Save the Children’s submission to the UN consultation call for papers

1. Lessons learnt from health MDGs: What are the lessons learnt from the health related MDGs?

The MDGs have been an important catalyst for impressive successes in health. Acknowledging health as a driver of both human and economic development, they have spurred unprecedented political and moral commitment and provided a framework for discussion and action at country level.

The MDGs afford significant priority to maternal and child health. This is both welcome and much needed attention, which has been reflected in the Secretary General’s Global Strategy for Women and Children’s Health, Every Woman Every Child, launched in 2010. This has also been reflected by an increase in official development assistance allocation to maternal, newborn and child health (MNCH), by over 2.5 times between 2003 and 2010 in real terms.

Having clear, measurable and time-bound goals and targets has helped to focus advocacy, resources and accountability. The MDGs also enabled remarkable global institutional innovation, for example with the establishment of the Global Fund to Fight AIDS, TB and Malaria.

The momentum created by the MDGs has also contributed to certain results. Reductions in AIDS, TB, malaria, maternal and child mortality have accelerated, demonstrating to some extent that increasing coverage of effective interventions significantly contributes to improved health outcomes. For instance, a fifth of the dramatic reduction in child mortality from almost 12 million in 1990 to 6.9 million in 2011 can be attributed to higher measles vaccination coverage. To some extent, the MDGs have prompted greater policy coherence although there remains much room for improvement on this front.

Despite the vital contribution of the MDGs to global health, the next development framework will need to go beyond the MDGs, building on their strengths and overcoming their limitations.

Firstly, the MDGs do not consistently confront **inequality**. Aggregate targets and indicators mask often huge disparities within countries. Countries may be praised for progress that benefits the low-hanging fruit, leaving the most poor, marginalized and vulnerable behind. Moreover, in some countries, inequalities are widening. These inequities have to be addressed in order to achieve MDGs 4 and 5. Relative targets (i.e. percentage reductions) mean different things for different countries, and allow for countries to be identified as ‘on-track’ despite very high rates of mortality. We have also seen disproportionately slow progress on the health-related MDGs in conflict-affected and fragile states.

Secondly, the focus of the goals on specific diseases and population groups creates artificial silos. This prompted undue emphasis on some health issues to the exclusion of others, and led to **vertical** approaches that have fragmented health services by using independent planning, staffing, management and financial systems. In many cases, this had a distortive affect, with funds following globally determined priorities not local disease burdens and needs. For instance, the focus on HIV and AIDS skewed donor resources with 75% of the total increase in health aid between 2002-6 allocated to just one disease. Other important diseases were neglected, as were more cross-cutting strategies to build robust, integrated and responsive health systems, such as sufficient investments in the health workforce to ensure an appropriately trained, remunerated, supported, equipped and motivated health worker in reach of every child. The health system itself is a determinant of maternal and child mortality, with out-of-pocket payments identified as a risk factor and low health worker density associated with high infant mortality.

Thirdly, since the introduction of the MDGs, the inadequacy of the global aid architecture has become increasingly apparent. Genuine and representative **country ownership** of the goals has been lacking from the outset, and processes have typically been top-down, with resources following donor interests rather than aligning with locally identified needs. Coordination has been weak leading to duplication and wasted resources, with funds often flowing through parallel systems at high transaction cost.

Finally, there has been an insufficient focus on effective **accountability**: both mutual accountability between donors, countries and beneficiaries, and independent accountability such as through the

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recently established independent Expert Review Group of the Global Strategy (iERG). While the iERG is an important attempt to start to address this accountability deficit, its ability to do so remains unclear and the inconsistency and weakness of country data are persistent challenges. Human rights mechanisms have been largely ignored, with inadequate efforts to empower citizens to hold governments to account. Similarly, there remains no formal system for non-state actors— including foundations, civil society and the private sector - to be held accountable, despite a growing interest in engaging the private sector. Poor data quality for mortality rates, health outcomes, intervention coverage, systems, domestic and donor resource flows, and disaggregation further undermines effective accountability.

2. Health priorities post 2015: What is the priority health agenda for the 15 years after 2015?

The priority health agenda within the next development paradigm must be integrated and comprehensive, building on the MDGs to be more ambitious and address their limitations in the following ways:

i. **Bring an end to preventable child mortality:**

At the core of this agenda must be child health. In 2011, 19,000 children died each day from mostly preventable causes. This is avoidable and unacceptable. The unfinished business of the MDGs requires increased resolve to bring an **end to preventable maternal and child mortality in all segments of society.** Keeping mothers and children alive, as particularly vulnerable population groups, should not only remain our first priority but it is also indicative of the the health system’s ability to provide basic essential services.

In response to the growing burden of non-communicable diseases in low- and middle-income countries, and the need for a more holistic framework, the post-2015 agenda must broaden beyond mortality to also address morbidity. Promote the quality of life, wellbeing and development can lay the foundation for progress on other goals. This is particularly true for children, as health contributes to a solid foundation for future social and economic gains, helping to break the intergenerational cycle of poverty.

ii. **Strengthen health systems for equitable and sustainable progress:**

We know the interventions that work, but we need to find more effective ways of overcoming supply- and demand-side barriers to expand access to quality care. While vertical approaches have no doubt had certain benefits for specific interventions and diseases, they also exposed and exacerbated weaknesses in health systems.  

**Universal Health Coverage (UHC)** provides a framework for more integrated and sustainable progress by increasing intervention coverage and expanding financial risk protection, so that no child dies because they can’t afford the care they need, and no family falls into poverty from the costs of

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health care. There is growing commitment to UHC reflected in the UNGA resolution\(^7\), and the Special Rapporteur on the right to health's interim report\(^8\). UHC addresses the fundamental issue of how we can sustainably fund quality health care for all. Achieving UHC requires a strong public-led health system, with investments across the pillars, including a strengthened health workforce. It requires political will matched with commensurate resources.

iii. Drive progressive realization of the right to health:

Completing the job started by the MDGs will require action to tackle wide and often growing inequalities in access to health care and in health outcomes between and within countries. Every child and their families have a right to the highest attainable standard of health. Yet those without access to essential health care are consistently the poor and less educated, often living in rural and remote areas, for whom health care would bring the greatest returns. Their predicament is shaped by economic, political and social conditions.

Addressing inequities must be a priority of the post-2015 agenda, with targets that drive progressive realization of the right to health. Closing the equity gap in health will necessitate a multi-sectoral endeavour to address the social determinants of health, such as hunger and education. It will also require global action, such as research and development agendas that respond to the burden of disease for the poor and the contexts in which they live, and more affordable medicines and vaccines so that countries have sufficient and sustainable supply. The health sector has the potential to serve as an ‘equaliser’, raising standards across the board, if designed appropriately and coupled with efforts to address demand-side barriers.

We are on the brink of a tipping point where we can get to zero preventable maternal, newborn and child deaths in the coming decades. To achieve this and to sustain gains we must address inequalities and strengthen health systems, ensuring that all children and their families have access to essential quality interventions, and that no household is impoverished from seeking essential care. This is sustainable development: providing for children and their families to live healthier, more productive lives.

3. Framing the future health goal: How does health fit in the post-2015 development agenda?

The post-2015 agenda presents a massive opportunity to improve global health, and reassert the centrality of health as an objective and driver of sustainable development.

Firstly, health is a human right, a matter of social justice, and a global public good.

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\(^8\) UNGA (2012) Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/67/302.
Secondly, better and more equitable health outcomes increase productivity and resilience, reduce poverty and promote social stability. As such, health is a platform for sustainable progress on other goals too.

Thirdly, given the command of social determinants in affecting health outcomes, health is a measure of sustainable development across all sectors.

The post-2015 paradigm also presents a potential threat: The new framework is likely to focus on agendas that are neglected in the MDGs. The health community is fragmented, and competition between health constituencies will risk losing the emphasis on health altogether. The health community should coalesce around a single high-level goal and seek to counter the fragmentation to which the MDGs contributed.

What follows in 2015 should be a more homogenous health goal, to which we can all align. It should assert a shared commitment to end preventable mortality for women and children, on whom the biggest burden falls. It should ensure universal access to quality preventive, promotive, curative and rehabilitative health care, through strengthening systems, addressing inequalities and expanding financial risk protection. Sustainable development means realization of human rights with strengthened systems of governance and accountability. A goal that identifies the twin targets of an end to preventable maternal and child mortality and universal health coverage is a global goal which resonates for all countries and requires shared solutions.

Due to the inextricable linkages between health and water, sanitation and hygiene, hunger, and environmental quality/pollution, the future development framework must promote more integrated, multi-sectoral approaches to promote sustainable development.

4. Measurement of progress towards the health goals: What are the best indicators and targets for health?

The next development framework should be globally agreed, but also locally relevant and owned. This requires a more dynamic approach, which could involve fixed targets and flexible indicators. This would allow space for local specificity, to be determined by a transparent, multi-stakeholder, participatory and evidence-based process at the country level. For the reasons cited above, the health goal should be an enabling framework that can be translated into a nationally relevant targets. Human rights principles such as universality, equality and inalienability must underpin everything that is agreed. And, unlike with the MDGs, these principles must be visible in the targets. Learning from the MDGs, the post-2015 health agenda must prompt all stakeholders to pursue equitable and sustainable health outcomes.

Addressing the unfinished business of the MDGs, the first target should be the end to preventable maternal, infant and child mortality for all segments of society, explicitly tracking reduction rates in the poorest two wealth quintiles (and other contextually appropriate equity measures such

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as urban/rural, ethnicity etc.). This requires disaggregated data to track equity criteria, and better national data to avoid overreliance on weak estimates.

Moving beyond mortality to apply more comprehensively to child health and the quality of life throughout childhood, the second target should be **UHC**. This target has multiple parts, and could be measured by an index:

- **Preventive, promotive, curative and rehabilitative intervention coverage** is a flexible category for which proxy indicators could be selected based on local needs. These should include essential interventions across the continuum of care and be determined by evidence of the burden of disease and the level of disparities across segments of society.

- **Health system strengthening**, across the pillars of the health system, such as frontline health worker ratios. Appropriate proxies could be based on a transparent and participatory assessment of bottlenecks.

- **Financial risk protection**, measured by out-of-pocket payments as a share of total health expenditure and rates of catastrophic expenditure and impoverishment, disaggregated by household characteristics. A recommended target threshold might be helpful for this.

- **Investment in health**, tracking total health expenditure by financing source, per capita and as a proportion of total government expenditure. Again, recommended thresholds for these categories of expenditure might be helpful.

- **Institutionalization of legal frameworks** on the right to health: a binary variable to monitor whether a state’s constitution or bill of rights identifies the right to health, and a national institution is mandated to deliver on the right to health.

Targets should guide reductions in inequalities while tracking average percentages, for instance through ratios between richest and poorest households etc. where applicable. Indicators should be disaggregated by equity criteria – such as wealth, geography, sex, urban/rural, as well as more contextually informed criteria, such as ethnicity or caste, as appropriate to local disparities.

While the targets and indicators will need to be measurable, we must seize this opportunity to match our ambition for sustainable development with substantial investment to improve the quality and frequency of data – both country routine health management information systems and survey data, including demographic and health surveys and multiple indicator cluster surveys.

While there is clear value in setting common global targets, there should also be space for contextual interpretation to ensure relevant and sufficiently ambitious yet achievable targets. The potential for the future framework to engage and hold accountable non-state actors should also be explored.

5. **Ensuring a process and outcome that is relevant to the key stakeholders**: How can country ownership, commitment, capacity and accountability for the goals, targets and indicators be enhanced? How can we ensure effective working relations between countries and global partners in terms of alignment and harmonisation with a focus on development results?

The parallel process for the post-MDGs and the Sustainable Development Goals is confusing and duplicative, and should be **integrated**.
The future development framework should be an enabling framework rather than an operational tool. Determining the priorities for sustainable development should primarily be a country-based dialogue involving all key stakeholders including ministries of finance and planning along with social sectors, development partners, parliamentarians, civil society and the private sector. The next development goals will only be locally accountable if they are locally relevant and locally owned, within a broader global framework.

The principles of aid effectiveness remain pertinent and a step change in donor behavior is needed to move towards a genuine partnership model in support of country ownership. Acknowledging the global shared responsibility to realize the right to health could benefit from a binding global framework, such as a Framework Convention for Global Health. The current aid architecture is inadequate to deliver to our level of ambition and should be reconfigured based on the necessary functions, addressing the existing imbalance of power.

Empowering countries means supporting the development of, and aligning behind robust national plans. Promising processes and effective tools to do this exist – for instance through the International Health Partnership plus related initiatives (IHP+) joint assessment of national strategies. Such initiatives should be revived to provide coordinated technical support to strengthen national plans, integrating effective evidence-based strategies to implement the country’s health goal and global commitment. Better data and robust evidence to guide priorities, strategies and investments are also essential.

But no goal will be achieved without funding. In many developing countries, this means increased domestic and donor resource allocation to health. It also means addressing inefficiencies in existing budgets, which is of course associated with good governance. A transparent process should be implemented to match resources to the costed plan, with donor funds filling identified gaps.

National plans provide a basis for effective mutual accountability between donors, countries and beneficiaries through a domestic platform. At the global level, an integrated framework and process for independent accountability could be convened, for instance merging the iERG and human rights mechanisms. Meaningful participation and accountability requires investments to build the capacities of local civil society to engage in such processes and represent poor and vulnerable communities effectively.

It’s time to keep our promise to women and children.

Save the Children works in more than 120 countries. We save children’s lives. We fight for their rights. We help them fulfil their potential

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