

Report on the

**Meeting to facilitate the implementation of the
recommendations of the Commission on
Macroeconomics and Health in the Eastern
Mediterranean Region**

Fez, Morocco
13–14 June 2003



World Health Organization
Regional Office for the Eastern Mediterranean

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CONTENTS

1.	BACKGROUND – INCREASING INVESTMENT IN HEALTH	1
2.	INTRODUCTION	1
3.	SUMMARY OF TECHNICAL PRESENTATIONS – THE KEY ROLE OF HEALTH IN THE DEVELOPMENT OF THE REGION	2
4.	COUNTRY PRIORITIES AND PLANS.....	6
4.1	Context of macroeconomics and health strategy.....	6
4.2	Plans of action	7
4.3	Critical issues	9
4.4	Group work	11
5.	CONCLUSIONS AND RECOMMENDATIONS.....	11
Annexes		
1.	PROGRAMME	16
2.	LIST OF PARTICIPANTS	18
3.	SUMMARY OF THREE KEY THEMES FROM THE CMH REPORT	21
4.	COUNTRY PROFILES AND DATA	26
5.	COUNTRY SUMMARIES	43
6.	BUDGET TEMPLATE FOR COSTING OF MACROECONOMICS AND HEALTH STRATEGY IMPLEMENTATION	48

1. BACKGROUND – INCREASING INVESTMENT IN HEALTH

In many countries of the Eastern Mediterranean Region there is growing awareness that effective investment in health is vital to human development and poverty reduction. Thus, health has been receiving a more prominent role in the political agenda and increased attention within the poverty reduction processes of many countries. The WHO Regional Office for the Eastern Mediterranean has been providing ongoing support to the countries of the Region as they examine new approaches to investing in health in order to deal with their health and development needs.

To facilitate this process, the Regional Office convened two consecutive meetings in Fez, Morocco, in June 2003, the first to formulate a regional strategy for sustainable health development and poverty reduction and the second to debate innovative approaches to investing in the health of the poor.

This report summarizes the main issues addressed during the second meeting, on facilitating the implementation of the recommendations of the Commission on Macroeconomics and Health in the Eastern Mediterranean Region. During the meeting, participants from seven countries highlighted the plight of millions of vulnerable people in the Region and the challenges to scaling up investment and interventions in health to reach every poor child, mother and adult in the Region. As daunting as these challenges might appear, participants heard that achieving the task was possible with government commitment and with the support of a macroeconomics and health approach which is based on the recommendations of the report¹ of the Commission on Macroeconomics and Health (CMH).

The discussions that took place in Fez centred on the planning of country work aimed at achieving increased political commitment and investment in health. Participants focused on the development of country-specific plans of action for the next six to twelve months. These plans of action highlight the steps necessary for mobilizing support at the highest political level, linking with public, private and not-for-profit sectors, and developing multisectoral investment plans that would impact on health, particularly for the poor. In all cases, the role of WHO would be to facilitate the preparation at country level of investment plans that will map out how priority health issues for the poor will receive attention within a national macroeconomics agenda. The plans also propose methods for the more efficient use of current resources and mobilization of additional domestic and donor funds for health.

2. INTRODUCTION

The meeting to facilitate the implementation of the recommendations of the Commission on Macroeconomics and Health in the Eastern Mediterranean Region was held in Fez, Morocco, on 13–14 June 2003. Over 35 senior officials from the ministries for health, finance and planning from Djibouti, Islamic Republic of Iran, Jordan, Oman, Pakistan, Sudan,

¹ *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva, WHO, 2001.

and Republic of Yemen, as well as WHO staff from three regional offices, five country offices, and headquarters attended the meeting. The focus of the two-day event was to debate the findings of the CMH report as applied to individual country set-ups and to introduce the particulars of the macroeconomics and health process. The objectives of the meeting were to:

- Adapt the global CMH findings to country-specific frameworks for the Eastern Mediterranean countries;
- Review progress to date by national teams on the implementation of the main conclusions of the CMH, as part of the macroeconomics and health strategy;
- Define the expected support that WHO will provide to interested countries;
- Develop specific steps to advance country-level macroeconomics and health strategy work;
- Discuss preliminary expectations for the outcomes of the Second Consultation on Global and National Responses to the Commission on Macroeconomics and Health Report: “Increasing Investments in Health Outcomes for the Poor,” planned for October 2003 in Geneva, and identify country inputs to that meeting.

The meeting agenda was structured to provide an overview of the macroeconomics and health strategy and the critical issues surrounding implementation of this approach in the countries of the Eastern Mediterranean Region, with emphasis on the three themes that provide a context for assessing and describing country progress. These were:

- Focusing on equity and better health for poor people
- Getting more financial resources for health
- Removing non-financial constraints.

Participating countries presented their plans of action and shared experiences and challenges encountered during the initial preparatory phases of country macroeconomics and health strategy work. The programme and list of participants are presented in Annexes 1 and 2, respectively. A summary of key themes from the CMH report is included as Annex 3. Annex 4 lists country profiles and data. Country summaries and a budget template for costing of macroeconomics and health strategy implementation are included as Annexes 5 and 6, respectively.

3. SUMMARY OF TECHNICAL PRESENTATIONS – THE KEY ROLE OF HEALTH IN THE DEVELOPMENT OF THE REGION

The WHO Regional Office for the Eastern Mediterranean has placed health at the centre of the Region’s development agenda and noted that the CMH report has been instrumental in this process. To this effect, the Regional Office has established a CMH task force under the Chairmanship of the Director of Health Systems and Community Development to promote the

findings of the report and encourage the formation of national mechanisms that would further the CMH agenda. A special focus of the task force will be to establish close links with existing community-based initiatives in the Region.

The meeting highlighted the importance of the CMH report as a tool for examining country health and poverty determinants, as well as an instrument for pursuing increased investment in health through the planning and implementation of the macroeconomics and health strategy.

During the meeting, country and regional participants emphasized that the process to develop health investment plans must generate cross-sectoral support as well as build donor confidence. This is dependent upon the macroeconomics and health strategy process, plans and products becoming fully integrated into existing national poverty reduction schemes. Emphasizing the country-led nature of the macroeconomics and health strategy process, WHO (headquarters, regions and WHO Representatives) should strive to work with governments to produce a local evidence base on the burden of disease impacting the poor and vulnerable, and then define cost-effective essential health interventions that will create the evidence base needed to push for new health strategies.

Another concern for the Eastern Mediterranean Region Member States was the issue of governance. Participants felt improved governance by itself was insufficient as the poor and vulnerable are faced with economic and social barriers restricting their access to the judicial system. A prolonged strategy of advocacy and information dissemination is required to reduce such impediments. It is not sufficient to merely put new policies in books and create more transparent mechanisms as access to health services are often blocked.

Key areas addressed included:

- An overview of the macroeconomics and health strategy with emphasis placed on the key findings and recommendations of the CMH report and the global interest generated. The objectives of macroeconomics and health strategy work were defined as responding to country demands for assistance with strategic planning and investment in health; catalysing and tracking additional resources for better health to alleviate poverty and support development; and supporting governments and their partners to develop investment plans and actions to produce better health outcomes among the poor.
- The critical issues and priorities for implementing the macroeconomics and health strategy in countries of the Region, including creating linkages with other WHO initiatives on the ground and connecting with existing mechanisms like sector-wide approaches, Poverty Reduction Strategy Papers, Heavily Indebted Poor Countries and work towards the millennium development goals. The Regional Office promoted the CMH recommendations during the 18th meeting of Regional Directors, has established the CMH task force, and initiated CMH implementation in six countries, including the establishment of a regional CMH plan and capacity-building in countries through orientation and training.

It was emphasized that WHO will back countries by providing financial assistance for technical work and support with advocacy and policy advice, analyses and planning including funding for consultants, studies, surveys and operational research.

- The application of the three themes of macroeconomics and health strategy that provide a context for assessing and describing country progress on CMH:
 - Focusing on equity and better health for poor people
 - Getting more financial resources for health
 - Removing non-financial constraints

The themes come together in the plans of action which are divided into three main phases (details on the three themes of the macroeconomics and health strategy are presented in Annex 3). Phase 1 involves a 6 to 12 month process for generating investment plans, including dissemination of information and intense advocacy as well as good communications strategies. Situational analyses and the use of existing data are important, as is learning from past experiences and from other countries. Partnerships play a key role, including the close involvement of the private sector and civil society. Linking with poverty reduction processes and reforms is critical as donor funding is channelled through these processes. Tracking progress and the achievement of objectives within a time frame is vital to continuing to Phase 2, the planning of the macroeconomics and health strategy. During this phase, priorities are determined, basic packages of services and interventions are developed, and resources are reallocated based on needs and disease burden. Phase 3 involves implementation of policies and strategies, mobilization of more resources and sequentially increasing capacity to absorb more funds.

- Role of advocacy, communications and information dissemination, and the four major steps in advocacy – documenting the situation; packaging the message; working with the media; and mobilizing others. The macroeconomics and health strategy global workplans were presented focusing on the development of advocacy messages and materials, maintaining the macroeconomics and health strategy website, working with the media and working towards developing country advocacy workplans. A way forward was proposed for a regional advocacy and communications workshop to address the issues pertinent to the Region, and a request was made to compile success stories from the Region.
- For products comprising country support strategies, WHO has opted for a strategic approach which encourages and supports country-driven analysis, debate, planning and action by a range of government ministries – specifically: finance, planning and health – in alliance with nongovernmental public, private and academic entities. The macroeconomics and health strategy objective is to improve the capacity of collaborating governments and their interested partners to make the difficult choices, *inter alia* in terms of targets, financing options and human resources, which are

necessary to better direct and increase investments in health outcomes. Several products have been developed to meet the requests of countries and regions, such as planning and budgetary guidelines that are then adapted by each country for their particular needs. A phased approach for the development of health investment plans has arisen from initial country experiences. Process-based, the content and specific objectives are locally determined to reflect the unique needs and context of each country.

- Participants were also briefed on the upcoming Consultation on Increasing Investments in the Health Outcomes for the Poor, scheduled for October 2003 in Geneva. Participants from some 30 countries implementing the macroeconomics and health strategy will come together with donors, development agencies and nongovernmental organizations to highlight the value of the macroeconomics and health strategy in supporting national poverty reduction processes and the achievement of millennium development goals. The Consultation will offer the opportunity to show how the process of the macroeconomics and health strategy has evolved following the adaptation of the CMH report recommendations by countries. It will also serve to maintain the momentum among interested countries and advocate for the importance of investing in health. Participating countries will present their experiences with engendering multisectoral support and leadership, progressing with the analyses of macroeconomic and health variables, planning policy steps and sequencing of actions, and tracking progress and outcomes.

The following points were emphasized during the discussion:

- The Eastern Mediterranean Regional Office CMH task force has been set up to support countries with analyses of financial flows and financing gaps and examination of sources of additional funding. Other key task force activities include supporting analyses on the burden of disease, promoting the necessity of investing in health within the country leadership, helping with the implementation of the macroeconomics and health strategy and tracking outcomes.
- The need for pursuing CMH recommendations through national commissions that will contribute towards improving the following:
 - The dialogue between ministries of health, finance, planning and others
 - The centralization of monitoring and evaluation of data gathered by a broad spectrum of national mechanisms and institutions
 - The identification of indicators pertaining to poverty, community involvement and inequity
 - The establishment of a central body to pursue policy analyses and provide advice
- The CMH process can contribute towards a model of cost-effectiveness for health investment. The value in pursuing a macroeconomics and health strategy is that health is

brought to the centre of the national political agenda. This innovative approach to health investment is neither an initiative nor a programme, but an approach, a set of arguments and a stimulus to increase investment and efficiency in health.

- Intersectoral collaboration is needed for improved outcomes between the multiple participants and diverse initiatives in countries.
- The government has a central and coordinating role to play in pursuing the macroeconomics and health strategy debate and in strengthening health systems to implement the proposed interventions of the CMH. The role of WHO is to support governments with this process.
- Clarity is required as to how the macroeconomics and health strategy process can identify new resources or make better use of current resources in the low-income countries of the Region.
- Macroeconomics and health strategy plans should be developed irrespective of requested additional funding; the better the plans devised, the more chances there are of getting the required funds.
- The macroeconomic management of the health sector is important to consider, as this sector deals too often with crises and not with long-term plans and vision. It would be essential to build close links and partnerships with other ministries, particularly those of finance and state planning, and to monitor closely the health component of the policies of other sector.
- The value of national health accounts as a basic tool for planning health sector work was emphasized.
- The macroeconomics and health strategy approach should not only serve as an advocacy tool, but as the means to channel additional resources to health.

4. COUNTRY PRIORITIES AND PLANS

4.1 Context of macroeconomics and health strategy

Six countries have been selected for the implementation of the first phase of CMH plans. Criteria for the selection included extent of poverty, size of population, national commitment and contribution for pro-poor health policies, previous experiences in implementing PHC and CBI, and potential for generation of additional resources. The six countries, Djibouti, Islamic Republic of Iran, Jordan, Pakistan, Sudan, and Republic of Yemen, presented their original macroeconomics and health strategy workplans, shared experiences in poverty reduction and health processes and presented lessons learned. Detailed country profiles, country summaries and the budget template to be used for costing the

implementation of a macroeconomics and health strategy are attached as Annexes 4, 5 and 6, respectively. Some important points highlighted were:

- Priority areas to be tackled in the macroeconomics and health strategy plans of action include the many inequities in care for poor people, the factors contributing to them and the provision for wider access to good health.
- The world is in possession of the technological advances and wealth needed so that poverty can be reduced in developing countries. The macroeconomics and health strategy work in countries is attempting to bring this ideal into actuality.
- High-level government officials must be challenged to invest more in the health of the poor. Governance must be improved as the poor and vulnerable are faced with economic and social barriers restricting their access to judicial systems. International agencies and nongovernmental country partners have a responsibility to deliver financial and technical support to countries.

4.2 Plans of action

Djibouti

The macroeconomics and health strategy support is expected to back the Ministry of Health in the implementation of health system reforms. The Djibouti CMH group will be under the direction of the Ministry of Health and will collaborate with the Ministries of Finance, Women's Promotion, and others. The proposed national macroeconomics steering committee will be managed by the Ministry of Health.

An initial macroeconomics and health strategy plan of action is in place and involves advocacy, training and research activities.

- Advocacy: production of educational materials, organization of high-level and awareness-raising meetings, seminars to debate the findings of the CMH report.
- Training: focus on the macroeconomics and health strategy process, goals and linkages with the developmental process, workshops on the role of ministries, civil society and other partners.
- Research and the preparation of a technical paper: focus on intersectoral collaboration for health promotion, the establishment of an integrated supervisory system and the harmonization of foreign aid in the health sector.

Islamic Republic of Iran

The macroeconomics and health strategy process will be implemented through an established secretariat office in the Ministry of Health while a multisectoral committee or national commission will be set up to plan and oversee work.

The macroeconomics and health strategy plan of action focuses on advocacy and consensus building, research and training.

- Advocacy: translation and wide dissemination of the CMH report and related documents.
- Consensus building, mobilizing political support and building partnerships: national seminar on CMH, briefings, orientation meetings and workshops.
- Research: documentation of case studies, integration of existing data and information, review coverage and performance of health services of poor populations.
- Training: national CMH staff and other stakeholders.

Jordan

- The plan of action for the first phase covers advocacy, research, cooperation with partners, and work to operationalize macroeconomics and health strategy.
- Advocacy: increase awareness on CMH concepts, develop consensus on priority issues.
- Research: identify list of essential interventions, workshop on CMH, research on needed issues.
- Cooperation with partners: WHO, donors, consultants, Ministry of Planning.
- Operationalize the macroeconomics and health strategy plan of action.

Pakistan

A national CMH will be established. The six month plan of action is in place and involves dissemination and advocacy, collection of data and mobilization of resources.

- Advocacy and dissemination of CMH messages.
- Collection of data and information on health investment, research, studies to generate evidence on health development and poverty reduction.
- Support mobilization of resources, generate funds to close the financing gap, advise on effective policies.

Sudan

A national commission and CMH national committee and secretariat will be established by December 2003. The six month plan of action includes activities related to orientation and

advocacy, situation analyses, capacity building and efforts to operationalize macroeconomics and health strategy work.

- Orientation and advocacy: national CMH conference, dissemination of information through printed materials and media coverage.
- Situational analyses: collection and analyses of data, support health system survey, ad hoc surveys on distribution of diseases across income segments of population.
- Capacity-building: consultants, building up the capacity of the planning unit at the Federal Ministry of Health, Ministry of Finance and other related ministries.

Republic of Yemen

A cross-sectoral national commission will be established and the national plan of action revolves around advocacy, research and situational analyses, capacity building, and work to operationalize the macroeconomics and health strategy process.

- Advocacy: dissemination of CMH concepts, printed and audiovisual materials, the media and organizing a macroeconomics and health strategy workshop.
- Research: expert group to research relevance, information gaps, the structure and roles of a national commission.
- Capacity-building: short term consultants, training for national health account team, training of commission staff.
- Operationalizing the macroeconomics and health strategy process: appointment of head, staffing, supplies, meetings.

4.3 Critical issues

Governments and national commissions

- Governments must take a leading role in facilitating partnerships and building alliances (with donors, nongovernmental organizations, communities and civilian groups) to meet the health investment needs of the country and its poor.
- Countries view the national commissions as instruments that can make intersectoral collaboration possible, galvanize commitment by policy- and decision-makers, and plan and monitor work across different sectors and health departments.
- Clear mechanisms and terms of references must be put in place for the national commissions and a clarification of the WHO contribution is required. Each country should set up commissions responsive to national infrastructure and mechanisms.

- National commissions must be headed by a high-level politician but should also have a functional head responsible for the day-to-day work.
- In some countries of the Region there can be clear coordination between the proposed macroeconomics and health strategy work and national poverty reduction processes. In these cases a national commission might not be necessary.
- The consultation in Geneva in October will provide the opportunity to describe progress at country level and will help sustain political leadership and commitment among interested governments. For countries of the Eastern Mediterranean Region, the Fez meeting is the beginning of a process that will continue well past the October consultation. During the consultation, countries of the Region will be able to interact with donors and challenge them for additional external resources for health services and health system strengthening in their countries.

Resources and assistance

- The level of external resources required to achieve the millennium development goals for health is much higher than what is available in low income countries, and their governments cannot dramatically increase domestic budgets for health, as proposed by the CMH report. With limited funds available, external donors should support these countries, and within countries, address the conditions that disproportionately affect the poorest communities. WHO has a key role to play in supporting low-income countries with this process.
- Some countries of the Region require technical assistance more than financial assistance. WHO is requested to support countries technically, particularly in the area of information technology for health system development.

Focus on the poor

- Experiences with the Islamic Republic of Iran and Oman have demonstrated the importance of community mobilization for improving primary health care and generating greater responsiveness to the health needs of the poor.
- In all countries, governance is not adequate, as the poor and vulnerable are faced with economic and social barriers restricting their access to health systems.
- There are many inequities in the health care of the poor (economic, cultural and geographical). The poor are less likely to use services provided by the health system and receive poorer quality of health care when they do. Greater attention to reducing the inequities in poor people's access to health must be implemented.
- Efforts to monitor progress in improving health services for the poor should include methods for measuring how these inequities are being reduced.

- Advocacy is required to mobilize more resources from the rich to the poor like Islamic forms of taxation, *zakat*, when rich people give money to the poor. Governments of Islamic countries must do more to direct *zakat* resources to poverty reduction processes.

4.4 Group work

Country plans of action were reviewed, taking into account the issues that were debated. Participants agreed to formulate plans based on outcomes, with clear milestones and measurable products.

Participants divided into groups by country, reviewed macroeconomics and health strategy plans of action in the light of feedback and debate. They focused on three key points prior to preparing final plans of action. These were:

- National CMH mechanisms will not replace or supersede existing structures; rather, they will provide a forum for a more strategic and cross-sectoral focus on key health issues.
- It is important that national data are disaggregated to show distribution of disease across income segments of population.
- Accurate data are important for building confidence in the ministries of finance and planning, district government, donors and all other partners.

Checklists for assisting plan development (based on key themes from the macroeconomics and health report) and for country plans of work for Phase 1 or Phase 2 activities are included in Annex 3. The group work resulted in outlines for the plans of action included in Annex 4.

5. CONCLUSIONS AND RECOMMENDATIONS

Key principles and perspectives

1. The role of the government is central to the macroeconomics and health strategy process. It is the principal motivator of better cross-sectoral collaboration and the plan of work should reflect this.
 2. Lessons from previous sustainable development efforts should be studied carefully, incorporating the insights gained from past experiences into current health investment strategies. CMH should not be perceived as a new initiative that has a separate bureaucratic structure.
- The macroeconomics and health strategy process builds upon existing efforts to reallocate and use resources more effectively. Several ministers of finance said they

would be more receptive to supplying more funds to health strategies if a strong, multisectoral plan existed for long-term investments.

- Linking to existing medium-term investment plans and incorporating other mechanisms appropriate to a country's needs, such as national health accounts, is vital to gaining support for a macroeconomics and health strategy and will be a principal objective of Phase 2.
 - Donors have also said a practical and clear plan, with measurable objectives and outcomes, would attract their support more readily.
3. The CMH process should stay focused on the strategic dimensions of health policy. It is necessary to identify the few critical foci that must be brought to the attention of senior policy developers.
 - 3.1. In addition to keeping the macroeconomics and health strategy process on the macro-level, those working on it should remain aware of all existing political mechanisms and seek to engage them.
 - 3.2. Relationships with civil society and development partners should be established early in the process.
 4. Countries should build internal capacity in health ministries to develop long-range health policy and strategic thinking.
 - 4.1. The macroeconomics and health strategy should foster the ability of ministries of health to put forward a plan that can convince ministries of finance to allocate more funds.
 - 4.2. A systematic approach is needed to examine how a health investment plan can be implemented over time in such a way that it does not get ahead of efforts to develop the absorptive capacity of the health sector to effectively handle the scaling-up of services and interventions.
 - 4.3. There is a major gap in local capacity to create an effective methodology to select and develop the right partners who will become the basis of a broad supportive platform for health investments.
 - 4.4. Reallocation is an important first step, but also needed are tools to conduct a needs assessment, assess all key environmental determinates of health and develop a cross-sectoral plan to increase investments in health services delivery in a rational and integrated manner.

Examining country strategies for implementation

5. The objectives for each phase should be clear and outcome-oriented.

- 5.1. **Phase 1** Develop an advocacy strategy to build partner consensus for the macroeconomics and health strategy process, do a brief situational analysis (e.g. map out current stakeholders, Poverty Reduction Strategy Papers, medium term expenditure frameworks, etc) and assess existing data to see what gaps exist. Country plans of work need to include terms of reference for any proposed technical support. It should also include a time frame and budget estimate, agreed upon with national authorities.
- 5.2. **Phase 2** Use the cross-sectoral national CMH mechanism to implement the macroeconomics and health strategy. Key products include in-depth situation analyses, focused research on causal links between poverty and health, cross-sectoral support for putting health into all poverty reduction processes and the long-term investment plan for health.
6. Countries should discuss the broad concept of long-term health investments with existing development partners. This discussion may identify some entry points for a macroeconomics and health strategy into existing development initiatives. It will also allow countries to realistically assess potential opportunities and challenges for multisectoral collaboration.
7. Countries should prepare terms of reference for any proposed national mechanism for CMH work prior to submitting their Phase 1 workplan. Preliminary terms of reference help focus on the national objectives and strategies required to implement a macroeconomics and health strategy.
 - 7.1. The national CMH itself, led by ministries of finance, health and planning, can generate significant political visibility for the macroeconomics and health strategy and can help institutionalize the process in the government. However, senior officials have too many pressing concerns to run the day-to-day operations.
 - 7.2. The national CMH mechanism could have a technical working group that is chaired by a full-time person of sufficient standing to ensure activities get done and momentum is maintained.
8. A timeline is critical for the country workplans and budgets, and each activity and strategy should have milestones and a time frame.
9. The following points should be taken into consideration when designing data collection processes.
 - 9.1. Many countries actually have useful data and only need help in organizing and analysing the data to better assess the macroeconomic factors impacting on poverty reduction and health.
 - 9.2. National data should be disaggregated to show how the burden of disease is spread across various income groups, especially the poor.

- 9.3. Local medical and nursing institutions should be engaged when possible. This can increase the public-health orientation of pre-service curricula, as well as build up local technical expertise in long-term health planning.
10. Countries should consider how Phase 1 activities will support Phase 2 efforts to show how the burden of disease and determinants of health are linked to poverty, stressing that the macroeconomics and health strategy aims to provide an essential package of sustainable health interventions.

The role of WHO

11. WHO should “lead from behind” by strengthening the capacity of countries to formulate and implement effective health strategies.
- 11.1. WHO does not mobilize resources directly; it focuses on providing the technical support that allows a country to implement a plan to attract additional investments into health.
- 11.2. WHO global advocacy activities can raise partner and donor awareness and help move health onto the agenda of country-level sustainable development initiatives. Headquarters and the Regional Office can undertake global political advocacy, which is crucial to getting health into international discussions of debt relief.
- 11.3. WHO should be a builder of bridges between the various development partners in a country. Activities to widely disseminate the key messages of the CMH report should be included in the country work-plan and its implementation.
12. With six countries entering Phase 1, a large amount of technical support will be required from headquarters and Regional Office, most of it in the same compressed time frame of about six months.
- 12.1. It would be useful to assess and develop a preliminary profile of potential experts at the regional and country level.
- 12.2. This type of initial mapping exercise should determine what technical support is available, to allow a rapid response to country requests for technical assistance.

Strengthening the process: next steps

Moving ahead from the main conclusions of the CMH report, the macroeconomics and health strategy will support countries on three fronts:

- Investment in better health for poor people
- Mobilization of more financial investments to enhance the capacity of health services
- Planning and implementation of the sequenced lifting of non-financial constraints so that countries can absorb funds better.

Governments must involve all internal and external partners and funding agencies from the beginning to build ownership and commitment to a long-term health investment plan, yet must retain control of and responsibility for the objectives and strategic focus of such a plan. The local WHO office can provide the point of entry for the technical support required for building coalitions with all stakeholders such as development agencies, the World Bank, regional banks, bilateral agencies, and civil societies.

13. The following actions should be undertaken by the Regional Office and by WHO headquarters to stimulate country efforts to integrate the macroeconomics and health strategy process into development schemes and create a long-term strategic plan for improved health investments.
 - 13.1 Supporting networks for policy and economic research, especially by fostering south-to-south communications and by collaborating with local and regional institutions.
 - 13.2 Offering technical support to facilitate analyses of country-specific issues and options, including those at regional or subregional levels, which can determine the national links between determinants of poverty and of health.
 - 13.3 Marketing and advocacy of successful country examples, especially in a form appealing and useful to decision makers such as finance and planning ministers, private sector agencies and other partners.
 - 13.4 Technical support in designing policy options to achieve specific cross-sectoral improvements in health determinants.
 - 13.5 Assistance in packaging the analyses, political statements, and strategic directions into country specific investments plans.
 - 13.6 Tracking outcomes, especially rationalized expenditure reports at national and sub-national level to ensure that public funding will flow to the community level.

Annex 1**PROGRAMME****Friday, 13 June 2003**

08.15–08.45	Registration
08.45–9.00	Introduction and opening remarks/Dr Belgacem Sabri Designation of rapporteurs
09.00–09.20	Presentation: Macroeconomics and health strategy, an overview/Dr Agnès Leotsakos
09.20–09.40	Presentation: Critical issues and priorities for implementing CMH in the Eastern Mediterranean Region/Dr Mubashar Riaz Sheikh
09.40–11.00	Moderated discussion: Applying the global CMH strategy to countries – what is needed to move forward?
11.00–11.15	Presentation: Three themes that provide a context for assessing and describing country progress on CMH/Mr Tom O’Connell <ul style="list-style-type: none"> • Focusing on equity and better health for poor people • Getting more financial resources for health • Removing non-financial constraints
11.15–11.45	Moderated discussion: How can countries measure their progress within each theme?
11.45–12.00	Presentation: Format for CMH country workplans: purpose and structure – what we are expecting for the draft country profiles?/Dr Mubashar Riaz Sheikh
12.00–12.30	Moderated discussion: Do they meet the Region’s needs?
12.30–12.40	Objectives for country presentations/Dr Hossein Salehi
12.40–14.30	Presentation: Draft country work plans – progress made and barriers encountered to date/Dr Belgacem Sabri <ul style="list-style-type: none"> • Djibouti • Islamic Republic of Iran • Jordan
14.30–15.00	Presentation: Draft country work plans – progress made and barriers encountered to date/Dr Belgacem Sabri <ul style="list-style-type: none"> • Republic of Yemen • Sudan • Pakistan
15.00–15.20	Presentation: The advocacy perspective on implementing the Macroeconomics and Health Strategy/Dr Agnès Leotsakos
15.20–6.30	Moderated discussion: Applying the global CMH strategy to countries
16.30–16.50	Presentation: Macroeconomics and health – Columbia University’s contribution to health gain/Dr Stephen Leder
16.50–17.30	Moderated discussion: Networking and coordinating mechanisms at country level
17.30–17.45	Summary of key points/Rapporteur

Saturday, 14 June 2003

09.00–09.05	Review of progress made Objectives for the day/Dr Belgacem Sabri
09.05–10.30	Presentation: Moving forward – guidelines and expected outcomes for small work-group discussions/Dr Mubashar Riaz Sheikh
10.30–11.00	Small work-group sessions: Each country's team to revise the draft plan and discuss specific steps for its implementation
11.00–13.30	Presentation: Changes to country work plans – timeline and action points/Dr Belgacem Sabri <ul style="list-style-type: none">• Djibouti• Islamic Republic of Iran• Jordan
14.00–14.45	Presentation: Changes to country work plans – timeline and action points/Dr Belgacem Sabri <ul style="list-style-type: none">• Republic of Yemen• Sudan• Pakistan
14.45–15.10	Presentation: Describing progress in macroeconomics and health strategy/Mr Tom O'Connell
15.10–15.30	Presentation: Preparing for the October CMH meeting/Dr Mubashar Riaz Sheikh
15.30–16.00	Discussion
16.00–16.15	Summary of key points and agreements
16.15–16.30	Closing/Dr Belgacem Sabri

Annex 2

LIST OF PARTICIPANTS

DJIBOUTI

Mr Saleh Bonita Tourab
Secretary General
Ministry of Health

Mr Almis Mohamed Abdillahi
Director, Budget
Ministry of Finance and Planning

ISLAMIC REPUBLIC OF IRAN

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Ministry of Health

Dr Ali Baghbanian
Head of Health Commission
Parliament of Islamic Republic of Iran

JORDAN

Dr Anwar Batiha
General Secretary
Higher Health Council

Mr Abdel Basbous
Ministry of Planning

Dr Lutifi Abu Hazim
Assistant General-Secretary
Ministry of Finance

OMAN

Dr Mohammed Khamis Al Farsi
Director General of Health Service, South East Region

PAKISTAN

Mr Ejaz Rahim
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Dr M Shafiquddin
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Dr Ashfaq Ahmed
Deputy Director General
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SUDAN

Dr Mustafa Salih
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Ms Mahasin Abdel Karim
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Ms Faiza Awad
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Dr Stephen R. Leeder
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REPUBLIC OF YEMEN

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Dr El Fatih El Samani, WHO Representative, Islamic Republic of Iran

Dr Khalif Bile Mohamud, WHO Representative, Pakistan

Dr Guido Sabatinelli, WHO Representative, Sudan

Dr Samia Habbani, Medical Officer, WHO Sudan

Regional Office for the Eastern Mediterranean

Dr Belgacem Sabri, Director, Health Systems and Community Development, WHO/EMRO

Dr Hossein Salehi, Regional Adviser, Health Economics, Legislation and Ethics, WHO/EMRO

Dr Mubashar Sheikh, Regional Adviser, Community-Based Initiatives, WHO/EMRO

Ms May El Sariakousy, Senior Administrative Assistant, WHO/EMRO

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Ms Mona Mohamed, Secretary, Community-Based Initiatives, WHO/EMRO

Ms Hala Hamada, Secretary, Community-Based Initiatives, WHO/EMRO

Annex 3**SUMMARY OF THREE KEY THEMES FROM THE CMH REPORT**

The macroeconomics and health strategy is driven by three themes: raise much more money for health to buy much better health outcomes, concentrate on investing in better health for poor people and plan and implement step by-step the solutions to the non-financial problems that waste funds and keep people in ill-health and poverty.

The following points are abstracted from the CMH report and the reports of the six working groups. They set the broad parameters for a process to achieve implementation of a national pro-poor health investment strategy. The three themes can be used as a checklist for planning.

Obtaining more financial resources for health

- Research to define ways to increase the long-term internal and external investments in health for essential pro-poor services, with a focus on sustainability.
 - Can the experience of regional efforts to develop the Global Alliance for Vaccines and Immunization financial sustainability plans be used?
 - Are there local institutions (e.g. universities) that can assist? Focus on sustainability.
- Defining country-specific mechanisms to increase the predictability of donor funding over the long-term.
- What can be done to make donors more attuned to country-defined needs and priorities?

Focus on better health for poor people and equitable health services

- Better health for poor people is achieved by concentrating on the priority health services and interventions that have the greatest proven impact on the poor.
- What is needed to develop country-specific analysis of the distribution of the burden of disease, especially among the poor and disadvantaged segments?
- What can be done to involve local universities and local experts in working for needs of community and for local poverty-reduction efforts?
- Are there community-based initiatives that can be built upon, where good cooperation and cross-sectoral activities are occurring on a micro-level?
- Of key importance will be recognizing the mutual dependence of various ministries and their outputs, and seeking cross-sectoral approaches that include priority health

interventions from the broader environment (e.g. access to clean water, adequate sanitation, access to education for children, etc).

Removing non-financial constraints (e.g. insufficient organizational and human resources capacities)

- Develop effective strategies that sequence policies and investments in an effective manner, i.e. to slowly build the absorptive capacity of implementing agencies and governments (e.g. in areas such as human resources, good governance, technical support, system absorptive capacity, and productivity/effectiveness).
- Assess the need for empirical research to define existing gaps, the causal elements of any deficits, and the impact on constraining the effective implementation of pro-poor health policies.
- How can local nursing and medical schools be involved so that the pre-service curricula reflect a pro-poor orientation for interventions?
- What are the lessons learnt from primary health care efforts, and how can long-term investments be used to strengthen primary health care, especially for the poor and vulnerable population segments?

CHECKLIST FOR COUNTRY PLANS OF WORK FOR PHASE 1 OR PHASE 2 ACTIVITIES

Suggestions for use: To structure plans to implement a national macroeconomics and health strategy. Use as a checklist to develop Phase 1 or Phase 2 macroeconomics and health strategy plans of work. It helps in processing submitted plans by ensuring key elements are included.

Timelines

- **Phase 1** Preparing for a health investment plan by developing a national macroeconomics and health strategy (6 months).
- **Phase 2** Creating the health investment plan (18 months).

Checklist of elements

Phase 1: Background and rationale

(Findings will be summarized in the introduction of the Phase 2 plan of work)

- Links to global or regional strategies:

- Role of the UN millennium development goals
- Poverty Reduction Strategy Papers, Heavily Indebted Poor Countries initiative, mid-term expenditure frameworks, other national development programmes
- Country situational analysis – clearly assessing the gaps between what has been done and what is still needed
 - Cross-sectoral elements: political, economic, social trends (was a UN common country assessment done recently?)
 - Strengths and weaknesses: analysis of public health services, and of linkages to planning and finance ministries
 - Policy gaps: national, regional/provincial and service-delivery levels
 - Governance gaps: infrastructure, transparency, independence, equity
 - Distribution of disease burden vs. population distribution
 - Mapping the allocation of health sector-resources with the poor/disadvantaged population distribution
- Relevant past and current experiences with sustainable development efforts
 - Internal
 - Sector-wide approach or other sector-wide reforms
 - Decentralization: type and degree, including privatization
- Partner-related: Include an analysis of relevant partner initiatives (e.g. Poverty Reduction Strategy Papers, sector-wide approaches, country cooperation strategies, Global Fund, Global Alliance for Vaccines and Immunization, health sector reforms, etc.)

Objectives

- Phase 1 (six months) Develop the macroeconomics and health strategy and increase support/commitment
 - Advocacy, communication, information, education efforts
 - Working within to enhance/expand existing partnerships and supporting networks
 - Support for needed research and analysis, managing information

- What empirical research is needed on non-financial constraints
- Phase 2 (18 months) Implement the macroeconomics and health strategy to develop a long-term health investment plan
 - Preparing for a long-term plan for health investment
 - Mapping of principle stakeholders
 - Mechanisms and processes required
 - Technical working groups
 - Support from broad range of government officials and ministries
 - How will it integrate with Poverty Reduction Strategy Papers, the medium term expenditure framework and other poverty reduction efforts?
 - Research to define long-term capacity development
 - How to correctly sequence strategies to lift non-financial constraints, e.g. development of human resources, organizational capacities, etc.
- Institutional needs, e.g. stronger data management
 - Linking it all together to develop a plan for health investments at end of Phase 2, 18 months
 - How to measure annual progress, and how to link to meeting
- Phase 3: Implementing a health investment plan

Activities Phase 1 and Phase 2

- Activities: who, what, where, how
- Products: to be delivered
- Outcomes expected: annual SMART objectives, medium and long-term goals, milestones and indicators, balance between chaos and proscriptive rigidity
- Timeline: flow of funds, reporting points, decision nodes (options-based planning?)

(A budget template to help with costing for implementation and to organize budget requests is attached in Annex 5.)

Budget: Phase 1 and Phase 2

- Plan of work budget
 - How will actual expenditures be monitored against the planned budget?
 - Show completion date for use of funds
- Source of funds for macroeconomics and health strategy budget
 - Assessment of sustainability of external and internal sources of funds
 - Assessment of predictability of sources of funds over the medium to long term

Expected achievements

As related to the objectives, to other national processes (especially any Poverty Reduction Strategy Papers, heavily indebted poor countries, medium term expenditure framework processes planned or on-going), and how they will link to achievement of the millennium development goals.

Synergies

What will be done to strengthen existing partnerships and how will the macroeconomics and health strategy add value?

Constraints

These comprise a description of possible obstacles to reaching the objectives, including some assessment of their significance and the likelihood of occurrence.

Medium- and long-term follow-up actions

- A timeline of main events, showing how Phase 1 and Phase 2 activities will be sequenced, and how they will lead to a national plan of health investment will be produced
- Accountability, responsibility and authority for various plan elements

Annex 4**COUNTRY PROFILES AND DATA****DJIBOUTI****Country profile**

Surface area	23 200 km ²
Arable land	6.3%
Cultivated land	0.4%
Population	500 000
Nomads	9%
Per capita GNP	US\$ 480
Health expenditure	1.6% of GNP (1999)
Health expenditure per capita	US\$ 13
Relative poverty, 2002	74.4%
Extreme poverty, 2002	42.2%
Relative poverty in rural areas, 2002	96.7
Unemployment	59%
Young population	58% of global unemployment
Crude schooling rate	42.7%
Infant mortality rate, per 1000 live births	114
Under 5 mortality rate, per 1000 live births	154
Maternal mortality rate, per 100 000 live births	740
Immunization coverage	
• Diphtheria–tetanus–pertussis	61%
• Measles	62%
• Oral polio vaccine	98%
HIV prevalence, 2002	2.9%
Source of health financing	
• Government	27%
• Partners	29%
• Households	24%
• Private enterprise	20%

Macroeconomics and health: Country plan of action*Current constraints*

- Lack of reliable data
- Lack of analyses of existing data
- Lack of donor coordination in the use of resources

- Incomplete evaluation of projects
- Lack of trained and qualified staff

Expected results

- Support the Ministry of Health in the implementation of health system reforms
- The CMH process will assist the Ministry of Health to demonstrate and convince other ministries and partners that the Ministry of Health must be considered as a real partner for development.
- Generate awareness among other ministerial departments, national and international partners on the importance of health as a milestone for socioeconomic development
- Create a “spirit of health pact” for health promotion.

Structural organization of macroeconomics and health strategy work

- Formation of a national commission for CMH composed of key ministries
- Formation of a CMH technical group that will:
 - be located in the Ministry of Health
 - liaise with and have participation from the Ministries of Finance, Women’s Promotion, and others, as well as national and international organizations
 - direct and coordinate activities
 - establish and produce reports
- Set up a national macroeconomics steering committee under the Minister of Health
- Set up a secretariat for CMH with the nomination of national focal points.

Advocacy activities

- Plan mission from the Earth Institute of Columbia University to assist the country with planning
- Produce educational materials on CMH concepts, objectives and processes
- Organize high-level meeting with ministers, ambassadors, heads of UN agencies, French cooperation, bilateral and multilateral agencies

- Set up a national one-day meeting for directors and technical personnel to raise awareness on macroeconomics and health strategy
- Organize a meeting with decision makers to discuss the CMH findings and exchange information relevant to the input from each department or ministry.

Training activities

- Two-day training for the members of the macroeconomics and CMH technical group
- Three-day training workshop on the role of ministerial departments, civil society and other partners
- Train national focal points and CMH secretariat (technical assistance is required).

Research and technical paper

- Definition of mechanisms for the development of the intersectoral collaboration for health promotion
- Definition of mechanisms for the establishment of the integrated supervisory system in the country
- Harmonization of foreign aid in health sector.

ISLAMIC REPUBLIC OF IRAN**Country profile**

Total area	1 648 000 km ²
Total population (2002)	65 201 100
Population growth rate	1.2% per year
National health expenditure (as % of GNP)	5.8%
Infant mortality rate, per 1000 live births	26
Under 5 mortality rate, per 1000 live births	36
Maternal mortality rate, per 100 000 live births	37
Health units and centres	3–4 per 10 000 population (more than twice the average for the Eastern Mediterranean Region)
Immunization coverage	Close to 100%
Poliomyelitis incidence	Zero cases for almost 3 years
Communicable diseases surveillance system	Well-established

Major health problems

Behaviour related diseases e.g. injection drug use, smoking, sedentary lifestyle, diet related illnesses, environment related illnesses

- Cardiovascular diseases
- Road traffic accidents
- Mental health
- Reproductive health
- Emergence of HIV and tuberculosis and persistence of some endemic diseases
- Inequity in distribution of services
- Epidemiological transition due to burden of risk factors as a consequences of globalization, industrialization, rapid urbanization and unhealthy lifestyles

Macroeconomics and health: Country plan of action

Country plans include work in the following areas:

- Advocacy
- Consensus building
- Mobilization of political support
- Media relations and coverage
- Use of *zakat* in poverty alleviation strategies

- Stimulating multisectoral involvement beyond the Ministry of Health and Medical Education
- Seeking the support of civil society and other national partners
- Call up the support of members of parliament.

Methodologies

- Establishment of a secretariat in the Ministry of Health and Medical Education from a multisectoral committee or commission
- Production of training and advocacy materials
- Identifying potential stakeholders in the field of macroeconomics and health in the country
- Identifying international consultants to support work
- Convening induction briefings, orientation meetings and workshops
- Organizing a one-day seminar on the CMH concepts
- Formulating strategies and developing a national five-year plan of action.

JORDAN**Country profile**

Population	5.3 million
• Urban	78%
• Rural	22%
Population > 65 years	2.7%
Population growth rate	2.8%
Life expectancy	70 years
• Male	69 years
• Female	71 years
Per capita income	JOD 1173
Adult literacy rate	89%
• Male	94%
• Female	84%
Poverty rate	14%–31% (depending on definition)
Infant mortality rate, per 1000 live births	23
Under 5 mortality rate, per 1000 live births	27
Maternal mortality rate, per 100 000 live births	38
Crude death rate	5/1000
• Male	5.5/1000
• Female	4.5/1000
Causes of mortality	
• Cardiovascular disease	42%
• Cancer	13%
• Accident	10.5%
Total fertility rate	3.6%
Crude birth rate	2.8%
Low-birth-weight infants	7.5%
Vaccine-preventable diseases are in decline as a result of the high immunization uptake.	
Disease incidence	
• Tuberculosis	5.8/100 000
• Malaria	All imported cases
• HIV/AIDS	Low
• Polio, diphtheria	No reported cases for the past five years
Health insurance coverage	60%–80%
• Royal Medical Services	26%
• Ministry of Health	20%
• United Nations Relief and Works Agency	11%
• Private	9%
• University	2%
Average number of hospital visits annually	3.5
Probability of admission	8%
Ministry of Health provides:	

• Outpatient visits	50%
• Hospital admissions	55%
Private sector provides:	
• Outpatient visits	40%
• Hospital admissions	21%
Health expenditure	10% of GDP (2002)
• Public	58%
• Private	38%
• United Nations Relief and Works Agency	1%
• Nongovernmental organizations	3%
• Curative care	58%
• Preventive and primary care	27%
• Average per capita expenditure on health	JOD 95
• Out of pocket expenditure	JOD 41
Sources of health funds	
• Public (Ministry of Health, Royal Medical Services, university hospitals)	45%
• Private (premiums paid to private firms, self insured companies, and out of pocket expenditure)	47%
• Donors	8%

Pharmaceuticals account for about one third of the total expenditure on health, 76% private.

Macroeconomics and health: Country plan of action

Plan of action for Phase 1 of CMH

- The High Health Council will be the governmental agency in charge of the initiative.
- Formation of the national CMH at the highest level of policy makers
- Formation of a technical committee on macroeconomics and health which will:
 - Prepare comprehensive situational analyses
 - Identify the charges necessary in the system to respond to the needs of the poor
 - Identify a preliminary list of essential interventions based on cost effectiveness, feasibility, and relevance to the health needs of the poor
 - Prepare for the workshop to be conducted on macroeconomics and health in Jordan
 - Conduct research and studies on fundamental issues

- Conducting a workshop aimed at:
 - Increasing awareness
 - Developing consensus on priority issues
 - Encouraging agreement on a course of action to pursue the CMH initiative
 - Refining the plan of action
- Cooperate with WHO, donors, and consultants to formulate strategies and finalize the action plan.
- Cooperate with the Ministry of Planning and other agencies to give health a central role in their strategies.

Suggested interventions

- Sustainability of current services
- Immunization
- Intensify and improve the quality of reproductive health services, particularly postnatal care, family planning, premarital examination and counselling
- Prevention and treatment of non communicable diseases
- Services to the elderly
- Accident prevention efforts
- Support nutrition
- School health programme
- Expand the health infrastructure to reach under served areas, outreach services
- Develop health personnel in the field of epidemiology, management, and health economy
- Motivate health workers
- Health insurance
- National health research centre.

Structural organization

- Formation of the national CMH at the highest level of policy makers
- Formation of a technical committee on macroeconomics and health
- Conduct a workshop
- Assess the available data
- Formulate strategies and action plans
- Capitalize on previous/current efforts to integrate CMH in ongoing and future initiatives.

Fez meeting

- Recognition of the CMH process globally, regionally and locally
- CMH is a process, not a programme
- It is an ongoing process and approach and not a one-time endeavour
- We should set realistic targets and objectives that can be implemented
- WHO should continue supporting CMH implementation in developing countries
- WHO should coordinate and cooperate with others in the international community to encourage them to support CMH.

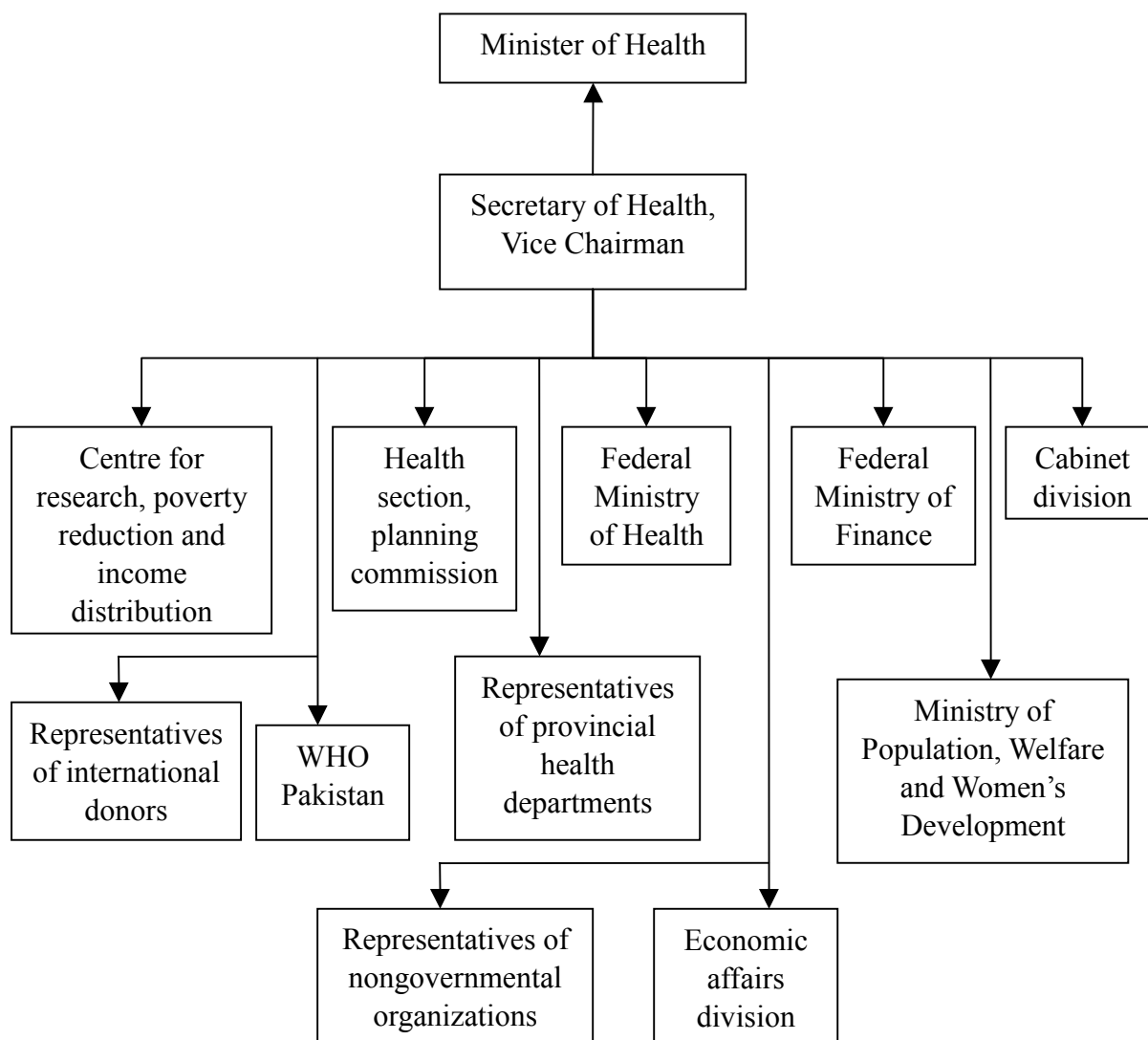
PAKISTAN**Country profile**

Total area	796 095 km ²
Total population 2002	144.2 million
Male : female	51.9% : 48.1%
Urban : rural	30 : 70
Population growth rate	2.1%
Crude birth rate	30.1 per 1000
Crude death rate	8 per 1000
Infant mortality rate, per 1000 live births	82
Maternal mortality rate, per 100 000 live births	400
Life expectancy	
• Male	63.9 years
• Female	63.5 years
Per capita income	US\$ 490
Public sector expenditure	
Total expenditure	
• 2002–2003	PKR 28.814 million (0.78% GNP)
• 2003–2004*	PKR 32.805 million (0.84% GNP)
Development expenditure	
• 2002–2003	PKR 6.609 million
• 2003–2004*	PKR 8.500 million
Non-development expenditure	
• 2002–2003	PKR 22.205 million
• 2003–2004*	PKR 24.305 million

*Estimated/projected

Prospective plan 2001–2011 (goals, targets and instrument matrix)

Goal 2011	Targets			Variable
	2001	2004	2011	
Rapid income growth	24	30	54	Per capita income, PKR 1000
Eliminate food poverty	2.17	1.82	1.6	Annual population growth rate, %
Significantly reduce human poverty (basic needs; opportunity; capability)	30	25	15	Percent of population unable to meet basic food requirement 2150 calories/day
100% adult literacy	44	35	25	Human poverty index (%)
Universal pre-college education	63	64	68	Life expectancy at birth (years)
	45	25	15	Population without access to health services (%)
	52	61	78	Adult literacy rate (%)
	39	47	67	Female literacy rate (%)
	83	94	104	Primary (%)
	55	64	80	Elementary (%)
	38	49	70	Secondary (%)
Eliminate malnourishment for children under 5	39	35	20	Malnutrition of children under 5 (%)
	111	77	46	Child mortality rate (per 1000 live births)
	400	300	250	Maternal mortality rate (per 100 000 live births).
	25	12	7	Incidence of low-birth-weight babies (%).

Macroeconomics and health: Country plan of action**Figure 1. Proposed organigram of national commission on macroeconomics and health***Objectives of national commission on macroeconomics and health*

- Dissemination and advocacy of the key messages of the national CMH
- Integration of health into poverty reduction strategies with a view to reposition health as a key component therein
- Collect reliable and comprehensive information on present investment on health and identification of critical gaps in information, data, research and advocacy to support national CMH process

- Assist the current laudable efforts of the government and initiate new steps for mobilization of resources and generating funds to fulfil the existing investment gaps in the Health sector
- Assist in achievement of the targets of the millennium development goals, Poverty Reduction Strategy Paper in the health sector

Terms of reference of national commission on macroeconomics and health

- Promote importance of health investment in the process of socio economic development
- To increase allocation of resources for health as centre of development
- Disseminate key messages of national CMH
- Manage and support studies to generate evidences for health development and poverty reduction
- Advice for rational use of resources
- Advice for an effective policy to increase the utilization rate of available health care services and encourage community involvement in planning and management of health care services

Major activities of national CMH during preliminary phase

- Formation of national CMH
- National seminar on CMH
- Preparing national document
- Consultation to assist national CMH
- Dissemination of advocacy and research documents
- Provincial seminars
- National training courses on national CMH

SUDAN**Country profile**

Total area	2.5 million km ²
Federal system (multitier)	26 states, 134 localities
Population	32 million
Growth rate	1.6% (population doubles every 27 years)
Maternal mortality rate, per 100 000 live births (1999)	509/
Under 5 mortality rate, per 1000 live births (1999) period 1995–1999	105
Distribution of population	
• Rural	68.0%
• Urban	29.2%
• Nomads	2.7%
Life expectancy at birth, years	
• 1973	Males 46
	Females 50
• 1993	Males 54
	Females 57
Per capita GDP, 2001	US\$ 395 (estimate)
Health expenditure, 2000	
• Public expenditure	14.6% of GDP
• Public health expenditure	0.9% of GDP
Malaria	
• Cases/year	8 million
• Deaths/year	35
• % of attendants to health facilities	20–40
HIV/AIDS prevalence rate	1.6%
Tuberculosis prevalence rate	1.8%
Bilharzia prevalence rate in pupils	28%–76% in irrigated areas

Macroeconomics and health: Country plans of action*Lessons learned*

- Developing ownership rather than just partnership between stakeholders
- The preparatory phase should focus on:
 - Situational analyses
 - Introduction of CMH concepts

– Building the capacity of Ministry of Health

- Advocacy should be evidence-based
- CMH strategies must fit within existing structures
- Macroeconomics and health strategy phases are interlinked
- CMH concepts should be strengthened and linked to ongoing strategies, e.g. Poverty Reduction Strategy Papers
- The plan of action should be realistic

Plan objectives

- To institutionalize the CMH in Sudan
- To advocate for the recommendations of the CMH among policy makers at different sectors and the community
- To assess the situation for identification of the information gaps and to conduct research to fill the gaps
- To build the capacity on planning at federal, states and local council levels

Institutionalization of the CMH process in Sudan

- Establishment of the national CMH
- Preparation of terms of reference for the committee
- Formulation of the CMH secretariat
- Scheduling of monthly meetings
- Recruitment of one full-time staff

Advocacy

- Introduction of CMH concepts by Professor J. Sachs through a national conference for all stakeholders
- Preparation of paper and leaflets to advocate the CMH recommendations
- Advocacy through leaflets and mass media.

Situation analyses

- Collection and analysis of available information by an expert committee
- Support to ongoing health system survey
- Ad hoc survey to assess the distribution of diseases across income segments of population.

Capacity building

- Technical support by international consultant
- Building capacity of the planning unit at the Federal Ministry of Health
- Building capacity of the Ministry of Finance
- Building capacity of the Ministry of Women's Social Development.

Plan outputs

By the end of December 2003 the following will be achieved:

- A macroeconomics and health commission has been established
- National committee on CMH, secretariat and staff have been selected and appointed
- The current situation has been reviewed, gaps identified and the medium-term plan has been reviewed and endorsed
- A household budget survey protocol has been prepared
- At least one person from each locality has been trained in health planning

REPUBLIC OF YEMEN**Country profile**

Total area	1 million km ²
Population	19 million
Infant mortality rate, per 1000 live births	76
Under 5 mortality rate, per 1000 live births	105
Maternal mortality rate, per 100 000 live births	350
Coverage with basic medical services	less than 50%
Total fertility rates	7.4%
Annual growth rate	3.5%
Per capita GDP	US\$ 361
Population under poverty line	17%
Health expenditure	
• Per capita	US\$ 20
• As a percentage of GDP	5.65%

Public health expenditure is the lowest in the Region

The public health budget was raised fourfold in the period 1996–2003 (YER 9 to 36 billion)

Macroeconomics and health: Country plans of action*Advocacy of the CMH report recommendations*

- Dissemination through short film
- Promotional leaflets and brochures
- Articles and editorials and success story
- Workshop for the media
- Workshop for senior health, finance and planning decision makers; donors and others.

Assessment of the situation and conducting research

- Expert group to investigate relevance of CMH report recommendations
- Expert group to identify gaps in information
- Working group to develop terms of reference, composition, budget and relationships of the commission.

Capacity building

- Short term consultancy to develop guidelines for the national CMH
- Training for the national health accounts team
- Exposure (abroad) for the members of the national commission to obtain a wider perspective
- Training for the national commission staff to provide guidance and expertise

Set up and operationalize the CMH process

- Functional head appointed
- Staffing
- Supplies and equipment
- Operational costs
- Periodic meetings for the national commission

Annex 5**COUNTRY SUMMARIES****DJIBOUTI**

A draft proposal to commence a process of long-term health investments was received by the Secretariat in May 2003. The government has shown a strong commitment to involvement in the process and has outlined some specific steps to create the necessary partner alliances of ministries, development agencies and civil society. Data on the impact of poverty on the poor is also available to some extent, with the government noting that an early priority will be research into the cross-sectoral linkages that impact the health of the poor and disadvantaged.

The tragic loss of the WHO representative Mr Fassi Fehri just prior to the CMH meeting (June 13–14 2003) did not prevent the country delegation from bringing to the workshop a draft plan of action for beginning a national CMH process. Noting that the Ministry of Health budget has declined from 5.7% to 4.2% of the total budget, the country delegation places a priority on raising awareness of the centrality of health to development strategies in other ministries and the most senior levels of government. Acting WHO Representative Ms Lilianne Boualam felt one short-term objective would be to strengthen the consensus within the Ministry of Health for building a multisectoral mechanism to develop health investment plans.

The Phase 1 country plan of work calls for a national macroeconomics steering committee and CMH technical group to be directed by the Health Ministry. Another key objective for Phase 1 is to map out a strategic action plan for increasing intersectoral collaboration to invest in all the key determinants of health, including water, sanitation and education. Discussions with the Secretary General for the Ministry of Health and the Director of Budgets for the Ministry of Financing and Planning led to revisions in the Djibouti work-plan, with a commitment to submitting a revised plan of action for Phase 1 activities to Regional Office and headquarters in the near future.

ISLAMIC REPUBLIC OF IRAN

Iran is in the process of establishing a national CMH composed of representatives from different departments and agencies. The CMH recommendations have been debated at the highest levels of the Ministries of Health, Planning and Budget.

In June 2003 Iran sent a team to the regional CMH meeting that included The Deputy Minister for Social Affairs and the WHO Representative, Dr El Fatih El Samani. They noted that a five-year health and development plan is being finalized now, creating a window of opportunity for applying advocacy and communication tools to raise awareness among the highest levels of government on the centrality of health to poverty and sustainable development strategies. They also felt that the basis of such multisectoral planning should be reliance on Iran's internal resources, with reallocation based on creating an evidence-base.

The Deputy Minister for Social Affairs, Dr Mahdavi, also felt WHO must have capacity to accurately match technical support to country needs. To complement this, the Ministries of Health, Planning and Finance are requesting WHO assistance in developing more effective systems to manage data and knowledge. All agreed advocacy and consensus building would be key Phase 1 objectives and that the analysis of existing data to develop an evidence base for pro-poor policies would be critical for success. Iran's team presented the existing solid base upon which the Republic can build a multisectoral approach to more health investments. Medical education is already integrated under the Ministry of Health, with provincial health ministers also filling the role of medical school deans. Poverty alleviation has long been an integral part of public sector strategies, and Iran is building upon the success of recent initiatives to increase community involvement in health. To achieve the millennium development goals, the country wishes to increase the effectiveness and reach of health service delivery systems to provide essential interventions. One key gap they have identified is the weakness of current information management systems to generate an analysis useful to decision-makers. WHO is being requested to aid in identifying information technology tools, and the Regional Office and headquarters will work with Iran to explore various options to remove this constraint to progress.

In assessing the macroeconomic and political constraints to increasing pro-poor health services, Dr Mahdavi noted that Iran and many other countries are facing opposite inputs: on one side are "neo-classical inputs promoting the privatization and downsizing of public sector services" while the other side is calling for "increasing investments in health services to the poor", which can "only be delivered by the public sector". The resolution of this "political question" needs the involvement of WHO in its role as global advocate for equitable health services.

JORDAN

Jordan participated in the June 2002 meeting in Geneva to discuss the findings of the CMH report. Since then, a national Commission on Macroeconomics and Health has been formed, chaired by the Health Minister and including the Minister of Planning and the Secretary General of the High Health Council. Advocacy work by the WHO country office has been very effective. Consequently, in the six countries of the Region, Jordan is one of the furthest along in preparing to commence a macroeconomics and health process.

While still primarily focused on advocacy and alliance building, Jordan has begun to define areas of research that will be needed to guide development of a long-term health investment policy. In addition, a comprehensive national report has been prepared highlighting government actions to increase health sector financing allocations and to focus on the needs of the poor.

During the regional workshop in June, the General Secretary of the High Health Council expressed his belief that the CMH process would be successfully implemented in Jordan. He was joined by the assistant general secretary from the Ministry of Finance and the coordinator of the community infrastructure programme from the Ministry of Planning, who also gave strong support to implementing the macroeconomics and health strategy process. They noted

that one preliminary objective for them was to assess available burden of disease data to see if it can be disaggregated by income quintiles. This would be a critical milestone in meeting the objective of defining a range of cost-effective interventions to address the needs of the poor and vulnerable. The Jordanian delegation was very focused on conducting a cost-effectiveness analysis to identify the most effective interventions to meet the health needs of all communities. They expressed a desire for WHO resources and assistance in developing a cost-effectiveness analysis of the current system and services.

Their revised Phase 1 plan will also include assessing available data on burden of disease and identifying the focus of a cost-effectiveness analysis to assess gaps and identify research needed. The team also agreed to include as a Phase 1 objective the defining of, and capitalizing upon, realistic entry points for the macroeconomics and health strategy process into existing poverty and development mechanisms.

The team presented a revised work-plan, which incorporated two themes that surfaced during the regional workshop – integrate the CMH process into current efforts for sustainable development; and capitalize on previous experiences and lessons learnt to reduce barriers and optimize opportunities to place health at the centre of the development agenda. For example, the Jordanian delegation felt the running of their Healthy Village Programme has created an opportunity to build upon experience. They felt this was especially relevant as one way of stemming the loss of medical and other health professionals from rural areas, one of the biggest constraints to effectively meeting the needs of the poor in Jordan.

OMAN

Oman participated in the regional meeting in Morocco, 13–14 June, 2003. While not actively pursuing the CMH process at this time, they shared their thoughts on priorities for developing long-term investment strategies. Encouraging partnerships and linkages between the Ministries of Finance, Health and Planning requires a two-pronged approach. An internal strategy is required, based on good epidemiological data and supported by clear health indicators of process and outcomes. But an external strategy is also necessary. It is the responsibility of WHO to provide a forum where health ministers can communicate their needs to finance ministers, and where finance ministers can discuss the criteria they require to allocate more funds to health services.

PAKISTAN

Pakistan has a multi-pronged approach to reduce poverty, based on the Poverty Reduction Strategy Paper and incorporating acceleration of economic growth, governance reforms, expanding social safety nets and investing in human resources. Health sector investments are viewed as part of poverty reduction plan, with attention shifting to the provision of primary care and community based initiatives. Good governance is seen as the foundation of the current health sector reform process. As the Poverty Reduction Strategy Paper is already finalized, the objective for Pakistan will be to disseminate the key messages and finalizing of the CMH report, translate them into the local macroeconomic context, and use them to define research to construct an evidence base for placing health more centrally in

the Poverty Reduction Strategy Paper. While reaching the millennium development goals is a high priority for the government, the pressing need is reach the 45% of the population that currently does not have access to essential health services.

WHO Representative Dr Khalif Bile Mohamud stressed technical support is more urgently needed than financial support and that increasing local institutional capacity was critical. He also stated that mobilization of additional resources not a CMH support unit function but a country responsibility. In his view, the support unit should provide the technical support to allow a country develop a process that attracts additional and substantive investments into health. These will include some macroeconomic tools for analysing and addressing health issues more effectively. The entry point for implementing CMH-related findings will be augmenting the capacity of countries to carry out strategic thinking and policy analysis that can support a multi-partner, multisectoral strategy for health and poverty reduction.

Secretary of the Ministry of Health Mr Ejaz Rahim made the case that the CMH process provides an opportunity to re-examine health strategies from a macroeconomic perspective. He strongly suggested that each health ministry include a separate policy development unit that has high political clout, is adequately resources to conduct macroeconomic analysis for strategic planning, and has at least one health economist and one political strategist included. This will aid in devising policies and strategies that will win support from the most senior levels of government. He also stressed that the national CMH mechanism be headed by the prime minister or president, someone who could break down sectoral walls and foster broad initiatives to strengthen all the key determinants of health. Due to the busy nature of leaders, the national CMH should also have technical working groups dealing with research, analysis, policy development and implementation. These would be chaired by influential political leaders, respected for their technical ability, and able to take concrete steps to achieve desired outcomes.

SUDAN

Sudan presented their experiences as a large country (32 million inhabitants) that has to cope with almost one million internally displaced people and a rural population close to 10 million. Within the context of severe civil strife and a large trans-national migrant population, long-term strategic health planning must rely on coordinating a diverse network of internal and external partners, aid agencies and other agents. Since the beginning of the push for primary health care, there has been a marked inability to foster intersectoral collaboration or to coordinate various plans, even within a single sector. The Poverty Reduction Strategy Paper is merely one of many UN initiatives, and the delegation felt some integrated framework to rationalize all these initiatives was needed. They expressed the hope that the CMH focus on building up existing networks and strengthening partner networks will lead to a real cross-sectoral dialogue and participation in poverty reduction efforts.

WHO Representative Dr Guido Sabatinelli stressed that CMH is not an initiative but a nationally owned process. He pointed out that there is a window of opportunity presented by Heavily Indebted Poor Countries funds, and that the International Monetary Fund has agreed

to funds going into Poverty Reduction Strategy Papers. A plan for health investment is needed soon to take advantage of this. Senior Ministry officials in the delegation (finance, health, social welfare) were reluctant to revise the plan too much as they had gone through a long process of negotiation to achieve the existing plan. They did agree to move some research elements into Phase 2, after discussions showing the benefit of good analysis of current data, in order to identify where the crucial gaps were.

REPUBLIC OF YEMEN

The WHO Representative for the Republic of Yemen was unable to be present at the meeting; however, the senior level delegation included Dr Jamal Thabet Nashaer, the Republic of Yemen's coordinator for the macroeconomics and health programme. The team identified key early priorities for a multisectoral, long-term plan of health investments as determination of gaps in burden of disease of the poor and vulnerable; advocacy; and the creation of consensus among stakeholders.

The health service reform initiative, which includes implementation of a district health system, has been identified as the entry point for CMH. The Poverty Reduction Strategy Paper process will be the vehicle for operationalizing the CMH process, with the Yemen macroeconomics and health programme coordinator maintaining momentum and developing buy-in from key stakeholders.

The CMH report was discussed at the 18th meeting of the Regional Director with WHO Representatives and Regional Office staff from 7–10 October 2002. Participants felt that the report could be a powerful tool for raising domestic and donor investments in health. The Republic of Yemen has appointed a Coordinator for the Macroeconomics and Health Programme within the Ministry of Public Health and Population and has set up an inter-sectoral national Commission on Macroeconomics and Health to adapt the CMH report to its national strategic priorities.

The coordinator attended the Eastern Mediterranean Region CMH meeting in June 2003, accompanied by the assistant deputy minister for foreign affairs from the Finance Ministry and the director general of projects from the Ministry of Planning. The Republic of Yemen's strategic priorities for Phase 1 work centre around dissemination of key messages, generation of a pro-active debate among senior decision-makers on how to make health central to development and operationalization of the national CMH to set the stage for Phase 2 work.

(Table can be attached to the end of phase technical report by a country to assess the impact of the macroeconomics and health strategy. Use to describe changes from planned timeline and any revision of costs. It can also help organize budget requests to show why new funds are needed.)

Products² (Actual outcomes leading logically from preparation to planning to implementing a macroeconomics and health strategy)	Activities required to achieve products	Funds required (Matched to activities and outcomes)	Timeline (Approximate dates of activities and planned date for delivery of outcomes)	Expected outcomes
Product 1	Activity 1	Funds required for activity 1	Time period activity 1	When will product 1 be delivered?
	Activity 2	Funds required for activity 2	Time period activity 2	How does product 1 support the process for macroeconomics and health strategy?
	Activity 3	Funds required for activity 3	Time period activity 3	
Product 2	Activity 1	Funds required for activity 1	Time period activity 1	When will product 2 be delivered?
	Activity 2	Funds required for activity 2	Time period activity 2	How does product 2 support the process?
	Activity 3	Funds required for activity 3	Time period activity 3	
Product 3	Same as above	Same as above	Same as above	Same as above
Product 4	Same as above	Same as above	Same as above	Same as above

² Related to CMH concept paper and the country's own macroeconomics and health implementation strategy.