduction of fee for service
- fee waiver bases ability-to-pay
- exemption bases some selected disease categories and/or public health services (TB, leprosy, etc.).

5) User fees at public facility

- introduced 50 years previously
- the fees are neither revised, uniform, nor retained at the point of collection (unofficial health tax).

6) Willingness to pay study finding

- The perceived quality was more important than the cost of medical care for providers choice
- Comprehensive user fee revision needs to wait until the quality is improved.

7) Community-based health insurance scheme

- it remains underdeveloped and the results of pro-feasibility assessment in both rural and urban setting are not promising for the short term

Taking Health Close to the Client

1) Decentralization

- Important element of the federal system of government

- This will result in the devolution of power to the regional governments
- Fiscal federalism provided regions full autonomy in budgetary process and actual expenditure
- Starting 2002/03 – fiscal decentralization will be further deepened into the districts and *woreda* ensuring district autonomy on resources
- Will also provide a basis for a meaningful participation by the people in local development (primary education, primary health care, rural water etc.).

2) **Health Extension Package (HEP)**

The Objective of HEP is to improve equitable access to essential preventive health interventions, through community/*Kebele* based health services, and will result in:

- the extension of services provided as a package, targeting households and in particular women/mothers at *Kebele* level
- the creation of a new cadre of health workers (of which 75% should be female)
- two agents in each *Kebele*, who will be accountable to the nearest health district.

3) Pastoralist Health

- Constitutes 11% of the Ethiopian population and 52% of the land
- A different health system is being designed.

The CMH Process in Ethiopia

1. The process was initiated in November 2002 and the Macroeconomics and Health team met with:
    - Government (Ministry of Health (MOH), Ministry of Finance and Economic Development (MOFED), MOCB, MOW, Parliament)
    - Civil Society
    - Academia
    - Professional associations
    - UN Agencies (UNDP, UNICEF, UNAIDS, WHO)
    - Private sector (Chamber of Commerce).
2. In March 2003 the Macroeconomics and Health team from Columbia University traveled to Ethiopia to continue to advocate for a MH process.
3. In April 2003, WHO presented the Macroeconomics and Health approach in the HSDP/Annual Review Meeting. The Ministry of Health endorsed the MH plan of action.

Plan of action

- Terms of Reference for MH country coordinator completed and accepted by MOH, WHO/HQ, WHO/Ethiopia, and Columbia University
- MH technical group consisting of members of MOH, MOFED, WHO/Ethiopia, and HPN donor groups
- MH country coordinator recruited.

Next Steps

- MH country coordinator review documents of the HSDP and Health Care Financing Secretariat
- Recruit Senior consultant to assist MOH in developing Human Resource Development Plan.

GHANA

Country Profile

Population	20 million
Population Growth	2.5%
GDP	US$ 5.3 billion
Per capita GDP	US$ 269
GDP	US$ 44.3 billion (PPP)
Poverty Indicators	
Population living under $1/day	44.8%
Population living under $2/day	78.5%
Health Situation	
Infant Mortality Rate	57 deaths per 1000 live births
Under 5 mortality rate,	100 deaths per 1,000 live births
Maternal mortality rate	108 deaths per 100,000 live births
Female Illiteracy	36.1%

Non Financial Constraints

- 1 Physician: 22,193 population
- 1 Nurse: 2,080 population
- Population with access to Health Care: 60%
- OPD Attendance per Capita: 0.46
- Access to urban water.

Financial Resources to Health	**2000**	**2001**	**2002**
% GOG Allocated to Health	5.9%	9.1%	11.1%
% Recurrent Budget for health	11%	10.2%	11.0%
% Non wage recurrent district expenditure	48.6%	40.9%	(6 months)
Total amount spent on exemptions	3.6%	3.2%	(6 months)

Trends in Health Expenditure

	1997	2000	2003 (Planned)	May 2003 (Actual)
Total Public Expenditure (US$) PHE (US$)	1,356,206,897 166,453,202	1,385,564,353 121,450,930	1,795,794,286 140,765,714	581,337,143 26,176,00
% GDP	2.4	2.4	1.8**	-
% Public Budget	12.3	8.8	7.8	-
US$ Per Capita	88	75.3	88	-
% ODA to Health	13.4	15.6	7.0***	-
US Per Capita total health Expenditure	10	6.6		

NON-FINANCIAL CONSTRAINTS

- 1 Physician : 22,193 population
- 1 Nurse : 2,080 population
- Population with Access to Health Care : 60%
- Outpatient Department Attendance per Capita : 0.46

The CMH Process in Ghana

Start-up

- The WHO Country Representative (WR) briefed Chairman and Members of Council of State
- President briefed by Chairman of Council of State
- CMH mentioned by the President to Cabinet and Ministers
- Participation in Meeting on National Responses to the Commission on Macroeconomics and Health Report, in Geneva (June 17-18, 2002) Ministers of Finance, Health, Economic Planning and Chairman of Council of State to WHO/HQ
- Process to implement the recommendations of the CMH in July 2002
- Formation of Policy Advisory Group
- Formation of Technical Committee.

Inter-Sectoral Collaboration

- National Development Planning Commission (Co-ordinating Agency)
- Ministry of Health
- Ministry of Finance
- Ministry of Works & Housing
- Ministry of Local Government & Rural Development
- Community Water & Sanitation Agency
- WHO; DfID; DANIDA; World Bank; Private Sector.

1. Policy/Advisory Committee

- Provides guidance for the formulation of the GMHI
- Play advocacy role at the national and international levels.

Membership:

- Ministers of Health, Economic Planning and Regional Cooperation, Finance Local Government and Rural Development, Works and Housing
- Majority Leader of Parliament
- Representatives of Parliamentary Select Committee on Health
- Chairman of the Council of State
- Director General of Ghana Health Service
- President of Ghana Insurers Association
- Vice Chancellor, University of Ghana
- Country Representatives of WHO, UNDP, UNICEF, DfID and the World Bank.

The first meeting of the committee took place on 31 July 2002. Members of the Technical Committee (TC) were invited to participate in the subsequent meetings of the advisory committee.

2. Technical Committee

1. Provides technical input towards the preparation of the main output of the initiative
2. Assesses the GPRS in the light of the recommendations made by the CMH Report
3. Makes recommendations for scaling up investments in health care, water and sanitation, in order to achieve coverage levels of targeted health interventions and per capita health expenditures comparable to those recommended by the CMH
4. Produces a document, which will serve as an addendum to the GPRS Document as well as an advocacy tool to attract more resources to health-related sectors.

Membership: Technical Committee

- Technical representatives of the Ministry of Health, Ghana Health Service, Ministry of Finance, Ministry of Economic Planning and Regional Cooperation, Ministry of Local Government and Rural Development, Community Water and Sanitation Agency, Ghana Water Company, DfID, DANIDA, WHO.

The first meeting of the technical committee was held on 10July 2002. TC met on a weekly basis beginning 10 July 2002 until the end of October when the draft papers were completed.

Goals and Objectives of the GMH Initiative

- Disseminate and discuss widely in-country the findings and recommendations of the CMH Report
- Provide strategic options for scaling up investments in sectors that influence the health status of Ghanaians, in order to have the desired impact on poverty reduction and economic growth in the shortest possible time
- Mobilize political support and advocacy at the local and international levels to
- Attract more resources to water, sanitation and health care.

Output of the GMH Initiative

- The GMH Initiative will result in a report –" Investing in Health and Macroeconomic Development in Ghana"

- The purpose of this report is to contribute to the revision of the health-related interventions in the Growth and Poverty Reduction Strategy (GPRS) in order to achieve coverage levels and per capita health expenditures comparable to those recommended by the CMH Report
- The resulting document to draw heavily on the technical papers, conclusions and recommendations of a technical workshop and further stakeholder consultations
- The document will also serve advocacy tool to attract more resources to health care, water and sanitation.

1. Joint Meetings

- The first joint meeting of the Technical and Advisory Committees took place on 31 July 2002
- The meeting discussed the Plans of Work of the GMH, the progress of work and the way forward towards the realization of the objectives of GMHI
- Five joint meetings were held to discuss and resolve policy and technical issues arising out of the preparation of the technical papers
- The joint meetings were also to foster interaction between the technical committee and the advisory committee to ensure that the views & recommendations of the advisory committee were reflected in the technical papers.

2. Technical Papers

- The Technical Committee assembled the evidence, and in some areas, generated additional evidence, pertaining to health problems and their links with poverty in Ghana
- Working closely with the GMH Advisory Committee, and drawing on the assembled evidence, the team examined the opportunities for high-yielding investments in sectors that influence the health status of Ghanaians
- The TC assessed investment opportunities to increase access of the poor to improved quality of potable water, sanitation, and preventive and curative health care.

List of Technical Papers

1. Establishing Health Insurance in Ghana: The District-wide Mutual Health Organization
2. Implementing Community-based Health Planning and Services (CHPS) as the basis of a "Close-to-Client (CTC)" Health System in Ghana
3. Waste Management: A Non- Medical Strategy for Health
4. Scaling–up investments in Community Water and Sanitation
5. Mobilizing Resources for Scaling –up Health Investments
6. Scaling-up Urban Water Investments

These papers will serve as background papers for the preparation of the main report of the GMHI.

Technical Workshop (19-20 Nov. 02)

The objective of workshop was to:
a) subject the draft technical papers to critical review by technical experts
b) solicit broad-based inputs in order to improve and finalize the recommended output and investments targets and

c) build consensus on domestic resource mobilization options for scaling-up investments in health care, water and sanitation.

About 60 technical experts on finance, health care, water and sanitation drawn from Ministries, Departments agencies, civil society, NGOs and development partners participated.

The participants were divided into the following working groups based on their field of expertise: Health Care Provision; Health Care Financing; Water and Sanitation Investments; Mobilizing of Resources to Finance Scaling-up of Investments in Health.

Way Forward

- Finalizing the main report of the Initiative - "Investing in health for poverty reduction in Ghana"
- Setting up mechanisms to attract adequate resources for scaling-up investments in health care, water and sanitation within the framework of the GPRS
- This will require support at the highest level of government and of our development partners
- The technical committee met several times since the completion of the technical papers to deliberate and build consensus on the way forward towards achieving the objectives of the GMHI
- Several activities have therefore been identified for implementation during the next phase of the GMHI.

On-going Activities of GMHI

- **Finalization of the main report of the GMHI using relevant inputs.** The main output of the initiative –"Investing in health for economic development in Ghana" is currently under preparation. This document will be a synthesis report of the technical papers, indicating strategic options for scaling up investments in health, water and sanitation in the light of CMH and MDG targets. It will include investment analysis of the proposed interventions and propose options for mobilizing resource to finance the investment gap. The Report will exploit linkages between the sectors to ensure synergy in the provision of health care water and sanitation services.

  The draft report was presented to stakeholders and discussed on 2 July 2003. When completed, this document will contribute to the revision of the GPRS in order to achieve coverage levels of targeted health interventions, and per capita health expenditures comparable to that recommended/outlined by the CMH Report and MDGs. It will also serve as an advocacy tool to attract more funds to scale up investments in health care, water and sanitation.
- **Linking the GMHI recommendations to the budget through the MTEF,** which is the mechanism for preparing government budget and managing public expenditure. Under this system sectoral resource envelopes are established for a three-year period taking into account government's strategic priorities and costed plans of MDAs. It is therefore essential to ensure that the GMHI is reflected in the policies of the relevant sectors during the budget preparation process
- A presentation on the GMHI was made to the budget preparation team from the MFEP and National Commission for Development Planning

- Subsequent meetings with the key staff of the health, water and sanitation MDA responsible for policy, planning and budgeting will be scheduled at the appropriate stages throughout the budgeting process
- Ensuring that GMHI recommendations are reflected in the district medium-term development plans
- Implementation of the GMHI recommendations will be mostly at the local government level in line with the government's policy of decentralization within the framework of the GPRS
- District Assemblies (DAs) will be expected to coordinate implementation at the local level in partnership with NGOs, Community Based Organizations, and other stakeholders
- They will also be expected to incorporate the recommendations into their district development plans and their annual work plans to ensure adequate funding
- Briefs on the GMHI were sent to all the District Planning and Coordination units to introduce them to the initiative and inform them of their roles in the implementation of the recommendations of the initiative prior to the completion of the main report.

Planned Activities

- Publishing/dissemination of the main report of the initiative and using it as an advocacy tool to attract more funds to health and related sectors (e.g. HIPC funds, IGF etc)
- Further consultations with stakeholders to build consensus and ensure ownership
- Subsequent revision of the GPRS targets using the recommendations
- A roundtable conference for relevant Ministers and their Chief Directors and other members of the Advisory Committee to sustain political support and advocacy
- Presentations on GMHI to Regional Ministers and District Chief Executives respectively during their next quarterly meetings
- Sustaining the initiative and mainstreaming it into government's programmes dealing with health, water and sanitation
- Round Table discussion with health partners/donors
- Visit to selected districts
- Influence the spending of HIPC savings fund to the health and allied areas
- Establishing Mechanism for Monitoring and Evaluation
- Burden of Disease Analysis/Cost Effectiveness Analysis/Risk Assessment (Preparatory Stage).

Challenges

- Urban water
- Human resources
- Data
- Absorptive capacity
- Fiscal decentralization
- Understanding of the concept "at the grassroots"
- Existing sectoral plans
- Completion of GPRS
- Multi-donor budget support *vis à vis* SWAP

ANNEX 7: COUNTRY PLANS OF ACTION

ANGOLA

Plan of Action: Proposed Process for Incorporating the CMH principles into the current national investment plans in Angola

Country Profile		
Surface Area		1,246,700 sq km
Population		10.7 million (2003)
GDP	purchasing power parity -	US$ 18.36 billion (2002)
Per capita GDP	purchasing power parity -	US$ 1,700 (2002)
Rise in GDP		US$ 3.3% (2001)
External debt		US$ 10 billion
State budget for health		US$ 5.8% (2001)
Poverty Indicators		
Population living under poverty line		68%
Health Situation		
Infant Mortality Rate		150 deaths per 1,000 (2001)
Under 5 mortality rate		250 deaths per 1,000 (2001)
Maternal mortality rate		108 deaths per 100,000 live births
Female Illiteracy		43%

Background for Process on Macroeconomics and Health in Angola

- Draft I-PRSP 3rd draft (Ministry of Planning)
- Draft Medium Term Development Plan (MTDP) until 2015 (Ministry of Health)
- Study on Public Expenditure years 1999-2002 (WHO, UNICEF, UNDP, IOM, Ministry of Finance, Ministry of Health, Ministry of Education)
- Report on Achievements: MDGs (UNDP, UNCT, Ministry of Planning)
- Country Cooperation Strategy (WHO, Ministry of Health, Government of Angola, partners)
- UNDAF 2005-08 in the phase of preparation
- Transition Plan for the year 2004 in the phase of preparation.

Planning the MH process

1. Meetings with Minister and Vice Minister of Health and Minister of Finance to explain on CMH followed by informal meeting with Minister of Health and Finance to report on Addis' CMH Meeting
2. Elaboration of a structured CMH presentation, and background on public health expenditure the main national development plans and initiatives already available either in draft or endorsed (I-PRSP, MTDP (2015), DDR/World Bank, CCS/WHO; UNDAF/UN
3. Meeting WHO Representative/Disease Prevention Control Officer (DPC) with Minister of Health, Vice Ministers of Health, Secretary General, Ministry of Health and Planning Cabinet, Ministry of Health for information and consensus building. Revision of the required actions for the process

4. Further involvement and consensus building with Directors from Ministry of Health
5. Formal Meetings to present MH process and concept of Technical and Political Task Force with:
   - Minister of Finance, Vice Minister for Budget and Director of Budget;
   - Minister of Planning;
   - PM Office? (Section for economic development)
   Constitution of the Political Task Force
6. Ensure technical skills available. Constitution of the Technical Unit to assist on technical aspects.. Endorsement from Political Task Force
7. Identify where best the Technical Unit would operate
8. Definition of the draft structure, components and focus, phases, responsibilities, etc in the revision and/or elaboration of the Health Investment Plan
9. How to ensure and maintain the involvement of the actors participating to the I-PRSP and the MDP
10. How to ensure participation of the Provincial Level to the Process
11. Involvement and Discussion with Consultative Group including Civil Society (national & international NGOs, Church, Professional associations, Politicians, Private profit, etc); Development Partners; Other actors: Armed Forces, etc.
12. Consensus building with UNDP, UNICEF, UNFPA/UNAIDS, and other potential partners. Set up a National Workshop with WB, IMF, other stakeholders
13. Many sectoral consultations already exist (GFAMT-Humanitarian Group, MDGs/I-PRSP, etc). Investigate the potential of this an opportunity for better integration among involved partners
14. Revision of existing National Plans and Elaboration of the Health Investment Plan (Costing Basic Package, its geographical distribution and focus on groups targeted by poverty reduction, institutional building
15. Consultation with partners and with strong commitment and involvement from Government of Angola
16. Decision on ways & contents & cost implications of this step to be prepared according to consultations held.

Main actions towards MH process

Presentation by the Political Task Force and discussion of the Health Investment draft Plan with:

- National Health Commission
- Consultative Group
- Health and Social Commission of the National Assembly
- To National Assembly (within the Country Development Plans) by Prime Minister.

BOTSWANA:

Plan of Action: Proposed Process for Implementing Macroeconomics and Health work

Country Profile		
Surface Area		600,370 sq km
Population		1.5 million (2003)
GDP	purchasing power parity -	$13.48 billion (2002)
Per capita GDP	purchasing power parity -	$8,500 (2002)
Poverty Indicators		
Population living under poverty line		47%
Health Situation		
Infant Mortality Rate		67.34 deaths per 1,000
Life expectancy at birth		32.26 years

1. Phase 1 Plans:
- Consensus building and setting up appropriate institutional arrangements
- Launch of a National Commission on Macroeconomics and Health (NCMH)
- Objective of the NCMH
- NCMH Activities

2. Stakeholders:
- Ministry of Health: DHS down to management
- District Health Management Team, Ministry of Finance and Development Planning (MOFDP), Ministry of Education (MoE)
- Others: NGOs, Civil society, Partners, Media.

3. Partners: Botswana Institute of Policy analysis; WHO

4. Consensus on the relevance of the CMH findings in Botswana
- Consensus building
- Identify priority areas for scaling up
- Form team from key ministries and stakeholders to prepare technical papers.

5. Setting up institutional arrangements to facilitate implementation of the CMH recommendations in Botswana

i). Health Partnership Forum meeting in September 03 to draw up TOR for NCMH

ii). Meeting of Key Stakeholders (Roundtable conference) for different levels and stakeholders
- Background document and resource people
- Invite Participants
- Roundtable discussion
- Feedback.

iii) Commission the preparation of technical papers on areas for scaling up and develop TOR for the various technical groups

iv) Dissemination of technical report and analyses by expert groups

v) Commission a consultant to synthesize various technical expert reports.

REPUBLIC OF CONGO:

Country Profile		
Surface Area		342 000 sq km
Population		2,954,258
GDP	purchasing power parity	US$ 2.5 billion (2002)
GDP per capita	purchasing power parity	US$ 900.00 (2002)
Poverty Indicators		
Population living under poverty line		-%
Health Situation		
General mortality rate per 1,000		14.3
Infant mortality rate		81 deaths per 1,000
Child mortality rate		96.5 deaths per 1,000
Life expectancy at birth		45.22 years

Actions principales de la phase 1 et activités requises

Objectif étape 1: Réaliser un consensus sur la pertinence des conclusions et recommandations de la CMS

Action 1: Campagne de sensibilisation des acteurs

- Compte rendu / Rapport de réunion Addis Ababa aux MSP, MF avec recommandation de mise en place d'un Groupe de travail inter-ministériel
- Élaborer les termes de référence du Groupe de Travail chargé de préparer le consensus sur CMS.

Consensus sur CMS

1. Campagne de sensibilisation des acteurs

- Identifier les acteurs concernés par la CMS
- Prendre des contacts individualisés avec les principaux décideurs pour présenter les conclusions et recommandations de CMS
- Organiser la diffusion des CMS auprès des acteurs concernés.

Etape 1: Consensus sur CMS

Action 2: Consensus sur les conclusions et recommandations de CMS

- Préparer l'atelier de consensus : documents de travail, organisation matérielle
- Tenir l'atelier de consensus sur les actions à entreprendre

Consensus sur CMS

Action 3: Mettre en complémentarité la finalisation du PNDS + finalisation DSRP intérimaire + conclusions et recommandations de CMS

- Diffuser les conclusions et recommandations de CMS aux Groupes de travail PNDS & DSRP

- Organiser un atelier d'analyse du financement de la santé et de sensibilisation et initiation aux CNS.

Objectif étape 2: Mettre en place le cadre institutionnel
Action 1: Faire le point des organes existants

- Identifier les organes de coordination existants dans les secteurs santé, finance et budget, plan, hydraulique, assainissement et environnement
- Analyser leurs mandats respectifs et élaborer des propositions d'arrangements institutionnels.

Mettre en place le cadre institutionnel (suite)
Action 2: Obtenir le consensus sur le cadre institutionnel

- Organiser des consultations avec les acteurs concernés
- Organiser un atelier de consensus sur le cadre institutionnel de mise en œuvre des conclusions et recommandations de CMS.

Pourquoi ces choix ? Quand ?
Processus en cours

  - Re – planification PNDS 2004 – 2008
  - Élaboration DRSP intérimaire, finalisation Décembre 2003 (point d'achèvement)
  - Intérêt de CMS = fournir une valeur ajoutée à ces deux processus par une meilleure information sur financement de la santé
  - Échéances en cours PNDS, DSRP.

Quel soutien ?
Décideurs politiques

- Ministres des finances, santé, plan, hydraulique, environnement et assainissement
- Parlement (Assemblée + Sénat)
- Conseils locaux.

Autres acteurs

- Agences NU, Coopérations bi-multilatérales, Secteur privé, ONG.

Quels obstacles & contraintes prévisibles ?

- Obligation de tenir compte des échéances PNDS, DSRP
- Diversité des programmes sectoriels et des intérêts des différents acteurs
- Faible niveau d'information des CMS.

KENYA:

Plan of Action: Proposed Process for Implementing Macroeconomics and Health work

Country Profile		
Surface Area		582,650 sq km
Population		31.6 million (2003)
GDP	purchasing power parity -	$32.89 billion (2002)
GDP per capita	purchasing power parity -	$1,100 (2002)
Poverty Indicators		
Population living under poverty line		50% (2000)
Health Situation		
Infant mortality rate		63.36 deaths/1,000 live births
Life expectancy at birth		45.22 years

Phase 1 :
Objective 1: To build consensus among key stakeholders on CMH

Activities
- Briefing the Minister for Health (MOH)
- Subsequent briefings to the Ministry of Finance (MOF) and Ministry of Planning and National Development (MOPND)
- Prepare for the 2nd Consultation on Macroeconomics and Health, October 2003
- Brief the Senior Management in MOH and relevant ministries
- Identify key stakeholders
- Organize stakeholders' workshops on CMH agenda
- Placing CMH agenda in the ERS investment planned meeting.

Objective 2: To identify areas/gaps requiring further research works
- Review existing related works/report
- Prepare Terms of Reference for the assignments
- Develop an IEC strategy & materials

Objective 3: To incorporate the CMH framework into existing institutional arrangement

Activities
- List existing institutional structures
- Setting up National Steering Committee on CMH (NSCMH)
- Set up a Technical Committee (TC)
- Develop Terms of Reference for TC and NSCMH.

Way forward
- Consult and finalize the plan of action
- Mobilize resources for Phase 1
- Prepare preparatory work for the development of the Health Investment Plan.

Where CMH will be Housed & Why
Ministry of Health
–Core issues are health sector related
–Trade offs to be done by Ministry of Health
–Health Investment Plan driven by Ministry of Health

Who will be contacted and when
- Cabinet sub-committee on social and economic development
- Parliamentary committee on health
- Permanent Secretaries briefing meetings
- PRSP/Medium-Term Expenditure Framework/Sector Working Group
- Donors' Forum
- UN Development Assistance Framework (UNDAF) Group
- Private Sector/NGO Council/Civil Society (select a few).

Opportunities for getting CMH into national agenda
- Placing CMH in ERS investment programme
- Placing CMH in the next National Development plan (2006-15)
- Integrating CMH into the budgetary process
- Integrating CMH into UNDAF workplan.

How to mobilize other resources
- Through budgetary process
- UNDAF Resources
- Reducing inefficiencies
- Improved partnership with private sector and NGOs.

Other sectors to involve
- Education
- Water
- Infrastructure
- Local Government
- Agriculture.

MALAWI

Plan of Action: Proposed Process for Implementing Macroeconomics and Health work

Country Profile		
Surface Area		118,480 sq km
Population		11.8 million (2003)
GDP	purchasing power parity -	$6.811 billion (2002)
GDP per capita	purchasing power parity -	$600 (2002)
Poverty Indicators		
Population living under poverty line		64%
Health Situation		
Infant mortality rate (2003)		105.15 deaths/1,000 live births
MMR		1120/100,000
Life expectancy at birth		37.98 years

Activities:

- Briefing the Minister for Health
- Subsequent briefings to the Minister of Finance and Minister of Economic Planning and Development
- Brief the Senior Management in Ministry of Health.

Expected Outcomes: Building Consensus among the ministers, directors and senior management of the ministries.

Activities

- Identify key stakeholders
- Organize stakeholders workshops.

Expected Outcomes

- Sensitization of the key stakeholders
- Identification of main areas for scaling up time frame.

2. Objective: Strengthening & setting up of institutional arrangement

Activities

- Establishing a task force comprised of Ministry of Finance (MOF), Ministry of Economic Development and Planning (MOEPD), and Ministry of Health and Population (MOHP)
- Draw up TORs for the task forceSet up a Technical Groups (TG)
- Develop Terms of Reference for TGs.
-

Expected outcomes

1. Task force established, and Terms of Reference drawn
2. Technical groups established and Terms of Reference drawn.

MOZAMBIQUE

Approach to the Macroeconomics and Health (MH) Processes

Country Profile		
Surface Area		801,590 sq km
Population		17.47 million (2003)
GDP	purchasing power parity -	$19.52 billion (2002)
GDP per capita	purchasing power parity -	$1,100 (2002)
Poverty Indicators		
Population living under poverty line		70% (2001)
Health Situation		
Infant mortality rate		199 deaths / 1,000 live births
Life expectancy at birth		31.3 years

MH Process - principles

- Take stock of existing strategies and development policies: Poverty Reduction Strategy Paper, Health Sector Strategic Plan, Five Year Government Programme and Health Investment Plan (2004-2013)
- Use established working groups
  - Within the Ministry of Health: GT –SWAP (Health Partners Working Group)
  - Between Ministries: PA Working Group
  - G 11 (bilateral agencies providing budget support)
- Strengthen Institutional Capacity
- Oportunities: review of the Poverty Reduction Strategy Paper, Health Sector Strategic Plan.

Goals

- Contribute to consolidate the new development paradigm in Mozambique: investing in health
- Streamline the analysis and evidence of the CMH into the national development agenda: Accelerated Economic Growth and Absolute Poverty Reduction
- Focus and Activities in Phase 1
- Identify Champions for MH work
- Use the support of the Minister of Health as a Pivot of the process.

Focus and Activities in Phase 1

- Drawing from studies, available data and policy documents, formulate a country specific report on MH
  - Health Expenditure Review
  - Expenditure Tracking and Service Delivery Survey
  - National and Sectorial Medium Term Financing and Expenditure Framework
  - Health Sector Strategic Plan, Health Investment Plan.

Expand the economic and social analysis

- Role of WHO Representative and WHO/AFRO
- Other institutions and or experts on the matter.

Focus and Activities in Phase 1

- Package the report contents for presentation:
  - use good communication techniques – user friendly (language)
- Mobilize technical and financial resources
  - bilateral partners – Common Fund.

Expand Terms of Reference

- GT- SWAP (Health Partners Working Group)
- G11, Ministry of Finance and Planning and Macrofinance Support Group.

Focus and Activities in Phase 1

- Trigger debates around country report on MH
- GT- SWAP (Health Partners Working Group)
- Sector Coordinating Committee
- Economic Council of the Cabinet
- Poverty Alleviation Working Group
- Parlamentarian Commission on Social Affairs
- Design and implement a participatory process involving provinces, districts and key stakeholders
- Strategize on how to include bodies such as National Council for National Development Agenda 2025.

Timing and budget

- Consider holding a National Health Summit in 1st quarter of 2004
- Consensus building on health priorities
- Time table will be worked accordingly
- Annual Work Plan for 2004: Budget
- Funding mechanisms
- Common Fund
- Off-budget funds – other partners.

NIGERIA

Macroeconomics and Health Plan of Action

Country Profile		
Surface Area		923,768 sq km
Population		133.8 million (2003)
GDP	purchasing power parity -	$112.5 billion (2002)
GDP per capita	purchasing power parity -	$900 (2002)
Poverty Indicators		
Population living under poverty line		60% (2000)
Health Situation		
Infant mortality rate		71.35 deaths/1,000 live births
Life expectancy at birth		51.01 years

6-months Objectives	Key Activities	Outcome sought	Timeline
Build consensus on the relevance of the findings of and recommendations of CMH at Federal, State and LG levels	Start up activities: Intra-Ministry of Health advocacy and consensus building Inter-ministerial advocacy and consensus building	Appropriate technocrats adequately sensitized on CMH	Mid August – Mid September 2003 Sept 2003
	Preparation for the October Geneva CMH Meeting by Ministries of Health, Finance and National Planning	Nigerian Delegation to 2nd Consultation on Macroeconomics and Health adequately briefed	September - October 2003
	• Advocacy to National Assembly (the 2 chambers) • Advocacy and consensus building to National Council on Health (meeting of Federal and State Ministers of Health) - CMH to be the theme • Advocacy to Council of Ministers (FEC) • Advocacy to Council of State(Chaired by President, attended by Governors and former Heads of State) • Advocacy to the private sector Donors, NGOs, Media, Professional Associations	All relevant groups adequately briefed and consensus built on relevance of CMH findings and recommendations to Nigeria All Stakeholders pledge support to the implementation of the CMH action agenda	End October – December 2003
Set up institutional mechanisms for advancing the CMH agenda	• Constitute and inaugurate a steering committee – Articulate TOR	Committee inaugurated	September 2003
	• Consultancy to formulate a concept paper on MH using existing evidence – Generate list of sources – TOR for consultant Conduct Situation Analysis of other initiatives like PRSP, NEPAD etc	Concept paper on CMH in Nigeria prepared Action agenda on CMH in Nigeria prepared	September – October 2003

1. Location of the CMH process

CMH process is planned to be located in the Department of Health Planning and Research of Federal Ministry of Health. This Ministry has already been assigned by the Federal Government to take responsibility for coordinating the implementation of the health components of on-going related initiatives such as NEPAD, PRSP, MDG etc.

2. Entry Point for mobilizing political support

The Minister of Health will be the entry point.

3. Key stakeholders: The President; Minister of Finance; Minister of National Planning; Minister of Water resources; Minister of Education; Minister of Women's Affairs and Social Development; Minister of Agriculture; Minister of Environment; Minister of Information; National Assembly; State Governors; State Assemblies; Development Partners; private sector and civil society; National Economic Summit Group; the media.

4. Opportunities for getting the CMH into national agenda

Important fora include: Council of Ministers; National Council on Health; Council of States; Ministerial Interagency Committee; National and State Legislative Assemblies (Health Committees); National Economic Summit Group.

5. How to mobilize other resources

All development partners active in health sector in Nigeria

Private sector organizations: oil 1A\ companies and other multinational corporations.

Other sectors such as women's affairs, water resources, environment, agriculture, education and information.

RWANDA:

Macroeconomics and Health Plan of Action

Country Profile		
Surface Area		26,338 sq km
Population		7.8 million (2003)
GDP	purchasing power parity -	$8.92 billion (2002)
GDP per capita	purchasing power parity -	$1,200 (2002)
Poverty Indicators		
Population living under poverty line		60% (2001)
Health Situation		
Infant mortality rate		102.61 deaths/1,000 live births
Life expectancy at birth		39.33 years

Etape 1: Diffusion et consensus sur le rapport CMH
La task team est en place

- Elaboration programme task team (reunions)
- Rédaction et transmission du rapport de l'atelier CMH
- Identifier les acteurs
- Elaborer le message à leur transmettre
- Multiplication et transmission des documents
- Diffusion aux differents niveaux pour le consensus (séminaires au niveaux central et périphérique).

Etape 2: Arrangements Institutionnels

- Identifier les institutions membres du comité de pilotage
- Mettre en place le comité de pilotage
- Doter d'un statut juridique le comité de pilotage.

SENEGAL:

PLAN D'ACTION DE LA PHASE 1

Country Profile		
Surface Area		196,190 sq km
Population		10.5 million (2003)
GDP	purchasing power parity -	$15.64 billion (2002)
GDP per capita	purchasing power parity -	$1,500 (2002)
Poverty Indicators		
Population living under poverty line		54% (2001)
Health Situation		
Infant mortality rate		57.57 deaths/1,000 live births
Life expectancy at birth		56.37 years

Étape I : Diffusion des Conclusions et recommandations de la CMS et recherche d'un consensus au Sénégal

Objectif : Dégager un consensus sur l'utilité des conclusions et des recommandations de la CMS

Résultats Attendus:

- Une liste des parties prenantes
- Une liste de consultants possibles
- Un consensus sur l'utilité des recommandations de la CMS
- Un engagement des différentes parties prenantes à aider le gouvernement à mettre en œuvre les recommandations de la CMS.

ACTIVITES

1. Mise en place de comite restreint de préparation de la réunion d'octobre 2003, Genève et des travaux de la CMS

1.1. Rendre compte aux Autorités des recommandations et conclusion du présent atelier en proposant la mise en place d'une comite restreinte préparatoire.

1.2. Mise en place d'un comité de 7 membres.

1.2.1. Composition : 3 représentants du Ministère de la santé de l'Hygiène et de la Prévention (MSHP), 2 représentants du Ministère de l'Economie et des Finances (MEF), 1 représentant de la Banque Mondiale et 1 représentant de l'OMS

1.2.2. Mandat :

- Préparation de la réunion d'octobre à Genève par la sensibilisation des ministres concernés et élaboration d'une note technique sur Macroéconomie et Santé;
- Définition du projet d'Agenda annoté des travaux de la C.M.S.

- Préparation des travaux de dissémination des conclusions du rapport de la C.M.S.

1.2.3. Mise en place du comité restreint ;

1.2.4. Calendrier de travail du comité ;

- Du 18 au 22 août : Travaux préparatoires de la première réunion du comite restreint ;
- Du 25 au 29 août : Réunion d'information et d'attribution des taches en vue de la sensibilisation et de la rédaction de la note technique pour la réunion d'octobre ;
- Du 25 au 29 août : Adoption de la note technique.
- Du 16 août au 16 septembre : Sensibilisation des Ministres concernés par le Représentant de l'O.M.S
- Du 18 au 31 août : Identification des acteurs et reproduction du rapport de la C.M.S.
- Du 1er au 30 septembre : Elaboration et adoption des termes de références.
- Du 6 au 10 octobre : Tenue du séminaire national de partage des informations sur les conclusions du rapport de la C.M.S.
- Du 10 au 30 octobre : Suivi des recommandations du séminaire ;

2. **Dissémination des conclusions de rapport de la Commission Macroéconomie et Santé**

2.1. Reproduire le rapport de la commission macroéconomie et santé.

2.2. Identifier les acteurs.

2.3 .Organiser un séminaire de partage des informations

- Elaborer les termes de références du séminaire.
- Tenir le séminaire.

3. Analyse de la situation sous l'angle Macroéconomie et Santé

3.1. Elaborer les termes de référence de l'étude sur l'analyse de la situation sous l'angle Macroéconomie et santé tenant compte de l'existant (Plan sectoriel, le DRSP, Toutes les études et enquêtes déjà menées)

3.2. Elaborer les termes de références pour la mise en place de Comptes nationaux de la santé

3.3. Recruter les consultants,

3.4. Organiser un Atelier de restitution, de partage et de validation des résultats de l'Etude

4. Plaidoyer au bénéfice de l'approche Macroéconomie et Santé

4.1. Identifier les acteurs clés et procéder à l'analyse de leurs forces et faiblesses dans le processus (PM, Parlement, MEF, MSHP, MH, MDCCL, MFPE, APCL, CONGAD, PARTENAIRES/SANTE, MEDIA, Université)

4.2. Définir l'argumentaire pertinent en fonction de chaque acteur

4.3. Faire un plaidoyer auprès des acteurs clés

D. Budget

5.1. Estimer le budget

5.2. Soumettre la requête auprès de l'OMS

Étape II : Mise en place des arrangements institutionnels pour faciliter la mise en œuvre des recommandations de la CMS

A. Objectif: Mettre en place les arrangements institutionnels pour faciliter la mise en œuvre des recommandations de la CMS

B. Resultants attendus:

- Un comite de pilotage Présidé par le PM , comprenant la Primature et les ministères clés, le parlement, les Présidents des Associations de collectivités locales, la société civile, le secteur privé, le système des Nations Unies et les autres partenaires au développement, est crée ;
- Une comite technique, chargée d'assurer le secrétariat du comite de pilotage, est crée.
- Le mandat de chaque comité est défini.

C. Activités:

1. Evaluer les cadres institutionnels existant pour mieux apprécier les arrangements institutionnels à mettre en place
2. Etablir la liste des membres des différents comités ;
3. Définir le mandat des comités ;
4. Organiser une réunion de concertation entre les membres potentiels des comités
5. Créer et installer la Commission Nationale Macroéconomie et Santé.
6. Proposer un agenda de travail de la CNMS

Opportunités:

- Volonté politique affirmée
- Cadre de concertation regroupant tous les intervenants et acteurs du secteur
- Volonté des Agences du SNU de travailler en synergie (UNDAF)
- Cadre de concertation des partenaires au développement du secteur coordonné par l'OMS
- Partenariat dynamique avec le MEF, et les ONG.
- Responsabilisation accrue des collectivités locales en matière de santé.

Comment mobiliser les ressources:

- Accentuer le plaidoyer au niveau du MEF pour l'augmentation et la mobilisation des ressources internes.
- Renforcer le plaidoyer au prés des autres secteurs
- Poursuivre la concertation avec les partenaires au développement par des contacts soutenus et des missions conjointes

Processus en cours:

- EVALUATION DES PRDS ET DES PDDS
- PREPARATION DE LA STRATEGIE A LONG TERME HORIZON 2025
- PREPARATION 2eme PHASE PNDS 2004-2008
- PLAN D'INVESTISSEMENT SANITAIRE (A verser dans l'exercice en cours

TANZANIA:

Proposed Framework for CMH plan of Action for six months November 2003-March 2004

Country Profile		
Surface Area		945,087 sq km
Population		35,9 million (2003)
GDP	purchasing power parity -	$20.42 billion (2002)
GDP per capita	purchasing power parity -	$600 (2002)
Poverty Indicators		
Population living under poverty line		36% (2002)
Health Situation		
Infant mortality rate		103.68 deaths/1,000 live births
Life expectancy at birth		44.56 years

Objectives

- To build consensus on the relevance of the findings and recommendations of CMH
- To establish institutional arrangements for facilitating implementation of the CMH recommendations.

Activities for Step 1:

- Invite one of the Commissioners to report on the CMH findings and recommendations to high level policy makers
- Selection of key officers to take forward the big idea (The Director of Policy and Planning will select the staff and provide them with the Terms of Reference)
- Develop dissemination materials
- Commission consultancy on promotion and advocacy of CMH
- Organize a series of dissemination workshops to different stakeholders
- Develop advocacy materials (especially to mass media).

Expected outcomes:

Consensus established/built on the relevance of the CMH finding and recommendations among stakeholders.

Activities for step 2:

- Commission a study to investigate the potential of existing structures in the implementation of CMH (WHO and Columbia University)
- Engage Poverty Reduction Strategy Paper (PRSP) and Public Expenditure Reviews (PER) Macro-economic Group on Macroeconomics and Health through regular meetings and workshops.

Expected outcomes:

Institutional arrangement for implementation of CMH agreed upon.

Where CMH is to be housed and why

- The current PRSP institutional arrangement will be used on temporal terms
- Study report outlined above will recommend the suitable positioning of CMH institutional arrangement.

WHO is to be contacted and when

- Senior Government Officers from the Director level onwards in Central Ministries. This will include the PRSP staff
- Senior Government Officers at the same level described above in health related sectoral Ministries; Education, Water, Community development, Agriculture and Local Government
- Cooperating Partners
- NGO's / civil society
- Mass Media
- Private Sector
- Parliamentarians
- Researchers and academic institutions.

OPPORTUNITIES

- Make it an agenda in the annual health sector review
- Annual Public Expenditure Review and Poverty Reduction Strategy Paper reviews
- Joint Ministry of Health/ Tanzania Mainland and Zanzibar meetings.

UGANDA

Plans of Action on CMH work

Country Profile		
Surface Area		236,040 sq km
Population		25.6 million (2003)
GDP	purchasing power parity -	$30.49 billion (2002)
GDP per capita	purchasing power parity -	$1,200 (2002)
Poverty Indicators		
Population living under poverty line		35% (2001)
Health Situation		
Infant mortality rate		87.9 deaths/1,000 live births
Life expectancy at birth		44.88 years

Overall Framework: CMH work will fit into ongoing processes:

- Revision of the Poverty Reduction Strategy Paper (PRSP) / Poverty Eradication Action Plan (PEAP)
- Developing Health Sector Strategic Plan II
- Studies to generate evidence for HSSP II
- Burden of Disease
- National health accounts
- Health systems performance assessment
- Benefit Incidence Analysis
- Inter-ministerial efforts to improve health and level of funding
- Health sector working group.

Six months objective: To articulate health and development in a comprehensive manner.

Key activities:

1. Develop a comprehensive paper putting all the different initiatives together under the frame work of health and development by a selected team
2. Discuss in detail with the team going to the 2nd Consultation on Macroeconomics and Health, the health and development paper. Health Policy Advisory Committee
    - Sector Working Groups
    - Other relevant sectors – by the Minister.

Outcomes sought: Consensus on carrying forward the work on CMH at the country level.

Timeline of activities:

1. A team in place developing a comprehensive paper on health and development: August 2003
2. Discuss with the team for the 2nd Consultation on Macroeconomics and Health / top management: September 2003 first week
    - Health policy Advisory committee: September 2003

- Sector working groups: September 2003
- Joint review mission, consists government and development partners who review sector priorities and performance: October 2003
- Other relevant sectors – by the minister: October 2003.

Where CMH is to be located and why: CMH process will be located in the prime ministers office.

- Easier coordination of all ministries
- Already mandated to coordinate an inter-ministerial task on health financing.

Who is to be contacted and when: Entry point is the Geneva meeting, which will enable us prepare the ministers of Health and Finance on CMH issues. Using this same opportunity the health financing task force will be strengthened.

Opportunities on the national agenda:

1. Government of Uganda and development partners Joint review mission. The comprehensive approach to health and economic development will be discussed and will automatically be in the PRSC
2. Revision of the Poverty Eradication Action Plan (PEAP)•Health Sector Strategic Plan (HSSP) II development process.

Mobilization of other resources: Additional stakeholders

- Development partners
- NGOs
- Civil society
- Infant mortality task force already started exploring these initiatives
- Ministry of finance
- Ministry of education
- Ministry of public service
- Ministry of local government
- Ministry of gender
- Ministry of water and sanitation
- Rural feeder roads.

Achieved by December 2004: Revised Poverty Eradication Action Plan

2. Results of Burden of Disease
3. National health accounts report
4. Benefit Incidence Analysis
5. Health systems performance assessment
6. Health Sector Strategic Plan (HSSP) II draft
7. Updating the Health financing strategy.