



**TRANSITIONING
FROM THE MDGs
TO THE SDGs**

This report synthesizes the main lessons learned from the MDG Reviews conducted by the UN System Chief Executives Board for Coordination (CEB) between April 2013 and November 2015. The exercise, which brought together United Nations and World Bank Group staff, summarized the country situation, identified bottlenecks to attainment, and suggested potential solutions in 16 countries and 1 subregion. Many of the observations and proposed solutions could prove useful in implementing the Sustainable Development Goals (SDGs).

This work is a product of the staffs from the United Nations Development Programme (UNDP) and the World Bank Group (WBG), as well as contributions from experts from outside these institutions.

The findings, interpretations and conclusions do not necessarily reflect the views of UNDP, the WBG and their Executive Boards or the governments they represent. UNDP and the WBG do not guarantee the accuracy of the data included in this work.

The report was not endorsed by the CEB and does not necessarily reflect the views of all of its members.

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PREFACE

The Millennium Development Goals (MDGs) were an expression of solidarity with the world's poorest and most vulnerable. They translated noble principles and great aspirations into a set of time-bound, shared targets. The Goals mobilized the world to tackle poverty's many dimensions, forming a framework for a global partnership that ushered in a new era of development cooperation. Yet for all the achievements, the international community faced many challenges during this 15-year journey.

In November 2012, with only three years until the MDG deadline, the United Nations System Chief Executives Board for Coordination (CEB), under my chairmanship, expressed a determination to step up action to accelerate progress towards the goals. World Bank Group President Jim Yong Kim proposed to devote a portion of each subsequent CEB session to overcoming country-level bottlenecks hampering MDG achievement. The intent was to redouble efforts to align the strengths, capacities and expertise of the United Nations system organizations in order to provoke cross-sectoral and cross-institutional thinking, enhance coherence and genuinely deliver as one.

The Executive Heads embraced the opportunity, sending a powerful signal to their organizations and the wider development community that the United Nations system was committed to pursuing a new level of coordination and collaboration to support governments in meeting the MDGs.

What followed was unprecedented – a truly integrated system-wide endeavour, championed jointly by World Bank Group President Jim Yong Kim and United Nations Development Programme Administrator Helen Clark. Before the end of 2015, the CEB completed five rounds of review, featuring sixteen countries and the Pacific Islands subregion. The review encompassed MDG targets on poverty and hunger, maternal and child mortality, water and sanitation, education, nutrition, employment and health.

The CEB MDG review triggered actions that have had a notable impact in the participating countries while demonstrating the great potential of an advanced model of country-level collaboration in support of national priorities that is backed by high-level global commitment.

The 2030 Agenda for Sustainable Development now sets the vision for the next 15 years of global action. It encompasses the unfinished business of the MDGs but goes well beyond poverty eradication, breaking significant new ground. It is a universal, integrated and human rights-based agenda for sustainable development. It balances economic growth, social justice and environmental stewardship and underlines the links between peace, development and human rights. In tackling this inclusive and interconnected agenda, it is my hope that the United Nations system will draw on and widely apply the integrated, cross-sectoral, "One UN" approach that had generated tangible results in countries participating in the CEB MDG review.

This publication seeks to convey the richness of the country teams' joint efforts to holistically and collaboratively address persistent development challenges and to distil the lessons learned from the CEB MDG review so that governments, United Nations system organizations and partners alike may benefit from its insights as we, together, strive to realize the 2030 Agenda's vision of a life of dignity for all.



Ban Ki-moon
United Nations Secretary-General

FOREWORD

Just weeks after I was appointed President of the World Bank Group, I visited the United Nations headquarters to discuss working more closely with UN Secretary-General Ban Ki-moon. We felt there were many opportunities to strengthen our partnership, including embarking on an ambitious joint effort to improve the lives of the poor by accelerating progress toward achieving the Millennium Development Goals.

The Secretary-General suggested, and I agreed, that the UN Chief Executive Board for Coordination should send a strong signal to our country teams and institutions to work together on this effort. UNDP Administrator Helen Clark and I asked our respective teams to jointly prepare plans with countries to accelerate progress toward reaching MDG goals, and then to present findings to the Chief Executive Board (CEB). Over the following three years, the CEB's MDG review included 16 countries plus one sub-region. The programs covered all regions and all eight MDGs. Across the board, the exercise produced valuable results and relevant lessons – especially on the value of setting targets and using deadlines to meet those targets.

Some country programs delivered strong results almost immediately. The Tanzania government, working with the UN and the World Bank Group, rapidly expanded its social safety net cash transfer program from 20,000 households in three districts to 1.1 million households in all 169 districts. This expansion helped cut extreme poverty in half, spurred infrastructure development, and improved connectivity with all districts. We helped governments scale up similar programs in Indonesia, Burkina Faso, and the Philippines. The Philippines expanded the reach of its cash transfer program to over 3.7 million people in five years. Scaling up these cash transfer programs has been transformative for development, creating numerous positive impacts.

If we are to now achieve the ambitious SDGs by 2030, we face another challenge ahead of us: closing current information gaps in household-level data. These gaps prevent us from knowing if people are rising out of poverty or falling back into it. The World Bank Group has pledged to work with developing countries and international partners to ensure that 78 of the world's poorest nations have household-level surveys completed every three years. The first round is to be completed by 2020. We can do much more to revolutionize countries' ability to collect data, especially with new, transformative technology at our disposal, such as open platforms and mapping tools.

Our CEB experience has changed how we do business and collaborate. In a UNDP-WBG survey of UN resident representatives and World Bank Group country directors, they universally agreed that the MDG-acceleration review improved how the UN and the WBG jointly impacted development results. They said it led to more harmonization, sharing of good practices, improved coordination, enhanced ownership, and a more targeted focus. Therefore, I propose we build on this success in pursuit of the SDGs and find new ways for our country teams to work closely together on specific targets. It is our hope that this publication will inspire all of our country directors and UN resident coordinators to seek ways to collaborate and help countries attain the SDGs in our common goal of ending extreme poverty in the next generation.



Jim Yong Kim
President of the World Bank Group

FOREWORD

When the Millennium Development Goals were adopted, some described them as too aspirational. Today, the world has seen the benefits of promoting a global development agenda. The MDGs were the most specific, measurable and broadly supported poverty reduction targets the world had ever established, and many significant results were achieved. They have been described by the UN Secretary-General Ban Ki-moon as “the greatest anti-poverty push in history”.

The Sustainable Development Goals are considered to be transformational. We all agree that a business as usual approach will not deliver these goals by 2030. This report presents evidence on the lessons learned from the Chief Executives Board (CEB) MDG Reviews, which the World Bank Group (WBG) President Jim Yong Kim and I championed across our respective teams. The Reviews were a forward-looking exercise meant to foster cross-sectoral collaboration across the UN system to accelerate off-track progress.

Implementation of the MDG Acceleration Framework (MAF) was backed by the UN CEB for Co-ordination in 2010, and provided the basis for understanding the bottlenecks to progress and then to removing them. This framework allowed for the identification of innovative and pragmatic solutions which brought implementing partners together in a joint push for success.

Much has been learned from the CEB Reviews and the MAF bottleneck assessments. The implementation of the 2030 Agenda for Sustainable Development requires an integrated approach which capitalises on the diversity and specialized strengths of individual agencies. For example, in Lao PDR and Nepal, the UN and WBG teams conducted a mapping of agency interventions and geographical presence to focus their efforts better, promote convergence of programmes, and eliminate fragmentation and duplication. Work on implementation of the MAF approach reconfirmed how indispensable country ownership and community mobilization are to ensuring the provision of essential services and scaling up proven interventions. To leave no one behind,

strong engagement with local communities and civil society is required. In the Democratic Republic of Congo, the UN Country Team and WBG Team developed a joint strategy to boost community involvement in order to increase demand for health related services, including HIV testing and family planning.

Achieving sustainable development is helped by having humanitarian and development actors working closely together. The CEB Reviews included countries in protracted crises and others recovering from natural disasters – such as Yemen, Colombia, Niger, Burkina Faso and the Philippines. In all of these countries, there was a clear need to pursue holistic approaches to development – seeing it as a continuum of activities which must address the short and medium term needs of people while also seeking long-term sustainable development.

As countries make the transition from the MDGs to the SDGs, it will be critical to invest in key accelerators of progress from the outset. This should include investments in the empowerment of women and girls, sustainable energy for all, and the sustainable use and conservation of biodiversity. I hope that the lessons from the CEB Reviews will provide useful guidance for stakeholders in their efforts to achieve the Sustainable Development Goals.

I thank the UN and the WB teams at country level and headquarters for their extensive engagement in the CEB Reviews. Our gratitude goes to the host governments that lent their support and saw this initiative as an opportunity to boost the coherence of the UN common system and to accelerate development progress.



Helen Clark

Administrator, United Nations Development Programme

ACKNOWLEDGMENTS

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The work was carried out under the overall guidance of Mahmoud Mohieldin (WBG) and Magdy Martínez-Solimán (UNDP). Jos Verbeek (WBG) and Renata Rubian (UNDP) managed the preparatory process for the CEB MDG Reviews and the drafting of the report.

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ACRONYMS

FAO	Food and Agriculture Organization
GIZ	German Agency for International Cooperation
ILO	International Labour Organization
IOM	International Organization for Migration
OAS	Organization of American States
OECD/DAC	Organisation for Economic Co-operation and Development/Development Assistance Committee
SIDA	Swedish International Development Agency
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCEB	United Nations System Chief Executives Board for Coordination
UNDAP	United Nations Development Assistance Plan
UNDP	United Nations Development Programme
UNIDO	United Nations Industrial Development Organization
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
WBG	World Bank Group
WFP	World Food Programme
WHO	World Health Organization

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EXECUTIVE SUMMARY

Lessons and recommendations from the CEB Reviews:¹ A forward-looking perspective from the MDG Era

BY MAGDY MARTÍNEZ-SOLIMÁN* AND MAHMOUD MOHIELDIN†

INTRODUCTION

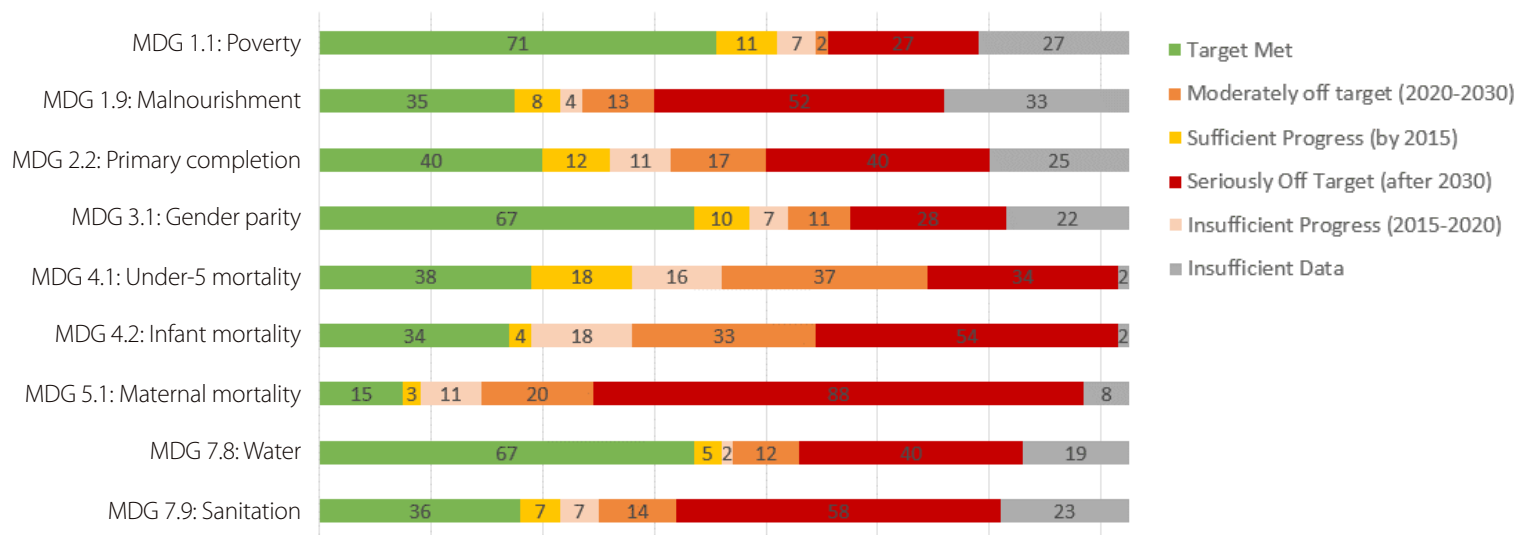
Many countries mainstreamed the Millennium Development Goals (MDGs) into their national and sub-national development plans and strategies, and implemented specific measures intended to achieve the associated targets. However, progress was uneven and, in spite of best efforts, many countries missed one or more of the MDG targets.

During the last three years of the MDG period, heightened efforts were made at accelerating progress. Acceleration efforts were expected to shorten the amount of time to completion and offer significant benefits

to the implementation phase of the Sustainable Development Goals (SDGs). Much has been learned through efforts of the last fifteen years, and there is enough evidence to guide such efforts. This report documents the experience of 16 countries and the Pacific Islands sub-region with acceleration efforts.

One important aspect of the MDGs has been their focus on measuring and monitoring progress. Estimates for the developing world indicate that the targets for extreme poverty reduction (MDG 1.a), access to safe

FIGURE 1: MDG PROGRESS BY NUMBER OF COUNTRIES (2015)



Source: World Bank, 2015. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change.

¹ This chapter is based on a paper prepared by UNDP and the World Bank for the 6th MDG Acceleration Review of the United Nations System Chief Executives Board for Coordination (CEB) held on 18 November 2015. The paper benefitted from the information prepared by country teams for the formal sessions of the CEB MDG Acceleration Reviews and country monitoring matrices. The paper also draws from inputs provided by country teams and CEB Sherpas through a survey on lessons learned from the CEB Reviews. This publication does not necessarily reflect the views of all CEB member organizations, nor was it formally endorsed by the CEB.

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drinking water (MDG 7.c) and improving the lives of at least 100 million slum dwellers (MDG 7.d) were reached ahead of the 2015 deadline (Figure 1). The target on ending gender disparity in primary education was met in 2010. Targets on gender equality in primary and secondary education (MDG 3.a) and the incidence of malaria (MDG 6.c) were met by 2015.

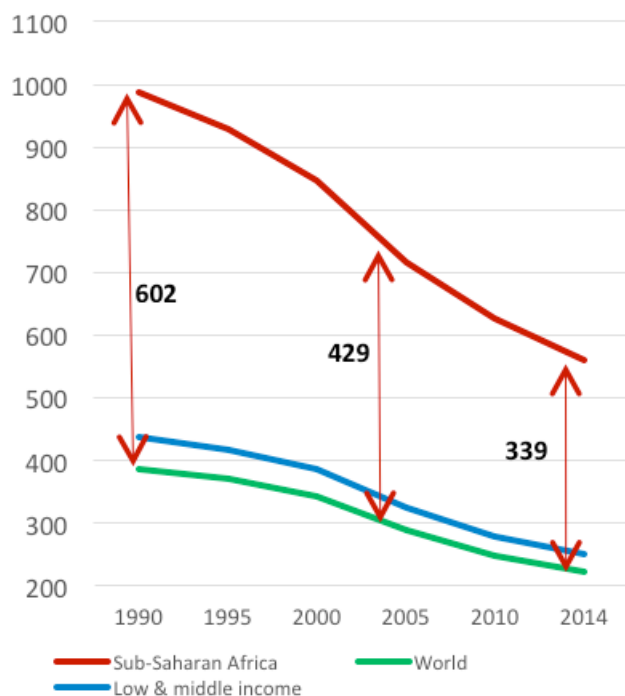
In contrast, progress on the remaining MDG targets lagged, especially for the education and health-related MDGs. The primary school completion rate reached 90 percent by 2012, but progress was off track to meet the target of a universal completion rate by 2015. Progress towards MDGs related to infant, child and maternal mortality (MDGs 4a and 5a), and access to basic sanitation (MDG 7c) were lagging behind by 2015.

The heterogeneity of outcomes at the country level translates into stark differences at the regional level. At one end, the East Asia and Pacific regions are estimated to have met all of the MDGs. At the other end,

sub-Saharan Africa is off target on most of the goals. The regions still falling short, in particular South Asia and sub-Saharan Africa, started from positions that required the most improvement. They have made significant progress in absolute terms, particularly on the health MDGs, which the world as a whole is struggling to meet. The relative nature by which many of the MDGs are defined tends to mask significant accomplishments in South Asia and sub-Saharan Africa (Figures 2a and 2b).

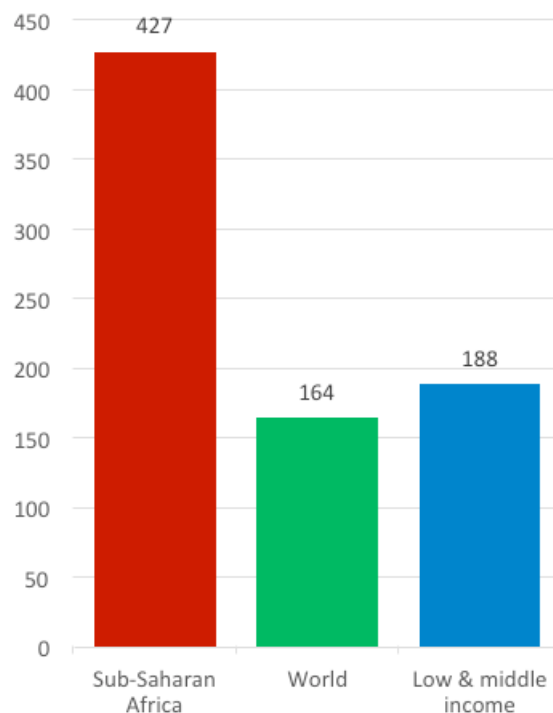
Progress towards the MDGs also varied sharply along two key dimensions: the rural-urban divide, and demographic features. People living in cities saw far more development progress than those in rural areas, reflecting the importance of scale economies in urban centres, and the challenges of providing services in more sparsely populated rural localities (Box 1). Countries where the demographic transition to low fertility and low mortality is either stalled or delayed have faced major challenges (Box 2).

FIGURE 2a: MATERNAL MORTALITY RATIO (PER 100,000 LIVE BIRTHS)



Source: World Development Indicators 2015 Database.

FIGURE 2b: ABSOLUTE PROGRESS: MOTHERS' LIVES SAVED, 1990-2014 (PER 100,000 LIVE BIRTHS, PER YEAR)



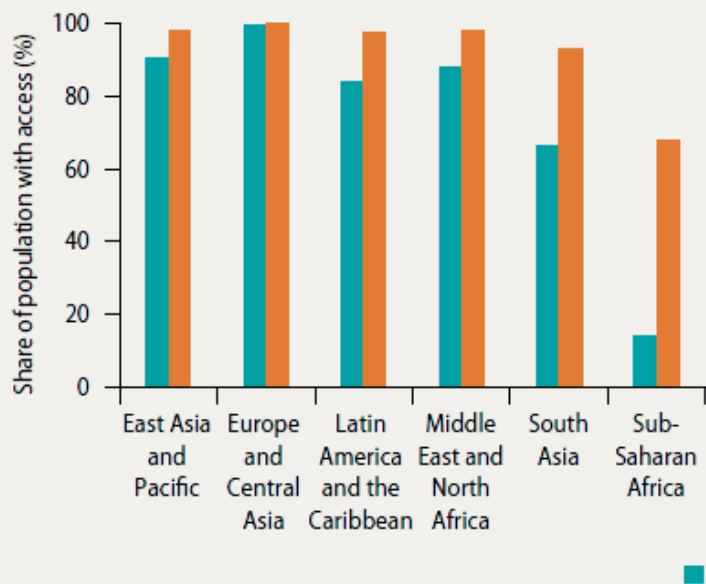
BOX 1: DEVELOPMENT OUTCOMES VARY SUBSTANTIALLY BETWEEN URBAN AND RURAL AREAS

Urbanization and development are closely interrelated. The agglomeration of people and activity in cities is both a cause and consequence of development. Virtually all countries that have transitioned from poverty to prosperity have also undergone rapid urbanization (Glaeser and Joshi-Ghani 2013). This is reflected in differential outcomes in rural areas on both the income and other dimensions of poverty.

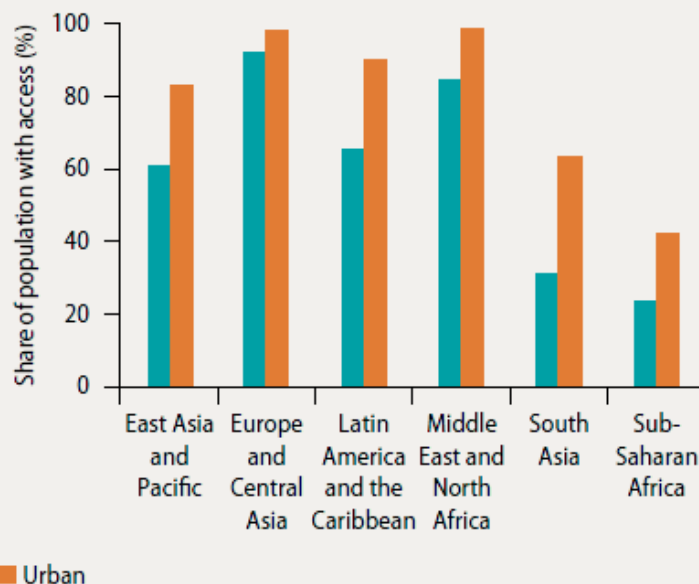
About three-quarters of the extreme poor live in rural settings, and in some regions, like East Asia and the Pacific or Latin America and the Caribbean, people living in rural areas are four times more likely than city dwellers

to be counted among the extreme poor. These gaps are also evident in access to basic public services and in corresponding development goals, such as (MDG 6) access to improved water and sanitation. In sub-Saharan Africa, the difference in access to improved water and sanitation between people living in urban and rural areas averages more than 25 percentage points (Figures 1.a and 1.b). Urbanization can help lower the unit cost of public service delivery, and contribute to productivity, growth and development. But if not managed appropriately, it can also result in slums and other social challenges².

1.a: ACCESS TO IMPROVED WATER SOURCES



1.b: ACCESS TO IMPROVED SANITATION FACILITIES



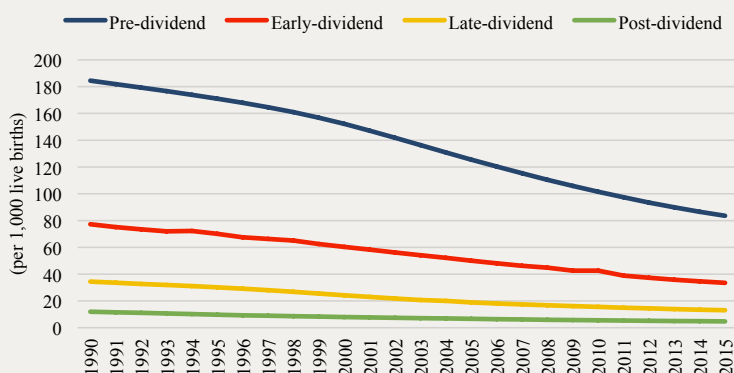
Source: World Bank 2015. Global Monitoring Report 2015/16: Development Goals in an Era of Demographic Change.

² World Bank/IMF (2013), Global Monitoring Report 2013: Rural-Urban Dynamics and the Millennium Development Goals.

BOX 2: DEVELOPMENT OUTCOMES VARY SUBSTANTIALLY DEPENDING ON DEMOGRAPHIC FEATURES

Demographic features are closely associated with countries' trajectories on the MDGs. Looking at country groupings based on the four demographic dividend typologies, pre-dividend,³ early dividend,⁴ late dividend⁵ and post-dividend⁶ (World Bank 2015a), it is apparent that different phases of demographic transition correspond to different levels of development.* In general, pre-dividend countries face extensive deprivations, whereas post-dividend countries demonstrate better outcomes. Sixty-eight percent of late dividend countries and 40 percent of early dividend countries were able to meet the MDG target of halving their poverty headcount rates from their 1990 levels, compared with only 2 percent of pre-dividend countries. Almost 90 percent of the world's poor live in pre- and early dividend countries, which also exhibit fast population growth.

2.a: UNDER-FIVE MORTALITY RATE



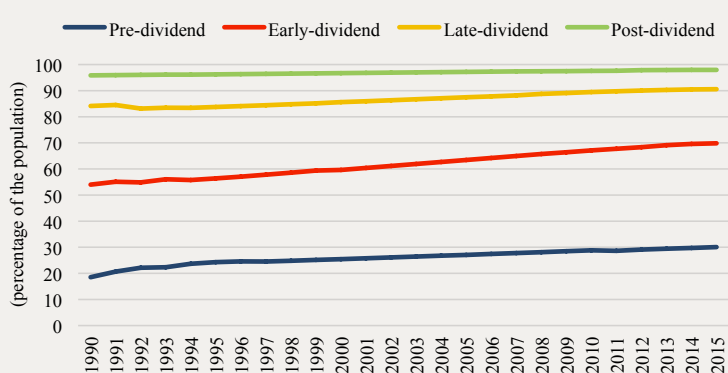
Source: World Bank staff estimates based on World Bank World Development Indicators 2015 Database.

Note: Data are simple averages of under-five mortality rates per 1,000 live births and the percentages of populations with improved access to sanitation for each typology over the period 1990-2015; countries with missing data are excluded.

* The typologies are based on the growth of the working-age population share during 2015-2030, and the total fertility rate in 1985 and 2015. Pre-dividend countries have growing working-age population shares and total fertility rates of more than 4 in 2015. Early dividend countries had growing working-age population shares and total fertility rates of less than 4 in 2015. Late dividend countries had shrinking or unchanged working-age population shares and total fertility rates of more than 2.1 in 1985. Post-dividend countries had shrinking or unchanged working-age population shares and total fertility rates of less than 2.1 in 1985. These typologies are detailed in Appendix C3 of the Global Monitoring Report 2015/16.

Although gains on several MDGs were made in absolute terms in pre- and early dividend countries, the starting point was a high level of deprivation. At the close of 2015, much of the unfinished MDG agenda was concentrated in these countries. The under-five mortality rate per 1,000 live births is estimated to have fallen from 184 in 1990 to 84 in 2015 in pre-dividend countries, but this rate remains three to five times higher than in early and late dividend countries (Figure 2.a). Despite some gains, access to improved sanitation has remained largely stuck for pre-dividend countries at below 30 percent in 2015 (Figure 2.b). These findings suggest that accelerating progress towards key development goals in the SDG period will depend in part on sparking a demographic transition to lower fertility rates.

2.b: ACCESS TO IMPROVED SANITATION



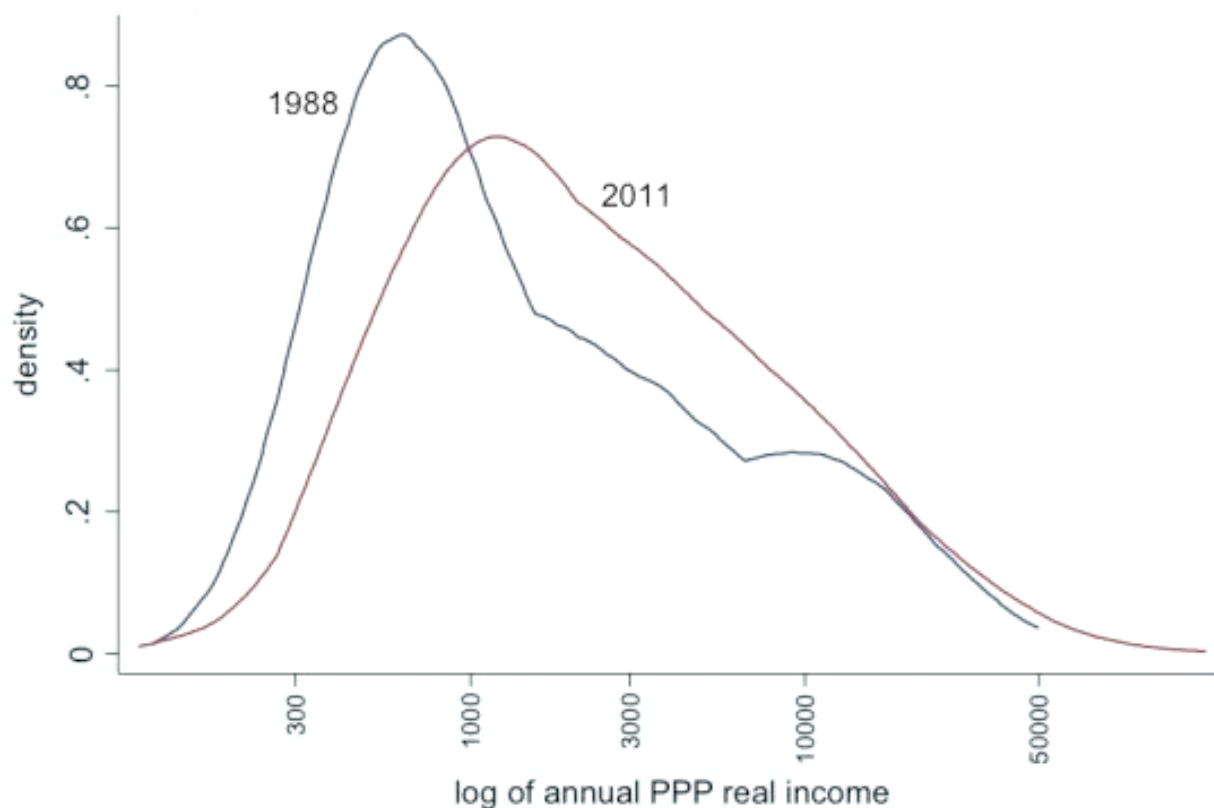
Although many of the MDG targets were not met in many countries, significant progress means the world we live in today is fundamentally different from the world when the MDGs were adopted. In 1990, 58 percent of the global population lived in a low-income country. In 2000, this declined to 41 percent, and in 2013, to only 12 percent. People in extreme poverty made up 36 percent of the global population in 1990 (1 out of every 3 people). This share declined to 28 percent by 2000 and 11.5 percent (1 out of 8) in 2015. Nonetheless, 850 million people still live on less than US \$1.25 a day.

These developments have led to major changes in the global distribution of income. In 1988, just two years before the benchmark year for the MDG period, the world could be divided into two distinct distributions of income (Figure 3). These distinctions have begun to blur today, as the world becomes more like one continuous group of countries instead

of one developing and one developed group. Similar conclusions can be drawn by analysing where global gross domestic product (GDP) is shifting. Keeping constant the initial grouping of countries by income category of 1990, low-income countries at that point produced approximately 5 percent of GDP. That same set of countries produced close to one-fifth of global GDP in 2013. Low-income and middle-income countries together produced close to 40 percent of global GDP in 2013, up from about 20 percent in 1990. Their economic growth rates significantly outperformed those of high-income countries.

The process of articulating the MDGs and building a consensus around core objectives as well as coalitions to achieve them played a positive role in some of these shifts (Box 3). It also yielded numerous lessons to inform movement on the 2030 Agenda and its SDGs.

FIGURE 3: GLOBAL INCOME DISTRIBUTION IN 1988 AND 2011



Source: Lakner, Christoph and Branko Milanovic (2013) Global Income Distribution From the Fall of the Berlin Wall to the Great Recession, World Bank Policy Research Working Paper 6719.

BOX 3: DID THE MDGs MAKE A DIFFERENCE?

The complexity of development means that attribution of progress to particular actors, causes and processes is typically impossible. Time lags between actions and effects add to the difficulty of identifying when a particular factor may have spurred improvement. These realities complicate efforts to ascertain the value of the MDGs. Although several methods have been used to assess their impact on development, including estimating counterfactuals and comparing how various indicators actually evolved (McArthur 2014), and using statistical tests to look for breaks in trends before and after the MDGs were adopted.

The results are mixed, showing that the MDGs had major impacts on some indicators but little direct effect on others. Under-five mortality (MDG 4), for example, has fallen dramatically in the poorest countries since the MDGs were agreed. Controlling for various factors, statistical methods applied to 19 MDG indicators checking for an interruption in the time series between 1992 and

2008 found an acceleration or deceleration in the trajectories after 2001 in five indicators (Friedman 2013). For instance, the incidence of tuberculosis (Target 6C) began falling sharply in 2000, especially in South Asia and sub-Saharan Africa (Figures 3.a and 3.b). For HIV declines (Target 6A), the turning point was 1996-1997, and for the adolescent birth rate (Target 5B), a marked fall began in 2004. Gender parity in primary school enrollment improved more quickly in South Asia and sub-Saharan Africa (Figures 3.c and 3.d).

The share of children under one who were immunized against measles (Target 4A) did not change significantly during the period under review.

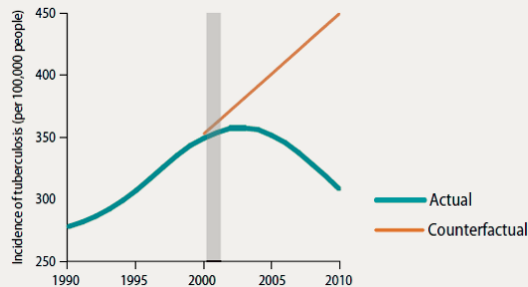
In a number of cases, discernable breaks in trends came before the turn of the millennium or much later, and it is more difficult to attribute impact.

INCIDENCE OF TUBERCULOSIS: ACTUAL PROGRESS COMPARED WITH COUNTERFACTUALS

3.a: SOUTH ASIA

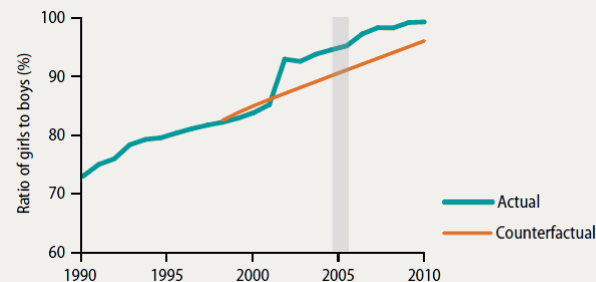


3.b: SUB-SAHARAN AFRICA

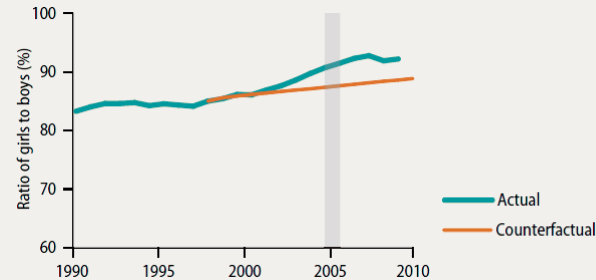


GENDER PARITY IN PRIMARY SCHOOL ENROLLMENT: ACTUAL PROGRESS COMPARED WITH COUNTERFACTUALS

3.c: SOUTH ASIA



3.d: SUB-SAHARAN AFRICA



World Bank 2015. Global Monitoring Report 2015/16: Development Goals in an Era of Demographic Change.

Note: The gray columns represent the year 2000, referencing the baseline situation before the adoption of the MDGs. The counterfactuals, represented by the red lines, extend the 1990-2000 (pre-MDG) trends into the 2001-2013 period, based on a regression including a trend and autoregressive terms. An alternate approach using the Hodrick-Prescott filter to extend the pre-MDG trends into the MDG period was also used, generating similar results. The Bai-Perron methodology was used to test for the presence of structural breaks. For tuberculosis, the test results confirmed the presence of a structural break for South Asia in 2004 and sub-Saharan Africa in 2002.

CEB MDG REVIEWS

During the final years of the MDGs, the United Nations System Chief Executives Board for Coordination (CEB)⁷ conducted a series of MDG acceleration reviews. These strongly advocated for **cross-sectoral and cross-institutional thinking** within the UN system to accelerate progress on off-track MDG targets.

Bottleneck analysis, proposed under the MDG Acceleration Framework or MAF (Box 4), helped UN organizations fully appreciate that investing in solutions within a particular sector may be necessary, but not sufficient to gain enough momentum to meet a particular target. For instance, interventions on poverty reduction, urban housing, and occupational health and safety also contribute to decreasing vulnerability to non-communicable diseases, as these issues are interlinked. Emphasis in the CEB reviews on close collaboration between the UN system and the World Bank Group country teams provided an extra impetus to improve efficiency and effectiveness.

The reviews also presented an opportunity to extract lessons. They included recognizing and identifying the interrelatedness of development goals, and the need for efficient resource allocation, strong government engagement, system-wide institutional coherence and collaboration, high-level system advocacy at the global level to steer actions, community mobilization as a critical element for acceleration and application of a multisectoral approach.

I. Rationale for the initiative

The Chief Executives of the United Nations tackled the problem of underachievement of the MDGs by asking fundamental questions: What stands in the way of reaching the MDGs at the country level? How can obstacles be removed? How can successful initiatives be scaled up? How can we accelerate progress? What incentive mechanisms can foster cross-cutting collaboration among government entities, the UN system

and broader development partners to build systems that are resilient and sustainable? How can the multilateral system better support countries? How can we foster joint collaboration and programming within the UN system?

At the November 2012 meeting of the CEB, the World Bank Group President proposed that MDG progress be reviewed, and the MAF used to bring bottlenecks and challenges to the level of heads of agencies, thereby focusing their attention on some key countries that are lagging behind. The CEB MDG acceleration reviews—championed by the World Bank and UNDP—became a semi-annual exercise, seeking to generate agreement around a road map that:

- I. Highlighted prevalent bottlenecks to MDG progress, and the potential for joint action to overcome them; and
- II. Defined concrete actions by individual CEB agencies to align their own efforts around country action plans considered at each review.

The CEB initiative brought together the broadest possible spectrum of organizations. Carrying out this initiative at the highest possible level of the UN system sent a strong signal of commitment to shared objectives and facilitated collaboration. Although only a limited number of countries were accommodated at each review, the reviews in general illustrated constraints and solutions. They encouraged sharing of these insights across countries as well as additional actions based on coherent policy support and better alignment with national plans.

⁷ The UN System Chief Executives Board for Coordination is the longest standing, highest level coordination forum of the United Nations system, composed of the Executive Heads of the United Nations Secretariat, its specialized agencies, the Bretton Woods institutions, the UN funds and programmes, and related organizations. Under the chairmanship of the UN Secretary-General, the CEB promotes effective coordination and coherence of policies and actions on a wide range of programmatic, operational and management issues. For more information, please see www.unsceb.org.

BOX4: RATIONALE FOR USING THE MDG ACCELERATION FRAMEWORK

The MDG Acceleration Framework (MAF) provided a response to clear requests from individual governments to accelerate MDG progress through an action plan specific to each national context and endorsed by governments. It helped the UN system provide an integrated response to sectoral problems, and focused on accelerating progress, identifying multisectoral solutions, supporting better policy coherence across the UN system and with the government, and improving UN system efficiency and effectiveness.

WHAT IS ACCELERATION?

Accelerating progress refers to increasing the rate of progress towards that target. This could come about in different ways, such as through additional investments in interventions proven to be effective, the removal of bottlenecks limiting the impact of otherwise effective interventions, additional interventions that take into account positive spillovers from accelerated progress on a related goal, or a combination any of these approaches. Acceleration assumes that a business-as-usual scenario will not yield the expected result, and it therefore calls for innovative solutions.

WHAT IS THE MAF?

In 2010, the CEB endorsed the MAF as a tool to help countries accelerate progress towards selected off-track MDGs. The MAF is now in use in over 60 countries, across regions and different levels of economic status.

It responds to a demonstrated political resolve to take concerted action on an MDG target that is likely to be missed.

The acceleration approach helps countries identify and prioritize bottlenecks to progress, and develop multipartner solutions through a collaborative, country-driven process. Solutions are reflected in country action plans implemented through joint efforts of the government and its partners. Action plans have been developed at both national and subnational levels, and, depending on country priorities, for different MDGs, encompassing hunger, rural poverty, maternal health, HIV/AIDS, access to water and others. The plans are nationally owned and based on existing policies and programmes. They help assemble robust partnerships among actors across sectors and mandates to carry out specific activities intended to accelerate progress. At the country level, UN and World Bank country teams, bilateral and multilateral organizations, non-governmental organizations (NGOs), academia and other relevant stakeholders typically support the government in developing and implementing the plans.

Experience has underscored the need for sustained, longer term engagement over the implementation phase. Advocacy and communication—at global, regional and national levels—are critical. They bring in new partners, help maintain interest and build momentum, and link strategically to broader initiatives.

Countries reviewed

Sixteen countries from across the world and the subregion of the Pacific Island countries took part in the CEB reviews, addressing several different MDGs. Countries were selected on the basis of readiness and interest in participating, the existence of a MAF action plan, clear government buy-in, sound UN and World Bank collaboration on the ground, and coverage of all geographical regions and country typologies.

Another important consideration was the ability of each country case to illustrate broader issues applicable to a range of countries, and important to accelerate MDG progress and sustain results.

CEB MDG ACCELERATION REVIEWS

	COUNTRIES	MDG-RELATED FOCUS
FIRST REVIEW (April 2013)	Republic of Ghana*	MDG 5: Accelerating progress towards maternal mortality reduction
	Republic of the Niger*	MDG 1: Accelerating progress towards reducing hunger and poverty
	United Republic of Tanzania*	MDG 1: Accelerating progress towards reducing hunger and poverty
SECOND REVIEW (November 2013)	Burkina Faso	MDG 1: Accelerating MDG 1 by improving food security and nutrition
	Republic of El Salvador*	MDG 5: Accelerating progress towards reducing maternal and neonatal mortality
	Republic of Indonesia*	MDG 5: Accelerating progress towards improving maternal health in Central Java and the potential use of this approach in other provinces of Indonesia
	Kyrgyz Republic*	MDG 5: Action plan to accelerate progress towards improving maternal health
	Federal Democratic Republic of Nepal*	MDG 7: Accelerating progress towards reaching universal sanitation coverage
THIRD REVIEW (May 2014)	Republic of Benin*	MDG 7: Accelerating access to safe drinking water and basic sanitation
	Republic of Colombia*	MDG 1: Accelerating MDG 1 achievement in a conflict-affected country (through a focus on backward regions and internally displaced people)
	Republic of the Philippines*	MDG 5: Accelerating progress towards improving maternal health (while building resilience to manmade and natural disasters)
FOURTH REVIEW (November 2014)	Lao People's Democratic Republic	MDG 1: Accelerating progress towards improved nutrition for women and children
	Islamic Republic of Pakistan*	MDG 2: Accelerating progress towards quality universal primary education (with a special focus on girls' education)
	Republic of Yemen*	MDG 1: Employment for youth and women, and improving rural livelihoods in fragile and conflict situations
FIFTH REVIEW (April 2015)	People's Republic of Bangladesh*	MDG 6: Accelerate progress towards reducing the incidence and prevalence of, and mortality from, tuberculosis
	Democratic Republic of the Congo*	MDG 6: Accelerating progress towards combating HIV/AIDS and malaria
	Pacific Island countries	MDG 5: Accelerating progress and sustaining results in reducing the incidence and prevalence of, and mortality due to, non-communicable diseases

Note: Hereinafter, *countries in this report will be referred to as Ghana, Niger, Tanzania, El Salvador, Indonesia, Kyrgyzstan, Nepal, Benin, Colombia, the Philippines, Pakistan, Yemen, Bangladesh, and DR Congo.

II. Observations and lessons learned from the CEB MDG acceleration reviews: 10 key takeaways

A great body of knowledge across the MDGs and country typologies was accumulated over the course of the five CEB MDG acceleration reviews.

This knowledge should inform UN system preparations for supporting the 2030 Agenda.

At each review meeting, UN Resident Coordinators and World Bank Group Country Directors provided details on country contexts, identified critical bottlenecks to the attainment of relevant MDG targets, and presented concrete, actionable opportunities to accelerate progress.

The reviews were useful in identifying recurrent bottlenecks that impeded progress towards the MDGs, such as low public spending on social services, insufficient and poor quality data, poor quality services

and inadequate demand for services, lack of coordination, lack of political commitment, poor implementation capacity, entrenched exclusion, conflict, natural disasters and disregard for human rights. A number of recurring themes also emerged, including the need to tackle inequality, boost resilience, promote human rights and women's empowerment, increase the focus on migration, promote the rule of law and institutions, facilitate the transition from humanitarian assistance to development, and enable cross-sectoral collaboration.

Commitments adopted by the UN system for each country underscore the potential to:

- Significantly scale up support for acceleration in identified countries;
- Promote greater alignment of agency programmes—including of non-resident agencies—around identified priorities;
- Encourage the support of actors from outside a specific sector to address bottlenecks to progress in a specific MDG;
- Facilitate cross-country knowledge-sharing in relevant areas; and
- Enable the identification of commonly occurring bottlenecks across countries, leading to opportunities for replicating solutions.

Country ownership and leadership in any CEB review process have been fundamental to generating the greatest impact. All CEB review countries reported greater focus on the MDG in question and strengthened engagement with national partners. Feedback from the UN Resident Coordinators and World Bank Country Directors indicates both concrete and less tangible but important gains, as well as areas where further improvements were made possible. This facilitated, in many cases the identification of bottlenecks, and, where possible, targeted action to reduce them. For example, joint advocacy guided by alternative policy options is underway in **Indonesia** to address national health budget allocations that are inadequate compared with those in other countries in the region with a similar development context.

The initiative has enhanced collaboration between the UN and World Bank country teams, under the leadership of the UN Resident Coordinators and World Bank Country Directors. Close working

relationships have led to improved interventions. For example, in **Tanzania**, the conditional cash transfer programme was augmented by considering nutrition interventions before scaling up. In **Nepal**, mapping partner activities helped to better identify gaps and what needs to be done to fill them.

The CEB initiative helped identify opportunities for non-resident agencies to make further contributions to the MDGs, including through using meteorological data to improve decision-making by farmers (e.g. World Meteorological Organization), and applying modern biotechnology and better soil fertility management to assist farmers in increasing productivity and incomes (e.g. International Atomic Energy Agency). Non-resident agencies working in tandem with those with a presence in the country remains a potentially powerful way to further leverage gains.

Here are 10 key lessons drawn from the CEB MDG acceleration exercise:

MDG ACCELERATION

I. Acceleration can happen, but it depends on the timeliness and effectiveness of policy instruments

The odds of achieving the MDGs are greatly improved where there is sustained economic growth that is inclusive and pro-poor; effective institutions foster peace and stability; and good policies promote inclusion, reduce inequality, boost sustainability and build resilience.

Through the identification of bottlenecks to relevant MDG targets and the pursuit of concrete and actionable opportunities to accelerate progress, the CEB MDG acceleration exercise highlighted that some policy instruments are more effective in the short run than others. Actionable solutions affect MDG progress directly, usually by scaling up an effective existing programme. In the case of **Tanzania**, for example, where the Government, in collaboration with the United Nations and the World Bank Group, decided to rapidly expand the coverage of the social safety net programme from of 20,000 to 1.1 million extremely poor households and those most vulnerable to extreme poverty. As a result, it reduced extreme poverty by half. Similar programmes were scaled up in **Burkina Faso** to reach an additional 40,000 poor households.

Other solutions to bottlenecks show their impact in the medium term. These often entail implementing policies and building institutions that specifically aim to accelerate the MDG in question, and typically rest on improved coordination between the UN system and the government, capacity-building, data collection and investments in infrastructure. In the **Lao People's Democratic Republic**, strengthened coordination among development partners facilitated integrated, scaled up support to the Government that backed a comprehensive package of interventions to reduce chronic malnutrition.

II. High-impact programmes depend on the efficient allocation of resources

The quality of public expenditures plays an important role in MDG acceleration. Public expenditure is most effective when targeted to alleviating bottlenecks directly linked to the targeted MDG, and when related projects are efficiently executed. There have been cases discussed at the CEB where inadequate policies and weak institutions proved to be the bottleneck, constraining the impact of resources spent. Reforms were necessary to improve the quality of spending and achieve desired progress.

In **Pakistan**, for example, MDG2 (achieving universal primary education) is a top priority, but poor-quality expenditures led to weak outcomes, leaving the country with the second-largest number of out of school children in the world. Acceleration efforts focused on improving governance and accountability through merit and need-based teacher recruitment and deployment policies, need-based school-specific budgeting, independent monitoring systems, and the revitalization of the roles and responsibilities of school councils. In the **Pacific Island countries**, a regional trust fund to catalyse action on the causes and symptoms of non-communicable diseases has the potential to boost country actions by mobilizing needed resources.

The CEB reviews also identified how the inadequate prioritization of certain MDGs in the budgeting process created a continued deficit in implementation, especially where MDG targets were heavily dependent on external resources. Most notable is investment in access to sanitation compared to water access, as seen from the experiences in **Nepal** and **Benin**. The CEB review of these countries aimed to identify areas for broader UN system support to complement government actions.

III. Recognizing and identifying the interrelatedness of development goals at the onset is fundamental

While the MDGs were expressed as sector-specific goals, they could not have been achieved in sectoral silos. For example, well-designed social protection programmes can help households achieve goals in different areas—health, education and nutrition. Likewise, the education of girls, security and human rights are essential to improve maternal and child health outcomes.

Although some countries put in place integrated plans for achieving the MDGs, the lack of integration among the goals themselves was a key limitation. That said, there are also several understandings of what integration means, why it matters and how it can be achieved. Integration can mean recognizing that progress on one MDG target can have a positive impact on another, or that interventions in certain sectors can have a multiplying impact on other sectors. Another perspective involves leveraging the interconnectedness of the MDGs to support acceleration of several goals.

In **El Salvador**, the MAF emphasized a coordinated multisectoral approach to maternal mortality. Security concerns hampered the ability of women and girls to access health centres, so the Government worked with a number of agencies to improve it. In **Bangladesh**, rapid urbanization proved to be a major bottleneck to addressing the spread of tuberculosis, necessitating a focus on managing cities to contain the disease, especially in slums and informal settlements.

Current MDG monitoring and reporting mechanisms did not recognize these forms of interrelatedness. As such, they did not capture correlations across MDG targets, whether positive or negative, and thus detracted from efforts to find solutions where impacts cut across multiple sectors.

IV. Strong government involvement ensures the greatest impact of MDG-related interventions

Countries participating in the CEB reviews needed to demonstrate clear government buy-in and commitment to addressing challenges to meeting a specific MDG. Governments are ultimately responsible for their own development, and their ownership ensures that efforts to achieve desired outcomes will have the support of policies and institutions, and the means of implementation.

Several country teams directly engaged government counterparts in various steps of the review process to ensure that the final outcome was aligned with national development priorities. In **Benin**, the Government established a ministry to take charge of MDG acceleration efforts and cross-sectoral actions, bringing different line ministries together. The MAF in Benin was chaired by the Prime Minister himself, giving it a very high political profile, while the CEB review helped generate additional impetus for implementation and galvanize partnerships. In **Pakistan**, a country with a decentralized governance structure, the MAF facilitated the coming together of provincial governors and heads of provincial departments of education to define subnational acceleration plans that informed the CEB review.

V. Lack of quality data and analysis poses a serious constraint to timely monitoring, policy development and the ability to target interventions where most needed

Massive data gaps are among the most pressing challenges confronted by many developing countries. Data generation requires capacity-building and infrastructure, which many countries have not been able to invest in. Twenty-nine countries have been identified as having no poverty data from 2002 to 2011. Twenty-eight other countries only had one survey during that entire period. This has proven a major challenge in making progress on the MDGs, both to monitor progress, and design accurate policies and programmes to meet targets. Traditional data sources are very important, but so are new opportunities presented by technology.

A 'data revolution' is part of the global push to use new technology and open data to revolutionize the ability of countries to collect data. It means working in different ways, putting different groups together across the public and private sectors, and being innovative in leveraging technology for development data. A central database for collection of data on food and nutrition security is being developed in **Lao People's Democratic Republic**, accompanied by measures to assure data quality accuracy and availability of data to inform decision-making and programming. In **Tanzania**, an innovative poverty mapping tool using GIS data is improving the geographical identification of the poorest villages, which are beneficiaries of the country's social protection scheme. A full and rigorous impact evaluation has been launched to provide additional information on targeting and programme results. In **Burkina Faso**, the World Bank Group and the United Nations provided a US \$750,000 grant to the National

Institute of Statistics to undertake a comprehensive national household survey, accompanied by technical assistance to strengthen monitoring and evaluation capacities within the Ministry of Economy and Finance.

In **Ghana**, the World Bank, in collaboration with the UN system and other partners, is supporting the Government to operationalize an Integrated eHealth System to reach underserved communities in the country. The process has involved developing a strategic plan for the system, establishing medical call centres, setting up wireless networks for selected district and regional health centres, and digitizing medical records in selected teaching hospitals and health centres. In **Indonesia**, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and partners are working with civil society and the private sector on the development of iMonitor – a mobile phone technology that enables people living with HIV, and other vulnerable groups, to share information about access to HIV prevention and treatment, and the quality of those services. It also allows users to report stock-outs of antiretroviral medicine and other HIV commodities, as well as rights violations in HIV service delivery and other settings. This technology has been adopted by a number of other countries within the CEB reviews.

UN SYSTEM PERFORMANCE

VI. Promoting system-wide institutional coherence in the United Nations is critical for integrated policy support and accelerated progress

The UN system has gathered a substantial body of knowledge and experience through its efforts to help countries—often in very different circumstances—achieve the MDGs. Some agencies whose mandates were closely tied to individual MDG goals and targets found it easy to connect; while others found it more challenging to identify clear entry points. Combined with a lack of incentives for longer-term inter-agency collaboration, this contributed to a 'working-in-silos' approach.

There is a strong recognition within the UN system that an integrated approach would significantly reduce fragmentation, duplication and lack of coherence. Various country teams participating in the CEB reviews proposed mapping their interventions to promote convergence within the UN system, as a step towards more focused support, the elimination of fragmentation and duplication, and the scaling up of interventions and development results.

In **Lao People's Democratic Republic**, the UN system, the World Bank and the Asian Development Bank conducted a systematic mapping of agency interventions on food and nutrition security. They have pushed for a convergence approach to programming—covering government targets on nutrition and priority geographical areas as well as UN sectoral and relevant cross-sectoral interventions—to improve alignment of actions. This has galvanized major bilateral development partners and civil society to also agree on an integrated approach. A task team, with the endorsement of the Government, is linking interventions and financial allocations from agencies to the national Multisector Food and Nutrition Security Action Plan. The Government has also proposed developing a country dashboard with clear target commitments by the UN system and intermediate indicators to measure progress.

A comprehensive mapping of sanitation services in **Nepal** defined geographical areas for better targeting of UN interventions in underserved regions. In **Kyrgyzstan**, UN agencies and the World Bank are using the MDG Coordination Council and the Development Partners Coordination Council as forums to draw attention at the Prime Minister's level to priorities for intersectoral cooperation and additional funding. An integrated approach to improving health services, nutrition and the protection of women, in the context of improved public sector management, has been effective in reducing maternal and neonatal deaths in **El Salvador**.

Overall, coordination among UN system entities improved sharply in the participating CEB countries. The CEB reviews helped organizations intensify their collaboration in a specific area; share information on ongoing programmes, available expertise and resources; reach common understanding on the scope of a challenge and possible ways forward; and demonstrate high-level political commitment. This process resulted in increased policy coherence and integrated policy advice at the country, regional and global levels. The CEB initiative also helped identify opportunities for non-resident agencies to make further contributions to the MDGs.

While these results are impressive, there may be a longer term challenge in maintaining such collaboration, both on the ground and at headquarters, particularly in facilitating a smooth transition to the

SDGs. Generating the right incentives for UN system-wide coherence is a complex issue that will require a concerted effort to define concrete mechanisms for better collaboration.

A high-level compact among UN Development Group Principals could be encourage collaboration at country level, including through specific benchmarks on common programming for the SDGs. Pooled funds could increase alignment among a wide range of agencies and improve aid effectiveness. These can act as vehicles for host country, private sector and individual giving, and help manage risks.

Collaborative efforts for joint planning, budgeting, results reporting and accountability are critical for cross-cutting collaboration and the promotion of greater effectiveness and efficiency, building on the joint programme model and other UN reform initiatives, including 'Delivering as One'. Seven countries participating in the CEB reviews are 'Delivering as One' countries: Benin (2010), Ghana (2012), Indonesia (2009), Kyrgyzstan (2009), Lao People's Democratic Republic (2010), Pakistan (2006) and Tanzania (2006).⁸

Moving forward, country teams should also explore institutionalizing a periodic meeting of high-level managers, such as UN Resident Coordinators, Resident Representatives and World Bank Country Directors, to review bottlenecks to SDG progress and decide on areas for joint collaboration.

VII. High-level global UN system advocacy can energize acceleration in countries

Advocacy by the UN system and the WBG at the highest levels provides a political push for accelerating efforts at the country level. Such high-level attention has resulted in more effective promotion of key policy and programme issues with national governments. For example, the UN system is delivering focused messages on maternal health in **El Salvador** and **Kyrgyzstan**. In **Pacific Island countries**, the World Bank and the UN system have convened different policy makers to discuss an epidemic of non-communicable diseases. At its Annual Meeting in Lima, Peru, the World Bank brought together senior policy makers from around the region to seek solutions to the non-communicable diseases crisis.

⁸ El Salvador only became a 'Delivering as One' country in 2014, after it participated in the 2013 CEB review. As of November 2015, 52 countries have requested that the UN development system adopt the 'Delivering as One' approach, which aims to capitalize on the strengths and comparative advantages of different UN organizations. Countries adopting it are experimenting with ways to increase the UN system's impact through more coherent programmes, reduced transaction costs for governments and lower overhead costs for the UN system. See a complete list of 'Delivering as One' countries at https://undg.org/wp-content/uploads/2014/11/Delivering-as-One-countries_Nov-2015.pdf.

Advocating for progress at the national level is critical, but not sufficient. Efforts at the regional level can take up sensitive and cross-boundary issues, and pool resources and build synergies across initiatives to increase coherence and cost-effectiveness. In the **Pacific Island countries**, most solutions proposed at the CEB were at the political advocacy level, as actions at the regional level, including across neighbouring countries, mobilize necessary traction on issues of national importance.

VIII. Communities and community mobilization are central to achieving development results

Common recurrent bottlenecks across CEB review countries include the inability to scale up interventions to cover all targeted populations, poor quality of services delivered and inadequate demand for services. In all review countries, there was a strong recognition of the centrality of communities and community mobilization in tackling these bottlenecks.

The CEB reviews exposed the need for the UN system to operate in a decentralized environment. Acceleration often requires interventions at subnational levels, particularly in countries with decentralized governance structures (e.g., Colombia, Indonesia, Pakistan and the Philippines). The UN system should work closely with civil society and local communities as key service delivery partners.

Many CEB countries have invested in measures to create demand for and enhance use of services. These efforts often involve engaging civil society and local communities. In the **Democratic Republic of the Congo**, stronger community engagement is helping boost preventive and remedial treatments and behavioural changes to reduce the prevalence of HIV/AIDS and malaria. Community-led education on nutritional practices and the use of local food products will further help to improve the situation of people living with HIV. UN agencies and the World Bank Group are committed to documenting various community approaches across the country, and to developing a joint strategy to achieve greater community involvement. Investments to build the capacities of civil society organizations and local communities, particularly young people can ensure durable results.

In the **Pacific Island countries**, a small grants component to finance community initiatives to fight non-communicable diseases is an integral part of a proposed regional catalyst trust fund. Lessons learned from

the multisectoral response to AIDS and UNAIDS are strengthening multisectoral responses to non-communicable diseases. Many other programmatic lessons can be shared and common approaches developed, particularly with regard to community mobilization and building civil society networks, and their inclusion in decision-making and accountability processes.

Bangladesh's attention to health outcomes, elementary education, family planning and gender equality, especially in education and workforce participation, was often a result of a good community network of health providers supported by the Government, the UN system and NGOs. In **Pakistan**, community management models, emphasized in Balochistan and Khyber Pakhtunkhwa's provincial education sector plans, offer a low-cost solution to addressing resource constraints, along with other demand and supply-side bottlenecks in conflict-affected areas. Examples are community-based schools and Parent Teacher School Management Committees that provide local transport with the help of community contributions. These models have been tested successfully but have yet to be scaled up.

In **El Salvador, Ghana, Indonesia, Kyrgyzstan** and the **Philippines**, community engagement has proved key in tackling gender inequalities and other social and cultural issues, especially linked to reproductive health care. These countries have set up community-based delivery facilities with a village midwife or private midwife facilities. Strengthening community-driven sanitation programmes increased access to sanitation in **Benin** and **Nepal**.

In transitioning from the MDGs to the SDGs, if the UN system is to help countries ensure that no one is left behind, robust models of engagement with local communities and civil society will be required.

IX. Achieving long-term development requires bridging the humanitarian and development agendas

Today, half of the world's people in extreme poverty live in fragile and conflict-affected countries. While the vast majority of non-fragile countries have enjoyed significant improvements in their Human Development Index rankings since the adoption of the MDGs, the scores in fragile states have changed little. Conflict, violence and vulnerability to manmade and natural disasters were major drivers in stalling or reversing MDG progress.

Most of the global MDG deficit persists in fragile states, responsible for 77 percent of school age children not in primary school, 70 percent of infant deaths, 65 percent of people without safe water and 60 percent of undernourished people.⁹

There has been a long-standing need to bridge humanitarian and development agendas within one coherent policy of engagement. This requires a fundamental shift in existing concepts and principles, goals and functions, programme approaches and practical questions about what works.

Several CEB review countries have focused on measures to build resilience, which have brought together humanitarian and development agencies.

Burkina Faso and **Niger** addressed vulnerability to food insecurity, **Yemen** sought to increase employment and livelihood opportunities for youth and women, the **Philippines** tackled maternal mortality during natural disasters, and **Colombia** focused on poverty reduction measures for internally displaced persons (IDPs).

In **Yemen**, as in many fragile and conflict-affected countries, private sector development is indispensable for inclusive growth and employment, yet extremely challenging. The UN system and World Bank Group need to be innovative to work effectively with the private sector, and help improve the business environment, ensure that skills training leads to jobs, create and exploit value chain strategies, and pursue systematic approaches to job creation among Yemen's diaspora and migrant populations, in cooperation with other countries. Since systematic exclusion, marginalization and impoverishment have led to extreme inequalities, conflict and radicalization, the UN system and World Bank Group also support local platforms and networks of marginalized groups for their inclusion in political and broader development processes.

In the **Philippines**, the UN system is engaged in mapping resource mobilization mechanisms to improve the resilience of the health-care system during disasters and emergencies, particularly with regard to immediate humanitarian responses and long-term rehabilitation.

IDPs comprise over 10 percent of **Colombia's** population, with an extreme poverty rate of 66.4 percent compared to 9.1 percent for the rest of the population. Through the CEB review, the UN system agreed to support

measures to accelerate reparations for victims, especially IDPs, and their rapid integration in the social safety net; the inclusion of vulnerable groups and areas through employment and entrepreneurship centres and services; protections for victims; and humanitarian demining to facilitate land restitution. The UN system pledged its commitment to the Government to support the Peace Accord and necessary steps for its implementation, facilitating a transition to sustainable development in conflict-affected areas.

The CEB reviews suggest that although there is scope in the immediate future to improve incentives for collaboration among humanitarian and development agencies at the country level, there is also a need to adopt a holistic perspective of development as a continuum. This encompasses both the immediate needs of people and long-term development measures. This is highly pertinent to the 2030 Agenda, which will require increased focus on the most vulnerable people.

X. Operating under a normative framework, the UN system needs to push for the inclusion of issues that may have been deprioritized at the country level

The UN system's leadership role in normative work remains one of its strongest comparative advantages. UN Member States have agreed on universal norms and standards on peace and security, economic and sociocultural development, human rights, the rule of law, health and environmental sustainability, and others, which the UN system is then mandated to advocate and uphold.

For the CEB reviews, some key areas of normative work entailed developing or updating norms and standards; supporting governments to integrate norms and standards into legislation, policies and development plans; assisting governments to implement legislation, policies and development plans based on international norms, standards and conventions;¹⁰ and using global political advocacy as a critical driver of change in domestic agendas. Over the past 15 years of MDG implementation, the UN system has pushed the threshold on issues that might otherwise have been overlooked at the country level.

The multilateral system can perform better, however, becoming 'fit for purpose' requires agencies to collaborate on high-level goals, to understand their complementary roles and to address weaknesses in

⁹ World Bank, 2011, *The World Development Report 2011: Conflict, Security and Development*.

¹⁰ Categories defined by the 2013 UNEG Handbook for Conducting Evaluations of Normative Work in the UN System, prepared by the UN Evaluation Group.

coordination. The CEB reviews have brought to attention lesser known programmes worthy of scale-up, a deeper appreciation of the roles and capabilities of the many institutions in the UN system, and a sense of the value of the United Nations' normative role.

Having common results and reflecting them in monitoring and evaluation systems helped CEB countries ensure that collaboration was sustained at the country level. **Burkina Faso** provides a good example. The monitoring mechanism put together for the development strategy included the Council of Ministers, the National Committee Management chaired by the Prime Minister, 15 sectoral groups for dialogue and 13 regional cooperation groups. The **Philippines** measured government performance through a scorecard and the UN system provided support to the government to address gaps identified by the scorecard.

Where progress has been slower than expected, the UN system and the World Bank have struggled with political commitment, implementation capacity, and long-standing issues of exclusion, social change, peace and security, and human rights. For example, in **El Salvador**, more work needs to be done on women's empowerment, and reducing gender-based violence and teen pregnancy. **Niger** needs to develop implementation capacities to deliver on its comprehensive Plan for Social and Economic Development. **Indonesia** needs to increase its public budget for health at national and sub-national levels.

Progress is also being made. The **Democratic Republic of the Congo** is building the capacities of civil society organizations, young people, members of Parliament and the justice sector on human rights and HIV/AIDS so that they can advocate for legislation to protect the rights of people living with HIV. This is aimed at reducing stigmatization and discrimination. In the **Philippines**, a database that tracks progress on women's rights is being developed to improve understanding of key issues and challenges to inform decision-making, to strengthen the capacity of the Regional Human Rights Commission to advocate and protect women's rights, and to advance gender-sensitive planning and awareness through public information and education.

Moving towards the 2030 Agenda, the UN system will need to apply a rights-based perspective on tackling inequalities and discrimination, and sustain a focus on leaving no one behind and eliminating extreme poverty. On the issue of the universality of the Agenda, the system will need to quickly define how it supports all UN Member States.

CONCLUSION: THE WAY FORWARD

The 2030 Agenda is recognized as a transformative, universal and integrated agenda. Implementation should not create 17 new silos around the SDGs. It is time to more systematically consider the 'how' of integration at the country level—how to draw on the comparative advantages of the UN system's diverse areas of expertise, how to work collaboratively and deliver together, and how to work on the continuum from the normative to the operational as a comprehensive and coherent UN effort.

The UN system will need to embrace strong ownership at the country level. It should continue its collaboration with existing partners, including philanthropic organizations, NGOs and civil society organizations cultivated during the MDG period. It should also expand and actively seek partnerships with the private sector, particularly in the areas of financing, data and implementation of the SDGs.

The CEB reviews showed that significant gains were possible when agencies came together to support an acceleration goal. Country teams improved the alignment and coherence of UN system activities on the ground, bridged sectoral silos while still valuing the specialized expertise of individual agencies, and more effectively advocated with governments and other partners. High-level coordination between UN country teams and World Bank country offices was repeatedly recognized as an accomplishment.

Three main conclusions clearly apply to the transition to the 2030 Agenda:

- Support cross-institutional collaboration between the UN system and the World Bank;
- Advance better understanding of cross-sectoral work, and the interrelatedness of goals and targets; and
- Promote global and high-level advocacy.

Support cross-institutional collaboration between the UN system and the World Bank

Recognizing that the SDGs require more integrated responses, the CEB is an adequate forum to promote institutional coherence across the UN system. A few lessons from the CEB MDG acceleration exercise could be considered not just by the UN system, but by many if not all development actors to make interventions more effective:

- Make sure that there is a mechanism in place that identifies recurrent common bottlenecks, especially those related to integrity, governance and the rule of law, that could provide guidance, through country case studies, on how best to integrate cross-cutting issues in attaining the SDGs. These are cross-cutting themes that do not fall neatly under any one institutional mandate, but can prevent the achievement of the SDGs.
- Define incentive mechanisms to foster cross-cutting collaboration. Coordination and alignment of system-wide and partner support could be reinforced through mechanisms such as round tables around cross-cutting issues with the participation of donors, NGOs and civil society, governments and the private sector. These could effectively connect the capacities and different forms of expertise of the UN system—including in non-resident agencies—to assist countries with planning, reporting and monitoring, financing and the overall implementation of the SDGs¹¹.
- Establish joint and pooled funding mechanisms, where relevant, to instill a culture of collaboration across the UN system. Such mechanisms can act as vehicles for host country, private sector and individual giving, and potentially help manage risks.

Advance a better understanding of cross-sectoral work and the interrelatedness of goals and targets

The CEB reviews were a forward looking initiative that strongly advocated cross-sectoral and cross-institutional thinking to tackle off-track MDG targets, with an implicit aim of drawing lessons for the SDGs. There is a shared understanding that investing in solutions within a sector was often not sufficient to meet a particular MDG target. The UN system could provide leadership on this issue through various initiatives. The following are a few examples that could encourage more collaboration across UN agencies and development partners:

- Provide knowledge products and monitoring systems that explicitly recognize interlinkages among and between policies, sectors, and horizontal and vertical dimensions of development. A dashboard to monitor the attainment of the SDGs could automatically identify and report on the interrelatedness of goals and their targets. Multisectoral

approaches and tools should be continuously developed to work with sectoral ones, and connect stakeholders for policy formulation and implementation, as done under the MAF.

- Discourage UN organizations from reorganizing along individual SDGs, so that a more holistic approach is applied to SDG implementation. The 2030 Agenda should be viewed by the UN system in its entirety, with an appreciation that implementation requires an integrated approach that capitalizes on the diversity and specialized strengths of individual entities.
- Support platforms for effective engagement at country level to assist governments and other stakeholders in better understanding the interrelatedness of goals and targets.

Promote global and high-level advocacy

High-level attention to specific issues encourages action at global and country levels.¹² Recognizing the value of advocating and communicating links among different issues and results achieved by the UN system on MDG acceleration, it will be important to consider the following:

- Advocate for the sequencing of development issues that require action today to accrue results in the medium and long term critical to meeting the SDGs. These may include climate change, investments in early childhood development, and the planning of sustainable and resilient cities, among others.
- Collectively advocate that UN Member States address recurrent common bottlenecks that could prevent the achievement of the SDGs, such as fragility and conflict.
- Advocate interrelated SDG issues rather than single goals. Identify issues of global relevance that merit strategic and political engagement, and have the highest levels of the UN system conduct dedicated advocacy to achieve better results on the ground.
- Mobilize political support among UN Member States for increased national budget allocations on social services, and demonstrate how services can be extended to the hardest-to-reach individuals and social groups.

¹¹ For instance, the MAF action plans do not exist in isolation, but as a part of UN development assistance frameworks (UNDAFs) or their equivalent at the country level. As such, monitoring and evaluation for results should continue within that strategic framework, with continued accountability to national governments and others should continue within that strategic framework, with continued accountability to national governments and other stakeholders.

¹² Global issues will still require country-specific solutions and actions tackled by respective country teams.

CHAPTER 1

ACCELERATING PROGRESS TO REDUCE POVERTY AND ELIMINATE HUNGER



From 1990 until 2015, extreme poverty was defined as living below US \$1.25¹³ a day in 2005 purchasing power parity (PPP). The MDG target was to halve the proportion of people living in extreme poverty; this target was met in 2010. MDG 1 also aimed to halve the rates of hunger and malnutrition by 2015, with a particular focus on children under the age of five.

The proportion of people living in extreme poverty fell from 36.4 percent in 1990 to 14.5 percent in 2011 to 11.5 percent in 2015,¹⁴ a drop of more than two-thirds from the baseline. The global achievement of the poverty target was greatly supported by the strong performance of China and India, the countries with the largest populations and numbers of extremely poor people in 1990. China's extreme poverty rate declined from 60.7 percent in 1990 to 6.3 percent in 2011, and India more than halved its rate, from 51.4 percent in 1990 to 24.7 percent in 2011.

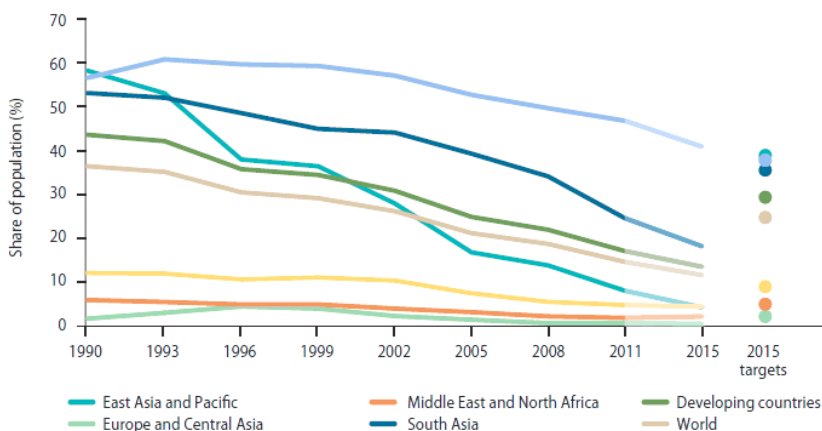
At the regional level, results have been varied. The East Asia and the Pacific region saw the fastest rate of poverty reduction, with extreme poverty falling from 58.2 percent in 1990 to a projected 4.1 percent in 2015. Europe

and Central Asia, Latin America and the Caribbean, and the Middle East and North Africa halved their rates of extreme poverty by 2010, and South Asia by 2011. Sub-Saharan Africa did not meet the 2015 target. There was less progress in reducing the absolute number of poor people, especially in regions and countries with rapid population growth. In sub-Saharan Africa, the number of people living in extreme poverty increased from 290 million in 1990 to a projected 403 million in 2015.

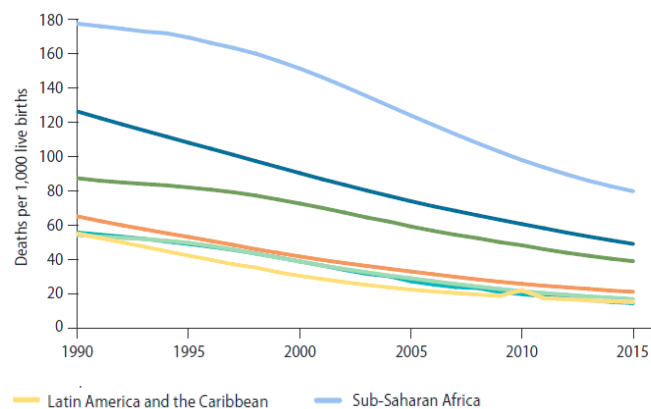
Nearly half of the world's 145 developing countries achieved the poverty target. However, 27 countries were seriously off track, meaning that at the current pace of progress, they will not be able to halve their 1990 extreme poverty rates by 2030. Twenty-one of these countries are in sub-Saharan Africa.

The prevalence of malnutrition among children under the age of five in developing countries dropped from 25 percent in 1990 to 16 percent in 2014. Developing countries, and in particular South Asia and sub-Saharan Africa, have not met the target. The increase in the under-population in sub-Saharan Africa — which rose by almost 75 percent between 1990 and 2014 — made meeting the target there difficult.

SHARE OF PEOPLE LIVING ON LESS THAN \$1.25 A DAY, BY REGION, 1990–2015



PERCENTAGE OF CHILDREN UNDER FIVE WHO ARE UNDERWEIGHT, BY REGION, 1990–2015



Source: World Bank, 2015. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change.

¹³ Extreme poverty is now defined as living under US \$1.90 a day.

¹⁴ 2015 rates are forecasts and based on the 2014–2015 *Global Monitoring Report*.

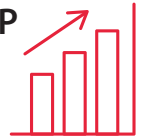
COLOMBIA

Accelerating MDG-1 Achievement in a Conflict-affected Country by Focusing on Backward Regions and Internally Displaced People

CONTEXT

- Colombia is a middle-income country and is on course to achieving the MDG1, but it still faces high levels of poverty, inequality and unemployment because of wide disparities across regions and population groups due to its long lasting conflict.
- Target indicators of MDG1 show favorable trends in recent years. Rapid economic growth during the last decade, particularly the last five years, when annual GDP growth averaged 3.8% has led to significant reductions in poverty rates.
- In 2015, 27.8% of the Colombian population lived under the national poverty line, and 7.9% under the extreme poverty line of \$1.25/day – totaling 13 million and 3.7 million people respectively. In 2002, these indicators were 49.7% and 17.7%, which means that almost 7 million are no longer living in poverty and another 3.4 million are no longer living in extreme poverty.
- These average trends hide wide disparities across regions and population groups.

AVERAGE ANNUAL GDP GROWTH 2010-2015
3.8%



POVERTY RATES
2002 2015
49.7% **27.8%**

EXTREME POVERTY
2002 2015
17.7% **7.9%**



BOTTLENECKS

SOLUTIONS/EFFORTS

Poor infrastructure development in lagging regions.



Construction of rural reservoirs that decreased the time spent by the indigenous Wajuu communities in fetching water, from 5 hours to 54 minutes, allowing more time for income generating activities such as livestock raising, agriculture, fishing and the production of handcrafts as well as schooling for children. For the first time, the capital of Rio Hacha has continuous running water., rural roads, among others.

Historical and socio-economic gaps across regions and groups, which often exacerbated by armed conflicts.



Acceleration of cadaster-registry and statistical/administrative information sources about disadvantaged groups and local areas, as indispensable tools to support important activities intricately related to the land restitution process, including formalization, regularization, redistribution, property taxation and effective management and use.

Lack of socio-economic stability of internally displaced persons (IDPs).



Cash for Work strategy to generate temporal employments in conflict areas of the country through the construction of storage centers, irrigation systems, hanging bridges, rural roads, among others.

Lack of integrity and effective supporting schemes in delivering services and allocating in-kind contributions.



Universalization of the opportunities for the productive inclusion of low-income groups and internally displaced persons (IDPs).

INTRODUCTION

Colombia is a middle-income country and achieved MDG 1, but it still faces high levels of poverty, inequality and unemployment because of wide disparities across regions and population groups. Gaps partly reflect Colombia's decades-long internal conflict, which created poverty traps, particularly in rural areas, where economic participation has proven to be a challenge, and public goods have been difficult to deliver. The peace talks concluded in August 2016 between the Government of Colombia and the FARC guerillas represent a tremendous opportunity to accelerate the achievement of the MDGs and their successor SDGs. Achievement in turn will support a sustainable peace by reducing deprivations and enhancing basic services in the least developed regions, the main areas of the armed conflict. Implementation of the SDGs presents a challenge and an opportunity for consolidating peace.

SITUATION ANALYSIS

The target indicators of MDG 1 show favourable trends in recent years. Rapid economic growth during the last decade, particularly for the last five years, when average GDP growth was 3.8 percent, has led to significant reductions in poverty rates. In 2015, 27.8 percent of the Colombian population lived under the national poverty line, and 7.9 percent under the extreme poverty line of US \$1.25 per day¹⁵ — totaling 13 million and 3.7 million people, respectively. In 2002, these indicators were 49.7 percent and 17.7 percent, respectively, which means that almost 7 million and 3.4 million people are no longer in poverty and extreme poverty. Colombia reached its MDG target on income poverty—28.5 percent with respect to the national poverty line and 8.8 percent with respect to the extreme poverty line—in 2014.¹⁶

Rates of unemployment and informal employment declined during the last decade. The national unemployment rate fell from 15.0 percent in

2001 to 8.9 percent in 2015, the lowest level in the last decade.

The informality rate declined only slightly, from 51 percent to 48 percent of urban employment between 2008 and 2015.¹⁷ The percentage of underweight newborns, an indicator of hunger within MDG 1, increased from 7.4 percent to 8.9 percent between 2001 and 2013. Although still below the country's 2015 target of 10 percent, its recent increase, associated with a rise in teenage pregnancies, requires attention.¹⁸

These average trends, however, hide wide disparities across regions and population groups, with the country's long history of internal armed conflict playing a significant role. While moderate poverty at the national level declined, relative differences at the department (provincial) level have become more pronounced. In 2002, the difference between the departments with the highest (Huila) and the smallest (Bogota D.C.) poverty rates was 37.8 percent, whereas in 2015, the difference between the departments with the highest (Choco) and the lowest (Bogota D.C.) poverty rates was about 52.4 percent. Evidence shows that the gap between the richer and poorer departments is still wide. Unemployment rates also show regional heterogeneity, ranging from less than 7 percent in Córdoba, Boyacá and Santander to rates of 12 percent and more in Quindío and Norte de Santander in 2015.

Even within departments, there are large differences across rural and urban areas. In 2015, the rural poverty rate was 40.3 percent, while the average figure across the 13 main cities was 15.4 percent. Differences are even more pronounced when using the extreme poverty rate—18 percent in rural areas, more than six times the 2.7 percent for the 13 cities.

The 6 million people internally displaced by the conflict are one of the most disadvantaged groups in Colombia.¹⁹ In 2010, 97 percent of them were classified as poor IDPs²⁰ also have high rates of illiteracy (14.9 percent), low levels of educational attainment (4.6 years of schooling),

¹⁵ The official moderate national poverty and extreme poverty lines have values of approximately US \$4.06 PPP (2005) and US \$1.83 PPP (2005 per capita per day, respectively). This report uses official poverty numbers by the Departamento Administrativo Nacional de Estadística of Colombia. For a report about the development process of the poverty numbers in Colombia, see J. P. Azevedo, 2013, "From noise to signal: the successful turnaround of poverty measurement in Colombia," Knowledge notes, Economic premise, no. 117, Washington, DC, World Bank.

¹⁶ UNDP, 2015, *Objetivos de Desarrollo del Milenio*, Colombia, p. 15.

¹⁷ The informality rate is the percentage of the employed who are non-professional self-employed people, non-remunerated family workers or salaried workers in firms of less than five employees. DANE, 2014, *Gran Encuesta Integrada de Hogares, Anexo*, Febrero.

¹⁸ UNDP, 2015, *Objetivos de Desarrollo del Milenio*, Colombia, pp. 16 and 18.

¹⁹ Commission to Monitor Public Policy on IDPs, 2010, *Third report of verification of the fulfillment of rights of the displaced population*.

²⁰ Statistics on IDPs are contentious. By 2012, the NGO CODHES estimated their number at 5,7 million while the Government has registered over 4,7 million since 1985, the date established by law for recognizing a person as a victim.

high rates of school dropout, and high rates of infant mortality and hunger.²¹ Seven percent do not have regular access to food, and only 15 percent of those aged 0 to 17 have access to food programmes. These figures show variation across departments, but with scant progress between 2008 and 2010, and little is known about their evolution since.²²

Other population groups—indigenous people, afro-descendants and women—also face significant barriers to satisfying basic needs and inclusion in labour markets. Ethnic minorities face high levels of deprivation—indigenous households have both the highest rate of multidimensional poverty (58 percent in 2010) and the lowest reduction between 2003 and 2010.²³

Achieving the MDGs and implementing the SDGs, it is imperative to close the gaps that have persisted historically across regions and groups whose socioeconomic indicators lag considerably behind others, often exacerbated by armed conflict. There are significant challenges that require more attention and go beyond income generation alone. For example, women have, on average, more years of schooling, but still have a higher unemployment rate than men. They are also more likely than men to work informally, which often leads to greater job insecurity, lower income and no access to a pension. Low quality and weak coverage of health and other essential services, especially in rural areas and regions affected by conflict, have led to high levels of maternal mortality, unwanted pregnancies and infant mortality. The conflict involved attacks against medical missions, the diminished presence of state institutions and poorer governance, all of which hindered the achievement of the MDGs.

BOTTLENECK ANALYSIS

Reaching affected populations and lagging regions

Recognizing the situation of the population in poverty, and of IDPs in particular, the Government of Colombia set the goal of socioeconomic stabilization for IDPs,²⁴ which implied the restitution of their rights and the provision of preferential access to education, health, income

generation programmes, housing and land. The same year (2006) saw the creation of the Social Protection Network against Extreme Poverty (Red Juntos, now called Red Unidos), and the ‘bank of opportunities’ to expand financial services to low-income groups. In 2009, They are also more likely than men to work informally, generation policy for low-income and displaced populations, with the purpose of developing and improving the productive potential of low-income and displaced populations, taking advantage of their capacities by expanding their opportunities.

The coverage and effectiveness of the policy is limited compared to the size of the problem. A 2013 evaluation by the national Government found that: i) many programmes are executed in a fragmented way, without an integrated institutional approach; ii) there is no coherence between the income generation policy and complementary policies (e.g., macroeconomic, education, employment, foreign trade, industry and rural development); iii) there is weak management and coordination capacity between national-to-national, local-to-local and national-to-local institutions; iv) reporting mechanisms and adequate information management systems are not in place; and v) the execution of programmes through contractors prevents consolidation of lessons and feedback that could improve the effectiveness of the policy framework and understanding of the requirements of low-income groups and IDPs.

The main recommendation of the evaluation was to universalize opportunities for the productive inclusion of low-income groups and IDPs. This could be achieved through a more accurate targeting process, creating innovative and effective supporting schemes, delivering integral services according to the productive environment and allocating cash and in-kind contributions to those interventions having greater impact.

Application of the MAF in 2010 at the subnational levels has helped deliver against this recommendation. This exercise was led at the national level by the National Planning Department, the Department for Social Prosperity and the National Agency for Overcoming Extreme Poverty, and at the subnational level by mayors’ offices working closely with trade associations

²¹ Data and analysis taken from: Accion Social, 2010, Agencia Presidencial para la accion social y la cooperacion internacional, “Indicadores de GED de la poblacion en situacion de desplazamiento,” Informe final, Bogotá D.C., Agosto 6.

²² Ibid.

²³ See R. C. Angulo, Y. Díaz and R. Pardo, 2011, “Índice de Pobreza Multidimensional para Colombia (IPM-Colombia) 1997-2010,” Archivos de Economía 009228, Departamento Nacional de Planeación, DNP.

²⁴ Policy document 3400 of 2006.

(e.g., chambers of commerce), educational institutions, business development service providers and academia. The resulting action plans identified bottlenecks and priority actions to bridge gaps between people, public and private institutions and disadvantaged groups. Prioritized actions included:

- Strengthening the capacities of local institutions, through the design and implementation of activities for productive inclusion. This comprises the consolidation of the centres for employment and entrepreneurship, one-stop-shops for employability and business development service delivery; extension of public employment services and labour market observatories; the creation of public-private networks for economic inclusion; and mechanisms for the democratization of the state procurement process, among others.
- Improving productive capacities and expanding income-generating opportunities for low-income groups and IDPs, and providing specialized services according to their needs and requirements. This includes facilitating access to fundamental services (e.g., health, nutrition, child-care services, identification, etc.); defining a personalized productive pathway for developing skills and competencies fostering human and social capital accumulation; improving inclusion in labour markets; increasing the productivity and competitiveness of business/self-employment endeavours through a varied range of business development services; and facilitating access to economic and financial assets (in-kind support, microcredit/insurance).
- Promoting inclusive business models that build on the interconnection of different regions and urban and rural areas through a modern transport infrastructure, efficient local governments, and financial access for small and medium-size enterprises. Regional differences are large partly because decades of conflict, inequality, and neglect have disconnected some areas of the country from centres of economic activity.

During the last five years, the MAF action plans for MDG 1 have led to the creation of 20 regional labour market observatories, 8 public-private networks for productive inclusion and 8 centres for employment and entrepreneurship. These activities clearly need further expansion given the size of the population that has to be reached.

The Government of Colombia is also developing a comprehensive legal framework on land restitution and reparation of victims.²⁵ This establishes judicial, administrative, individual and collective reparation measures, and is being implemented by the Victims Unit and the Land Restitution Unit in all regions of the country. Land restitution is a key element for inducing the economic participation of IDPs. In January 2012, the Special Administration Unit for Land Restitution was established to administer the process. As of 28 February 2014, 57,278 requests for restitution had been submitted for 489,204 hectares of land, but only 989 cases has been adjudicated, representing 20,153 hectares. This is a very slow process given the magnitude of the task. New efforts are needed to accelerate the process.

Experiences with various initiatives illustrated above indicate that there are three main bottlenecks that hinder the acceleration of the MDGs in disadvantaged regions and population groups. First, not enough resources are being devoted to addressing the challenges, given their magnitude. Second, coordination among actors is limited. Third, interventions are insufficiently focused on disadvantages regions and population groups.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Poverty reduction, pro-poor growth and inclusive socioeconomic development are possible only when national institutions, local governments, the private sector, academia, NGOs, multilateral agencies and donors work jointly, articulate their interventions, pool their resources and coordinate their efforts with government institutions, producing cross-sectoral, comprehensive responses.

Taking into consideration the experience with MAF implementation in reducing inequalities in nine regions in Colombia, and the recommendations of the Commission of Experts on the national income generation policy, in 2014, the National Government asked for an expansion of MAF planning and implementation in 10 new regions.²⁶ This has proven to be a unique platform for putting together the expertise and experience of the United Nations and World Bank, increasing impacts and coordination at the national and subnational levels.

Partnerships between the country, UN agencies, the World Bank and bilaterals are critical in addressing the development challenges of forced displacement, and support Colombia's efforts towards sustainable peace

²⁵ Victims and Land Restitution Law 1448/2011.

²⁶ Florencia (Caqueta), Giron (Santander), Jamundi (Valle del Cauca), Montería (Córdoba), Neiva (Huila), Ocaña (Norte de Santander), Popayan (Cauca), Puerto Asís (Putumayo), Tumaco (Nariño) and Yopal (Casanare).

and development. Several international agencies—the United Nations system, the United States Agency for International Development (USAID), the International Organization for Migration (IOM), the Organization of American States (OAS) and the World Bank—are supporting policy dialogue on victim reparations through the Victims Unit’s donor coordination mechanisms. The World Bank and United Nations agencies are assisting implementation of laws related to victims and the Victims Unit in a framework for collective reparations through local development interventions in selected areas. In particular, the World Bank has a project with three main components:

- Strengthening national and subnational capacities for reparations;
- Developing and implementing a framework for collective reparation that integrates local development and peacebuilding efforts in prioritized areas; and
- Systematizing operational lessons with an emphasis on documenting good practices and assessing collective reparation interventions.

The Victims Reparation Project will be implemented in collaboration with the Swedish International Development Agency (SIDA) through the Colombia Peace and Post-Conflict Support Multi-Donor Trust Fund.

In addition to these initiatives, three specific strategies would help address the challenges highlighted earlier:

- a. Expansion of centres for employment and entrepreneurship, public employment services and business development services so that they reach all disadvantaged regions and population groups;
- b. Extension of coverage of social services related to nutrition, health, education, gender equality, child protection and economic opportunities for disadvantaged regions and population groups, so that access to these services is guaranteed through the Victims and Land Restitution units, and local and national entities in charge of public goods provision; and
- c. Acceleration of cadaster-registry and statistical/administrative information sources about disadvantaged groups and local areas, as indispensable tools to support important activities intricately related to the land restitution process, including formalization, regularization, redistribution, property taxation, and effective management and use.

Clearly the agreement to finish the armed conflict by itself will not be the solution to Colombian problems. However, it will bring a great opportunity to close population and geographical gaps as necessary conditions for having a long-lasting peace. The CEB membership could offer its collective support to helping realize the development dividend from a peace agreement as and when one is concluded, and at the request of the Colombian national authority.

PROGRESS SINCE THE CEB REVIEW

UNDP and the Government began a cash-for-work programme to generate temporary employment in conflict areas of the country through the construction of storage centres, irrigation systems, hanging bridges and rural roads, among other examples. Another programme being implemented is Hands to Peace, a governmental initiative to strengthen local capacities for peacebuilding and sustainable development, where students in their last semester participate in internships in municipalities.

The World Bank continues to facilitate infrastructure development in lagging regions. In La Guajira, one of the poorest departments in Colombia, with a large population of indigenous communities, and an area hard hit by the current El Niño-induced drought, a World Bank project has made impressive gains in improving the quality of water supply and sanitation services in urban, peri-urban and rural areas. Tangible results include the construction of rural reservoirs that have significantly decreased the time spent by the indigenous Wajuu communities in fetching water, from 5 hours to 54 minutes, allowing more time for income-generating activities such as raising livestock, agriculture, fishing and the production of handicrafts as well as for schooling for children. For the first time, the capital of Rio Hacha has continuous running water. Other water and sanitation investments are currently under preparation in lagging parts of the Pacific region; these will benefit largely afro-descendent communities as well as significant populations of IDPs.

The World Bank, the United Nations system, the Inter-American Development Bank and the European Union all have special trust funds that focus on financing post-conflict initiatives, such as assisting ongoing peace negotiations. As such, high-level coordination among all four institutions is taking shape and will be formalized. The World Bank’s work to strengthen government institutional capacity to scale up collective reparations received a boost with a new pledge from SIDA to the Colombia Peace and Post-Conflict Support Multi-Donor Trust Fund.

The World Bank's work on victim reparations is only a small part of a broader cross-cutting program of post-conflict support, as articulated in the new Country Partnership Framework for 2016-2021, discussed by the Board of Directors in 2016. Under it, the World Bank is supporting policy and institutional reforms to strengthen development, and coordinating implementation of multilevel territorial planning that will improve the management of public monies and investment at the subnational level, and in the long term, contribute to narrowing the gap in living standards across and within regions. These reforms include, inter alia, a medium-term policy to update cadastral records, strengthen the institutional framework of the cadastral system and improve the quality and usefulness of cadastral information for land tenure regularization; the establishment of the Rural Development Agency and the National Land Agency to advance formalization of property rights, increase access to land for low-income/vulnerable population and implement rural development projects; and a new territorial planning policy to develop department-level territorial plans for investment prioritization, and update municipal land-use plans with strengthened urban-rural linkages.

The World Bank, in partnership with the Inter-American Development Bank, is investing in technical assistance to improve the core management of service delivery at the subnational level, with a focus on lagging departments and municipalities impacted by conflict, as well as to strengthen the central Government's capacity to manage the Decentralization and Territorial Management Framework. To date, over 50 municipalities have benefited from technical assistance focused on the development and monitoring of action plans stemming from each municipality's Territorial Management Model.

Due to the dynamics and consequences of the internal armed conflict, many development interventions by the UN system are oriented towards victims, supporting the reestablishment of their rights and access to basic services. Indigenous peoples, afro-Colombian groups and women are prioritized in the delivery of interventions.

As the country transition into the SDGs, the Government has established a high-level commission for SDG implementation and has integrated the 2030 Agenda in the national development plan. The United Nations has developed a virtual course on the SDGs with an emphasis on the subnational level to build the capacity of local government officials.

LESSONS LEARNED FROM THE COUNTRY EXPERIENCE

The CEB review supported ongoing initiatives and highlighted the relevance of other needed interventions. It stressed the importance of strengthening interagency coordination, from planning to implementation, and from the national to the regional level. The CEB also provided high-level policy orientation towards effective implementation, monitoring and evaluation (to follow up on targets and indicators), and resource mobilization to achieve targets. Although the private sector was involved in the strategy, more alliances are needed, particularly to achieve the new 2030 Agenda.

Based on programme implementation experiences in recent years, the World Bank Group is keen on ensuring better management of its financing and analytic and advisory programme. For investment financing, the Bank has consolidated its portfolio, closing small, over-aged projects in favour of larger investments with broader, multisectoral impacts that disproportionately benefit the poor and vulnerable, including conflict-impacted communities. This approach aligns with the Government's directive to impose a 'minimum' project financing size of US \$100 million. The Government's desire for the World Bank to engage at the subnational level in lagging regions where capacity is low has forced the World Bank to ensure high quality at entry and readiness for implementation, and to increase the likelihood of measureable results.

Given the massive financing needs of the post-conflict development agenda, the Government and all stakeholders must ensure a high level of coordination with development partners, following the Government's lead. With all four major multilateral institutions supporting the post-conflict agenda through multi-donor trust funds, there is a risk of duplication, disaggregation of resources and effort, and supply-driven programming that does not necessarily align with government priorities. The development community is working diligently to ensure coordination through monthly donor Given the massive financing needs of the post-conflict development agenda, the Government typically leads discussion of its strategy and priorities across various areas.

The need to improve coordination extends to headquarters and field offices, for both the World Bank and UN agencies. On several occasions, local offices were not fully informed by their respective headquarters of joint initiatives at the corporate level that were expected to be implemented on the ground.

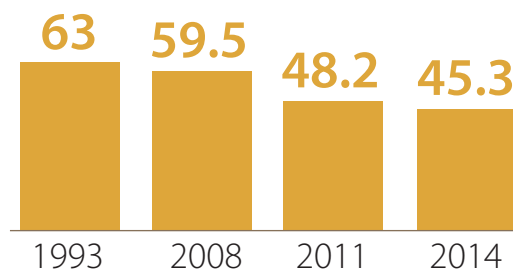
NIGER

Accelerating progress towards reducing hunger and poverty

CONTEXT

- Niger achieved three MDG targets by 2015: reducing the prevalence of HIV, increasing access to clean water and increasing access to improved sanitation.
- Progress towards both hunger and poverty objectives has been slow. The share of the population living below the extreme poverty line was 63 per cent in 1993, 59.5 per cent in 2008, 48.2 per cent in 2011, and 45.3 per cent in 2014.
- The rate of underweight children remains very high and has not changed since 1992 (36.4% in 2012 versus 36% in 1992). The incidence of stunting among children under five rose significantly, from 32 per cent in 1992 to 46.4 per cent in 2005.

PEOPLE LIVING BELOW POVERTY LINE (%)



BOTTLENECKS

SOLUTIONS/EFFORTS

Unsustainability of food supply.



Integrate short and long-term approaches by facilitating access to inputs and sustainable land management; improving advisory support and access to water for small-scale producers; strengthening social safety nets and creating income-generating activities for vulnerable household.

Inadequate production of and access to food.



Rehabilitate degraded land, and provide rotating credit arrangements and guarantee systems for small producers

Weak resilience of food chains.



Strengthen prevention and intervention mechanisms for crisis situations and natural disasters; strengthen the capacity of community and systems to manage risks.

Weak capacities of small-scale producers and vulnerable populations.



Open field schools and provision of extension services; establish cereal banks train management committees on all aspects of cereal bank management.

INTRODUCTION

Niger achieved three MDG targets by 2015: reducing the prevalence of HIV, increasing access to clean water, and increasing access to improved sanitation. In the face of persistent food and nutrition insecurity, the country focused acceleration efforts on MDG 1, on eradicating extreme poverty and hunger, and more specifically, Targets 1.A (halve, between 1990 and 2015, the proportion of people whose income is less than a dollar a day) and 1.C (halve, between 1990 and 2015, the proportion of people who suffer from hunger).

Progress towards both hunger and poverty objectives has been slow.

In 1993, 63 percent of people were living below the extreme poverty line. This figure dropped to 59.5 percent in 2008, to 48.2 percent in 2011 and to 45.3 percent in 2014. The rate of underweight children remains very high, and has been unchanged since 1992 (36.4 percent in 2012 versus 36 percent in 1992). In 2015, 46 percent of children between the ages of 6 and 59 months were stunted- and increase from 32 percent in 1992. This represents a net increase in the prevalence of chronic malnutrition of about 14 percentage points over the past 23 years, or a 43 percent increase in the rate of chronic malnutrition since 1992. According to the World Health Organization (WHO), a rate of more than 40 per cent is critically high. Both prevalence and an increasing trend over time are much more pronounced in the regions of Maradi, the economic centre of the country, and Zinder. Furthermore, according to annual assessments that started in the severe food and nutrition crisis of 2005 to 2006, very high rates of acute malnutrition persist, often between emergency alert levels (over 10 percent) and critical emergency levels (over 15 percent).

SITUATION ANALYSIS

In 2010, the President initiated an acceleration plan to tackle hunger and poverty. In line with the MAF, it sought to identify key interventions; address bottlenecks preventing achievement of related MDG targets; harmonize approaches across sectors; and mobilize a coalition of partners from across the UN system, civil society and other actors to support these national efforts.

The action plan integrated short- and long-term approaches, and prioritized five interventions: 1) access to inputs and sustainable land management, 2) improving of advisory support and access to water for small-scale producers, 3) strengthening social safety nets and creating income-generating activities for vulnerable households,

4) reducing malnutrition and providing access to clean water, and 5) strengthening prevention and intervention mechanisms for crisis situations and natural disasters.

BOTTLENECK ANALYSIS

Implementing the MAF action plan and key bottlenecks

The MAF action plan has been integrated into the country's '3N – Nigeriens Nourish Nigeriens' Initiative, a strategic framework for addressing food security. The first phase (2012-2015) has been completed. The development of a new 2016-2020 investment plan is underway. The first four of the five axes of the 3N Initiative: 1) growth and diversification of forestry, agricultural, pastoral and fish production; 2) regular availability of agricultural and food products in rural and urban markets; 3) improving the resilience of Nigeriens facing climate change, crises and disasters; 4) improving nutritional status and 5) facilitating and coordinating the initiative itself—correspond closely to the priority areas of the MAF action plan. While political commitment to tackling nutrition has been expressed at the highest level, there are significant challenges in expanding nutrition-specific and nutrition-sensitive actions, and in terms of an enabling environment, including a lack of evidence-based policy-making and strategy development. The 3N Initiative has developed a multisectoral nutrition and food security policy that could be reflected in the new investment plan. The legal adaptation of this policy and elaboration of an accompanying evidence-based plan of action and costing along with a clear accountability framework will improve the enabling environment and be of paramount importance to ensuring effective actions on nutrition security.

An ad hoc working group for coordination, chaired by the Government's 3N High-Level Commissioner assists with the implementation. Members include representatives of line ministries, the UN system (Food and Agriculture Organization or FAO, UNDP, the World Bank and the World Food Programme or WFP), donors (European Union, Germany, Luxembourg, Switzerland, USAID) and international NGOs (Oxfam, Concern).

An initial commitment by the Government of US \$30 million over five years from domestic resources contributed to the MAF action plan through the 3N Initiative, and stimulated partner interest, support and contributions. As part of this commitment, the Government, through the Banque Agricole du Niger, has put in place rotating credit arrangements

and guarantee systems for small producers totalling over US \$7 million. In 2011-2012, the Government also subsidized the distribution of over 6,000 tons of seeds to small-scale producers, worth about \$8 million. During this initial phase, international partners contributed more than 25 million euros and aligned activities in their plans with priorities outlined in the MAF plan. Official figures (2014 Economic and Social Development Plan Review) underline that in 2014, about US \$660 million was mobilized for 3N Initiative implementation, although 56 percent of this went directly to address urgent needs. Significant budget gaps remain. Over 95 percent of all funds for direct nutrition interventions were contributed by humanitarian partners, with a question regarding sustainability and comprehensiveness.

Several regional and global initiatives support 3N objectives. These include the National Agricultural Investment Programme in the framework of the Economic Community of West African States' African Agricultural Development Programme; the African Development Bank's Pilot Program for Climate Resilience; the Global Alliance for Resilience Initiative; and global partnership and advocacy initiatives such as the Renewed Effort Against Child Hunger and Undernutrition (REACH)²⁷ and Scaling Up Nutrition (SUN). Although Niger joined the last in 2012, the level and quality of coordination requires attention.

UN system and World Bank Group support to the MAF action plan, which includes interventions for improving agricultural productivity and animal husbandry, strengthening resilience, strengthening the capacities of small-scale producers, providing meals to school children, enhancing safety nets and income-generation opportunities, improving nutrition education and access to water, and developing the capacity to anticipate and plan for shocks and disasters.

Using humanitarian interventions to lead the way towards longer term stable gains is embedded in the 3N Initiative. The 2012 drought in Niger exacerbated the protracted nature of the hunger crisis, and underlined the need to build stronger resilience. Due to the good results of the 2011-2012 agro-pastoral campaign, the number of people exposed to food insecurity decreased from 5.5 million (34.9 percent of the population) to 3.1 million (19.1 percent), among whom 5.5 percent were in a situation of 'severe'

food insecurity, with no food stock or livestock, according to the Office for the Coordination of Humanitarian Affairs. The agro-pastoral campaign of 2012-2013 also had surpluses in cereal and fodder, leading to fewer pastoralists in humanitarian centres during the 2012 drought compared to the previous drought of similar magnitude. The 2014-2015 campaign has resulted in higher cereal production than in 2013-2014. As a consequence, the cereal balance is in surplus of 229,000 tons. However, according to the Ministry of Livestock, the fodder balance shows a deficit of nearly 9.4 million tons.

The implementation phase underscored several additional challenges. In 2015, Niger was ranked last out of 188 countries on the UN Human Development Index. The 3N Initiative was therefore integrated into the country's national development and poverty reduction strategy—the Economic and Social Development Plan 2012-2015. The successor programme of the plan has yet to be developed, underscoring planning and integration challenges. At the November 2012 donor round table in Paris to support implementation, commitments amounting to approximately US \$4.8 billion to be delivered (mostly) over the 2012-2015 period were recorded. The 2014 Economic and Social Development Plan Review report states that about US \$6 billion was mobilized between 2011 and 2014, at least one-third of which was allocated to the 3N Initiative.

The nutrition situation remains critical. While the willingness to tackle undernutrition is strong, implementation of evidence-based actions to address specific determinants of undernutrition has to improve. The overwhelming majority of the funds used for direct nutrition interventions mainly focus on treating acute malnutrition, with increasing but insufficient financing for preventive actions. The nutrition sensitivity of other investments prioritized through 3N Initiative and other socioeconomic development initiatives needs strengthening.

The support provided by UN agencies and the World Bank towards implementation of the MAF action plan, although producing results, is limited in scope and reach, and could be more effective and synergistic.

²⁷ REACH is a joint initiative of IMPACT, its sister-organization ACTED, and the United Nations Operational Satellite Applications Programme (UNOSAT). REACH was created in 2010 to facilitate the development of information tools and products that enhance the humanitarian community's decision-making and planning capacity. All REACH activities are conducted in support of and within the framework of inter-agency aid coordination mechanisms.

Priorities for maintaining and further accelerating progress

Identification of current gaps in support has led to a joint commitment by agencies involved to **scale up efforts to build the resilience of vulnerable communities to food insecurity, malnutrition and agro-climatic hazards** as their top priority. This commitment required an approach that seeks to increase the capacity of the most vulnerable people to anticipate, mitigate and recover from hazards. It contains four axes:

- 1. Increased coordination and scaling up of activities to strengthen the resilience of the food chain.** This axis aims at strengthening the food chain, from farm to fork. It targets the increase in agricultural productivity in a sustainable and resilient way, adapted to local agro-climatic circumstances; ensures that agricultural value chains are more efficient; and enhances the nutritional condition of the most vulnerable. Specific actions to be scaled up are underway and include improving access to inputs, through strengthening locally adapted seed systems; the sustainable management of land and livestock; and access to water for productive means. All actions were expected to benefit from increased coordination in the ad hoc working group under the auspices of the 3N Initiative. This working group's objectives are to mobilize and coordinate efficient use of resources including capitalization of different expertise and experiences.
- 2. Strengthening the capacities of communities and systems.** This axis aims at enhancing the resilience of communities and systems to shocks, and strengthening households' access to food in fragile ecosystems through asset creation and improving disaster preparedness and mitigation measures. It covers social protection programmes, measures to improve nutritional status, the appropriate management of water resources, and strengthening capacities for disaster risk reduction and response capacities in crisis situations. Increased attention is needed to bolster capacities at decentralized levels, in order to allow for improved flows of information and context-specific interventions.
- 3. Strengthening the capacities of small-scale producers and their organizations.** This axis corresponds to interventions aimed at providing advisory support to all manner of small producers—farmers, pastoralists, fisher folk and foresters. While important actions are already being undertaken, efforts need to be scaled up by aiming for more inclusive geographical coverage and strengthened capacities at all levels of producer organizations. Activities to strengthen producer

organizations should be mainstreamed across different implementation activities. Increased information-sharing and coordination should help streamline approaches.

- 4. Expand high-impact nutrition-specific actions, tackle non-optimal traditional/cultural practices, and ensure the nutrition sensitivity of efforts that aim to achieve food and economic security.** The technically validated draft nutrition policy and action plan provide a good framework for both scaling up nutrition actions and improving the enabling environment.

Beyond these key areas of work, there are three cross-cutting priorities:

1. Scaling up pilot programmes

Many solutions are currently underway through region-specific or pilot projects like the sustainable management of arid ecosystems by local authorities in Agadez region, or small irrigation projects in the Tillabery region. Significant gaps remain in terms of regional coverage and depth of intervention, however, hampering broader achievement of targets. Scaling up needs to be done with special attention to the sustainability of interventions after they end, the predictability of future financing and the further improvement of the targeting of the most vulnerable populations.

2. Strengthening effective coordination

To enhance cooperation in the implementation of the MAF action plan, agencies in Niger use existing coordination mechanisms: the UN country team and inter-agency coordination system; the Partners' Coordination Committee and its Secretariat, in particular, its subcommittee on food security, bringing together the international development community in Niger; and the ad hoc working group for the implementation of the 3N Initiative, which brings together representatives of the international development community and relevant national authorities. All of these mechanisms require full commitment by the various agencies in order to be successful.

3. Addressing statistical capacity constraints

Data on some MDG targets are scarce. Since 2005, the National Statistics Institute of Niger has carried out yearly Child Nutrition and Survival Surveys. And since 2008, two major Living Standards Measurement Surveys have been conducted in 2011 and 2014 to calculate poverty indicators. The 2015 Vulnerability Survey is also available.

Overall, Niger requires both access to regular sources of funding and sustainable capacity-building to set up a more reliable monitoring system. The Partners' Coordination Committee has agreed to scale up efforts and coordination for the development of enhanced data collection, analysis and monitoring and evaluation systems. The aim is to provide real-time data on selected nutrition, food security and poverty indicators, improve the follow-up and capitalization of policies being implemented, and strengthen the capacities of national institutions.

Managing challenges and risks

The main risks hampering further progress are possible climate change and the deterioration of the security situation, as a consequence of the conflict in Mali and Boko Haram activities in Nigeria. Resilience against the risk of drought is being addressed through the MAF action plan itself, and several other national and regional initiatives. Sporadic Boko Haram attacks, however, are hampering follow-up activities and missions by UN and World Bank staff in Diffa in the south east. Several initiatives are underway to reduce the humanitarian and development impact of such attacks on the population.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Enormous challenges hamper Niger's development, but the country itself is included in many regional and global initiatives, and there is strong commitment by the international development community to strengthening the resilience of vulnerable communities in the Sahel. The World Bank Group and UN country teams warmly welcome all these efforts, and encourage agencies to continue their **engagement and strong advocacy** in favour of Niger's development.

The CEB review provided a strong opportunity to reconfirm UN system and World Bank Group commitment to the Niger MAF action plan and the 3N Initiative. Country teams are fully committed to stepping up their efforts to implement the MAF by **scaling up their activities and improving their coordination** around the priorities identified above, under the overall framework of the UNDAF and the World Bank Country Assistance Strategy. Since 2014, the UN system has enhanced its support to the 3N Initiative and the MAF action plan through the "Commune de convergence" project, which aims at reinforcing the resilience of populations, households, communities and institutions.

Scaling up acceleration activities requires additional resources. An important landmark in this regard was the Paris Round Table in November 2012, where US \$4.8 billion was committed to priority investments under the Economic and Social Development Plan, of which the 3N Initiative is an integral part.

Gaps in the availability of data and capacities to use them for policy direction will require joint and sustained efforts by CEB agencies.

PROGRESS SINCE THE CEB REVIEW

Several activities were conducted to support the MAF action plan and 3N Initiative. FAO and WFP purchased and distributed more than 1,600 megatons of rain-fed seeds to vulnerable people affected by the 2012 cereal deficit crisis; 1,200 tons of rain-fed seeds were distributed in Ouallam to strengthen the resilience of vulnerable populations; 2,650 MT of animal feed and 1,650 MT of improved seeds were provided by FAO in 2014, which is working on strengthening statistical capacities (US \$800,000 has been mobilized, including \$200,000 with WEMU). As part of its activities in strengthening community resilience and livelihoods, FAO provided 1,386 tons of cereal and legume seeds to vulnerable households for the 2015-2016 rain-fed campaign, through the *Communes de convergence*, with funding from Belgium, France, Sweden, the United States, the Central Emergency Response Fund and UNDP. For the irrigated crops campaign, FAO provided 3,500 kilogrammes of vegetable seeds, 300 tons of maize seed and 100 tons of potato seeds, with funding from France, Luxembourg, the Office of US Foreign Disaster Assistance, USAID and the United Nations High Commissioner for Refugees (UNHCR).

The International Fund for Agricultural Development (IFAD), through the Ruwanmu small-scale irrigation project, financed the rehabilitation of 600 hectares of degraded lands; 154,635 seedlings were produced by local populations, 160 hectares land was irrigated and 1,353 hectares of new plots were equipped. Literacy classes were conducted in 36 centres for 1,000 learners. Through other interventions, IFAD financed 400 communal and individual micro-projects (cereal banks, small business firms, etc.) worth US \$2.7 million. Around 13,000 hectares were restored and 23,000 small ruminants restocked for vulnerable people. Similarly, 24 field schools were implemented for 720 farmers, including 240 women and 240 young farmers. Since 2011, through its local economic development support project known as PADEL, the United Nations Capital Development Fund (UNCDF) has been supporting the elaboration and implementation of a departmental strategy for food and nutrition security in the region of Maradi, creating 27 cereal

banks for women with an initial stock of 397 tons. Management committees have been regularly trained on all aspects of cereal bank management, including self-evaluation techniques that improved management and services offered to members.

To assist the decentralization of disaster management in Niger, UNDP made disaster risk reduction specialists available in Niger's eight regions, supported the creation and/or reactivation of nine vulnerability monitoring observatories and promoted the organization of 200 villages in three regions into 20 community structures for early warning and response. Community resilience to shocks increased and household access to food was strengthened through income-generating activities such as agro-processing, sheep fattening and market gardening, helping improve the food security of 1,850 people, including 1,100 women. Under the UNDP *Projet de Lutte Contre l'Ensamblage des Cuvettes Oasiennes* (PLECO) project on desertification, 521 households were involved in fixing 625 hectares of dunes through cash-for-work initiatives, which improved income and food security. To strengthen the capacity of communities and the Government, UNDP continued its support to the Government's 3N Initiative through a package of activities implemented as part of the *Communes de convergence* approach. Finally, 1,285 tons of mineral fertilizer and 257 tons of improved millet seeds were provided to over 25,000 households in 15 municipalities.

In 2016, UNAIDS, together with the Ministry of Public Health and other partners, began facilitating the development of an HIV treatment acceleration plan for the prevention of mother-to-child transmission. The REDES study found an increase in the government contribution to HIV expenditures in 2015; external funding (60 percent) decreased against public funding. UNICEF continues to support the expansion of high-impact health and nutrition interventions that have huge bearing on the survival and development of children. It helps treat about 400,000 children with severe acute malnutrition on an annual basis, and covers over 90 percent of eligible children with vaccines, vitamin A supplementation and deworming. The expansion of other maternal and child health and nutrition services has reached hundreds of thousands of children and mothers every year, including through improving access to water and sanitation facilities.

LESSONS LEARNED FROM THE COUNTRY EXPERIENCE

To support the MAF action plan and the 3N Initiative, all stakeholders (the Government, civil society, the private sector and development partners)

have been working together since 2011. In 2012, the Government created the High Commissioner to the 3N Initiative and developed its investment plan for 2012-2015. It stimulated stakeholder participation through multisectoral strategic piloting committees led by line ministries and major partners such as UNDP, the European Union, the World Bank and USAID.

Since 2014, the UN system has enhanced its support to the 3N Initiative through the *Communes de convergence* concept, in collaboration with the Government, NGOs and local communities. *Communes de convergence* is an innovative way to strengthen community resilience, based on the principle of joint planning of complementary activities by UN agencies, NGOs and the Government. The aim is to establish integrated and participatory measures that boost community resilience to recurrent crises and enable the most vulnerable populations to resist, absorb and manage various shocks without jeopardizing their livelihoods. It is a deliberate and conscious effort to do things differently and harmonize short-, medium-, and long-term programmes. Synergy and complementarity among the activities of involved organizations arise from joint planning, which allows a bundled and effective package covering various fields (agriculture, food security, health, nutrition, education, water, local governance, management risks, etc.). This focus and concerted approach encourages communities to lead their own development process.

The 3N Initiative represents the third axis of Niger's 2012-2015 Economic and Social Development Plan, developed through participation by all national stakeholders. The UN system and other development partners support the plan through the inclusive Partners' Coordination Committee, which has enhanced technical cooperation with the plan's Permanent Secretariat. In 2014, due to limited public sector performance, as reflected by various indicators (poor funding absorption rate, poor design and implementation of development projects and programmes, the unavailability and poor quality of public services, etc.), a capacity-building programme known as PAPMO was developed to accelerate plan implementation. Given that efforts to date have not resulted in positive changes in nutritional status, and the prevalence of undernutrition, including among the richest quintile of the population, responses that are evidence-based, effective and address local determinants need to be expanded as a matter of urgency. An enabling environment, including finance for nutrition, improved coordination and governance at all levels, and a well-elaborated accountability framework for the nutrition policy, is likely to facilitate actions that will improve nutritional outcomes.

TANZANIA

Accelerating progress towards reducing hunger and poverty

CONTEXT

- Poverty rates declined from 34.4% (2007) to 28.2% (2012) — the first significant decline in 20 years
- Hunger and malnutrition rates dropped slowly between 2000 and 2007, and have stagnated since. In 2012, an estimated 7.5 million Tanzanians were still considered to be food insecure, with the situation especially severe in rural areas. Malnutrition, especially chronic malnutrition (stunting), remains widespread and decreased only slightly (from 38 percent in 2004 to 35 percent in 2010).
- With about 80% of the poor living in rural areas, promoting agricultural productivity and income-generating opportunities is a priority to reduce poverty.

POVERTY RATES (%)
2007 2012
34.4 28.2



MALNUTRITION (%)

38 35
2004 2010



BOTTLENECKS

SOLUTIONS/EFFORTS

Lack of income and livelihood opportunities for the poor.



Invest in alternative livelihoods not directly linked to the agriculture sector (e.g. tourism); facilitate access to domestic and external markets for agricultural commodities.

Lack of means for accelerating and scaling up interventions.



Expand the coverage of the Tanzania Social Action Fund (TASAF)'s Productive Social Safety Net (PSSN) programme (e.g. a plan to cover 275,000 households has been expanded to reach the poorest 1.2 million households).

Data capacity constraints.



The country recently initiated a complete overhaul of its system of collecting agricultural statistics.

Food insecurity.



Reinforcing the National Food Reserve Agency (NFRA) to strengthen food distribution programmes for households vulnerable to food insecurity, targeting the most vulnerable households through the Tanzania Social Action Fund (TASAF).

INTRODUCTION

Tanzania was a pilot country for the MAF rollout in 2010. Although it was making good progress on several MDG targets, including those related to primary education, gender equality, child mortality, HIV prevalence, and access to drinking water and sanitation in urban areas, the country was off-track with regard to poverty and hunger. The MAF was an opportunity to direct attention to these areas.

Poverty rates declined from 34.4 percent to 28.2 percent between 2007 and 2012—the first significant decline in 20 years.

The difference in the incidence of poverty over this five-year period indicates a decline of one percentage point per year. If this rate of decline continues, the target to halve the proportion of people in poverty by 2030 could be achieved.

Hunger and malnutrition rates dropped slowly from 2000 to 2007, and have stagnated since, making it unlikely that targets will be met. In 2012, an estimated 7.5 million Tanzanians were still food insecure, with the situation especially severe in rural areas. Malnutrition, especially chronic malnutrition and stunting, remains widespread. It decreased only marginally between 2004 and 2010, from 38 percent to 35 percent. Food poverty rates dropped from about 17 percent in 2007 to 9.7 percent in 2012, meeting the 2015 target of 11 percent.

SITUATION ANALYSIS

Tanzania's plan for accelerating progress on hunger and poverty was led by the Ministries of Agriculture and Health and Social Welfare, coordinated by the Ministry of Finance and Economic Affairs. It brought together actions related to the four dimensions of food security: the physical availability of food, access to adequate amounts by households, proper utilization so that individuals are nourished according to their needs, and protection against short-term shocks to the first three dimensions. The plan sought to improve the effectiveness of existing interventions along these dimensions, and to promote new ones where needed. Interventions included those related

to enhancing agricultural productivity, strengthening livelihoods and making them more robust, and targeted measures to enhance nutrition, improve sanitation and help cope with shocks.

With about 80 percent of the poor living in rural areas, promoting agricultural productivity and income-generating opportunities there is a priority. Such opportunities could arise in agriculture-related activities, bolstered by improving access to both domestic and external markets by facilitating trade. Sectors not directly linked to agriculture—such as tourism—could also provide opportunities in specific parts of the country.

Improving nutrition outcomes requires a parallel attention to other instruments such as school feeding, micronutrient supplementation, deworming, sanitation and water supply, social protection and advocacy. Global initiatives and movements such as SUN, where Tanzania is a prominent member, and the Zero Hunger Challenge provide the chance for country efforts to gain greater impetus by linking to a broader spectrum of actors.

BOTTLENECK ANALYSIS

A review of the implementation of the MAF action plan indicates that more needs to be done. The Government is playing an active role in improving agricultural productivity, value addition and access to markets, resolving land issues to encourage individual investments, and promoting infant and child nutrition. But the effects of several of these efforts are limited. Some have not been large enough. Others have not had the desired results due to inefficiencies in targeting. For example, leakages from the agricultural input voucher (subsidy) system are common, which limits impacts on the productivity of poor farmers. Challenges include capacity gaps, weak institutional structures, and poor coordination for food security and nutrition. At the same time, the catalytic nature of UN support makes UN interventions heavily dependent on other stakeholders, including the Government, for scaling up and sustainability.

In terms of filling gaps to its support, especially through activities where an early impact was likely to occur, the UN and World Bank country teams identified three priority areas:

- a. Raising agricultural productivity and strengthening livelihoods:
 - Infrastructure, including simple area-appropriate irrigation technologies and helping to link small producers to markets;
 - Scaling up climate-smart agriculture to improve food and nutrition security;
 - Supporting farmer organizations for accessing rural financial services; and
 - Assisting in developing export markets for agricultural products and strategically located special economic zones.
- b. Supporting community-based nutrition and social safety net programmes:
 - Scaling up in-kind nutrition and food assistance programmes alongside conditional cash transfer schemes; and
 - Streamlining and harmonizing existing initiatives and partnerships in order to achieve these objectives.
- c. Improving sanitation:
 - Scaling up assistance for piped water and sanitation facilities; and
 - Supporting the finalization of the costed action plan for national sanitation and its use for resource mobilization.

Several activities are likely to have rapid impact:

- d. **Scaling up conditional cash transfer programmes coupled with nutrition interventions** to better reach the poor and vulnerable. Such an effort, to be carried out through collaboration among FAO, the International Labour Organization (ILO), UNAIDS, UNDP,

the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), WFP, WHO and the World Bank Group, would include the following elements:

- Expanding the coverage of the Tanzania Social Action Fund– Productive Social Safety Net programme. A planned scale-up to cover 275,000 households would be accelerated and expanded to reach the poorest 1.2 million households. This venture would bring together, in an integrated manner, individual/joint efforts by the identified agencies to scale up their respective community-based programmes featuring nutrition interventions for vulnerable populations such as pregnant women, public employment during the lean season and conditional cash transfers. It would exploit complementarities and synergies, and help reach the most vulnerable and food-insecure communities throughout the country.
 - Funding the expansion through the existing programme, which is supported by multiple donors and UN agencies. An assessment of financing needs, accompanied by implications of the expansion for targeting, monitoring and sustainability, would be undertaken. Recent lessons learned from using community processes for household identification and monitoring, and mobile money mechanisms would be used.
- e. **Reinforcing the National Food Reserve Agency to strengthen food distribution programmes for households vulnerable to food insecurity.** A collaboration primarily between the World Bank and WFP, targeting the most vulnerable households would be improved through collaboration with the Tanzania Social Action Fund. Options to better manage finances would also be explored, given that the need for assistance varies in both predictable (agricultural lean season) and unpredictable (sudden weather shocks) ways over time. This could also allow the National Food Reserve Agency to play a part in agricultural development by being able to undertake consistent, reliable and effective procurement from smallholder farmers.

f. **Increasing income and livelihood opportunities for the**

poor: such an effort, to be carried out through collaboration among FAO, ILO, UNDP, the United Nations Industrial Development Organization (UNIDO), WFP and the World Bank, would include the following elements:

- Organizing small scale farmers into associations/cooperatives to achieve economies of scale and enable them to access agriculture inputs;
- Identifying, documenting and sharing good agricultural practices in key sub-sectors (cassava, rice, horticulture, livestock) for adoption and scaling up;
- Supporting regular knowledge-sharing, demonstrations and capacity-building of farmers/farmer groups through extension officers/farmer organizations and agricultural service centres on new agricultural technologies and good practices, while ensuring environmental sustainability;
- Supporting the enhancement of agricultural income and livelihoods through increased household production of staple commodities (maize and beans), followed by procurement of surplus; and
- Linking small producers/producer associations to markets and assisting them to increase the value they gain from their production.

It is also important to indicate some cross-cutting priorities:

g. **Improving coordination and mutually supportive actions**

Existing mechanisms such as the UN Development Assistance Plan would be built upon to promote better coordination in implementation by the UN agencies and the World Bank.

h. **Addressing data capacity constraints**

Data and statistics available for monitoring the different components of MDG 1 vary in quality and availability. For example, four nationally representative household budget surveys have been conducted since 1990; they provide good-quality estimates of household consumption and expenditure, in addition to other socioeconomic characteristics. panel surveys were conducted in intermediate years, providing additional information on the dynamics of poverty. Together, these household and panel surveys hold the potential to improve

understanding of living conditions and poverty. Other household surveys such as the Demographic and Health Surveys provide reliable information for some indicators of nutritional and health status, such as the prevalence of underweight children.

Labour market information is collected infrequently, making it harder to detect and respond to trends in a timely fashion. For food security, too, generating reliable statistics can be a challenge. The country has recently initiated a complete overhaul of its system of collecting agricultural statistics with the help of the US Department of Agriculture and FAO, and is further improving its analytical capacity with the help of FAO and the World Bank.

i. **Managing challenges and risks**

Acceleration initiatives can only demonstrate impact if there is continuing political commitment from the Government. As the country's own experience over the past decade shows, periods of rapid growth may not translate into commensurate improvements in the well-being of the poor. It is important for the Government to maintain its level of commitment to inclusive development.

As the Government of Tanzania intends to reduce donor dependency, financing its development work, in particular MDG-related activities, depends very much on how successful and effective it is in mobilizing resources and managing its public finances. To do so effectively, the Government will have to complete and strengthen core reforms.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Conclusion and recommendations for the CEB review include the following:

- **Concrete opportunities exist for the CEB agencies to better align their efforts in supporting the Government's efforts**—three possibilities have been identified above and would need the support of the principals to carry forward to coordinated execution.
- **Additional opportunities may exist for resident and non-resident agencies** to complement their efforts and provide a thrust for acceleration through coordinating actions around priorities indicated above. The CEB could require an identification of such opportunities and their implementation.

- **Improving data collection and statistical systems through joint analytical work** that will help enhance understanding of the interrelationship between poverty and nutrition and thus improve policy responses.

PROGRESS SINCE THE CEB REVIEW

The Productive Social Safety Net programme has managed to fully enrol and start providing income benefits to over 1.1 million vulnerable households in 161 project area authorities and 9,960 villages *mitaa/shehia* throughout the country. The programme has made 13 consecutive payments since its start, and during the last three payment cycles, over 1 million households received cash benefits.

Following a successful scale-up, the focus is now on continuing payment to all enrolled beneficiaries in a timely manner, monitoring compliance, processing claims and grievance redress, information updates, applications or requests, and training project area authority staff and community management committees. Preparatory work to roll out public works, including enrolment of beneficiaries, has been completed by all 44 project area authorities, and implementation of sub-projects have started in September 2016.

In 2014 the Government established a task force, chaired by the Prime Minister's Office and comprising members from different sectors and stakeholders involved in social protection, to revise the national social protection framework. The task force was assigned to work on comments raised when the previous draft framework document was presented to the Cabinet. The framework is the overarching policy document aimed at providing guidance on designing and implementing the social protection system in Tanzania. Revision of the document has been finalized after addressing issues and comments raised by the Cabinet and incorporating inputs from other key stakeholders. The task force is currently preparing a cabinet paper so the framework document is formally resubmitted for Cabinet approval.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

The CEB review process showed that:

- Government leadership is critical when it comes to scale. This is shown by the Government's implementation of a strategy to massively scale up its social safety net (the Productive Social Safety Net, comprising conditional cash transfers, labour-intensive public works and livelihoods enhancement) to reach the poorest 1 million households (15 percent of the total population).
- Multistakeholder platforms can be critical bridges to a wider set of actors.
- Integrated solutions help address duplication of effort and also offer sustainable solutions to development challenges.
- The UN system should support governments in the adoption of multistakeholder processes and play convening roles in establishing national platforms.
- Relevant citizen groups, including those involving the most vulnerable, should be engaged from the beginning.
- The lack of data and quality statistical analysis poses a serious constraint to timely monitoring, policy development and the ability to target interventions where they were most needed. The CEB reviews demonstrated that more could be achieved if efforts were redoubled and actions scaled up in locations and among populations where they would have greatest impact.
- A people-centred approach, moving beyond diseases and grounded in human rights, is critical to improve health outcomes.
- Increasing citizens' voice and knowledge of their rights (such as to information and quality service delivery) is important if citizens are to be able to demand value for money.
- Horizontal and vertical policy coherence is essential to achieving transformative development results.



BURKINA FASO

Accelerating MDG 1 through improving food security and nutrition

CONTEXT

- One out of three children suffers from chronic malnutrition. The prevalence of acute malnutrition exceeds the critical threshold of 10%.
- The share of the population people living on less than the minimum calorie intake dropped from 46.6 per cent in 2003 to 36.5 per cent in 2007.
- The share of the population living in extreme poverty fell only slightly, from 49.2 per cent in 2003 to 46.7 per cent in 2009. They are much higher in rural areas, among women, and in certain parts of the country.

PEOPLE LIVING WITH LESS THAN MINIMUM CALORIE INTAKE (%)

2003	2007
46.6	36.5



EXTREME POVERTY

2003	2009
49.2	46.7

BOTTLENECKS

Poor targeting and coverage of vulnerable areas.



Improve data collection techniques/technologies to enable regular monitoring and evidence based decision making.

High cost and lack of access of energy, other inputs and equipment.



Extend rural energy/multifunctional platforms to reach 50% of rural population by 2015 to spur development of small businesses and improve income (US\$ 120 million).

Low levels of integration in the market economy, their level of education, access to information, training and to property ownership of women.



Collaborate to assist the Government to establish a well-targeted social safety net system and scale up cash transfer programs to reach 50,000 households in the four vulnerable regions by 2015 (Social Safety Net Program, US \$50million), focusing on women.

Weak capacity of farmers to transform product and improve value chain.



Poor access to productive capital, employment and financial services.

Scale-up food and nutrition security, income generation and social safety net programs: Raising agricultural productivity for 500,000 households; scaling up nutrition programs to 1 million children per year; scaling up safety net system to reach half of the chronic poor (2.4 million) would cost about \$90 million per year or less than 1% of GDP and reduce chronic poverty by 21%.

Burkina Faso has enjoyed strong economic performance, with real average annual GDP growing by more than 5 percent during the 2000s. It nevertheless has little change of reducing the share of the population living in extreme poverty or suffering from hunger enough to meet the MDG 1 targets.

The rate of extreme poverty has not changed significantly, easing only from 48.6 percent in 2003 to 46.7 percent in 2009. The poverty rate, defined at the US \$1.25 PPP threshold, is estimated at 38.5 per cent in 2015 - remaining a long way from the target of 22.3 percent. The proportion of the population with a calorific intake below the minimum level fell from 46.6 percent in 2003 to 36.5 percent in 2007. If current trends continue, the indicator is estimated to be 36.6 percent in 2015 - almost three times the target of 13.3 per cent. The prevalence of chronic malnutrition fell from 46 percent in 1998 to 43 percent in 2003, reaching 33 percent in 2012.

Promoting economic growth is not enough by itself to accelerate poverty reduction. That growth must be shared, especially with poor and vulnerable populations. This must happen through, for example, creating jobs, combating gender inequalities, implementing social protection safety nets and increasing agricultural outputs.

In 2011, Burkina Faso adopted its plan for accelerating the MDGs, with particular emphasis on Targets 1.A and 1.C. This acceleration framework made it possible to identify some 50 solutions to persistent bottlenecks. These were organized into 13 interventions proposed by the diverse actors, and aligned with the Accelerated Growth and Sustainable Development Strategy (Stratégie de Croissance Accélérée et de Développement Durable).

Certain factors limit the effect that growth has on poverty reduction and improvements in food security. They include high population growth, low levels of human capital, poor agricultural productivity and unpredictable weather conditions.

SITUATION ANALYSIS

The Ministry of the Economy and Finance is coordinating supervision of the implementation of the MAF for MDG 1. Ministries responsible for agriculture, animal resources, the environment, water and health are providing expertise. The MAF addresses matters associated with the availability of food, access to sufficient quantities for households, and appropriate use of food.

Interventions are intended to enable small agricultural producers and poor livestock rearers to achieve food security, improve their incomes and combat malnutrition. Interventions target regions vulnerable to food insecurity and malnutrition. Their aims include: a sustainable increase in crop production; control and management of water; development of infrastructure for connecting isolated areas; diversification of revenue sources; organization of sectors and advice and support for small producers and livestock rearers; reductions in malnutrition among vulnerable persons; increases in the quality and quantity of food for the population as a whole; and management of natural disasters and emergency situations.

BOTTLENECK ANALYSIS

Implementation of the MAF action plan and principal gaps

The Government of Burkina Faso chose to implement the MAF action plan through the National Rural Sector Programme (Programme national du secteur rural) and the National Nutrition Policy (Politique nationale de la nutrition). These constitute frames of reference for interventions in rural development and the fight against malnutrition. In order to facilitate funding for the MAF, the Government adopted the strategy that prioritized selected solutions. These are set within the frameworks of medium-term expenditure of ministries responsible for sectors covered by the MAF. UN agencies contribute to the MAF through their action plans linked to the UNDAF, and the World Bank through its country strategy.

Implementation has already begun for most of the solutions identified within the MAF, although with a number of difficulties. Some efforts suffer from inadequate coverage in the most vulnerable areas. Others have produced limited outcomes due to insufficient funding for scaling up. Difficulties have also been apparent in targeting small producers. There are questions regarding the sustainability of certain

interventions. They include the following constraints: the slow rate at which improved varieties of seeds are being adopted; the very low levels of equipment among small producers; poor efficiency of government technical services; and lack of maintenance for irrigation infrastructure. It is essential to monitor the use of skills acquired in training courses.

In terms of nutrition, the weaknesses include: limited production of local food products for the prevention and treatment of malnutrition; delays in delivering imported products for the prevention and treatment

of malnutrition; poor integration of social security networks; delays in social protection activities such as universal health insurance; and limited technical and operational capacity of the technical staff of local authorities on questions relating to mobilization for hygiene and sanitation. In addition, delays in formulating National Rural Sector Programme plans and activities have had serious effects on the implementation of MAF solutions and on the coordination of support.

Priorities for increasing support and acceleration in reducing poverty and malnutrition

In order to fill the gaps identified, the UN system and the World Bank Group selected four main priorities:

a. Improving agricultural productivity and developing value

chains: Implementing this priority would increase the supply of food products and raise the incomes level of small producers. Doing this requires the following actions: (i) strengthening small-scale irrigation, including the management of low-lying lands and improvements to the management and maintenance of irrigation infrastructure, as well as facilitating sustainable access to inputs and agricultural equipment for small producers; (ii) strengthening agricultural value chains; and (iii) transferring adapted agricultural technologies, including storage equipment to reduce post-harvest losses; facilitating small producers' access to credit and creating a mechanism that encourages purchasing from small agricultural producers.

b. Strengthening the resilience of small producers and improving governance to manage food crises and disasters:

Improving the livelihoods of small producers requires the sustainable management of natural resources and soil fertility through: anti-erosive measures; the protection of river banks and the production and use of organic materials to restore the organic status of soils. These actions must be supported by appropriate rural land management and the strengthening of measures for adaptation to climate shocks.

c. Prevention and treatment malnutrition. Routine screening and care are needed for children aged 6 to 59 months with severe or moderate acute malnutrition. The following are considered crucial: combating anaemia through the introduction and widespread use of supplementary feeding at home, for children aged 6 to 23 months; deworming for children aged 12 to 59 months; iron supplements for

women of child-bearing age; and large-scale supplementary feeding and systematic use of occasional iron supplements for adolescents, using the education system and community networks for contacts, and linked to other health-related interventions such as the prevention and treatment of malaria. All of these efforts involve strengthening the technical and operational capacities of health-care centres and hospitals in providing this type of care and strengthening the quality and coverage of interventions that promote best practices in feeding infants and young children. This will occur by implementing the scaling-up plan and controlling salt imports and the organization of salt importers in order to achieve necessary universal salt iodination.

d. Strengthening integrated care for childhood diseases and malaria:

It is vital to ensure acceleration in reducing infant/child mortality by developing a dedicated strategic plan to consolidate government commitment to a 'renewed promise'. The commitments of the 2030 Agenda must be taken into account in promoting the Survival and Development of the Young Child strategy, as well as health factors on which other sectors are based (WASH, awareness and advocacy). This will require: (i) implementing the scaling-up plan for treating diarrhoea with oral rehydration salts and zinc; (ii) extending use of electronic consultation records for diagnostic treatment within health-care and social promotion centres as scaling up treatment of acute respiratory diseases at the community level, based on the outcomes of the evaluation of the pilot project in two districts; (iii) revising the strategic plan 2011-2015 for the fight against malaria by extending the use of rapid diagnostic tests in the community; (iv) implementing occasional preventative treatment for malaria among infants and seasonal malaria chemoprevention.

In order to implement these priorities and accelerate progress towards MDG 1, it is important to consider the following further actions:

a. Improve inter-agency coordination: The MAF is an opportunity to accelerate progress towards MDG 1 targets, but it requires increased commitment on all sides. The CEB could encourage country offices to pay more attention to the selected priorities, with a view to conducting midway reviews for programmes under way and encouraging agencies to create a platform for partnership and shared action for food security.

b. **Strengthening government ownership of actions to accelerate progress toward MDG 1:** Greater government ownership is considered crucial. The same is true for accelerating the National Rural Sector Programme and especially action plans for its subprogrammes. There must be greater ownership of the programme by all actors and partners.

c. **Strengthening synergy in the action and support of the UN system and the World Bank in implementing the solutions identified:**

A framework for facilitating exchange and dialogue between the UN system and the World Bank is crucial to improve coordination of actions and profit from from experiences and lessons learned in implementing solutions.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Almost all the solutions proposed are in the process of being implemented with the ongoing support of UN agencies and the World Bank. Analysis of gaps in support shows that improvements in quantity and quality are possible. Such improvements would make the actions of the United Nations and World Bank more effective in accelerating progress towards MDG 1. As such, the following recommendations were addressed to the CEB review:

I. **Advocate for prioritizing the development of small-scale irrigation, the management of low-lying lands and sustainable land management** with the aim of substantially increasing the availability and diversification of food and improving the incomes of small producers. Activities involving agricultural operations, market gardening and animals will provide a springboard for developing value chains. These will include access to inputs, equipment and markets, thus contributing to strengthening the added value of productivity and incomes. Such actions also mobilize the participation of women in significant numbers. At the same time, they strengthen capacities of adaptation and resilience in facing climate shocks. Numerous operations of the World Bank and UN agencies already support such actions, but there is a need to scale up to increase the percentage of the target population that benefits.

II. **Prioritize the fight against diarrhoeal diseases, the prevention of malnutrition and intersectoral coordination for water and sanitation (WASH) and nutrition:** Screening and care for children aged 6 to 59 months with acute malnutrition must become routine. Efforts should focus on the fight against anaemia through the following means: introduction and extended use of supplementary feeding at home to benefit children aged 6 to 23 months; deworming of children aged 12 to 59 months; iron supplements for women of child-bearing age; supplementary feeding on a large scale; and routine use of occasional iron supplements for adolescents. It is important to implement the WASH-in-Nutrition minimum package in health-care centres and in nutrition recovery and education centres. It is also important to promote basic hygiene at community level, strengthen the technical capacities of community health-care agents in terms of the water chain, and promote treatment and conservation of drinking water in households. The World Bank, UNICEF, WFP and WHO are already collaborating in this area through various projects, but additional resources will be vital for scaling up the various interventions.

III. **Improve governance and the ability to manage food crises and disasters:** It is important to consider the negative consequences of climate and other external shocks that destroy the effects of actions to reduce poverty. National food reserve stocks and their management need to be strengthened, especially through better targeting of vulnerable populations. Measures to prevent food crises and disasters, and monitoring and evaluation systems must improve. Also important is the extension of social support networks, such as through cash transfers. Institutions need capacities, including human and logistical resources, for efficiently preventing and managing food crises and disasters. The World Bank is currently preparing a social networks project; WFP and UNDP are also working on this issue.

IV. **Strengthen UN actions for increasing non-agricultural incomes in rural areas:** During the winter season, small producers need income-generating initiatives or small amounts of credit and other appropriate training to develop activities that support their livelihoods. The World Bank, ILO, WFP and UNDP could come to an agreement on programmes in areas covered by the MAF.

PROGRESS SINCE THE CEB REVIEW

A series of actions complementary to those undertaken by the Government of Burkina Faso and its various development partners are helping to address key bottlenecks, including:

- **Scale up food and nutrition security, income generation and social safety net programmes**

The United Nations and the World Bank Group have supported the attainment of relevant development results, including through the SUN initiative; a mapping of national and regional stakeholders and nutrition interventions under the REACH initiative; a common result framework for reducing various forms of malnutrition; and the development of a joint 2015 action plan in nutrition with a focus on the three most vulnerable regions (North, Sahel and Est). Under the SUN movement, the Government has created three networks in partnership with the United Nations, World Bank Group, civil society and academia. The United Nations and the World Bank Group have also supported the Government to develop a new national nutrition policy and a national strategy (2016-2020) in line with the multisectoral approach to nutrition and the 2025 global nutrition targets defined at the 2012 World Health Assembly.

UN agencies and the World Bank Group have continued to promote the multisectoral approach to nutrition—including food security, health, water and sanitation, and education—through scaling up appropriate community infant and young child feeding practices. As a result, indicators have continuously improved over the past three years.

- **Support better coordination mechanisms for ensuring the protection of the most vulnerable**

United Nations and World Bank support to the Prime Ministry and the Ministry of Economy and Finance led to the official set-up of the Permanent Secretariat of the National Social Protection Policy in 2013. Since 2014, monthly consultations between relevant UN agencies and the World Bank Group have resumed to enhance the development of joint strategies and projects linked to climate change, chronic hunger and harvest reduction, in support of the Government.

- **Access to energy needs to expand more quickly to reach 50 percent of the rural population by the end of 2015; current plans to expand access only cover 30 percent of communes**

The United Nations and World Bank will extend rural energy/multifunctional platforms to reach 50 percent of the rural population by 2015 to spur the development of small businesses and improve income. A World Bank Electricity Sector Project became effective in February 2014, and additional financing to scale up energy availability in rural areas has been agreed to with Government. This will provide access to 173,600 households in 76 communities. UNIDO will support energy cost-reduction initiatives by developing solar power technology and facilitating a technical cooperation programme for cost-saving energy, energy efficiency and renewable energy. A five-year country programme was signed at UNIDO's General Conference in 2013.

- **Support small farmers to better manage their crops through the provision of climate services, and agricultural water and soil management**

Burkina Faso has a lead project in sub-Saharan Africa to develop a national framework for climate services. This needs to be translated into a national initiative. The World Meteorological Organization (WMO) is working with the UN country team to implement a pilot project to increase the uptake of meteorological information by farmers to improve crop yields, and to provide advice on the basis of meteorological data to transform products into services that can be used by farmers. WMO has organized roving seminars targeting farmers in villages. It is enhancing the capacity of agro-meteorological staff, including through collaboration with the European Organisation for the Exploitation of Meteorological Satellites (EUMETSAT), to deliver training courses on applying satellite information to crop monitoring and early warnings of droughts and floods. Other efforts focus on creating an enabling national framework for climate services and strengthening governance structures.

Through regional and national projects, the International Atomic Energy Agency (IAEA) has been working on small-scale irrigation and crop nutrition within regional and national projects to enhance the productivity of high-value crops and income generation. The IAEA has contributed to

improving the productivity and profitability of small ruminant farms by applying genetic characterization and artificial insemination for breeding and utilizing local feed resources to improve nutrition as well as medicinal plants to control parasites. Food security and poverty are promoted through induced mutagenesis, modern biotechnology (through the use of integrated isotopic and nuclear techniques) and improved soil fertility management in voandzou and sesame-based cropping systems. Capacity-building activities for scientists and farmers and equipment were provided through national and regional programmes in a coordinated manner. Meteorological stations were provided to guide soil and water management advice, including through soil and water monitoring and meteorological data.

UNDP and FAO are retooling training for livestock experts and small producers, with a particular emphasis on the needs of women (out of 13,952 small farmers trained, 4,537 [31 per cent] were women). In 2015 and 2016, the United Nations, World Bank and partner NGOs continued their support to the MoH to implement national scaling-up plans and strategies for providing good-quality treatment for 119,000 children with severe acute malnutrition; 300,000 pregnant and lactating women received infant and young child feeding services.

LESSONS LEARNED FROM THE COUNTRY EXPERIENCE

Long-term predictable resources are needed to fund the implementation of the national plan to scale up infant and young child feeding interventions. This will strongly contribute to: (i) strengthening resilience among the most vulnerable communities by using locally available resources; (ii) reducing infant and child mortality, as well as the number of malnourished children every year; and (iii) reducing the cost of management of severe acute malnourishment. Additional funding is also needed for purchasing micronutrient powders to allow home fortification of food for the most vulnerable households.

According to the national Scaling Up Nutrition Roadmap, it is urgent to develop a plan to scale up the management of moderate acute malnutrition to complement the existing plan to scale up treatment of severe acute malnutrition, in order to provide a complete service for the treatment of acute malnutrition.

The October 2014 uprising caused major delays in the new social safety net project; cash transfers restarted in August 2015, with a target of reaching 13,000 beneficiary households.

Challenges remain with respect to scaling up and prioritizing coordination of the national strategy on free health care for children under five. These include different targeting approaches and the lack of a national single registry or common database, which would likely hamper monitoring and evaluation as well as evidence-based policy discussions.

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Accelerating progress towards improved nutrition for women and children

CONTEXT

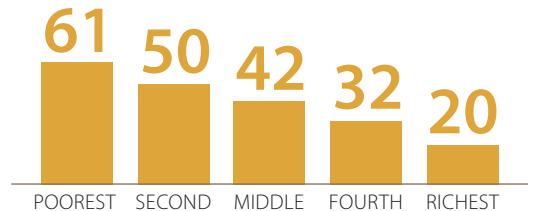
- Chronic undernutrition in children remains an enormous development challenge, despite falling poverty: an estimated 44% of children under five are stunted.
- Chronic undernutrition affects brain development and means worse education, worse health, and reduced chances for life.
- Undernutrition shows strong inequalities across regions and groups, and is associated with poverty. To effectively tackle undernutrition, it requires (1) a wide cross-sectoral collaboration and (2) more predictable resources.

UNDERNUTRITION IN CHILDREN UNDER FIVE YEARS OLD (%)

44



CHILDREN UNDERNUTRITION (%)



BOTTLENECKS

SOLUTIONS/EFFORTS

Budget allocations are inadequate to address undernutrition. Limited data on nutrition expenditures.



Lao government institutions increasingly prioritize nutrition in their plans and budgets. The Nutrition Mapping demonstrated that health sector spent an estimated \$2.8 million in 2015 on priority nutrition interventions, including WASH.

Lack of policy coherence has resulted in too many priorities (44 separate interventions).



Align behind the Lao Government's new Multi-sectoral Food and Nutrition Security Action Plan (2016-2020) to support the convergence of nutrition actions to priority districts and the 1,000 Day Households.

Limited capacity to access remote areas and ensure quality of implementation.



The Scaling Up Nutrition (SUN) framework, already adopted by Lao PDR, recommends a rapid scaling up of nutrition-specific interventions.

Combine programs and resources in food and nutrition security to improve service delivery.

Female illiteracy, strong traditional beliefs and the lack of awareness about nutrition impede efforts to change behavior.



The Secretariat of the National Nutrition Committee and the Ministry of Health initiated the Strategic Action Plan for Social and Behavioural Change Communication for Improved Health and Nutrition, with support from partners.

The Lao People's Democratic Republic has seen strong economic growth over the last few years; social progress was weaker. The economy, based largely on natural resources, especially hydropower and mining, grew at an average annual rate of 8 per cent in the past five years. Poverty declined from 33.5 percent in 2002-2003 to 23.2 percent in 2012-2013, helping the country halve extreme poverty by 2015. It is significantly off-track on nutrition, however, having a higher stunting rate than many countries with lower income, such as Togo and Uganda. Forty-four percent of children under five years of age (around 417,000) are stunted, 27 percent are underweight and 6 percent are wasted.²⁸ Since the early 1990s, stunting has declined at an average annual rate of 0.8 percent;²⁹ less than the average population growth rate. If this trend continues, the number of stunted children will likely increase. Furthermore, Lao People's Democratic Republic is one of 16 countries that still have "extremely alarming" or "alarming" levels of hunger.³⁰

Undernutrition has high human and economic costs. It accounts for around 45 percent of young child deaths and at least 20 percent of maternal mortality. Moreover, undernutrition during pregnancy and the first two years of life (the first 1,000 days) affects physical growth, impairs cognitive development, and affects educational performance and future earning potential. Childhood anaemia alone is associated with a 2.5 percent drop in adult wages. The economic cost of undernutrition is estimated at 2-3 percent of GDP (\$200-\$300 million a year).³¹

The Government at the highest levels has committed to focusing on improved nutrition for women and children in the first 1,000 days window, including through its objective of exiting from least developed country (LDC) status by 2020, where undernutrition prevalence is one of the indicators. Investing in nutrition has the largest benefit-cost ratio of any human capital investment. Actions to improve nutrition will also benefit other MDG areas, such as poverty reduction, education, gender equality, child mortality reduction, maternal health, and improved water and sanitation (MDGs 1, 2, 3, 4, 5 and 7).

SITUATION ANALYSIS

Patterns and determinants of child undernutrition

The three immediate determinants of undernutrition in children are feeding and care practices, food and nutrient intake, and a low burden of infectious diseases, especially diarrhoea. Underlying determinants include the mother's health and nutrition status, women's knowledge and education, food availability and dietary practices, a hygienic environment, safe water and good sanitation, and health care services.

Undernutrition shows strong inequalities across regions and groups, and is associated with poverty. In mountainous rural areas without road access, stunting and underweight prevalence rates are twice those in urban areas. Stunting in children from Hmong-lu Mien and Sino-Tibetan ethno-linguistic groups exceed 60 percent, nearly twice as high as among children from the Lao-Tai group. Wasting varies across provinces by a factor of five. Underweight varies by two to three times across provinces, reaching 46 percent in one province. The prevalence of stunting among children from the poorest households is three times higher than in the richest households. This gap has widened in recent years, with little progress among the poorest children. Even among the richest households, 20 percent of children suffer from stunting.

The key determinants of these undernutrition outcomes are summarized below:

- **Infant and young child feeding practices are generally poor.**³² Only 40 percent of children under the age of six months receive exclusive breastfeeding. The use of formula has more than tripled from 2006 levels. Formula-fed babies are twice as likely to have diarrhoea.
- **Dietary diversity and nutrient intake are suboptimal, leading to micronutrient deficiencies.** The typical diet is imbalanced,³³ with higher carbohydrate and lower fat and protein consumption relative to WHO-recommended levels. An estimated 42 percent of children under

²⁸ Undernutrition in boys is 1 to 3 percentage points higher than in girls, a phenomenon seen in most countries, as boys seem to be more vulnerable to health risks than girls.

²⁹ The average annual reduction rate worldwide is 2.1 percent (UNICEF, WHO and World Bank, 2012).

³⁰ The Lao Child Anthropometry Assessment Survey 2015 (tag-on to the National Immunization Coverage Survey). conducted by the MoH suggests a stunting reduction of 35.6 percent. The report is not yet published.

³¹ 2012 GDP data.

³² According to standards recommended by UNICEF and WHO.

³³ For example, the Food and Nutrition Security Survey from 2015 (five provinces only) suggests that less than a third of children received minimum dietary diversity. The report is not published yet.

five are iron deficient, and 45 percent are deficient in vitamin A. Twenty percent of households do not consume iodized salt and are at risk of iodine deficiency.

- **Twenty-two percent of people are undernourished.** Even during harvest time, around 13 percent of rural households have insufficient nutrient intake, with a diet low in animal protein, fruits, oil and fat. While household assets and living conditions have improved over the past decade, families do not necessarily consume food in sufficient quantities or with sufficient quality.
- **Local agro-ecological systems are often not sustainable or conducive to food security and nutritional health.** Population and land pressure have contributed to soil degradation and decreasing yields. Large-scale investments and climate change pose threats to household food security, and are already having discernible impacts on the country's ecosystems.
- **The disease burden among young children is still high.** Despite progress, the country still has one of the highest under-five mortality rates in the region (79 per 1,000 live births). Infectious and preventable diseases, such as diarrhoea, account for around 39 percent of these deaths.
- **Poor sanitation and unsafe water are significant factors.** Stunting affects 51 percent of young children from households with poor water and sanitation, compared to 34 percent of those using improved water and sanitation. Some 38 percent of households still practise open defecation.
- **Female education and health strongly influence child nutrition.** Stunting rates are four times higher among children of uneducated women than among children of mothers with secondary or higher education. High anaemia rates, low contraceptive use and high fertility rates contribute to poor maternal nutrition. High adolescent birth rates among the non Lao-Tai groups (22 percent to 39 percent) are another contributor to child stunting.
- **Lao-specific cultural beliefs and food taboos among the 49 ethnic**

groups are not always conducive to good nutrition. Infants in their first or second month are often given chewed glutinous rice, a practice associated with stunting and possibly with bladder stones in childhood. In urban areas, lactating women consume a diet excessively based on glutinous rice, which puts infants at risk of vitamin A, vitamin C and thiamine deficiencies.

National commitment towards accelerating progress on nutrition

Lao People's Democratic Republic's 2010 MAF action plan emphasized the reduction of inequalities and 'reaching the unreached'. Improving the nutrition of women and children appears as one of 30 priorities. The plan later influenced the Government's Seventh National Social and Economic Development Plan.

With the Eighth National Social and Economic Development Plan (2016-2020), accelerating progress in nutrition is a high priority, especially for achieving the Government's objective of graduating from LDC status. Recognizing the need to engage ministries and partners across sectors, the Government established a National Nutrition Committee in July 2013, with the goal of accelerating and intensifying the implementation of nutrition activities in line with the UN recommendations on the Multisectoral Food and Nutrition Security Action 2014-2020³⁴ and the updated National Nutrition Strategy to 2025 and Plan of Action 2016-2020. These developments indicate a favourable environment within which a more coordinated approach to nutrition by development partners can complement the Government's efforts and potentially deliver stronger results.

BOTTLENECK ANALYSIS

Policy and planning

Coordinating and working across sectors remain challenging for both the Government and development partners. International experience indicates that reducing undernutrition requires high coverage by critical interventions and convergence of multisectoral interventions in the same communities, as in Bangladesh and Peru. In Peru, stunting in rural areas fell from 40.1 percent in 2005 to 31.3 percent in 2010 (Mejia-Acosta 2011). In Lao People's Democratic Republic, however, until the establishment of the National Nutrition Committee in July 2013, the Government and development partners worked in a fragmented manner. Coverage with evidence-based nutrition interventions has been low.

³⁴ Prepared with support from the United Nations and other development partners.

Budget and financing

Government allocations to address undernutrition have been inadequate. Despite increases in the national budget allocation to social sectors and prioritization of nutrition spending within some sectors, such as health, the delivery of nutrition interventions remains dependent on external funds, which poses sustainability challenges and makes planning unpredictable.

Limited data are available on nutrition expenditures. Existing domestic and external budget tracking systems do not allow the monitoring of nutrition-related expenditures. Nevertheless, the Office of the Secretariat of the National Nutrition Committee initiated in 2015 a Nutrition Stakeholder and Action Mapping with a specific subcomponent on nutrition expenditure tracking. This activity is supported by the European Union, UNICEF and other UN organizations. If implemented annually, as envisaged, it has the potential to generate nutrition spending data essential for nutrition policies and budget-related advocacy.

Service delivery

There is limited capacity to access remote areas and ensure quality of implementation:

- Remote areas are difficult to access, and health and nutrition logistics and supply systems are weak. Vitamin A distribution, for example, does not reach 41 percent of children aged 6 to 59 months.
- The capacity of the health workforce needs strengthening, as do the training programmes to address this issue. Primary health centres are typically understaffed, even by national health planning standards.
- Some agricultural interventions, such as home gardening, are not clearly designed and widely implemented or fully integrated into the Ministry of Agriculture and Forestry's work.
- Only 12 percent of people in the poorest quintile have access to safe sanitation.

Service utilization and awareness

Female illiteracy, strong traditional beliefs and lack of awareness on nutrition impede efforts to change behaviour. The different languages

and food taboos among the 49 ethnic groups pose challenges. In areas without road access, only 41 percent of young females (15 to 24 years old) are literate.

Interventions to address the bottlenecks

Actions to resolve policy, planning and financing bottlenecks

The National Nutrition Committee coordinates ministries and interventions in different sectors. It supports convergence of nutrition actions in priority districts and the 1,000 day households.³⁵ This will help to address bottlenecks caused by weak coordination and sharpen the focus on a multisectoral convergent response in the updated National Nutrition Action Plan 2016-2020, which aims to accelerate stunting reductions to 2 to 4 percentage points per year.

Despite increases in the domestic and external funding allocation to nutrition, financing gaps remain significant. Implementing the National Nutrition Action Plan for 2016-2020 was estimated at US \$82 million per year.³⁶ At the same time, the 2015 Nutrition Stakeholder and Action Mapping revealed that annual spending on nutrition amounted to US \$42 million. Similarly, the 2015 Nutrition Stakeholder and Action Mapping showed that five-year commitments under the updated National Nutrition Action Plan lack an estimated US \$200 million or around 50 percent of the total costs for 2016 to 2020. On the positive side, government institutions increasingly prioritize nutrition in their plans and budgets. The mapping demonstrated that the health sector spent an estimated US \$2.8 million in 2015 on priority nutrition interventions, including water and sanitation.

The UN system and World Bank support the National Nutrition Action Plan; however, more is required to address undernutrition. The SUN framework, already adopted by Lao People's Democratic Republic, recommends a rapid scaling-up of nutrition-specific interventions of proven effectiveness, such as micronutrient supplementation, salt iodization and deworming, combined with the progressive adoption and implementation of nutrition-sensitive approaches in health, agriculture, education, water and sanitation, and social protection. Development partners have been supporting the national nutrition programmes for more than a decade, but coverage remains low, and more efforts are needed to ensure sufficient and predictable financing and the delivery of nutrition

³⁵ 1,000 day households refer to households with pregnant and lactating mothers and children under the age of two, which are priority groups for nutrition interventions in Lao People's Democratic Republic.

³⁶ Costing of the National Nutrition Strategy/National Nutrition Action Plan 2016-2020.

interventions to all target women and children. Achieving universal coverage with the national nutrition programmes is estimated to cost between US \$9 million and US \$12 million a year.

Accelerating the reduction of child stunting requires external resources to fill the gaps in the Multisectoral Food and Nutrition Security Action Plan and national nutrition programmes. Findings from the 2015 mapping show that known and expected funding available for nutrition for 2016 to 2020 is over half of that required relative to the costing at US \$217 million. While the reported amount is significant, the remaining gap of almost US \$200 million for five years requires significant resource mobilization efforts to implement the 22 priority interventions.

Development partners are supporting public financial management reform and other measures to transition from external funding to the national budget. Lao People's Democratic Republic has potential for increased social sector spending, given the fiscal space created by its economic growth and natural resources. The Nam Theun-Hinboun hydropower project has already set a precedent, where electricity sales finance environmental initiatives.

Actions to resolve service delivery bottlenecks

The current delivery mechanisms for disadvantaged groups require greater attention. The following groups have the lowest access to services:

- The population living in rural areas without road access (7 percent of the total population)
- Households in the poorest quintile (19 percent of the total)
- Families with uneducated or poorly educated women (21 percent of the total population)
- The non-Lao-Tai ethnic groups in the country (33 percent of the total population)

Reaching these groups with services will, therefore, require more attention to increasing participation, including through the engagement of women, incentivizing village health volunteers, and empowering networks such as the Lao Women's Union, farmer groups and village extension workers.

Actions to resolve bottlenecks in service utilization and awareness

A stronger focus is needed on changing social norms and behaviours. Building on previous success in increasing exclusive breastfeeding, the MoH aims to expand the promotion of complementary feeding and counselling, using health providers and Lao Women's Union volunteers. Providing financial incentives has worked previously in changing behaviour, notably by providing cash transfers to pregnant women in exchange for health-seeking behaviour.³⁷

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Guiding recommendations for the CEB review

The Government's commitment to a multisectoral approach is supported by development partners. The National Nutrition Action Plan makes clear that malnutrition needs to be addressed in a coordinated, sequenced and targeted manner in the health, water, sanitation, agriculture and education sectors and would benefit from linkages with other rural development and resilience initiatives. Without significant coordination efforts at all levels, Lao People's Democratic Republic will be unable to accelerate the reduction of stunting.

More focus and better coordination are needed to improve service delivery, including for addressing systemic issues of capacity development and local governance. For instance, until recently, there were five different 'packages' of free maternal and child health programmes supported by development partners in the health sector. Nutrition-specific interventions are not yet explicitly included in these packages, and further efforts are needed to harmonize the implementation and funding strategies. Furthermore, there is scope for increased efficiency in current spending and improved quality of nutrition services provided. A strong push for growth monitoring in the health sector is likely to yield more results if combined with nutrition counselling, and linked to the delivery of health and nutrition services such as management of acute malnutrition.

Lessons learned from past efforts need to be applied to make capacity development efforts successful. Incentive schemes are one option. Particular attention should be given to strengthening community mobilization and resilience; expanding livelihood options, particularly among women; and improving risk management and adaptation to challenges affecting food security and livelihoods, such as climate change.

³⁷ Antenatal care coverage among pregnant women increased from 46 percent to 75 percent (World Bank, Vientiane).

Gains will only be long-term and self-sustaining if measures for increased gender equality and women's empowerment are implemented. This will require a focus on empowering the local structures of the Lao Women's Union and the Women's Advancement Committee to reach out to women and girls in rural remote areas with services, knowledge dissemination and behaviour change interventions that also address men.

The World Bank and the UN system in Lao People's Democratic Republic recommend to the CEB that all agencies commit to the following in support of the Government:

a. All agencies align themselves fully behind the national strategy and plan of action:

- Update nutrition mapping on an annual basis to monitor trends in spending and programme coverage, identify gaps and overlaps, and inform corrective actions;
- Continue to mobilize both domestic and external resources to ensure that the National Nutrition Action Plan is fully funded and implementable;
- Institutionalize and implement sectoral and multistakeholder interventions that enhance food security and nutrition, including through resilience-building and livelihood opportunities for women; and
- Strengthen local governance mechanisms and capacities for planning, delivery and monitoring.

b. Ensure that the coordination structure among development partners facilitates joint support to the Government:

- Further promote multistakeholder engagement and responses; and
- Revise its role to move from mainly information-sharing by individual agency programmes towards developing a joint programme that provides financing and implementation support to the National Nutrition Committee.

c. Develop and monitor a performance scorecard:

- Monitor the implementation and outcomes of national food security and nutrition strategies, and those of the convergent approach in the selected provinces;

- Monitor budget allocations and spending in high-priority districts to identify funding gaps; and
- Establish mechanisms for increasing transparency and accountability in reporting.

d. Support behavioural change to reduce undernutrition among women and children, including through the development and implementation of a national social and behaviour change strategic action plan for nutrition:

- Take stock of what has worked and what has not, including in dissemination mechanisms;
- Identify priority behaviours and social norms to be addressed, and formulate clear communication objectives, messages and tools;
- Use innovative channels and different interventions as appropriate to reach all segments of the population; and
- Establish an effective monitoring mechanism for social and behavior change communication.

e. Strengthen the dialogue around the Government's budgetary allocations and spending, with the aim of shedding light on how much is budgeted and spent on priority districts, and on which sectors. Such information is currently missing in the dialogue with the Government, making it difficult to quantify funding gaps.

- Take joint action on filling funding gaps for food security and nutrition; and
- Rationalize public expenditures for increased efficiency in the use of the national budget.

f. Strengthen sustainability of interventions and results:

- Expand the scope of the approach to ensure multistakeholder participation beyond the four priority sectors;
- Facilitate the gradual involvement of the private sector and NGOs;
- Institutionalize nationwide interventions into national systems and plans for sustainable and predictable delivery at scale; and
- Devolve decision-making power and implementation to the community level.

PROGRESS SINCE THE CEB REVIEW

In 2015, a multistakeholder process for the development of the National Nutrition Strategy and Action Plan was facilitated by the Secretariat of the National Nutrition Committee, with the support of the UN team and the SUN civil society network. The strategy and action plan were presented to the first National Nutrition Forum in November 2015, and have been printed and distributed in Lao and English.

The development of a Strategic Action Plan for Social and Behavioral Change Communication for Improved Health and Nutrition has been initiated by the National Nutrition Committee's secretariat and the MoH, with financial and technical support from the World Bank, UNICEF, European Union and other development partners. Consensus was reached on the multisectoral scope of the strategy, which includes key behavioural clusters around maternal care and nutrition, infant and young child feeding, water and sanitation, and agriculture and food security-related practices. In the interim, a media campaign—via national and local TV and radio stations—has been implemented. A community-based integrated nutrition package is being supported in selected districts with the highest rates of undernutrition, food insecurity and poverty.

Coordination with the Government has continued to link to the National Nutrition Committee Secretariat and other national mechanisms. The informal development partners' group, co-convened by the European Union and UNICEF, has met quarterly to discuss key policy and programme implementation issues. In 2015, the UN country team supported an initiative led by the Ministry of Agriculture and Forestry to develop a roadmap for the national Zero Hunger Challenge.

Mapping of existing programmes was conducted by the office of the secretariat to the National Nutrition Committee with support from UNICEF, the European Union, the SUN network and other development partners. The mapping has generated information on nutrition coverage, budgets and activities of priority interventions. Findings showed that a large number of stakeholders are supporting nutrition interventions, but their efforts often fail to translate into high coverage geographically or of target groups. Of 13 evidence-based, high-impact direct nutrition interventions, only some micronutrient and deworming interventions are at scale.

Almost US \$42 million was reportedly spent in 2015, half of what is required per year for the next five years; funds reached only a limited number of beneficiaries. Just over half of the funding required for 2016 to 2020 is either allocated or expected from donors and multi-stakeholder partnerships.

In May 2016, an independent review on food security and nutrition commissioned by WFP identified challenges and gaps in achieving SDG 2 to end hunger, achieve food security and improved nutrition, and promote sustainable agriculture.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

The Government has made significant progress in institutionalizing and implementing multisectoral and multistakeholder interventions that enhance food security and nutrition. Initial progress has been made on strengthening local governance mechanisms and enhancing the capacity for planning, delivery and monitoring. The UN system has fully aligned behind the National Nutrition Strategy and Action Plan, with significant progress on a number of activities as described above. While overall coordination has been improved at the central level, it remains weak at the provincial and district levels.

The informal development partners' group has been useful to facilitate the coordination of joint support to national priorities, including through the promotion of multistakeholder engagement and responses, and collaborative programming in areas such as the behaviour change campaign. Development partners have held dialogues around government budgetary allocations to quantify funding gaps and target upcoming support.

The development of the Strategic Action Plan for Social and Behavioural Change Communications for nutrition is well underway with all development partners aligned behind it. This work could be seen as a model for other sectors.



REPUBLIC OF YEMEN

Accelerating MDG-1: Employment for youth and women and improving rural livelihoods in fragile and conflict situations

CONTEXT

- Yemen is undergoing a volatile political transition. The country's popular uprising in 2011 ended with the signing of a Transition Agreement, facilitated by the UN Special Adviser to the Secretary-General on Yemen on 23 November 2011.
- Poverty is estimated to have increased from 35% (2006) to 54.4% (2011), as food prices soared and incomes fell. Over 80% of the poor reside in rural areas. Almost half of them live on less than \$2 a day.

POVERTY RATE INCREASED



UNEMPLOYMENT RATE

13.5% AGES 15 AND ABOVE

24.5% YOUTH AGES 15-24

22.7% CHILD LABOR AGES 5-14

BOTTLENECKS

SOLUTIONS/EFFORTS

Lack of job opportunities and shortage of workers with relevant skills and education.



Inclusive growth and employment for women, youth and marginalized groups
Creation of sustainable private jobs through MSMEs and skills development, focusing on economic empowerment for youth and women.

Insufficient coverage of social protection mechanisms such as the Social Fund for Development and the Social Welfare Fund.



Promote inclusive service delivery and social protection in underserved regions especially rural areas.

Underdeveloped risk assessment tools.



Need to develop rapid assessment tools for generating data on social, economic, environment indicators and risks (e.g. UNESCO developed a mobile application for assessing the preservation of historic cities, antiquities and museums).

Political fragility, collapsing state institutions, fiscal crisis, and armed conflict hinder progress and reverse development gains.

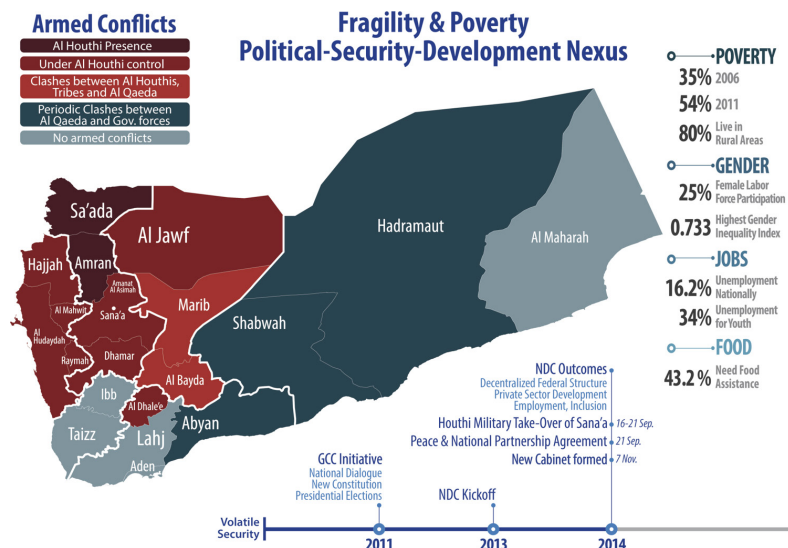


Strategies for effective social inclusion of marginalised groups.

Yemen is undergoing a volatile political transition with uncertain outcomes. Following recent political events, the likelihood of economic collapse is high. Yemen's popular uprising in 2011 ended with the signing of a Transition Agreement, facilitated by the UN Special Adviser to the Secretary-General on Yemen, on 23 November 2011. Key priorities for the transitional period include: (i) the organization of an inclusive and participatory National Dialogue Conference, (ii) the drafting of a new Constitution and the organization of a referendum, and (iii) the organization of general elections. The National Dialogue Conference (2013-2014) was the most participatory body in Yemen's political history, 30 per cent of its members were women and 20 percent were youth. With 1,850 recommendations, the final report outlines the contours of a modern Yemeni federal state and a new social contract that covers issues of state-building, grievances of the Southern and Northern regions facing economic and socio-political exclusion, employment generation, private sector development, and support to women, youth and marginalized communities.

UN Security Council resolutions reaffirmed the need for the full and timely implementation of the Transition Agreement. The implementation of National Dialogue Conference outcomes is of critical importance to address popular grievances, build and reform institutions, and deliver services across the country while ensuring accountability. Only with those changes in place will Yemen enjoy stability and sustainable inclusive growth. The national capacity to prioritize and implement the National Dialogue Conference outcomes, however, has been constrained by weak capacity, lack of resources and political uncertainties.

Conflict increases poverty, which rose from an estimated 35 percent in 2006³⁸ to 54.4 percent in 2011,³⁹ as food prices soared and incomes were lost. Over 80 percent of the poor reside in rural areas and almost half of the rural population lives on less than US \$2 a day.⁴⁰ Yemen's UN Human Development Index is at 0.500, giving it a ranking of



154 of 187 countries. Its Gender Inequality Index of 0.733 puts Yemen at the bottom of 149 countries measured.⁴¹

Conflict is making Yemen one of the most food insecure countries in the world; progress to improve the situation has been slow.⁴² More than 14.4 million (approximately 56 percent) of people in Yemen need some form of emergency food and/or livelihood assistance.⁴³ Yemen depends on imports for 95 percent of wheat, its main staple, which makes the country highly vulnerable to international food commodity price volatility.⁴⁴ The forthcoming Integrated Food Security Phase Classification will provide updated data on the overall caseload of food secure households in Yemen.⁴⁵

Employment of youth and women decreases poverty and promotes stability. Nearly 63 percent of Yemenis are under the age of 25.⁴⁶ The official unemployment rate (age 15 or older) is 13.5 percent, while

³⁸ Household Budget Survey 2005/2006.

³⁹ World Bank 2012, Poverty Assessment.

⁴⁰ IFAD, 2011, "Enabling Poor Rural People to Overcome Poverty in Yemen."

⁴¹ UNDP Human Development Report 2014.

⁴² FAO, IFAD and WFP, 2015, *State of Food Insecurity in the World*.

⁴³ Food Security and Agriculture Cluster, 2016 *Humanitarian Needs Overview*.

⁴⁴ FAO Global Information and Early Warning System: www.fao.org/gIEWS/countrybrief/country.jsp?code=YEM.

⁴⁵ The next International Food Security Phase Classification analysis led by FAO and partners will be completed in early June 2016.

⁴⁶ Estimation for 2014, according to 2010 population projections (2005-2025) by the Central Statistical

unemployment among youth aged 15 to 24 years is 24.5 percent. Child labour (5 to 14 years) stands at 22.7 percent of the workforce.⁴⁷ Opportunities to work in neighbouring countries are dwindling, making youth more vulnerable.⁴⁸ Female participation in the labour market is 6 percent compared to 65.8 percent for men.⁴⁹

Harnessing the potential of youth and women is essential to promote stability. The transitional government aims at accelerating poverty reduction through improving rural livelihoods and employment for women and youth. Youth and women played an instrumental role during the 2011 demonstrations, and the National Dialogue Conference clearly established their potential as agents for change. Youth employment is key for ensuring stability as it provides one possible alternative to radicalization, and supports stabilization at the local, subnational and national levels. Without addressing this priority, political transition and democratization risk being unsustainable.

Limited coverage of safety nets and outreach increases vulnerability. Yemen's public spending on programmes like the Social Welfare Fund (covering approximately 33 percent of Yemeni households), the Social Fund for Development programmes and other programs accounts for just 0.6-1.0 per cent of GDP.

Yemen's post-2011 economic recovery was inadequate to make a dent in unemployment. Reforms were postponed for fear of derailing the national dialogue. The macroeconomic situation deteriorated further in 2014, with increased sabotage of power and oil facilities, causing severe fuel and power shortages, and reducing oil revenues. Public expenditures were reduced in 2014 with cuts in fuel subsidies, public sector wages and social transfers, impacting the poorest. Yemen was granted support in mid-2014 through the IMF's Extended Credit Facility. The ability to deliver services that protect the poor remains highly vulnerable to the country's security environment, and related stability of oil production and exports.

Yemen is supported by a small donor group with regional donors playing a highly significant role. These large donors are expected to withdraw their support following the Houthi takeover, which will have severe economic consequences.

The private sector is weak and employment remains limited. Investment risks are high and investor confidence low. In 2011, 91.4 percent of Yemenis made a living in the informal sector, including two-thirds of the wealthiest people.⁵⁰ The private sector is confronted with red tape, the high costs of basic services, corruption and high security risks. With weak state institutions and a bloated public sector, jobs can be created by building investor confidence. The Peace and National Partnership Agreement attempts to do this by developing a comprehensive competitiveness plan. In 2014, less than one-third of Yemenis were employed by the formal sector.⁵¹

SITUATION ANALYSIS

Eradication of poverty through rural livelihoods and employment generation would improve the standard of living of Yemeni families and ensure inclusion of the poor in the Yemen of tomorrow. To foster stability, the government should give youth employment special attention. The Multidimensional Livelihoods Assessment in Conflict Areas (UNDP 2014) indicates that over half of the rural population owns assets, conducive for introduction of livelihoods and resilience-based interventions to improve household incomes, while delivering on other MDGs. However, critical assets in many communities have been destroyed, reducing the prospects of achieving MDG 1.

MAF priority interventions are nested in wider challenges. The MAF consultation process has led to prioritizing three interventions focusing on women, youth, marginalized groups and rural areas. These are aimed at:

- I. Building capacities and skills for employability and entrepreneurial opportunities;
- II. Promoting the growth of micro-, small-, and medium-size enterprises and diversifying rural livelihoods; and
- III. Implementing social protection mechanisms to address risks and vulnerabilities faced by women and youth.

⁴⁷ UNDP Human Development Report 2014.

⁴⁸ IOM, "31 August 2014 Update," Yemen.

⁴⁹ ILO, 2014, *Yemen Labour Force Survey 2014*, www.ilo.org/beirut/publications/WCMS_419016/lang--en/index.htm.

⁵⁰ UNDP *Multidimensional Livelihoods Assessment in Conflict Areas in Yemen 2014*.

⁵¹ ILO, 2014, *Yemen Labour Force Survey 2014*, www.ilo.org/beirut/publications/WCMS_419016/lang--en/index.htm.

Political stability and security is critical prerequisite for ending extreme poverty. Without a significant improvement, MAF actions will not succeed. The interdependent nature of economic, political and security elements makes simultaneous progress on all three issues critical. The UN family and World Bank Group have instruments to deploy simultaneously on all three fronts. The MAF is expected to boost a concerted multipartner effort to tackle identified bottlenecks.

With the legacy of the previous regime, which fostered inequality and exclusion, the National Dialogue Conference calls for a more equitable and inclusive society and economy. Youth, women, people in extreme poverty, IDPs, migrants, refugees, and social minorities such as the Muhamasheen face social and economic marginalization and discrimination. All interventions will work to increase inclusion.

Interventions incorporating strengthened risk mitigation measures will require actions at the national and subnational levels. The structure of the future federal state is yet to be determined. Nevertheless, some governorates are keen to implement the MAF at the subnational level, and to serve as pilots for decentralization,⁵² allowing a localized and flexible implementation.

BOTTLENECK ANALYSIS

MAF engagement areas

I. Developing the capacity and skills for employability and entrepreneurship of women and youth with a focus on marginalized groups and rural areas

Even where demand for labour exists, creating employment opportunities for Yemeni women and youth because of their lack of relevant skills and education. Incentives and mechanisms for skills development in the private sector are weak. Current technical and vocational training opportunities do not meet demand or respond to the needs of women and youth, including refugees, IDPs and migrants. Training programmes do not provide the necessary skills for self-business creation. Livelihoods are likely to come from informal agricultural and non-agricultural employment, but there is space to expand formal private sector employment. Community-driven skills development may focus on

livelihoods and skills to manage assets, and could be launched through existing and reinforced community-based organizations to increase resilience. Market-driven skills development responding to needs for skills and delivered through market mechanisms can unlock opportunities for educated youth. Identified solutions to tackle this include: (i) identification of labour market needs for skills linked to assets and abilities for low-skilled and vulnerable women and youth; and (ii) integration of gender perspectives during the design stage of vocational training policy and programming, and in farmer field schools.

II. Promoting the growth of micro-, small, and medium-size enterprises and diversifying rural livelihoods, with a focus on women, youth and vulnerable and marginalized groups

Vulnerable groups face high barriers to accessing finance, in particular in rural areas, inhibiting their ability to generate income through micro-, small and medium enterprises, and diversify their livelihoods. Requirements for collateral and high interest rates prevent the poor from getting loans. This stems from the legal framework, which is not conducive to the provision of finance for smaller businesses.

Solutions for promoting growth hence include: i) improving access to finance by strengthening the physical outreach of microfinance and financial institutions, targeting products to vulnerable groups and identifying innovative instruments for inclusion; ii) supporting the provision of international and local funding for microfinance and financial institutions by establishing a loan guarantee programme; iii) adopting new micro-, small and medium enterprise laws and regulations to enhance the legal framework and support entrepreneurship; iv) diversifying rural livelihoods through the development of off-farm activities, water management and renewable energies for new agricultural value chains and women's access to productive assets; and v) strengthening governance mechanisms affecting businesses. Employment creation programmes have mostly been carried out through fragmented interventions, without a coherent private sector involvement strategy, which would allow more active stimulation of private sector growth, and better guide policies generating catalytic impacts and help achieve inclusiveness and replicability. Micro-, small and medium enterprises

⁵² In an unprecedented MAF consultation engaging over 220 participants, a geographic focus was on Al Janaad province, while the bottlenecks and solutions identified are relevant and applicable for the country as a whole.

possess an unmet potential from a development perspective within a fragile state such as Yemen, particularly in the areas of service delivery, social protection and employment.

III. Implementation of social protection mechanisms and service delivery for women and youth

In a country where over half of the population is poor, the role of social protection is crucial. Yemen's social protection mechanisms, mainly the Social Welfare Fund and the Social Fund for Development, need support to protect the most vulnerable groups. The key challenges facing the Social Welfare Fund are the value of cash transfer benefits and the scale of programmes. The recent Muhamasheen Mapping Survey revealed that 80 percent of the poorest Muhamasheen households are still not covered by the Social Welfare Fund.⁵³ The lack of graduation mechanisms is a major bottleneck in improving overall coverage. The National Dialogue Conference outcomes acknowledged such challenges and called for improving targeting and increasing financial allocations. Savings from the exclusion of non-poor beneficiaries could be used to enrol the poorest. Secondly, the Social Fund for Development's Labour Intensive Works Programme offers cash for work for low-skilled labour in rural and urban areas, but faces bottlenecks in coverage and targeting. It is particularly important to design programmes that attract women, Muhamasheen and mainstream refugees, IDPs and migrants. The National Dialogue Conference outcomes called for scaling up the Labour Intensive Works Programme to help reduce unemployment.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Guiding recommendations for the CEB review

Yemen is fragile on several fronts. The volatile security situation, political uncertainties and deteriorating economic situation enforce one another, and no solution on one front can happen in isolation from the others. This poses a unique challenge, since several instruments will have to be deployed simultaneously, and business cannot continue as usual. Recommendations for the CEB are as follows.

Recommendation 1: Supporting service delivery in a volatile transition to a future federal state. Yemen is moving from a highly centralized to a federal state, although the architecture needs to be defined by the new Constitution and by-laws that will take time. The recent Houthi takeover has started to undermine government legitimacy and functionality in the capital and beyond, and may lead to a redrawing of regional boundaries. The United Nations System and World Bank Group are already supporting the decentralization process, but will need to continue to respond meaningfully at the local and central levels to pressing service delivery challenges caused by severe institutional and capacity deficits, without pre-empting national decisions in regard to decentralization, the devolution of authority and the future structure of the state.

Recommendation 2: Ensuring meaningful and sustainable inclusion in the development process. Systematic exclusion, marginalization and impoverishment of many population groups have led to extreme inequalities, conflict and radicalization. For women, youth and civil society, the 2011 revolution and the National Dialogue Conference created historical space for political participation and inclusion. The United Nations System and World Bank Group should support platforms and networks of marginalized groups for inclusion in political and developmental processes. Under the MAF, they should undertake an assessment of economic opportunities for marginalized groups (e.g., women, youth, extremely poor people, Muhamasheen, refugees, IDPs, migrants). The CEB is invited to share ideas to sustainably cultivate inclusion, social cohesion and a human rights-based system of governance and access to services, to prevent a loss of recent gains.

Recommendation 3: Supporting the private sector to boost job creation. In Yemen, as in many fragile and conflict-affected countries, private sector development is indispensable for inclusive growth and employment, yet extremely challenging. The United Nations System and World Bank Group need innovation in assistance modalities to work effectively with the private sector, including to improve the business environment, ensure that skills training leads to jobs, create and exploit

⁵³ UNICEF, 2014, Social Welfare Fund (Muhamasheen Mapping Survey).

value chain strategies and pursue systematic approaches for job creation with Yemen's diaspora and migrant populations in cooperation with other countries. Targeted investments to improve competitiveness at the national and cluster level as a positive shock to increase investor confidence should be supported. High-level political commitment to a programme of fundamental business climate reforms is needed. The CEB is invited to contribute solutions to work with the private sector in a fragile state in conflict.

Recommendation 4: Creating joint UN-World Bank facility in support of the implementation of the National Dialogue Conference

outcomes. The United Nations and the World Bank have agreed to establish a joint facility to support Yemen's transition to an effective and responsive federal state based on National Dialogue Conference outcomes. The facility will maximize and coordinate the strengths of both institutions to work across the tight political-security-development nexus, with a focus on analytical and capacity-building work to support the Government of Yemen in the prioritization, implementation and monitoring of assistance related to National Dialogue Conference outcomes. This joint support to Yemen's state-building efforts will be critical to help build a more stable future for the country. Special attention will go to supporting women and youth as important agents of change and to creating sustainable structures for their economic empowerment and political participation. To ensure full support to the political process, the UN Special Adviser to the Secretary-General on Yemen will lead the work of the facility, and the United Nations will be the main account holder for the accompanying trust fund under one decision-making structure. A joint donor mission will establish the initial programmatic framework. The facility's design and focus is innovative and untested, but necessary risks need to be taken to achieve results in Yemen's fast-changing and challenging landscape, with the hope of providing a model for other countries facing similar transition challenges.

PROGRESS SINCE THE CEB REVIEW

The United Nations, in particular through UNICEF, has been advocating for the resumption of Social Welfare Fund operations. The Special Envoy's team has shared with donors a project document to propose emergency

reactivation. It details how the fund operations will provide immediate cash transfers to millions of Yemenis and help prevent the collapse of a key social protection mechanism.

On the humanitarian cash transfers side, the United Nations, through UNICEF, started interventions in late 2015, with a total target of 15,000 households in Taiz and 5,000 households in Sana'a, and with a major focus on Muhamasheen households. So far, 12,700 households have been covered with monthly cash transfers of USD 100 for six months. Prior to the interventions, Muhamasheen Community Mapping Surveys were conducted to serve as baselines and to register households. Mothers and female care-takers were the primary recipients to promote gender empowerment among such very poor communities. Cash disbursements were implemented by Alamal Micro-Finance Bank, which succeeded in reaching Muhamasheen beneficiaries in the very difficult security areas of Taiz City Enclave. A national research institution is providing third-party monitoring, focusing on verification of cash distribution as well as on post-distribution monitoring. A national NGO in Taiz is conducting social accountability activities on humanitarian cash interventions among the most vulnerable communities. To strengthen Social Welfare Fund, staff and governorate level offices had a key role in targeting and managing the complaints and appeals mechanisms. Results of the post-distribution monitoring revealed that the cash transfers have had a major impact on improving the lives of the poorest families.

Within its mandate and as part of its CEB commitments, UNDP pursued job creation and private sector linkages to promote community-based economic resilience. Since November 2014, UNDP has helped develop the business and vocational skills of over 2,600 youth across six governorates, equipping them with the capacity to turn their ideas into viable business plans. Following the outbreak of the war in March 2015, UNDP promoted social entrepreneurship as a bridge between private sector support and meeting the rising needs of crisis-affected communities, realigning its interventions to emergency employment and business resilience through assets and grants. During this period, nearly 155,000 work-days were generated, and resource mobilization to support the Social Fund for Development and its Labour Intensive Works Programme is underway.

UNDP has also led joint initiatives encouraged by the CEB, through the Enhanced Rural Resilience in Yemen project, which builds on the comparative advantages of UNDP, FAO, the ILO and WFP to address community vulnerabilities by creating jobs. Women and youth continue to be a core focus of UNDP's interventions, with its Women's Economic Empowerment Project in Taizz Governorate and a dairy value chain initiative targeting 500 young women from vulnerable households. UNDP launched the first crowdfunding platform for Yemen, "Yemen Our Home," to connect local communities in need with the Yemeni diaspora and the private sector through innovative finance. Consultations are underway between the World Bank and UNDP to support the Social Fund for Development and the Public Works Programme.

In response to the conflict in Yemen, the United Nations Educational, Scientific and Cultural Organization (UNESCO) developed a mobile application for rapid damage assessment, provided required equipment, and trained experts from the General Organization of Preservation of Historic Cities of Yemen, the General Organization of Antiquities and Museums and the Social Fund for Development on emergency documentation and rapid assessment of cultural heritage at risk. External coordination meetings to develop and implement heritage action plans on the ground were coordinated. An International awareness-raising campaign, "Yemeni Heritage Week—Museums United for Yemen" was organized together with 10 leading museums around the world to raise awareness about cultural heritage at risk.

Several agencies involved in education, including UNESCO and UNICEF, participated in the Preliminary Damage Needs Assessment to prepare for post-conflict interventions.

Several agencies involved in education, including developing and producing lifeline programmes to better report on the humanitarian situation, and to meet the information needs of communities affected by the crisis. Together with Yemeni journalists, local media organizations, international press freedom groups and UN agencies, a Plan of Action on Supporting Yemeni Media in Promoting Peace and Dialogue was developed.

A number of activities, such as those undertaken by UNFPA, could not be implemented due to the conflict.

LESSONS LEARNED FROM THE COUNTRY EXPERIENCE

The CEB and the MAF processes in 2014 were key in focusing on national social protection mechanisms, as well as tailored programmes that target marginalized groups. There have been major bottlenecks and challenges facing various social protection interventions, mainly related to the high-risk environment and the very difficult security situation. Although a pre-crisis baseline revealed that more than half of the people in Yemen live under the poverty line, the current conflict has further pushed millions more people into extreme poverty. This has increased demand for social protection in general and Social Welfare Fund cash transfers specifically, as now much more than 8 million people are in need of urgent transfers. Advocacy to reactivate the Social Welfare Fund was led by UNICEF, but would have not been possible without extensive coordination with the World Bank. Currently, UNICEF and the World Bank are working closely to finalize a technical assistance plan for reactivating the fund.

Challenges to implementing humanitarian cash transfers in Taiz have included difficulty in accessing the city enclave due to the conflict. The provision of transfers has been possible mainly due to the extensive coordination of the disbursing bank with both sides of the conflict, as well as the good reputation and neutrality of implementing partners. Applying technology and biometrics, where the fingerprints of beneficiaries were used for cash disbursements, has greatly improved efficacy. Other key areas have been third-party monitoring of cash distribution, given such a high-risk environment, and real-time feedback on the verification of cash distribution. Coordinating with key UN agencies working on social protection has proven its value. UNICEF has extensively coordinated with WFP at the central and governorate levels, including in referring poor households not targeted by humanitarian cash transfers to WFP food and voucher distribution.

The 2015 crisis that derailed the transition period brought about a radical shift in priorities for the United Nations in Yemen. While the complex political, security and economic nexus remains relevant, the humanitarian crisis culminated in the declaration of a Level 3 emergency⁵⁴ in June 2015. This highlighted the need to adopt innovative approaches and seek new partnerships bridging the development and humanitarian world for the attainment of MDG 1. In the absence of a coherent central government, UN agencies like UNDP benefited from a decentralized approach that engaged local-level actors in the design and implementation of resilience-building interventions. The refocus of its existing portfolio towards economic restoration and the delivery of services to affected populations was designed to ensure that the social fabric would not erode further, and to prevent negative coping strategies that would set back previous employment gains. To increase the impact of CEB initiatives, the original regional focus on Taiz and Ibb governorates proposed during the MAF process could have helped to address bottlenecks to employment generation for women, youth and other vulnerable groups in a way that maximized thin resources.

The unraveling of Yemen's political and security context after the CEB review did not allow work on the joint United Nations and World Bank facility. The UN Special Adviser to the Secretary-General was replaced in April 2015 by a new UN Special Envoy to the Secretary-General to start a renewed round of political talks in the much-altered political reality of the Hadi Government in exile in Riyadh, with the capital, Sana'a, under the control of the Houthi and Ansar Allah, supported by ex-President Saleh. Military operations between the Houthi/Saleh alliance and Hadi/Saudi-coalition forces since March 2015 are ongoing, continuously altering the geographical landscape of power on the ground.

The UN country team and the World Bank conducted an internal retreat in May 2015 to draw lessons from the transition and brainstorm a way forward in recovery preparations. One output is the preliminary Damage and Needs Assessment in collaboration with the European Union and the Islamic Development Bank that was finalized in May 2016. An informal consultation among Yemeni stakeholders was also jointly undertaken by the United Nations, World Bank and European Union in Larnaca in October 2015 to pinpoint priority needs of the Yemeni population and institutions under the conflict and political crisis. Consultations are ongoing between the United Nations, the World Bank, Gulf Cooperation Council and other international partners with the Yemeni Government (Hadi) on preparations for post-conflict recovery and reconstruction.

⁵⁴ This is the global humanitarian system's classification for the response to the most severe, large-scale humanitarian crises. Countries like Iraq, Syria and Yemen are classified as L3.

CHAPTER 2

ACCELERATING UNIVERSAL ACCESS TO EDUCATION



The primary focus of MDG 2 was to ensure that all children complete a full course of primary education by 2015. Progress is measured by the primary school completion rate, which is defined as the proportion of children completing the last grade of primary education, regardless of age.

Few developing countries met MDG 2, although many made significant gains. The primary school completion rate increased from about 79 percent in 1990 to 91 percent in 2013. This achievement is noteworthy in light of the increase in the number of students growing from 88 million in 1990 to 103 million in 2013. This increase means that nearly 25 million more children were able to complete primary education. And despite the completion rate remaining at 91 percent since 2009, 1 million more children were able to complete primary education.

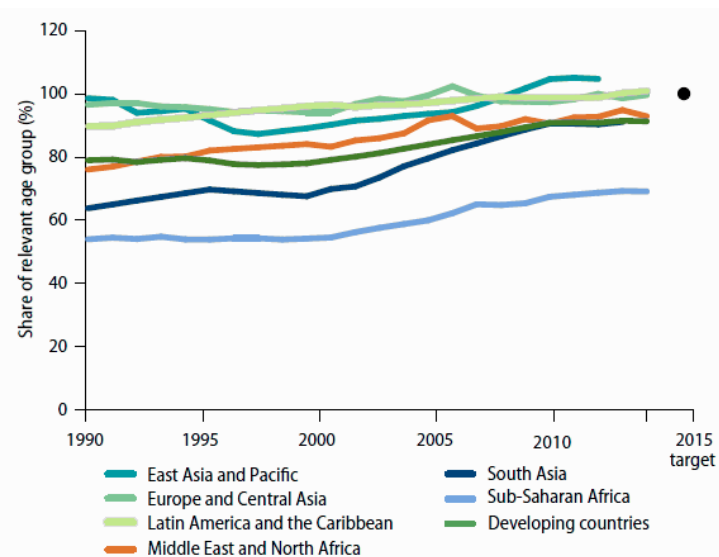
On a regional level, East Asia and the Pacific, Europe and Central Asia, and Latin America and the Caribbean reached the target; other regions did not. The situation in Sub-Saharan Africa is especially challenging. It has the lowest primary school completion rate, despite an increase from 54 percent in 1990 to 69 percent in 2013. In 2013, it was nearly 20 percentage points below the average rate for all developing countries.

At the same time, sub-Saharan Africa has the fastest-growing population of primary school-age children among all regions, placing more pressure on its education system.

Regional averages often conceal variations in performance across countries. For example, although East Asia and the Pacific, Europe and Central Asia, and Latin America and the Caribbean have met the target, 18 countries in these regions are unlikely to achieve it even by 2030. Meanwhile, nine countries in Sub-Saharan Africa achieved the goal, although the region as a whole has lagged.

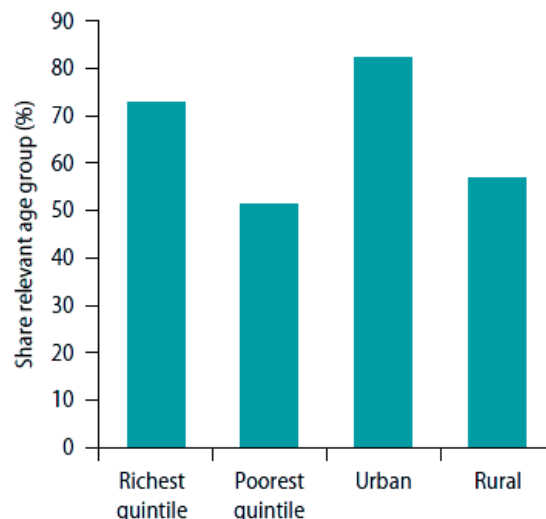
Variations are evident not only across countries but within countries—between the rich and poor, and between urban and rural residents. Children in poor families and those living in rural areas are less likely to enrol or remain in school. In Senegal, for example, 83 percent of children in urban areas completed primary school while only 57 percent in rural areas did so. Ensuring equitable access to education is a key challenge. To complete a course of education, children need to enrol and stay in school. But many children still never attend school, start school but attend intermittently or drop out before completion.

PRIMARY SCHOOL COMPLETION RATE



Source: World Bank, 2015. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change.

PRIMARY COMPLETION RATE IN SENEGAL, 2012



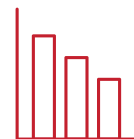
PAKISTAN

Accelerating progress towards quality universal primary education

CONTEXT

- Pakistan has the world's second highest out-of-school population (12% of the total in the world), 56% of them girls. The completion rate for primary education is among the lowest in the world: Less than half of the country's population has completed primary education.
- Pakistan has one of the lowest investments on education in the world (less than 2% of GDP).
- 50% of the country's out-of-school children live in 25 of the country's 144 districts. There are large differences in primary net enrolment rates across provinces and even larger differences at the district level, ranging from 13% (Dera Bugti, Baluchistan) to 93% (Chakwal, Punjab).
- Based on the current birth rate, 500,000 new children will come of school age every year. A constitutional commitment ensures free and compulsory basic education for all.

**EDUCATION
SPENDING LESS
THAN
2% OF GDP**



**CHILDREN AGED
10+ WHO CANNOT
READ AND WRITE
42%**



BOTTLENECKS

Lack of evidence-based decision making and weak accountability; supply-demand mismatch.



Very poor learning outcomes. Large numbers of school leavers do not achieve minimum mastery of math, reading and language (as defined by the national government).



Inadequate level and inefficient composition of education expenditure.



Poor teacher quality.



SOLUTIONS/EFFORTS

Build rural reservoirs that reduce the time spent by indigenous peoples. Strengthen collection and use of high quality data the capital of Rio Hacha has continuous running water.

Pilot integrated programmes in the 25 lagging districts that account for the largest number of out-of-school children.

Proactively engage with leadership to translate commitments into implementation (girls' education, spending and accountability for performance). Create an enabling environment for private sector expansion. Incentivize private sector expansion in the 25 lagging districts.

Scale up successful local transport models through community-based schools and parent teacher school management Committees with the help of community contributions.

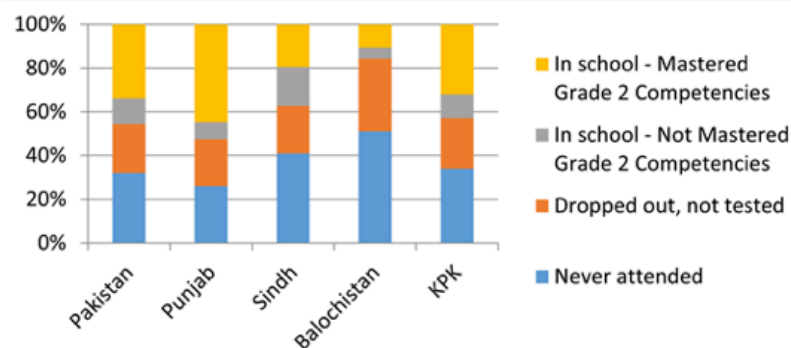
Over the past decade, Pakistan has made considerable efforts in improving access to education through a series of reform initiatives, led by provincial governments, some of which have been supported by development partners. Enrolment has increased, but several key outcomes are lower than in other countries in South Asia or countries elsewhere with similar levels of per capita income. Pakistan has the world's second highest out-of-school population (6.7 million, 12 percent of the world total); 56 percent are girls. It ranks 113 out of 120 countries in UNESCO's Education for All Development Index.⁵⁵ Less than half of the country's population has completed primary education, one of the lowest completion rates in the world. About 42 percent of people aged 10 and above cannot read and write.

SITUATION ANALYSIS

Pakistan faces the twin challenges of low enrolment rates and early exits combined with low levels of learning for who children who do attend school. The primary net enrolment rate,⁵⁶ at 68 percent in 2012-2013, is lower than in other countries in the region except Afghanistan. There are large differences in rates among the country's four provinces, and even larger differences at the district level within provinces, with rates ranging from 13 percent (Dera Bugti, Balochistan) to 93 percent (Chakwal, Punjab).

Children from poor families residing in rural areas have very low enrolment rates; girls are more disadvantaged than boys among these children. Fifty percent of the out-of-school population resides in 25 of the country's over 100 districts, mostly in rural Punjab and Sindh. Children from poor households appear to suffer a large education disadvantage at all levels; for example, only 43 percent of children aged 6 to 10 years belonging to the poorest two wealth quintiles are enrolled. The enrolment gap rises sharply for rural households at the middle and secondary education levels; only 36 percent of rural children between the ages of 11 and 15 are enrolled in grades 6 to 10, compared with 56 percent of urban children. The gender gap at middle and secondary education

FIGURE 1: PRIMARY-AGE COHORT IN PAKISTAN



Notes: *Never attended* is computed as 6-10 year olds who are out-of-school
Dropped Out: Those who attended school but did not complete primary by the age of 13
Mastered Grade2 Competencies is computed as proportion of those who survived till grade 5 and can read words and subtract two-digit numbers.
Sources: PSLM (2011-12); ASER(2012-13)

levels among rural households is even greater: only 30 percent of rural girl aged 6 to 10 compared to 46 percent of boys in this age group attend middle or secondary school.

The second challenge is very poor learning outcomes. A large proportion of school leavers do not achieve a minimum mastery of mathematics, reading and language (as defined by the national government). The problems of low access, poor retention and low learning for the country and four provinces are depicted in Figure 1.

The private sector in Pakistan is emerging as an alternative to public schooling, even for children from poor households. Today, one-third of primary and secondary students in Pakistan attend private schools. Between 2004-2005 and 2010-2013, the overall share of children aged 6 to 10 enrolled in private schools increased 7 percentage points. Growth in the private sector has been concentrated in urban and wealthier areas and some districts.

⁵⁵ The Education for All Development Index is a composite index that provides an assessment of a country's education system in relation to four Education for All goals: universal primary education, adult literacy, quality and gender.

⁵⁶ The net enrolment rate measures the share of children of official age for a given level that attend that level. In Pakistan, the official age for primary schooling is 6 to 10 years. Net enrolment rate data are not available for Azad Jammu and Kashmir, Gilgit Baltistan and the Tribal Areas, which together account for an estimated 5 percent of the country's population of 180 million.

BOTTLENECK ANALYSIS

Main contributing factors to low education outcomes

Issues in the supply chain of education: Policy and planning, financing and budgeting, and service delivery bottlenecks

Poor teacher quality. Teachers across the country have low content knowledge and weak pedagogical skills. This is in part attributable to the country's weak recruitment policies and practices, and political influence on recruitment decisions. Punjab, Sindh and Khyber Pakhtunkhwa provinces have introduced test-based teacher recruitment, which could significantly improve teacher quality at entry. This is an important reform that needs to be replicated nationally and protected from political pressure to backtrack. At the same time, teacher training, both pre- and in-service, remains weak, compounded by the absence of an effective accreditation and certification mechanism. Teacher development programmes lack standardization and do not provide adequate incentives for improving one's qualifications. The paucity of qualified teachers for early childhood education reflects the lack of emphasis this component receives in existing teacher development programmes. The quality of in-service training is weakened by the limited capacity of the provincial institutes of teacher education to implement continuous professional development programmes.

Weak teacher accountability. Measured by high absence rates and minimal effort, weak teacher accountability is the main cause of poor learning outcomes even when teachers are sufficiently qualified. In most parts of the country, teachers can be dismissed or have deductions made from their salaries for misconduct, corporal punishment, absenteeism and poor performance. There is no evidence that these strictures are enforced, however, system accountability does not focus adequately on the teaching and learning processes in classrooms. Past attempts to document learning outcomes and diagnosis challenges in the system could not be mainstreamed in management priorities. Underperformance of administrative staff is also a concern.

The placement of teachers shows wide variations: Some schools have fewer than five students per teacher, and others more than 100. Schools in the worst-performing districts are also the ones with the highest student-teacher ratios. Political interference in teacher placement and transfers is the main contributor to the imbalance. Particularly in rural schools, teachers may be appointed to vacant positions, but use political pressure to transfer their posts within a few months, leaving remote schools understaffed or sometimes without a teacher altogether. Government policies dictating student-teacher ratios and teaching loads exist, but enforcement is weak and made harder by external influences.

Inefficient budget management. The country has one of the lowest rates of public expenditure on education as a share of GDP (1.9 percent). More than 90 percent of the education sector's recurrent expenditure is related to salaries. This leaves very limited budget for spending on critical non-salary inputs, such as teaching and learning materials, repair and maintenance of school infrastructure, and teacher professional development. The lack of a link between school needs and financing results in worsening conditions of schools especially in rural areas.

Lack of evidence-based decision making. Data, not always easily accessible, are rarely used either by the system to improve education decision-making or by parents to demand school accountability. Student assessment systems are inadequate for providing systematic and reliable information on student learning outcomes.

Students are disillusioned by the schooling experience. A large number of government primary schools in Pakistan lack proper infrastructure. The majority of schools, especially in rural areas, have one or two teachers and multigrade teaching environments for which teachers have not been trained. Basic facilities are missing—including toilets, drinking water, adequate furniture, drainage and boundary walls—constituting a major cause of dropouts and a disincentive for enrolment. These problems are more acute in rural areas where the poorest people reside.

There is a perception of low returns to education, contributing to early exit and dropout. Most people do not have access to a secondary school.

Constraints in the enabling environment for education: demand side bottlenecks

Poverty continues to limit the ability of families to send their children to school. The vast majority of out-of-school children are in the poorest 40 percent of the population. Moving a child from the bottom wealth quintile to the top wealth quintile doubles the probability of attending school. At the same time, economic shocks (food prices) and natural shocks (earthquakes, floods) disproportionately affect the poorest children.

Security issues affect the mobility of children, especially girls. Security concerns impede the free movement of children to schools throughout the country. The problem is particularly in the tribal belt, where literacy rates are just 17 per cent. Schools have been destroyed by militants, and the state presence is actively challenged. The security of girls is an especially critical issue, inhibiting their schooling.

Pakistan has high rates of child malnutrition. One-third (32 percent) of children under five years are underweight and 12 percent are severely underweight. Malnutrition during pregnancy and early childhood compromises cognitive and physical development; reduces learning ability, school enrolment and performance; and lowers productivity in adulthood.

Pakistan has made minimal progress in improving nutritional outcomes among children and mothers over the last four decades. The 2011 National Nutrition Survey reveals that rates of child stunting have not changed in Pakistan since 1965.

Civil society is not organized to demand basic service delivery, especially for the poor and vulnerable. Civil society has not played a role in organizing communities to demand better quality services through information-sharing or creating communication links between communities and policy makers. Mechanisms for social accountability are for the most part absent.

The good news

Pakistan has formalized its commitment to achieving universal basic education by amending its constitution to include an article

(Article 25A) that guarantees free and compulsory basic education for all children aged 5 to 16. An active Interprovincial Education Ministers conference is being held regularly to coordinate standards and curriculum, monitor subnational performance on education indicators and discuss ways in which bottlenecks can be removed to improve performance.

To accelerate progress towards the MDG target of universal primary education, the four provincial governments and four administrative areas of Pakistan have prioritized the MDG related to primary education for acceleration. Regional governments have developed MAF action plans and closely aligned their education sector strategies/plans. These action plans identify priority interventions required for increasing primary enrolment and retention and removing bottlenecks. They propose feasible, cross-sectoral and innovative solutions for addressing bottlenecks with potential partners. They have built on the National Plan of Action for education, which quantified the number of out-of-school children and identified strategies for maximizing enrolment within three years.

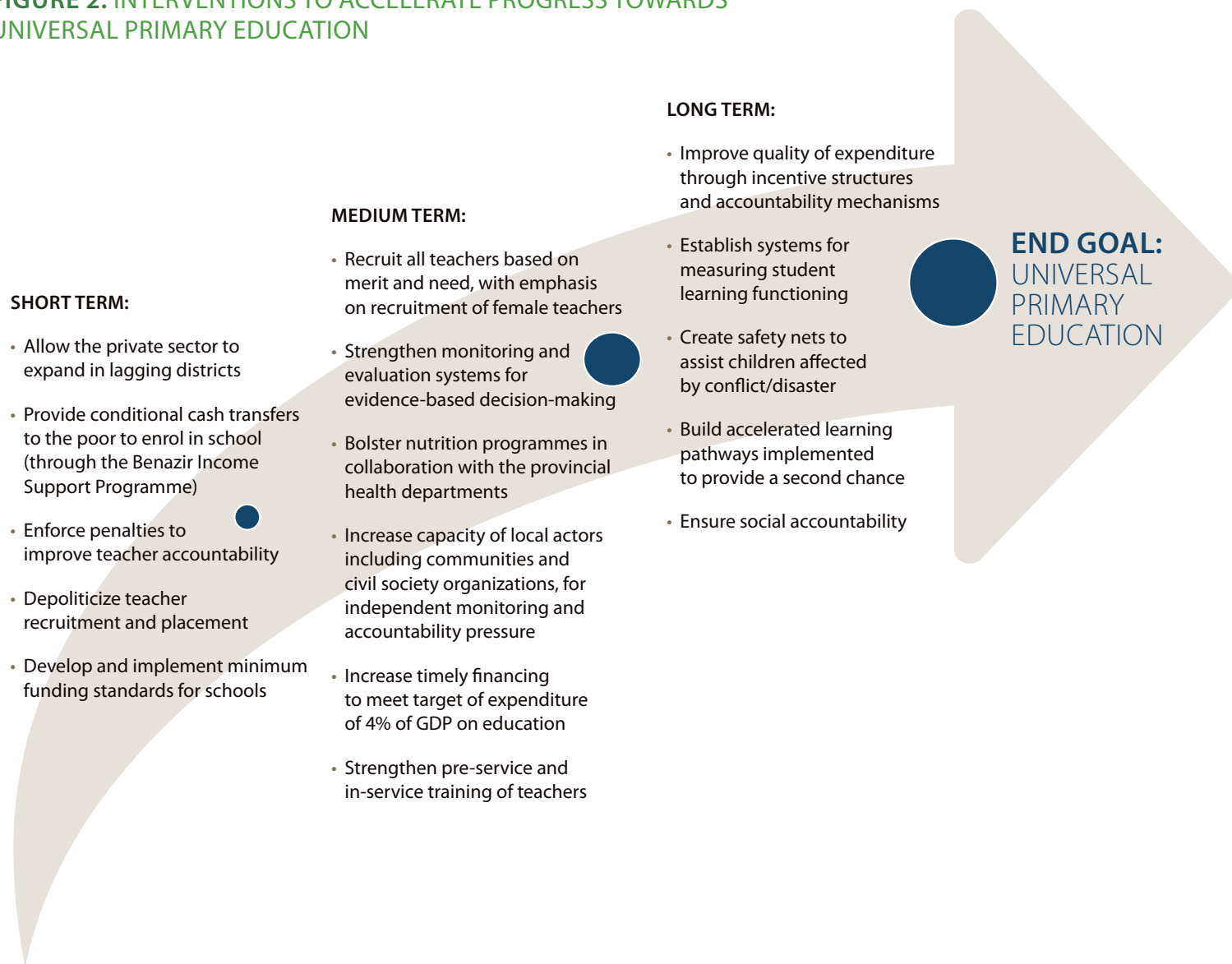
PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Identified interventions to accelerate progress towards universal primary education: guiding recommendations for the ceb review

Investing in transformational changes to accelerate progress towards achieving universal primary education. The UN system can play an important role in education achievement by supporting a few key actions, summarized in Figure 2. It needs to strongly communicate to Pakistan's leadership that the current level of effort is not enough to reach national education goals.

Sustained political will to implement these interventions is a key factor for achieving the education goals of the country. Not only does the current culture of political intervention in human resources and school placement decisions need to be reversed, but the political will to improve the current state of education needs to be harnessed to strengthen and expand implementation of promising reforms, and build systems that demand accountability from the highest levels of leadership. Policies for effective teacher performance management and accountability exist, but there is a need for high-level support to implement these in letter and spirit.

FIGURE 2: INTERVENTIONS TO ACCELERATE PROGRESS TOWARDS UNIVERSAL PRIMARY EDUCATION



The UN system can build and sustain this political will through continued engagement, especially to offset the frequent political changes in the country. Continuity of the reform process is critical, and the United Nations can play a prominent role in this aspect through high-level advocacy and pressure for change.

In addition, the **UN system can engage with the Council of Common Interests**, consisting of the Prime Minister and chief ministers of the provinces, **to play an important role to facilitate the discussion of the intersectoral links needed to improve the enabling environment for child school participation.** Multi-sectoral efforts, including nutrition for children and cash transfer programmes for poor families, are essential to achieving universal primary education. There could be large educational

payoffs to ensuring coordination and coherency of programmes such as the Benazir Income Support Program and the recently launched initiatives to improve nutrition with the initiatives of the provincial/area education departments.

Recognize that the Government cannot do it alone. A sizeable and rapidly expanding low-cost private schooling system can serve as a viable alternative to the government school system for even low-income and rural households. Evidence from Sindh and Punjab confirms that the growth of such a dynamic school system is increasingly reaching low-income and rural households. It also suggests that student achievement in private schools tends to be higher than in government schools, and that this higher achievement is obtained far more cost-effectively than in government schools, possibly arising from a combination of private schools' lower labour costs and the influence of market competition. Currently, private schools are concentrated in a few districts in the country. They could be rapidly replicated to improve performance in lagging districts. A conducive regulatory environment is crucial for the growth and vitality of private schools.

Community management models, emphasized in Balochistan and Khyber Pakhtunkhwa's education sector plans, offer a low-cost solution to addressing resource constraints along with other demand and supply-side bottlenecks in conflict-affected areas. Community-based schools and Parent Teacher School Management Committees providing local transport with the help of community contributions are examples of this. These models have been tested successfully, but are yet to be scaled up by the Government.

Strengthen demand-side accountability through improved communication. The role of civil society in generating and widely disseminating information on performance on education indicators can pressure the Government for improved service delivery and is critical for transformation of the current system. The UN system can play an important role in building the capacity for advocacy and improved social accountability, using data that are already available.

They could be rapidly replicated to improve performance in lagging districts. A conducive regulatory environment is crucial policies that focus on teacher performance and management. The provinces

have launched reforms to improve teacher quality and accountability, emphasizing recruitment and management policies. Implementation of these remains weak due to political bottlenecks. The following four need to be prioritized in dialogues with the government.

- First, clear standards for recruitment, deployment, transfers and postings, with strong safeguards against decisions not based on merit.
- Second, pre-service and in-service training to operate on three levels: raise teacher subject knowledge, equip teachers with up-to-date approaches to teaching, and help teachers adopt effective pedagogical methods to enhance student learning.
- Third, programmes to provide intensive support to teachers in low-performance schools need to be introduced. These should regularly provide on-site teacher support to address the challenges they face in their particular environments (a multigrade classroom, for instance).
- Fourth, a system that rewards teachers for acquiring skills and penalizes them for failing to do so. To improve teacher performance, incentives that link teacher pay to performance need to be built into the system. Accountability mechanisms (such as penalties for absenteeism) that exist on paper need to be implemented.

In addition, school finance systems must be reengineered to provide necessary resources so that all students, regardless of background, can learn. All provinces and areas need mechanisms that ensure adequate resources for all schools. Minimum funding standards for schools should be developed and implemented—and be objective, criteria-based and linked closely with the needs of schools. Such standards are essential to ensuring that schools have toilets and clean drinking water and a conducive school learning environment.

Concentrated effort. The UN system could focus its attention on the 25 districts that account for the largest number of out-of-school children to ensure necessary resources are diverted to these lagging regions to achieve better outcomes. There is also the potential of the demonstration effect—if the UN system, with

concentrated effort, can help turn around these districts, not only will it have a significant impact, but also prove that the education challenge can be tackled by focusing on the 'right' issues.

PROGRESS SINCE THE CEB REVIEW

To accelerate efforts for addressing the unfinished business of the MDGs and Education for All, the UN system in Pakistan, in collaboration with the Ministry of Federal Education and Professional Training, organized extensive national and provincial/area consultations on SDG 4. Given the devolved context of education in Pakistan under the 18th Amendment to the Constitution, engagement with the four provincial governments (Balochistan, Khyber Pakhtunkhwa, Punjab and Sindh) was crucial to operationalize the new education agenda. As such, the four provinces, together with the four geographical areas (Pakistan Administered Kashmir, the Federally Administer Tribal Areas, Islamabad Capital Territory and Gilgit Baltistan) were fully taken on board to steer the consultations in their respective areas from February to May 2016.

The main objective of these consultations was to ensure the integration of SDG 4 targets and indicators into the existing provincial/area-specific education sector plans and priorities, and to keep the momentum created through the MAF. A wide range of education officials, national and international development partners, parliamentarians, and representatives of academia, civil society and media participated.

So far, one national and six provincial/area consultations have been completed. SDG 4 task forces have been established at the national and provincial/area levels for reviewing the Education Sector Plan in line with SDG 4 targets, identifying gaps and missing areas, and examining the applicability of the targets and their implications. Based on their findings, each task force is to prepare a recommended way forward to localize SDG 4 and develop a province/area-specific education 2030 strategy document.

The province and area-specific roadmaps will feed into a national roadmap or strategic country document for SDG 4 implementation. The draft was further discussed and finalized at the national validation conference in July 2016 in Islamabad. The final document was presented to the Inter-Provincial Education Ministers' Conference in mid-2016 for approval and to support the implementation of SDG 4, in collaboration with development partners in each province/area.

LESSONS LEARNED FROM THE COUNTRY EXPERIENCE

The CEB MDG Acceleration Review Initiative was useful in bringing together diverse stakeholders, including UN agencies, government departments and the World Bank, all working towards the same goals—in this case, improving primary enrolment. The initiative helped in addressing the silos that exist within the Government as well as across UN agencies and the World Bank, and assisted in building partnerships across public and non-public institutions. The MAF identified some of the bottlenecks missing from the discourse on primary education in Pakistan, for example, the importance of governance beyond brick and mortar. The need to focus on a few districts where the bulk of out-of-school children live and to address inequalities, in particular focusing on the situation of girls, was another innovation that the MAF approach introduced.

A couple of interventions would have made the initiative more effective. First, a country level steering or oversight committee should have the mandate to review progress, and discuss coordination and partnership issues. Second, engagement between the Government and UN and World Bank committees or technical groups should have been more systematic and frequent. Third, the MAF was applied towards the end of the MDG period, when implementation time was already limited. The focus on the SDGs took away attention from the MDGs in their last days of operation. Fourth, donors should have been more substantively engaged in developing and rolling out the MAF. Fifth, breaking down silos through institutional partnerships and coordination is a big challenge. One single entity cannot do it alone. It is important that technical or theme-focused institutions (in the Government and outside) convene the MAF process. They in turn need to be supported by institutions with experience in convening diverse stakeholders and mandated for overall coordination, both within the Government and the UN system.



CHAPTER 3

ACCELERATING THE REDUCTION OF CHILD AND MATERNAL MORTALITY



GLOBAL STATUS OF CHILD MORTALITY INDICATORS

The target for MDG 4 was to reduce the under-five mortality rate by two thirds. And while the first indicator measuring progress against this target is the under-five mortality rate, another key indicator is the infant mortality rate.

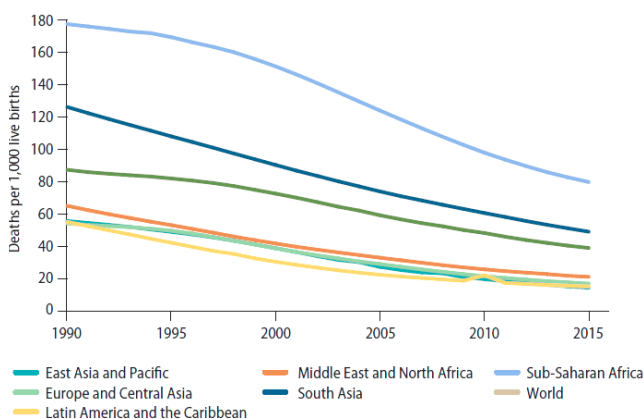
Over the past two decades, under-five mortality was cut by more than half, from 13 million in 1990 to 6 million in 2015. At least 16,000 fewer children die each day. The global rate of mortality declined from 91 deaths per 1,000 live births in 1990 to 43 deaths per 1,000 in 2015. Despite these significant gains, the world did not meet the MDG4 target of reducing this rate by two-thirds. The global average annual rate of decline accelerated from 1.8 percent over the period 1990–2000 to 3.9 percent over the period 2005–2015.

On a regional level, despite significant improvements since 2000, Sub-Saharan Africa and South Asia have the highest child mortality rates. In Sub-Saharan Africa, while the rate declined by more than half, it remained high at 83 deaths per 1,000. However, the number of deaths declined by only 24 percent largely because of the the nearly 76 percent increase in the under-five population. East Asia and the Pacific, and Latin America and the Caribbean have achieved the target.

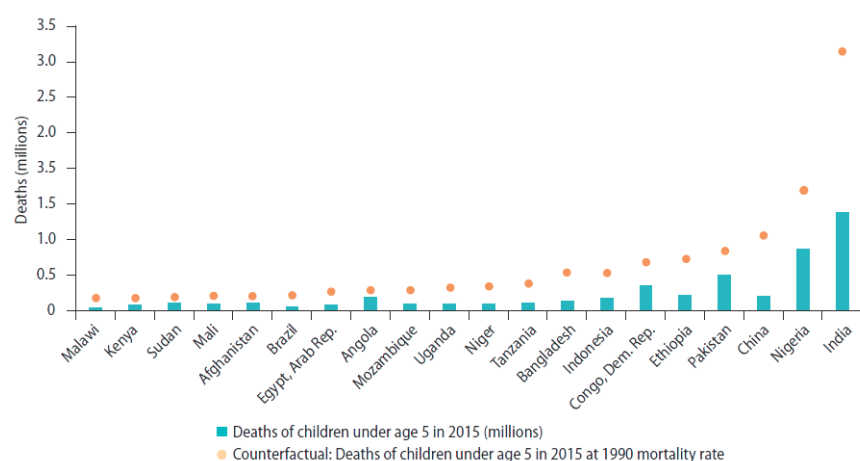
Among 145 countries evaluated, 57 met the target by 2015. Thirty-five countries were seriously off track, and more than one third of these countries are in sub-Saharan Africa. In 2015, around 4.3 million deaths — about 73 percent of all such deaths — occurred in 20 developing countries. Most of these countries have large populations, often with high birth rates. Many have substantially reduced mortality rates over the past two decades. Of these countries, Bangladesh, Brazil, China, Egypt, Ethiopia, Indonesia, Malawi, Mozambique, Niger, Tanzania and Uganda met the target.

Urbanization is associated with lower levels of child mortality. This may be because urban residents tend to be more affluent or have better access to health facilities and more cost-effective interventions. In urban areas, women also tend to be better educated and have better access to contraception than their rural counterparts, which contributes to lower fertility rates and better health for the mother and child. However, this is not always the case. Child mortality tends to be high in countries with large slum populations.

UNDER-FIVE MORTALITY RATE (PER 1,000 LIVE BIRTHS)



NUMBER OF DEATHS OF CHILDREN UNDER AGE FIVE IN 2015



Source: World Bank, 2015. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change.

GLOBAL STATUS OF MATERNAL HEALTH INDICATORS

The MDG 5 target calls for reducing the maternal mortality ratio (MMR) by 75 percent between 1990 and 2015, the highest percentage reduction among all MDG targets.⁵⁷

Every day, around 800 young women lose their lives before, during or after childbirth. Most of these deaths are avoidable.⁵⁸ Globally, an estimated 289,000 women died from maternity-related causes in 2013, and 99 percent of these deaths occurred in developing countries. From 1990 to 2013, the MMR declined substantially in developing countries as a whole, from 430 maternal deaths per 100,000 live births in 1990 to 230 in 2013. Despite this very significant progress, most developing countries did not achieve the MDG 5 target.

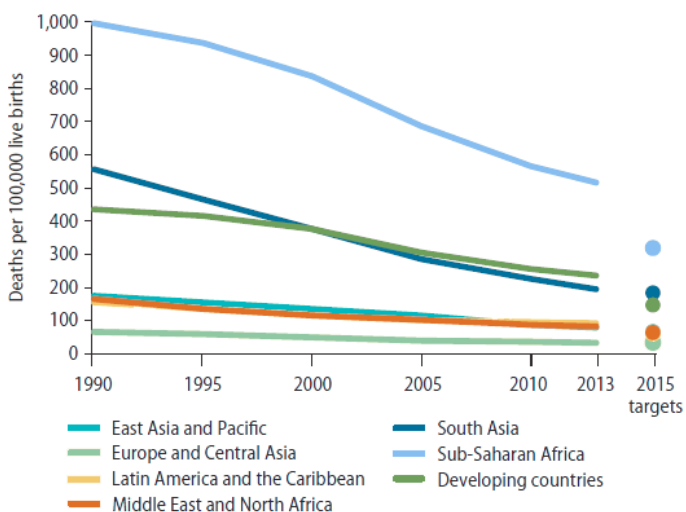
Sub-Saharan Africa experienced disproportionately high maternal deaths, accounting for 62 percent of the global total, followed by South Asia, which accounted for 24 percent. However, countries in both South Asia and sub-Saharan Africa have made substantial progress. In South Asia, the MMR fell from 550 in 1990 to 190 in 2013, a drop of 65 percent.

In sub-Saharan Africa, it dropped from 990 in 1990 to 510 in 2013, a decline of almost 50 percent. Despite not meeting the target as a region, the number of maternal lives saved is significant. East Asia and Pacific, Europe and Central Asia, and the Middle East and North Africa have all reduced their MMR by more than 50 percent.

Improved maternal health care is found to be associated with lower maternal mortality. Reducing maternal deaths requires a comprehensive approach to women's reproductive health services, particularly through better access to contraception. Women who give birth at early ages are likely to bear more children and are at greater risk of death or serious complications. Higher prevalence of contraceptive use can reduce the number of pregnancies, the likelihood of unwanted pregnancies and therefore the prevalence of unsafe abortions, which is one of the main causes of maternal deaths.

Investing in better maternal health not only improves a mother's health and that of her family, but also increases the number of women in the workforce and promotes the economic well-being of communities and countries.

MATERNAL MORTALITY RATIO BY REGION, 1990–2013



Source: World Bank, 2015. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change.

SHARE OF BIRTHS ATTENDED BY SKILLED HEALTH STAFF, BY REGION



⁵⁷ MMR is calculated based on the number of maternal deaths per 100,000 live births.

⁵⁸ WHO.



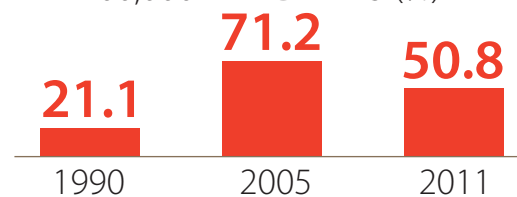
EL SALVADOR

Accelerating progress towards reducing maternal and neonatal mortality

CONTEXT

- Maternal mortality ratio reached 50.8 per 100,000 live births (2011). Maternal causes of death have been regarded as preventable in 59.7% and potentially preventable in 37.5% of cases.
- Under-five mortality rates fell only slightly between 2005 and 2011, from 9.9 to 9.3 per 1,000 live births.
- Poverty incidence in rural areas decreased slightly in 2010. Poor people's access to social security declined from 19.1% (2002) to 14.1% (between 2008 and 2010). Exclusion of particular social groups in the health sector is estimated to be high.

MATERNAL MORTALITY PER 100,000 LIVE BIRTHS (%)



UNDER-FIVE MORTALITY PER 1,000 LIVE BIRTHS (%)



BOTTLENECKS

Absence of provision of sexual and reproductive health education in schools.



Strengthen institutional capacities, establish standards and promote behavioral changes (e.g. school curriculum). Focus on the poorest districts, adolescents and youth at risk.

Outdated monitoring and data system on maternal and neonatal mortality.



Improve the vital statistical system in the country (e.g. strengthening the clinical surveillance system in hospitals with maternity units and the supervisory system at the family level in case of neonatal mortality, including civil registries in the municipalities).

Gang-related violence hinders service demand. Conservative society (gender bias and stigma), preventing the advancement of sex education and behavioral change.



Support social programmes of social inclusion for women and youth at risk, strengthening the social fabric and creation of social spaces free of violence.

Inadequate budget and financing of health care.



Facilitation of political dialogue on fiscal matters, aiming to link public resources to development policies.

El Salvador has made great effort towards MDGs achievement.

The progress made in the last 18 years towards most of the MDG targets is grounds for optimism towards their achievement in 2015. The country has demonstrated real commitment to the MDGs, reflected in concrete policy and positive results along most indicators. However, the last national MDG Report (2009) called attention to the health-related MDGs that were lagging behind. El Salvador ranks 105 in the HDI (Human Development Index) and is considered a lower-middle-income country. Women make up 52.8 percent of the population; 63.7 percent of the population is below 30 years of age; and 62.6 percent of the population live in urban areas.

El Salvador's MDG acceleration effort focuses on maternal and neonatal mortality (MDGs 4 and 5). According to official data, the MMR in El Salvador (MDG 5, indicator 1) reached 50.8 per 100,000 live births in 2011 (with some statistical difficulties in establishing accurate long term trends comparing the period 2006-2009 and 2009-2012). However, regional disparities are pronounced. About 28 percent of maternal deaths occur among adolescents, of which 40.6 percent are due to pregnancy-related suicide. Maternal causes of death are regarded as preventable in 59.7 percent of cases and potentially preventable in 37.5 percent of the cases.

SITUATION ANALYSIS

Under-five mortality declined only slightly between 2005 and 2011, from 9.9 to 9.3 per 1,000 live births. There is an increasing trend in neonatal mortality (deaths before reaching 28 days of age, per 1,000 live births), which accounted for two thirds of these deaths. Perinatal mortality (the sum of neonatal deaths and foetal deaths, i.e., stillbirths, per 1,000 births) has slightly decreased from 11.9 in 2005 to 10.6 in 2011. These figures are higher in municipalities with lower values of the Human Development Index HDI, with significantly higher rates for maternal and neonatal deaths in rural areas.

El Salvador has achieved the MDG target on extreme poverty during the period 2002-2010, but gains along other poverty measures were less pronounced. Between 1992 and 2012, extreme income-poverty diminished from 27.8 percent to 8.9 percent (a nearly a two-thirds reduction). However, the reduction in the poverty rate measured against the national poverty line was less marked, changing from 59 percent to 34.5 percent, and relative income-poverty also fell less sharply from 31.2 percent to 25.6 percent.

Poverty incidence in rural areas decreased slightly in 2010. Poor people's access to social security declined from 19.1 percent in 2002 to 14.1 percent between 2008 and 2010, due to the global economic crisis. Social exclusion on health is estimated high with an average value of 0.28 on the FGT (Foster, Greer and Thorbecke) index.

These data indicate that El Salvador is on the diminishing returns part of the curve for MDGs 4 and 5; that is, the achievement and sustainability of these goals may be hampered unless smarter interventions are made and the effects of recurrent shocks such as those due to the economic, food and environmental crises are countered. Hence, it is important to intensify the efforts to prevent/minimize the effects of these events, to address the social determinants of risk, and to promote intersectoral work, in order to maximize the gains from sectoral efforts.

El Salvador is striving to achieve universal health coverage, by means of a reform process led by the MoH that promotes equitable and quality services organized in integrated health networks. The MDG acceleration plan for El Salvador using the MAF has been carried out in the context of this reform exercise, as also the UN System's Delivering as One effort. The acceleration solutions must be aligned with the ongoing health reform process and harmonized with national health policies, the national development plan, and the UNDAF.

BOTTLENECK ANALYSIS

Priorities to sustain acceleration of progress of MDGs 4 and 5: main bottlenecks identified

The MDG acceleration plan to improve achievement of MDG 4 and sustain achievement of MDG 5 was led by the MoH, in collaboration with PAHO/WHO (lead agency), UNICEF (co-lead), UNFPA and UNDP; and the World Bank.

Partners also included other ministries, agencies, and NGOs. The process identified four sets of bottlenecks that must be addressed in the short and medium term

to enable the acceleration of progress towards MDGs 4 and 5:

- 1. Policy and planning:** (a) Coordination and financing of joint efforts; (b) Information and coordination with other sectors related to pre-maternal and neonatal health. (c) Reinforce the normative framework compliance.
- 2. Service offer improvements:** (a) improving education on sexual and reproductive health (SRH); (b) strengthening the skills of medical staff so that social, medical, obstetric risks, other obstetric complications and obstetric, perinatal and neonatal emergencies may be adequately identified and treated; (c) strengthening women's referrals and returns, in coordination with institutional and community level actors, in order to ensure transfers when deemed necessary; (d) ensuring postpartum care to mothers and neonates, according to international quality standards; (e) improving management and research, through supervision based on quality standards, staff training, education as well as periodic certifications, and operational research for decision making processes; and (f) establishing systems for monitoring and data collection on maternal and neonatal mortality, by updating the existing system, strengthening the active supervising component, increasing family participation in reporting the deaths of newborns at home, and increasing municipal reporting of deaths.
- 3. Budget and financing of health care:** (a) coordinated efforts of cooperation agencies to strengthen complementarity and conduct cost effective studies to measure the impact of interventions; and (b) engagement with the Technical Secretariat of the Presidency, for advocacy with the Parliament and Treasury to improve budget allocation in health.

- 4. Intergovernmental and Non-Governmental working spaces:** This area needs to address: (a) capacity development on food and nutritional security; (b) service accessibility (which is hindered by cultural and geographic factors as well as gang-related violence); and (c) the scaling up and institutionalizing of efforts to reduce teenage pregnancy and suicide prevention to be scaled up and institutionalized. Specific attention needs to be paid to gang-related violence that affect access to maternal and neonatal health care for the opposite gang members.

Implementation of the acceleration plan and key gaps: main solutions identified

The health reform has put in place a structure of health services with integrated networks across various levels. These operate from the community level (Family Health Community Teams or ECOS), to municipal and county hospitals, maternity services and specialized national hospitals. They include governmental and non-governmental spaces such as CISALUD (the inter-sectoral commission for health issues), that during the last four years coordinated NGO and other ministries related to health and civil society participation through mechanisms like the National Health Forum.

These entities will be responsible for leading the acceleration efforts and implementing the action plan. They will be supported in a coordinated way by the UN mechanism that will be established as a result of the Delivering as One strategy and the UNDAF and country strategies of PAHO/WHO, UNICEF, UNFPA, UNDP and WFP; as well as that of the WB. All of these are being articulated with partnering NGOs. All these international instruments open collaborative working spaces between the UN system and the WB in El Salvador. The CISALUD will be the coordination mechanism at the national and regional levels with the UN and other stakeholders like NGOs, private sector and donors.

The acceleration plan highlights that both articulation and alignment of international cooperation, as well as private sector participation in maternal and child nutrition must be strengthened by the Government. The Government has supported the reform process, and developed special maternal and neonatal health care models. Best practices – such as integrated nutrition and health services, obstetric and neonatal training centres, neonatal transportation, asphyxia

management at the hospital and community level, management of emergencies at hospital level both for maternal and neonatal care, infection prevention at community and hospital level, adolescent friendly services – need to be scaled up based on results. Also, it is urgent to strengthen management capacity in order to achieve collaboration and efficiency. Issues such as the loss of basic supplies and the re-equipping of hospitals to provide maternal and neonatal services need to be addressed. The collaboration and coordination between the UN agencies, programmes, funds and the WB, presents an important step forward in this direction.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

The solutions identified in the action plan address bottlenecks to existing policies, plans, strategies and guidelines, and target the main causes of maternal/neonatal deaths. They contain actions that aim to: (a) improve the implementation of norms and procedures; (b) improve the quality of services, including food and nutritional protection of mothers and newborns; (c) monitor the development of preterm; (d) improve health service management, and other key elements such as inventories, medicines, and medical supplies programming; (e) increase applied research on supply service and demand, with specific actions intended to ensure service access, accessibility and adaptability (especially in rural areas and with an emphasis on the most vulnerable populations), and the promotion of further social participation and governmental and non-governmental coordination spaces focusing on maternal and neonatal health.

According to the data obtained during the MAF exercise, the bottlenecks to reduce maternal and neonatal mortality mainly affect women who live in rural areas, have 4 or more children and did not finish primary education; as well as women with medical conditions that contraindicated pregnancy. The solutions regarded as the priorities will therefore especially focus on this population as well as adolescents, and they will also target the prevention of pregnancy in women with chronic diseases. These solutions would be integrated and will benefit both maternal and neonatal deaths.

Acceleration efforts for MDGs 4 and 5 require an integrated working approach. They require coordination between several social sectors and government entities related to the health field, including those involved in providing food to enrolled children, micronutrient supplementation, deparasitation, safe water provision, sexual and reproductive health education in schools, and social protection for pregnant women and children under two. This implies the participation of actors from different ministries and civil society in order to work at the national, regional and local levels, especially in this level, where most of the bottlenecks in service provision have occurred. Issues related to service demand and utilization also require engagement with a broader spectrum of actors.

In accordance with the action plan, the UN agencies, programmes and funds, as well as the WB, have agreed to support the following areas given their potential for high and quick impact:

- Scaling-up risk detection and the use of quick tests for obstetric morbidity that affect prematurity and neonatal mortality.
- Provision of clinical and information tools to assist obstetric and neonatal complications.
- Initiation of an intergovernmental and interagency model to ensure nutritional and development follow-up of premature children until they reach two years of age, and of pregnant women in order to avoid growth restrictions of newborns.
- Dissemination at a national level of the most successful experiences to train and certify health personnel by set up a national committee for human resources.
- Design of educational and training programmes for staff in health and sexual and reproductive health education.
- Strengthening the management capacity of maternity units and improvement of decision-making processes through information systems and operational research.

- Strengthening the Clinical Surveillance System in hospitals with maternity units, the Supervisory System at the family level in case of neonatal mortality, as well as the people who are in charge of civil registry in the municipalities;
- Prevention of teenage pregnancy by means of intersectoral work with key behavioural information campaigns;
- Support of social programmes of social inclusion of youth at risk, strengthening the social fabric and creation of social spaces without violence;
- Development of a complementary methodology to the income-based method to measure poverty, to achieve a multidimensional approach to guide social policy conceptualization and its programs definition;
- Facilitation of political dialogue on fiscal matters, in order to link public resources to development policies.

Some crucial cross-cutting issues that need to be addressed in order to achieve sustainability are:

- Interagency coordination and synergies in order to address this acceleration plan.
- The MoH's management capacity to attract external cooperation in areas related to maternal and neonatal assistance.
- The coordination capacity among the different centralized ministerial entities, and between these entities and other local and regional coordination spaces.
- The capacity to improve the supervisory system to generate better quality data, especially regarding obstetric and neo-natal morbidity and mortality. A special emphasis must be placed on the data required by national entities to estimate the denominators that are needed to report vital statistics.

A thorough risk analysis should guide the implementation of the acceleration plan, especially due to the coming 2014 presidential elections. Supporting the new government authorities will be of utmost importance in facilitating a political transition that will nevertheless continue to emphasize the focus on maternal and child health.

Additionally, some critical priorities need a credible financial commitment in order to be nationally escalated. Resource mobilization will be a key success factor for the implementation of the acceleration plan.

PROGRESS SINCE THE CEB REVIEW

Since the CEB, the national maternal and child health programme, which is also linked with other programmes for the protection of women against domestic violence, received medical equipment to strengthen its ability to respond to victims of violence. It also completed the purchase of equipment for early detection of cervical cancer in 28 specialized centres around the country and provided specialized equipment for neonatal care at the hospital and community level. In addition, some of the committed initiatives described in paragraph 15 are now in place, such as the strengthening of the clinical surveillance system in hospitals with maternity units, and the supervisory system at the family level in cases of neonatal mortality, and the design of educational and training programmes for staff in health and sexual and reproductive health education, among others.

However, progress in the achievement of health indicators is threatened by the sharp increase in violence in the country, in particular in marginal neighbourhoods dominated by gangs. Introduction of community efforts have been delayed because of the lack of security in certain zones where health educators and primary care providers need to work in.

LESSONS LEARNED FROM THE COUNTRY EXPERIENCE

The role of partnerships — including between the government, civil society, UN, and the WB, as well as the initiation of an interaction with the private sector — was extremely positive in terms of creating a sense of shared responsibility and improving the efficiency of investments. The Government made an effort to cover many of the activities discussed with the partners and its role was defined as key in the effort to reach the MDGs. That said, the reliability of donor funding is essential; otherwise, expectations are raised, creating tensions between partners. In addition, through this process, individual agencies found their respective roles in the partnership and potential for integrating their work in the future. Still, a leading role should be given to the Government in these meetings, offering the opportunity to align commitments and cooperation around the national health priority agenda.



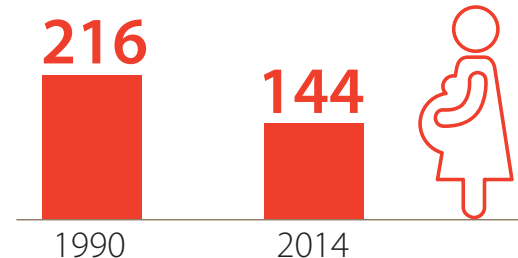
GHANA

Accelerating progress towards maternal mortality reduction

CONTEXT

- The maternal mortality ratio fell from 216 per 100,000 live births in 1990 to 144 per 100,000 live births in 2014, short of the global target of 54 per 100,000 live births in 2015.
- Overall maternal mortality is thought to be higher. Disparities are persistent between urban and rural areas: skilled birth attendants attended to 84% of births in the Greater Accra region as opposed to only about 27% in the Northern region.
- MMR is highest in regions that have low levels of attended births, poor nutrition, anemia, high levels of fertility and early-teen pregnancy.

MATERNAL MORTALITY PER 100,000 LIVE BIRTHS



BOTTLENECKS

Poor road network makes it difficult for pregnant women to deliver or to receive prenatal and neonatal care in health facilities.



Districts lack infrastructure for referral and emergency response.



Health planning services lack capacity to deliver maternal and neonatal health and nutrition services.



Lack of harmonization of approaches and policies impairs progress on maternal health.



SOLUTIONS/EFFORTS

\$100 million was mobilized through the Ghana Private Road Transport Union to help pregnant women getting to birth centers for free.

Smartphones are helping to transmit data from Community-Based Health Planning and Services (CHPS) compounds to districts. 92% of the health facilities in Ghana have access to at least one network.

Financing a \$73 million maternal and child health project in February 2015 helps strengthen the functionality of the Community Health Planning Services delivery platform.

Promoting integrated approaches for antenatal, delivery and postnatal care into the National Health Insurance scheme and boosting enrolment (over 140,000 poor people).

Ghana was a pilot country for the MDG Acceleration Framework (MAF) roll out in 2010. The country was making good progress on several MDG targets and was expected to reach most of them at the national level. However, the latest available data showed the country to be off-track on (i) maternal health; (ii) under-five mortality; and (iii) access to sanitation. Furthermore, even where progress at the national level had been satisfactory, disparities at sub-national levels were apparent with, for example, the three Northern regions tending to lag behind others on a host of dimensions.

Ghana's target for 2015 was to reduce the maternal mortality rate to at least 185 per 100,000 live births – according to the rate of progress in 2009, it was estimated that this would instead be around 340, a considerable departure from the target. The central maternal health target for Ghana is to reduce by 2015, the maternal mortality rate (MMR) to a quarter of its value in 1990. For Ghana, this would mean reaching a level of at most 185 maternal deaths per 100,000 live births in 2015, compared to a value of 740 per 100,000 in 1990. Since 2000, Ghana has introduced and strengthened interventions that directly address the causes of maternal mortality – such as extending emergency obstetric care, improving the early detection of complications, and enhancing the coverage of family planning services. Maternal mortality fell, accordingly, to about 340 per 100,000 live births as reported in 2009, but progress was too slow a rate to reach the target.

These national statistics mask considerable variations across regions and populations. The 2010 Population and Housing Census (PHC) indicates that the MMR is at its highest in the Upper East (802 per 100,000 live births) and Volta (701 per 100,000 live births) regions, and lowest in the Greater Accra (355 per 100,000 live births) regions. This mirrored the availability and use of critical services – for example, skilled birth attendants attended to 84 percent of births in the Greater Accra region as opposed to only about 27 percent in the northern region.⁵⁹ The northern part of the country was also more likely to have less qualified health personnel, and worse working environments.

Rural areas also have poorer nutrition indicators (such as anaemia), which are directly related to maternal and neonatal health. The risk of maternal death was highest for women under the age of 15 and over the age of 40.

SITUATION ANALYSIS

Prioritizing acceleration solutions for maternal health

Addressing maternal mortality is an important domestic priority: the president of Ghana declared maternal mortality to be a national emergency in 2008, following up subsequently with incorporation of antenatal, delivery and postnatal care into the National Health Insurance scheme. By 2010, there were over 37 distinct policies and strategies to respond to the issue, and the country, through the MoH, approached the UN system for assistance in formulating an acceleration plan for speeding up progress. This acceleration plan used the MAF to build upon the available evidence and harmonize approaches to mobilize a coalition of partners from across the UN system, CSOs and other actors to support these national efforts.

The plan seeks to improve the impact of interventions already targeting the direct-pregnancy related complications such as severe bleeding (haemorrhage), hypertensive diseases, infections and abortions and indirect causes of maternal deaths such as nutrition, social and cultural issues that curtail women's access to sexual and reproductive health services - causes of maternal deaths (Ghana Health Sector Review (2010)). Interventions areas included emergency obstetric and neo-natal care; skilled delivery; and family planning. However, in several cases key bottlenecks that impeded the efficacy of interventions lay outside a narrow sectoral definition. In other cases, their relative importance varied by region. For example lack of information on signs of pregnancy complications and access to basic laboratory services were important causes of maternal deaths in all regions, but more so in the Northern and Upper West regions (where only 60 percent and 67 percent respectively have access to laboratory testing).

⁵⁹ 2014 GDHS gives greater Accra as 92.5% and Northern region 35.4% -see table 9.5 page 115 of the 2014 DHS.

Maternal mortality goes beyond being a clinical or health issue and is a development issue requiring multifaceted approach and responses. In particular, lack of education for women and girls creates barriers to accessing health information and services; reduces the likelihood of women and girls utilizing modern health services; and increases the chances of early marriage and consequent pregnancies. The sociocultural and religious status of women has an impact on maternal health in general including the uptake of family planning.

Implementing the acceleration plan

The primary impetus for implementation, which commenced in 2011, has come from the Government. Some points of note:

- **The plan has helped influence the national 'Reproductive Health Policy and Protocol** in areas such as maternal death audits, task shifting for family planning personnel, guidelines on antenatal care and reproductive health commodity security.
- **Innovative partnerships are advancing identified actions – for example mobile phones are being used in many areas for referral and emergency response;** and smartphones are helping to transmit data from Community-Based Health Planning and Services (CHPS) compounds to districts for processing and improving service delivery. About 92 percent of health facilities in Ghana have access to at least one network, and MoUs are under negotiation with some of the companies for discounted rates.
- **Partnerships have also been established with other entities on the ground,** for example with the Ghana Private Road Transport Union to help transport pregnant women at the time of delivery to birth centers free of charge at the time of delivery through a voucher system.
- **Approximately USD 100 million for maternal health has been mobilized** through the plan, primarily from traditional donors but also including catalytic amounts from the local private sector. These resources will address critical gaps in family planning services; ante-natal and emergency care as well as strengthen capacity for monitoring pregnancy and delivery.

- **An ad-hoc Steering Committee has been providing oversight to the implementation,** to re-examine the prioritization of bottlenecks and identify whether there is a new set of binding constraints limiting progress, given that the initial set of constraints identified in 2010 have received focused attention over the interim.

he UN and WB have lent support to the action plan that includes interventions in the areas of ensuring contraceptive security; strengthening the skills of service providers in family planning as well as maternal health; Reproductive Health Policy and Protocol such as blood banks, ambulances and medicines; improving maternal and newborn nutrition; PMTCT of HIV; enhancing advocacy to address cultural factors related to maternal health and improving the demand for related services; and further developing capacities for planning and monitoring, including at decentralized levels.

BOTTLENECK ANALYSIS

Addressing gaps – Priorities for sustaining and further accelerating progress

Preliminary trends in the most recent data available are encouraging.

The institutional MMR (IMMR) that normally tracks the MMR has dropped from 230 per 100,000 women in 2008 to 173 in 2011. Some indicators of service provision have also improved over the same period: The share of skilled deliveries rose from 59 percent to 74 percent as a percentage of all births (Multiple Indicator Cluster Survey [MICS] 2011; DHS 2008; GDHS 2014) and the contraceptive prevalence rate for modern methods rose from 17 percent in 2008 (DHS 2008) to 23 percent in 2014 (2014 DHS), offsetting a reversal in the trend that had occurred between 2003 (19 percent) and 2008 (17 percent).

The UN agencies and the WB, working together on the ground have identified the following as key to continuing the acceleration of progress in each of the specified intervention areas, with a special focus given on addressing regional disparities.

a. Family Planning

- Education and demand creation for the services;
- Increasing of technical advisory support to the Nurses and Midwifery Council and the Ghana Health Service.

b. Skilled Delivery

- Rating of health facilities on the basis of service provision;
- Equipping health facilities to provide essential basic emergency obstetric and newborn care (BEmONC);
- Building skills for essential maternal and newborn care including early post-natal home visits;
- Supporting the development of the subnational level operational plan to scale up PMTCT and eliminate HIV transmission from mother to child by 2015;
- Providing community referral of pregnant women to deliver in health facilities;
- Supplying quality health services delivery using performance-based financing;
- Facilitating of WHO/AFRO Regional Guidelines on FANC;
- Disseminating of a CD of e-partograph training nationally;
- Streamlining nutrition in all areas of the acceleration plan;
- Providing nutritional support and education to borderline malnourished pregnant and lactating women who currently do not meet the WFP entry criteria but who could easily slip into.

c. EmONC (Emergency Obstetric and Neo-natal Care)

- Facilitating the acquisition and adaptation of MAMMAS software;
- Conducting a mid-term EmONC assessment during midline evaluation of MAF;
- Upgrading health centres and maternity homes to be EmONC compliant.

d. Crosscutting Issues

- Strong community platform to improve demand for services utilization and outreach activities;

- Improved productivity of health workers and compliance with quality standards using performance based financing;
- Support for capacity strengthening of the FHD to manage and conduct effective M & E and track resources to ensure accountability;
- Support to improve decentralized monitoring of bottlenecks and evidence based planning and budgeting at the regional and district level for quality MNH care;
- Support the Ghana Statistical Service in improving the timely production of quality data at the national and sub-national levels for development planning and M&D.

e. Managing challenges and risks

- **Acceleration solutions require synergistic implementation**, bringing together contributions – both financial and technical – from a diverse group of partners to provide coordinated support to the Government. Risks include fragmented implementation, delayed release of resources, and procurement gaps, among others. The Steering Committee was initially an *ad hoc* one and now it is now well constituted and chaired by the MoH. Other partners include representatives from the Ministry and its agencies, UN agencies and bilateral agencies as well as civil society organizations. The aim is to improve national coordination and oversight supervision.
- **Availability of timely and reliable data** is key to the successful monitoring and periodic updating of the action plan. Since population-based surveys such as the Ghana DHS, the MICS and administrative data sources are the most reliable, efforts must be made to ensure the regular and quality production of these data sets and the decentralization of monitoring of bottlenecks by using District Health Information Management System (DHIMS) data for informed decision-making to respond to barriers of MAF implementation.
- **Several solutions will be most effective when ministries, departments and agencies not traditionally associated with maternal health prioritize activities that can have a catalytic effect.** For example, poor road networks limit the effectiveness of solutions such as the agreement with the Ghana Private Road Transport Union to transport pregnant women to hospitals.

Departments and agencies that lead on infrastructure would need to prioritize investments – wherever possible - towards achieving these priority health outcomes.

- **Stronger structures and capacity to manage the coordination, monitoring and evaluation are needed.** The inflow of additional resources and the urgency in action plan implementation may need stronger structures and capacities to manage coordination and M&E, as well as to document experiences and lessons learned to develop knowledge products for learning. For instance, the M&E capacity of the MoH and Ghana Health Service may need augmenting to meet the monitoring requirements.⁶⁰

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

The acceleration plan for Ghana has been significant in that it translated a domestic political commitment into shared priorities for action and then followed it up with implementation. As implementation proceeds, the following priorities will be key:

- Supporting a **stronger coordination mechanism** that will provide oversight guidance to implementation;
- **Providing implementation support** to priorities already identified in the acceleration plan, as well as emerging priorities as these initial priorities are addressed;
- Strengthening **innovative solutions**, such as those based on mobile technology;
- Fostering **higher quality and more timely data "availability – for use in policy and planning"**; and
- Tackling **gender inequality and other socio-cultural issues** at community level, which impact reproductive health seeking behavior.

PROGRESS SINCE THE CEB REVIEW

Despite the country's shortcomings in achieving the Millennium Development Goals (MDGs) to reduce child mortality by two-thirds and reduce maternal mortality by three-quarters, there have been significant improvements in health care service delivery, especially in rural communities, which have contributed to the improving trends in maternal and child mortality. The 2014 Demographic and Health Survey (DHS) shows some improving trends: 97 percent women received antenatal care from a skilled provider compared to 82 percent in 1998; 73 percent of births occur in a health facility, up from 57 percent in 2008; 74 percent of births were attended by a skilled provider, up from 59 percent in 2008; and childhood mortality (infant, child and under-five mortality) dropped to 41 percent, 19 percent and 60 percent respectively in 2014 from 50 percent, 31 percent and 80 percent respectively in 2008). While 95 percent of women received antenatal care, only 51 percent did so during the critical first trimester of their pregnancies. The women who received post-natal care in the first 48 hours rose to 78.2 percent. In 2014, Ghana's maternal mortality rate (MMR) stood at 340 per 100,000 live births and was falling only very slowly. MMR was highest in those regions that lack availability or have poor utilization of health services including the low levels of attended births, poor nutrition, anemia, high levels of fertility and early-teen pregnancy.

It is also worth noting that since 2008 there has been only a marginal decline (3 percent) in neonatal mortality compared with 38 percent, 18 percent, and 25 percent declines in postneonatal, infant, and under-five mortality over the same period.

Efforts to accelerate progress in Ghana invested by the UN System and the World Bank include:

- UN Humanitarian Response Depot (UNHRD) providing warehouses to store reproductive health commodities and contraceptives including condoms, procured at the request of government, following the devastating fire-gutting of the Central Medical Stores (CMS).

⁶⁰ The Steering Committee provides guidance and oversight monitoring of MAF, while the M & E role is the actual monitoring and evaluation of MAF at technical level.

- Building institutional capacity in health training institutions and health care facilities that improved quality of health care delivery, increased skilled attendance and reduced maternal mortality.
- Creating awareness for HIV prevention through the celebration of Safe Motherhood Week, Family Planning Week, International Day of the Midwife, and Zero Mothers Die campaign led by the First Lady of Ghana since 2013.
- Financing the 2016/2017 MAF strategic and operational plan, which targets procurement (75.6 percent) for service delivery with EU and DANIDA providing 162.6 million Ghanaian Cedis (over \$45 million) to support Task shifting efforts that led to community health nurses (CHN) being trained in the insertion and removal of implants to enhance access to long-term family planning.
- Financing a \$73 million maternal and child health project that became effective February 2015 and will strengthen the functionality of the Community Health Planning Services delivery platform, especially in its capacity to deliver maternal and neonatal health and nutrition services.
- Including the Health Results and Innovation Trust Fund (HRITF) of \$5 million as part of the above project in which community health teams are incentivized through a performance-based financing (PBF) pilot in four of the most affected regions to identify and link pregnant women, teenagers and children to the available health services as a means to accelerate achievement of the MDGs.
- Including "as part of the \$97 million provided in support of the eTransfrom Project" an Integrated eHealth System focusing on developing foundational systems and outreach to underserved communities in the country; medical call centers; wireless networks for selected district and regional health centers; and digitizing medical records in selected teaching hospitals and health centers.
- Providing additional financing to the Social Opportunities Project to establish the Ghana National Household Registry. The registry will be used across all social protection programs and the National Health Insurance Scheme to improve beneficiary targeting.

- Supporting the Africa Health Markets for Equity Project, which was launched in April 2015 and will build on the foundation laid by the Health Insurance Project and support the identification and enrolment of at least 140,000 poor persons onto the National Health Insurance Scheme using a proxy means test tool.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

One of the key lessons learned from the country experience is that effective collaboration with different partners can lead to improved knowledge and shared outcomes. Again, availability of data will contribute to successful monitoring. In addition, well-built structures and capacity for management and coordination are crucial for achieving action plans.

Moreover, partnerships with the Government, UN agencies, other DPs, civil society organizations, media and the private sector have resulted in the improved coordination of financial and technical resources for accelerated action on maternal and child mortality. These partnerships have also heightened organizational urgency towards achievement of the MDG targets. Collective identification of needs and the provision of resources towards building the capacity of health care providers at all levels; pre-service and in-service has boosted the confidence and motivation of service providers. However, data quality remains a challenge. Tertiary health care facilities like teaching hospitals do not report data through DHIMS (the central data reporting software), thus diluting data. Regular dialogue with the group and efforts by MAF to support them has resulted in the group agreeing to either migrate or input data into DHIMS for quality data assurance.

One case in particular that can be a valuable lesson was in 2013 when the EU suspended the release of funds for the MAF implementation. This stimulated further transparency and the full engagement of all partners. The resulting level of accountability led to a re-engagement with the EU leading to the release of funds and the continuity of the MAF implementation and sustainability of gains made.

INDONESIA

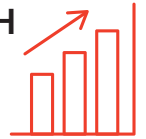
Accelerating progress towards improving maternal health

CONTEXT

- Indonesia has made progress toward achieving MDG5, but maternal mortality ratio (MMR) remains high.
- MMR decreased from 600 maternal deaths per 100,000 live births in 1990 to 220 in 2010, to 126 in 2015.
- Despite strong economic growth and falling poverty in the last decade, inequality is rising in Indonesia and many households continue to live on the edge of poverty. With a population of 247 million, Indonesia's GDP per capita is US\$3,557 (2012) and GDP growth has averaged 6% from 2010-2012. However, Indonesia still has a large population (30 million) living below the national poverty line (just below PPP\$1.25 a day).

ANNUAL GDP GROWTH
(2010-2012)

6%



MATERNAL DEATHS
PER 100,000

600

220

126

1990

2010

2015



BOTTLENECKS

Lack of a comprehensive methodology to identify solutions to address regions lagging on MDG achievements.



Establishment of Indonesia's MDG Secretariat and development of 112 district action plans for accelerating progress on the MDGs.

Limited number of social protection and health coverage for the most vulnerable, poor and near-poor.



Improving and expanding UHC to develop incentives for public and private providers to address the needs of the poor and near-poor and increase use by eligible individuals (e.g. Healthy and Bright Generation Programme (PNPM-Generasi), which provides community block grants to rural communities in 369 sub-districts to ensure universal coverage of services).

Inadequate standards for assessing the quality of health care throughout the system.



Strengthening quality assurance policies governing the education of health professionals by improving the accreditation system of public and private health professional training institutions and developing national competency standards.

Inadequate availability of antiretroviral treatment for pregnant women with HIV/AIDS.



Antiretroviral treatment is being rolled-out to key populations at risk, including pregnant women who are HIV-positive (e.g. starting with 10 pilot sites to reach 74 districts).

INTRODUCTION

Indonesia has made progress towards achieving the MDG5, but the MMR remains high. According to the Maternal Mortality Estimation Inter-Agency Group, the MMR decreased from 600 maternal deaths per 100,000 live births in 1990 to 220 in 2010, indicating that Indonesia has made substantive progress towards MDG5.⁶¹ Based on *Survei Penduduk Antar Sensus* (The Intercensal Population Surveys) organized by the Central Bureau of Statistics, the MMR in Indonesia in 2015 was 305 maternal deaths per 100,000 live births. Indeed, other MDG 5 indicators have also improved in the last two decades: the proportion of births attended by skilled health personnel increased from 32 percent (1991) to 91.51 percent (2015); the contraceptive prevalence rate (all methods) increased from 50 percent (1991) to 58.99 percent (2015); and antenatal care is nearly universal, with 85.72 percent (2014) of pregnant women making the recommended four or more visits. The level of unmet need for family planning (MDG 5.B) slightly declined from 17 percent (1991) to 11.4 percent (2012). Recent progress notwithstanding, the MMR level remains high in Indonesia, at more than double the MDG 5 MMR target of 102 by 2015. And concerns remain regarding quality of and access to maternal health services and disparities across provinces, illustrating a lack of shared progress. For instance, 94 percent of pregnant women in Central Java Province delivered with the assistance of skilled health personnel, in sharp contrast to only 40 percent in Papua. Therefore,, **progress toward MDG5 needs to be monitored closely and adequate attention given to bottlenecks that may be impeding progress and causing inequitable achievement.**

Although **Indonesia was on track to achieve some MDG targets related to health, progress was largely uneven and unequal.**

Indonesia was projected to meet the MDG 4 target on child mortality, but there are large geographic and income-related inequalities in this and other health outcomes. Access to quality health care remains a problem, particularly in remote provinces and districts. For instance, infant mortality in West Sulawesi Province is almost four times higher than in Special Region of Yogyakarta Province. Infant and child mortality rates among the poorest wealth quintile of households are more than double that in the richest. Based on the SUPAS (Mid census survey) 2015 the child mortality

decreased to 26.29 per 1,000 live births. There is also wide geographic variation in the prevalence of stunting in children under five. Nationally, the rate is 36 percent, but in Nusa Tenggara Timur Province, stunting exceeds 55 percent based on MoH's basic health survey in 2013. Indonesia is not on track for MDG 6 related to HIV/AIDS and is one of four countries in Asia (except for Bangladesh, the Philippines and Sri Lanka) where the estimated incidence rate of HIV infection among adults (15-49 years old) has increased.

Despite strong economic growth and falling poverty in the last decade, inequality is rising in Indonesia and many households continue to live on the edge of poverty. With a population of 247 million, Indonesia's GDP per capita is \$3,557 (2012) and annual GDP growth averaged 6 percent in 2010-2012. However, Indonesia still has a large poor population (30 million live below the national poverty line, which is just below PPP \$1.25 a day) and the pace of poverty reduction is slowing. An additional 65 million people live above the poverty line, but are highly vulnerable to falling back into poverty, and inequality is growing. Based on the newest data, the percentage of population below national poverty lines is 11.22 percent according to The National Statistic Office Socio-Economic Survey BPS 201562). Indonesia's Human Development Index rank is low (at 121 of 187 countries) and the Gini coefficient increased from 0.32 in 1999 to approximately 0.41 in 2011.

SITUATION ANALYSIS

Lagging Health MDGs in Indonesia: Understanding the Problem and Identifying Solutions

Indonesia is characterized by low levels of public spending on health, which, at only around 0.9 percent of GDP (2011), is one of the lowest in the world. The budget allocation for the health sector was 3 percent of the total state budget, less than the 5 percent mandated by the 2009 Health Law. The allocation went up to 5 percent only in the latest 2016 annual budget. However, only 0.53 percent is allocated to reduce maternal and infant mortality rates. Moreover, the country has relatively low levels of total and government health spending per capita (US\$95 and US\$32 per capita, respectively). By contrast, Malaysia (US\$346, US\$148), China (US\$278, US\$155), and Thailand

⁶¹ MMEIG is the UN/WB Group responsible for producing MDG5 MMR data for tracking. However, there is uncertainty about the exact level of Indonesia's MMR. Aside from MMEIG's model-based estimates, the Institute of Health Metrics and Evaluation model estimated an MMR of 189 in 2011. 2012 DHS estimates based on sibling-survival data indicate an MMR of 359, although it is important to note that the report acknowledged sampling and non-sampling errors and a wide confidence interval, and recommended caution in interpreting the results.

⁶² Indonesian National Social and Economic Survey.

(US\$353, US\$152) spend far more on health per capita. As higher total expenditures on health per capita is a key determinant of MMR, the Government of Indonesia (GOI) should increase fiscal space for health, particularly to correct geographic inequalities hampering inclusive growth. The GOI's commitment to universal health coverage (UHC) by 2019 is a very positive sign and will markedly increase public health spending. In concert, a major thrust behind the UN-supported national Roadmap to Accelerate MDGs Achievement is supporting national and subnational governments in using poverty maps and MDG data, particularly data on lagging MDGs, to maximize budget allocations. UNICEF and UNDP are supporting the development of a fiscal incentive scheme to stimulate greater investments in lagging MDGs. The WB-supported study on maternal health expenditure would also provide critical data for advocacy and decision-making.

The 2001 decentralization of services, including health to districts, was undertaken with little support to subnational governments, challenging effective local service delivery. It also lacked: (i) clear distribution of functions between central, provincial and district governments; (ii) incentives for subnational governments and frontline providers to deliver; and (iii) appropriate resources and capacity-building to enable subnational governments to deliver. Inadequate capacity and resource constraints remain key challenges, limiting the ability of districts to achieve MDGs locally. Districts need support and funding to proactively implement pro-poor development policies, ensure adequate allocation of resources to build capacity, encourage public and private investments to improve rural health infrastructure, improve outreach, and upgrade the quality of public health services. The WB, UNICEF, WHO, UNFPA, UNAIDS and UNDP have been working with national and subnational governments to analyse the adequacy and efficiency of maternal health spending; assess the quality of maternal and newborn health care at the provincial, district and subdistrict levels; share best practices in improving quality of care; introduce pro-poor and pro-MDG planning and budgeting methodologies; and improve the capacity of subnational bureaucracies.

UN agencies and the WB have developed and are implementing, jointly with the GOI, a number of initiatives to understand the causes of lagging health MDGs and identify corresponding solutions. These efforts are guided by the GOI Roadmap and the GOI Action Plan for the Acceleration of MMR Reduction and include:

- A comprehensive maternal health assessment to fully understand challenges to reducing MMR, including a review of maternal health policies and programmes (completed);
- The introduction of the MAF in Central Java with subsequent extensions, and replicated to Banten Province and East Java Province as well as to other MDGs where progress is slow, such as water supply in province West Nusa Tenggara, access to sanitation in Bengkulu Province, and HIV/AIDS control in Riau Island Province (completed);
- Follow-up of the 10 recommendations of the Commission on Information and Accountability for Women's and Children's Health to improve information for better results and resource tracking and to strengthen oversight and accountability of results and resources at all levels, with a special focus on reproductive and maternal health (ongoing);
- An Evidence-based Planning (EBP) or Investment Case (IC) approach to provide evidence on maternal, neonatal and child health (MNCH) bottlenecks at the district level, identify solutions, and cost them to better leverage and allocate district budgets for health (ongoing);
- The application of the One Health Tool to identify appropriate interventions, estimate their potential impact, and cost them in the development of the National Child Health Strategy (ongoing);
- A service availability and readiness assessment related to UHC, including maternal health interventions (ongoing).

BOTTLENECK ANALYSIS

A number of bottlenecks and priority actions to resolve them have been identified by the GOI with technical expertise from the UN and WB and many of these actions will also impact outcomes related to newborn health, another area of poor progress in Indonesia:

- Addressing service availability and readiness gaps, including infrastructure, human resources and other supply-side inputs. Provision of vital supplies for maternal health, such as drugs, blood and routine and emergency delivery equipment are often irregular;
- Enhancing the linkages between community-based delivery facilities (such as a village midwife or a private midwife facility) and hospital services. The challenge consists of improving coordination such that the timing of referrals, the reception of the referred patient and the time to management are shortened and the quality of care by the hospital is improved;
- Standardizing the quality of care throughout the system, starting with providers and including all types of facilities through accreditation, certification and sanction by government or professional organizations to improve quality;
- Improving Universal Health Care (UHC) reforms and expansion to develop incentives for public and private providers to attend to the needs of the poor and near-poor and improve use by eligible clients;
- Improving family planning services and engaging the community in their use;
- Addressing social norms that create barriers to accessing maternal and other health care services;
- Removing administrative constraints to allow trained staff to work more effectively.

Experiences from Central Java and elsewhere suggest that **good models of service delivery exist, but that scaling them up is challenging**. For example, a pilot in 10 districts in East and Central Java focused on stabilizing the incomes of midwives (performance-based contracting), coupled with demand creation (issuing of coupon books), and had promising results, but was not institutionalized at the national

level. Innovations in the delivery of antiretroviral treatment can also provide lessons on how to strengthen Indonesia's health system to reduce MMR.

There are also several problems with measuring MMR and collecting appropriate, policy-relevant data, which need to be tackled and could be addressed by implementing the Commission on Information and Accountability and related data system improvements. Vital registration systems and hospital records are inadequate, maternal deaths occurring outside health facilities are not always recorded and/or may be misclassified, and there is a lack of subnational data on spending against key health outputs and outcomes.

Government efforts to accelerate progress towards the MDGs, particularly maternal health

In 2010, a presidential decree required central government and all provinces to develop programmes for MDGs acceleration, part of a final push towards achievement of the MDGs. Subsequently, the GOI designed the Roadmap, which serves as a central point of reference for all stakeholders working to support the MDGs. It is backed by a Ministry of National Development Planning decree requiring all provinces to prepare action plans for accelerated MDG achievement. These plans are receiving support from provincial budgets and a new incentive fund to reward MDG achievement was approved by the national legislature.

In 2011, the GOI established a national MDG Secretariat and the institutional and policy framework for MDG acceleration building on lessons learned from previous initiatives. This helped finalize the Roadmap and the Ministry of National Development Planning 2012 'Report of the Achievement of the MDGs in Indonesia 2011'. It also supported the enactment of ministerial and gubernatorial decrees providing a legal status for the National MDG Team and Secretariat and provincial MDG teams, and the preparation of technical guidelines for provinces and districts to design MDG action plans. A Guidelines for MDG M&E mechanism, a fiscal incentive programme, a policy framework and guidelines for corporate social responsibility to support the MDGs were also designed. All 34 provincial action plans were developed and ratified through Governor Regulations. These national and subnational efforts, which are being supported by the UN, are mainstreaming and strengthening mechanisms for incorporating the MDGs into development planning, budgeting, and monitoring of development outcomes.

In 2013, the MoH launched the Action Plan for the Acceleration of MMR Reduction (2013-2015) to improve the coverage and quality of maternal health services and to enhance the provincial governments' role in supporting health care programmes and in empowering families and communities to strengthen access to health services. The GOI also launched the Action Plan for Prevention of Mother-to-Child Transmission of HIV (2013-2017) to guide and support the scale-up of PMTCT services at the provincial and district levels.

The GOI's commitment to Universal Health Coverage is a major step towards achieving the health MDGs. Indonesia is implementing health system reforms aimed at attaining universal health care by 2019. The GOI's existing health insurance programme for the poor and near-poor (Jamkesmas) will be scaled up from covering 76.4 million poor and near-poor beneficiaries to 86.4 million, with a comprehensive benefits package that includes inpatient and outpatient care and maternal and preventive care. This is expected to contribute towards MMR reduction by increasing equitable access to maternal health services. In 2011, the GOI launched Jampersal to achieve universal coverage for the poor and near-poor by providing free birth delivery assistance to those without insurance coverage; antenatal, birth delivery and postnatal services at primary care facilities; and referral services for maternal and neonatal complications at secondary and tertiary hospitals.

These efforts are complemented and supported by innovative GOI programmes, with UN/WB support, that could significantly enhance the delivery of the establishment of the National MDG Secretariat and its services in rural in Indonesia:

- The establishment of the National MDG Secretariat and its strengthening was supported by UNDP. Aside from the 34 provincial action plans, UNDP, with the funding support from DFAT Australia, has also facilitated the development of 112 district action plans for the MDGs, and 30 percent of them were formalized as Major Regulations. Since the MAF was introduced, UNDP with the Ministry of National Development Planning has promoted the adoption of a MAF bottleneck assessment methodology for solutions to MDGs that were lagging behind. Between 2010 and 2015, annual national progress reports were published and provinces were required to submit biannual progress reports.
- With support from the WB and donors, the GOI has allocated substantial budget resources to the Healthy and Bright Generation Programme (PNPM-Generasi), which provides incentivized community block grants to rural communities in 369 subdistricts to reduce poverty, maternal mortality, and child mortality and to ensure universal coverage of basic education. PNPM-Generasi will be expanded to 130 new subdistricts where the use and access of basic health and education services is poor and levels of childhood stunting are above average, combined with key supply-side inputs, such as training for community facilitators and service providers on maternal health and nutrition and micronutrients for pregnant women.
- Indonesia's CCT programme (*PKH*) provides cash benefits to very poor households (1.5 million, expanding to 3.2 million by 2014) with pregnant women or children, including a mother's verified attendance at prenatal and postnatal check-ups and a professionally attended birth. Partners are enhancing PKH with the introduction of 'Family Development Sessions', i.e., monthly videos and training materials for communities to promote early childhood education, managing household finances, and health protection and promotion, focusing on newborn and early child care, maternal health and basic emergency obstetric and newborn care (BEONC).
- With WB support, the GOI is strengthening quality assurance policies governing the education of health professionals by improving the accreditation system of public and private health professional training institutions and developing national competency standards and testing procedures for the certification of health professionals. Efforts to improve the quality of care are also being supported by funding, technical assistance, and research provided by UNICEF, WHO, UNFPA and UNAIDS.
- With technical and funding support from UNFPA, the National Population and Family Planning Board is developing a new initiative to address issues of unmet need for family planning (MDG 5.B) as one of the pillars of Safe Motherhood.
- To reduce new HIV infections, the MoH, with support from the UN Joint Team on HIV/AIDS, is rolling out antiretroviral treatment to key populations at risk, including pregnant women who are HIV-positive, without reference to CD4 levels, starting with 10 initial demonstration

sites, to reach 74 districts. The initiative will leverage ‘treatment as prevention’, and explore innovative ways to support district-level health facilities to work together and with community groups to support the continuum of care – from outreach and diagnosis to linkage to treatment, treatment follow-up and retention. Lessons from this initiative have the potential to strengthen the health facilities that are needed to support services to reduce maternal mortality.

- WHO and UNFPA supported the MoH in conducting two nationally representative studies: an assessment of maternal and neonatal health quality of care and an assessment of pre-service training of midwifery and nursing schools.
- UNICEF is supporting selected districts in Eastern Indonesia to increase access to maternal health services, including emergency obstetric care, by supporting initiatives like maternity waiting homes and the midwife-traditional birth attendant partnership and by building the capacity of the provincial health office to perform its stewardship and replication of successful strategies and approaches.

Application of the MAF to reducing MMR in Central Java

Within the broader and concerted GOI MDG efforts, **the MAF has been applied to accelerate progress towards the MMR target in Central Java Province.** Central Java is the third most populous province, with 32 million people, or 15 percent of the country’s total population. Although lower than the national average, the MMR in Central Java had stagnated since 2005. Its MMR was about 116-117 (2011), with a 2015 provincial target of 60, which was unlikely to be achieved if additional efforts were not put in place.

Central Java was chosen because of its strong commitment to achieving the MDGs. Eight other provinces followed this example. Central Java completed a Provincial MDG Action Plan first, with clear targets, indicators, a timeline, and budget requirements to implement the national MDG Roadmap. The MAF, through reviewing subnational data and identifying bottlenecks to progress in reducing the MMR, identifying solutions to address these bottlenecks, and developing concrete actions and timelines to achieve them, contributes by providing the evidence

to leverage the available subnational resources and secure political commitment from local leadership. Helping Central Java accelerate MMR reduction would promote national efforts to improve maternal health and guide the use of this approach in other provinces, as discussed below.

In Central Java, the MAF is led by the provincial planning authority, which works closely with the Ministry of National Development Planning. It has been supported by UN agencies, domestic NGOs, professional associations and academia. The exercise: (i) reviewed and identified gaps in existing policies and interventions related to maternal health; (ii) identified and prioritized bottlenecks across policy and planning, budget and financing, service delivery, service use and cross-cutting areas; (iii) identified cost-effective and cross-sectoral solutions to accelerate progress on maternal health, building on lessons learned locally; and (iv) helped understand the reasons behind geographical differentials in MMR progress and the strategies needed to address these differentials.

The Central Java MAF prioritized key interventions to improve the quality of maternal health services and human resources, institutional coordination and monitoring. The bottleneck analysis identified issues, many of which are relevant for other provinces:

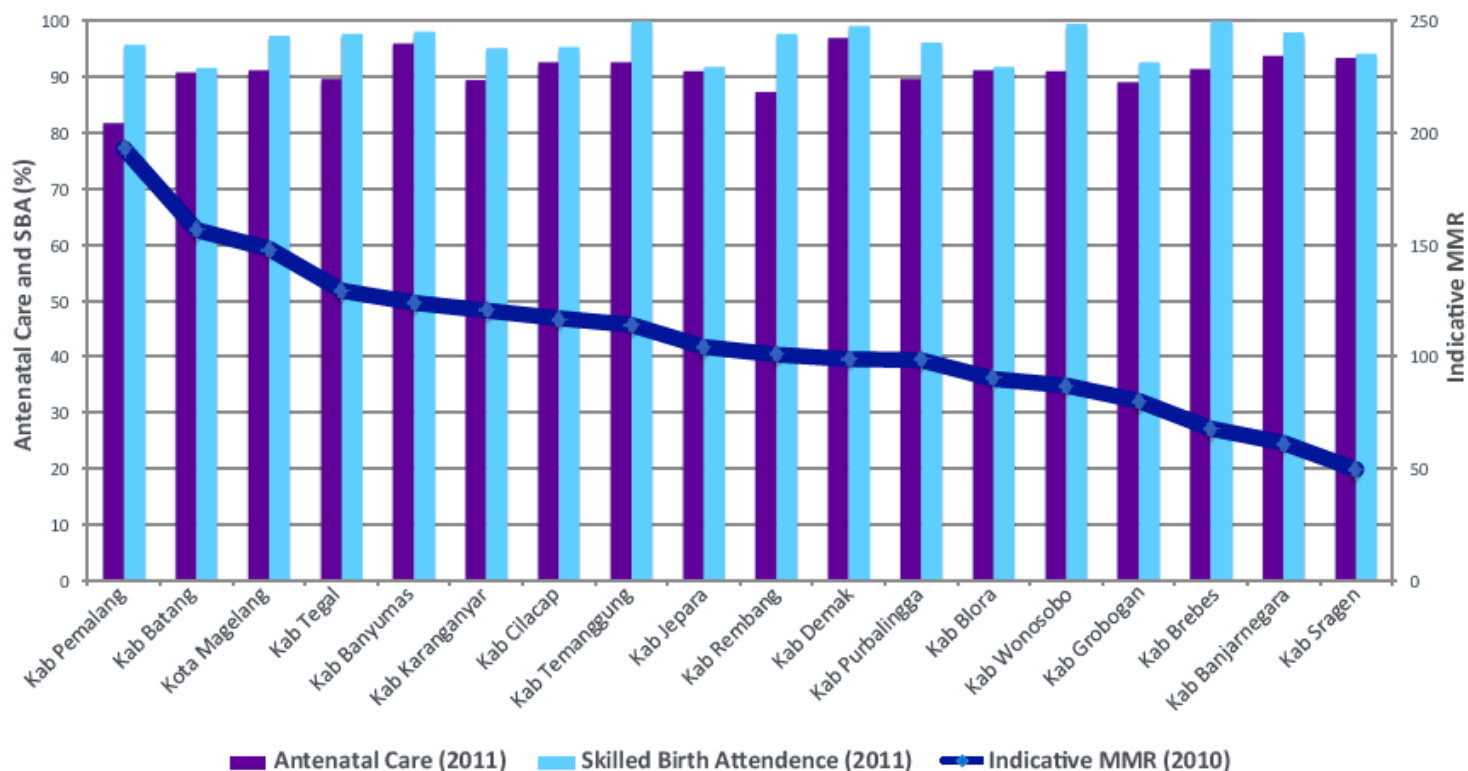
- **Human resources:** Although midwives have been deployed in many villages, their training is often inadequate and they may not be present at their assigned locations. Maintaining internationally accepted standards at training institutions and helping deliver effective pre-service and in-service training are critical for midwives and other health professionals. Improving the capacity for managing human resources efficiently at all levels is needed. For example, nurses and midwives need clear authority for the curative services they provide.
- **Improving quality of services:** Scaling up BEONC and comprehensive emergency obstetric and newborn care (CEONC) through primary health centres (Puskesmas) and district hospitals requires supplies and equipment, maintaining standards of service, and ensuring accreditation based on technical and administrative criteria. Similar considerations also apply to family planning service providers. In addition, effective and clear referral pathways are needed.

- **Facilitating access:** Different social safety schemes exist to assist people in getting adequate maternal and child health care, including: the National Social Security System; *Jamkesmas*; *Jampersal*; *BOK* (health operational fund); and subnational programmes. These potentially complement each other, but more could be done to maximize their impact.
- **Enhancing coordination across government levels:** This includes improving data for district-level planning and timely financial flows from the centre to subnational levels. In addition, national and subnational priorities may not be completely aligned. For instance, access to family planning services for married couples and others was adversely impacted following decentralization when it was deprioritized in many locations.

- **Data quality and collection:** The country lacks a comprehensive vital registration system with causes of deaths, and sentinel surveillance of deaths has not been representative. Future data collection exercises are needed to improve data quality and representativeness as well as timeliness for district planning use.

Central Java is notable for its nearly universal coverage of essential interventions such as antenatal care and skilled birth attendance (see figure below), which have contributed to driving the provincial MMR (116 per 100,000 live births) below the national average (220 per 100,000 live births). However, the MAF findings suggest that the apparent plateauing of the MMR at the provincial level over the last few years, along with the wide variation in the MMR across districts and towns achieving similar levels of coverage in these interventions, indicates that complementary actions to improve service quality, referral and access to emergency care are essential to drive progress.

DISTRIBUTION OF MMR AND SERVICE COVERAGE IN CENTRAL JAVA AND DISTRICTS (2010-2011)



Source: UNDP (2013), Accelerating Progress, Sustaining Result.

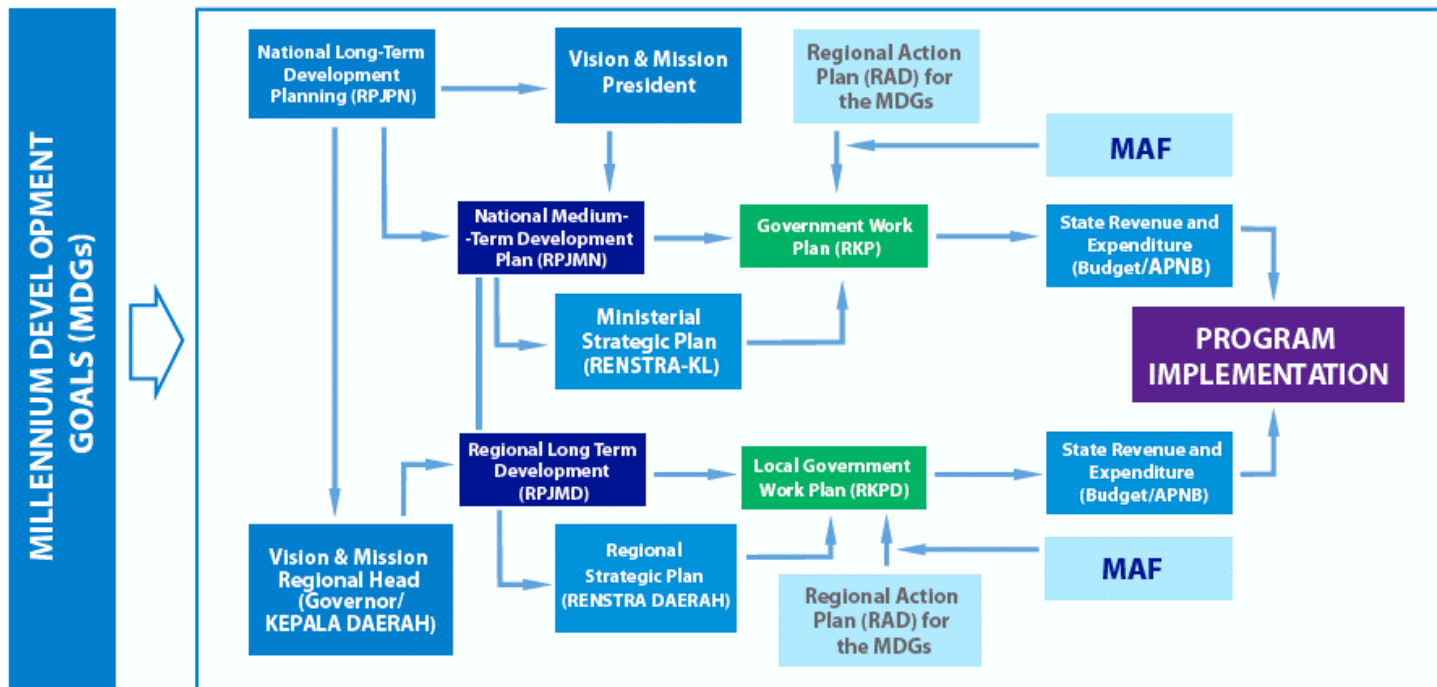
PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

A number of global initiatives established in recent years have raised the global and country profiles of critical MNCH issues. However, these require adequate coordination and linkages at both levels to avoid confusing countries and leading them toward working within vertical structures or silos. **The CEB can play an important role in ensuring that these initiatives are well aligned at the global level, with agreement across different agency technicians on how these initiatives can be harmonized for application at the national and subnational levels.**

Building synergy and coordinating efforts by UN agencies and the WB to support national and subnational implementation of complimentary MDG actions was also important. The International Health Partnership (IHP+) has achieved success and elements of this model could be explored for application in Indonesia. For example, the approach employs a core team of international policy advisors and experts to support the resident UN and WB country teams to mobilize government, development agencies, civil society and others to support

a single, country-led national health strategy or plan, a single M&E framework, and a strong emphasis on partners holding each other to account. The CEB could signal its support and work to expand adoption and application of such a model to support government-led efforts in Indonesia. These UN/WB coordinated efforts must converge to leverage large government resources to steer policy and deliver results across a large and diverse middle-income country like Indonesia.

The MAF implementation has facilitated **a platform for cross-sectoral collaboration to break down silos across national and subnational levels to accelerate the reduction of maternal mortality.** Moreover, this approach enhanced transparency and accountability for MDG results at all levels. BAPPENAS proposed the integration of the MAF as a key component of policy and decision-making and budget allocation at the central and subnational levels and worked closely with line ministries to implement this initiative (see Figure below). The UN and WB supported the GOI to strengthen cross-sectoral coordination around the MAF and provided key technical support to MAF implementation at the subnational level.



Source: BAPPENAS, MoH, and UNDP (2013), Indonesia: Accelerating progress towards improving maternal health in Central Java.

Lessons learned from the MAF in Central Java informed the roll-out to other provinces and generated traction for achievement of targets contained in the Roadmap. The MAF was replicated as part of implementation of the Action Plan for the Acceleration of MMR Reduction (2013-2015) in eight other provinces: North Sumatra, South Sumatra, Lampung, DKI Jakarta, Banten, West Java, East Java, and South Sulawesi. Combined with Central Java, these nine provinces make up 71 percent (169 million) of Indonesia's population, with about 85 million women. The UN and WB need the support of principals to expand provision of needed technical assistance and capacity-building for roll-out.

The UN agencies and the WB will support efforts to promote horizontal learning among provinces and districts by identifying more examples of effective and innovative policies and strategies for health service delivery that can be documented, shared and replicated.

The MoH recently asked for support to establish a real-time reporting system for maternal mortality. UN agencies such as WHO, which is leading the effort to advise the GOI on maternal and perinatal death surveillance and response, can play a role. The MAF, COIA and the Countdown process (particularly at the subnational level) are options that, either individually or through the merging of the different approaches, could contribute to meet this request. A coordinated technical team of international policy advisors from key CEB agencies could support this effort.

The UN and WB will also take steps to scale up advocacy for greater allocation of the national budget for health. This will be paired with intensified support to the provinces and districts to increase and optimize allocations for lagging MDGs, with particular focus on the MMR and other health-related MDGs.

PROGRESS SINCE CEB REVIEW

In 2015, Indonesia achieved 49 of 67 MDG indicators. MDG Goal 2 (Achieve full primary education) and MDG Goal 3 (Promote gender equality and empower women) were fully achieved. However, MDG Goal 5 (Improve maternal health) remains a big challenge.

During its inception, the MAF on MMR in Central Java was only piloted in two districts. After its launch in 2013, 10 more districts were added as focus areas. The MoH used the framework for scaling up the intervention through the National Action Plan for reducing MMR 2012-2015⁶³ with focus areas in the nine most populous provinces and 64 districts and municipalities. UNDP and the National MDG Secretariat under the Ministry of National Development Planning assisted two of them in developing the MAF MMR in 2014:

1. East Java (674 maternal deaths in 599,168 live births in 2014); and
2. Banten (216 maternal deaths in 383,840 live births in 2014). Similar to the process in Central Java, for the development of the MAF in Banten and East Java the MoH was invited along with professional organizations such as midwife associations and Cooperation, obstetric and gynaecological associations (such as POGI), faith-based organizations (Nadhlatul Ulama, Aisyah), community-based organizations like the Family Welfare Movement, and academic and other related organizations.

UN agencies and the WB together with the GOI have developed a number of efforts and initiatives to close the gap of lagging health MDGs. These efforts include the following:

- By 2015, the Government of Central Java had changed the on-call basis medical personnel to on-standby medical personnel. Each public hospital now has at least three obstetricians and three anaesthesiologists on stand-by. The appointed BEONC Primary Health Centers (*PONED Puskesmas*) are able to have midwives on standby too. Even though the numbers of recorded maternal deaths are not decreasing, the number of antenatal care and skilled birth attendants are improving.

⁶³ *Rencana Aksi Nasional Angka Kematian Ibu/RAN AKI.*

- Between 2011 and 2014, the number of districts that met the minimum requirement of four primary health centres with BEONC per district increased by 8 percent (from 241 districts to 347 districts in 2014 or 2,037 BEONC increased to 2,855). The number of hospitals with CEONC increased from 388 to 476 in 2014. The MoH increased its allocation for nutrition, maternal and child health by 24 percent from \$30 million in 2011.
- MAF action plans was developed by considering available local resources, not as a wish list for resource mobilization. The plan was supported by the issuance of a Circular Letter by the Ministry of Home Affairs to provincial governments to develop provincial action plans. The Circular Letter paved the way for domestic or local financing. Moreover, at provincial level, a Governor Regulation was issued to provide extra assurance for planning and budget allocation to implement the Provincial MDG Action Plan. The MAF can be considered as a specialized action plan for specific MDG indicators.
- In 2014, the MAF was replicated for three other areas with full support from the National MDG Secretariat and the UNDP Scale Up Fund. As a result, there is a MAF for sanitation (in Bengkulu Province), water (in NTB Province); and HIV/AIDs (in Riau Island Province). In Rejang Lebong district, one of the focus areas in the Bengkulu Province, in 2014, the MAF was replicated for three other areas with full support from the National MDG Secretariat and the UNDP Scale Up Fund. As a result, there is a MAF for sanitation next fiscal year (both national contribution and district allocation). Bengkulu has also promoted community self-funding activities such as the *Arisan Jamban*⁶⁴ for good sanitation practices.
- The supply side availability and readiness assessment conducted by the WB and the National Health Institute Health Research and Development, has been a part of the national health sector review which later was adopted in the current 2015 – 2019 national strategic plan. The study highlights achievements, identifies new and remaining challenges, and outlines policy recommendations to address gaps in service delivery and supply side readiness for maternal health services in the context of JKN implementation. Some part of the increase of 2016 central government financing to meet the Health Law requirement was allocated to address health service gap issues especially in the primary health facilities.
- The WB-funded Citizen Voice Action for Improved Accountability (CVA) project, which aims to inform the design of the social accountability component of the GoI's Frontline Service Delivery (FSD) program. CVA project focuses on MCH and combines several elements, namely: civic education, a system of rating through a community scorecard, a social audit, an interface meeting that brings all stakeholders together, and community driven advocacy. In its first year, CVA has shown some positive outcomes. Having facilitators routinely visit members of the communities to inform them about minimum services and standards at clinics and health posts have helped mothers in remote villages in Nusa Tenggara become more aware of the standard health service they are entitled to and enabled them to engage in more critical dialogues with the providers.
- The WB is leading efforts to support the GoI to produce transition plans for externally funded programs including the MDG 6 targets, including HIV, TB and malaria, and also immunization. The efforts will be implemented with collaboration with the Government, MoH, Bappenas, and MoF, and relevant UN agencies UNAIDS and UNICEF.
- The WB, at the request of GoI, is preparing a new lending project focused on improving frontline service delivery for primary healthcare services, with a focus on MCH and nutrition services in priority districts. It is likely that the project will support the Healthy Indonesia through family health approach program. Key strategies would be improving supply side readiness at the puskesmas level, promoting health and nutrition services and improved population behaviors at the community level, use of technology to improve accountability and ensuring last mile service delivery and improving financing systems to meet needs and reward performance. The project is currently scheduled to receive board approval in March 2017.

⁶⁴ A saving system utilized in small neighborhoods, where households collect small amounts of money monthly for a certain period of time until they have enough to build a toilet for each household that participated in this system.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

Currently, the GOI is preparing a roadmap for the implementation of the Sustainable Development Goals (SDGs), drawing on experiences gained from the MDG era.

The availability of data to support SDG indicators has been mapped out, and support for drafting legal documents has been provided. Taking into account the experience from the UNDP-BAPPENAS pilot on “Localizing Goal 16”, the governance of the SDGs will be more inclusive by placing representatives from civil society organizations, private sectors, academia and philanthropies in the national coordination mechanism, and the Technical Working Group meetings will be open to all interested parties.

In general, the implementation of the SDGs will take into consideration the following lessons learned:

- A strong legal background was necessary: The basis for MDG implementation was the Presidential Instruction No.3/2010.
- Development of a National Action Plan (RAN) and Local Action Plans (RAD) is needed. During the MDG era, the Government developed a National MDG Roadmap, 33 Provincial Action Plans and at least 6 percent of Districts developed District Action Plans (33 out of 500 districts in Indonesia).
- Development of guidelines and tools is useful. The MDG implementation had many guidelines and tools at its disposal.
- Development of annual reports should be part of accountability processes; the MDG Secretariat coordinated the drafting of the Annual National MDG Report and collected Annual Provincial MDG Reports.
- Provision of non-financial scheme through MDG Awards for the province with the best MDG performance was useful.
- Development of a database and an M&E system was critical. An online M&E system was very helpful for timely reporting.

- Development of an MDG website was important for communication and advocacy.
- The presence of a secretariat (with dedicated staff) is very important to assist the coordination and speed up the implementation of the MDGs.
- Learning from MAF, districts and provinces should be encouraged.
- Identifying key Government stakeholders and understanding the political economy among the key players are crucial.
- Consultation on preliminary results and agreement on key messages, and followed by a discussion on possible policy options including their potential implications.



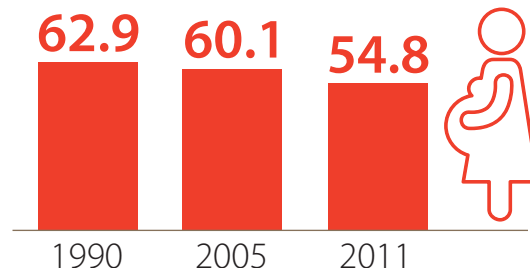
KYRGYZSTAN

Action plan to accelerate progress towards improving maternal health

CONTEXT

- About 38% of the population lives below the poverty line.
- The national MDG MMR target for 2015 was set at 15.7 per 100,000 live births. Kyrgyzstan was unable to meet this target by 2015. Since 2000, the MMR has been on the rise, with the indicator almost never falling below 50 per 100,000 live births. In 2011, the rate was at 54.8 per 100,000 live births. In 2005, MMR was 60.1 and in 1990 it was 62.9 per 100,000 live births.
- Kyrgyzstan registered one of the highest maternal mortality ratios among Eastern European and Central Asian countries.

MATERNAL DEATHS PER 100,000 LIVE BIRTHS



BOTTLENECKS

SOLUTIONS/EFFORTS

Brain drain of experienced health professionals affects quality and access of services.



Continue to advocate for an increase in national budget allocation to health to improve the condition of the health system and workers (national budget allocation increased from 4.4% in 2000 to 6% in 2011 as a share of GDP%).

Unmet need for family planning is high.



Strengthen the capacity of national partners on family planning, reproductive health and HIV; improve the procurement of contraceptives via a total market approach.

Insufficient awareness and information on addressing the danger signs of pregnancy and postnatal complications.



Launch awareness and public information campaigns.

Lack of proper transportation and basic infrastructure (e.g. supply of energy and heating, sanitation and clean water).



Increase infrastructure investments to improve conditions for safe delivery.

INTRODUCTION

Kyrgyzstan adopted the MDG Acceleration Framework (MAF) in 2013 to tackle maternal mortality (MDG 5), an off-track goal with no evident progress made in the past decade.

Kyrgyzstan is a landlocked mountainous Central Asian country with a multi-ethnic population of 6 million. With an estimated GNI per capita of US\$ 1,250⁶⁵, Kyrgyzstan is one of the poorest economies in the region. Approximately 38 percent of the population lives below the poverty line and life expectancy at birth is estimated at 70 years.⁶⁶ Kyrgyzstan is ranked 120 on the Human Development Index, which falls under the medium human development category.⁶⁷ The country has demonstrated good progress towards (i) reducing extreme poverty rates, (ii) reducing child mortality and (iii) improving access to clean water and reducing greenhouse emissions. However, these achievements, especially with regard to poverty reduction, are at risk of reversal because of the shaky economic foundation and increasing inequalities and disparities across regions and population groups. The livelihoods of the vulnerable, especially internal migrants, single-headed households, the long-term unemployed, the working poor and others who do not benefit from social support networks, are especially prone to shocks. The situation with maternal health and reducing the incidence of HIV/AIDS remains disconcerting.

SITUATION ANALYSIS

The MDG and national maternal mortality target for 2015 was set at 15.7 per 100,000 live births.⁶⁸ However, since 2000, the maternal mortality trend has been on the rise compared to 1990, with the indicator almost never falling below 50 per 100,000 live births.

As of 2012, the rate was at 49.1 per 100,000 live births. Since 2010, Kyrgyzstan has registered one of the highest maternal mortality ratios

among Eastern European and Central Asian countries.⁶⁹ In order to reach the target benchmark, the MMR had to be reduced by more than 2.5 times by 2015, reason for the need of acceleration efforts to be implemented.

One of the key reasons for the recent rise in maternal deaths is continuous deterioration in the quality and accessibility of services due to the brain drain of experienced medical and other professionals and the lack of infrastructure investments in health facilities since the breakdown of the Soviet Union in 1991. The recent national health reform programmes (such as *Manas Taalimi*⁷⁰ and *Den Sooluk*⁷¹), supported by development partners through the Sector-Wide Approach (SWAp) mechanism, have focused on improving efficiency and equity by decentralizing decision-making and resources to the primary care level through the introduction of key health financing reforms, including the State-Guaranteed Benefits Package (SGBP), which provides free basic primary health care (PHC) services, and a mandatory health insurance (MHI) system. This established a strong foundation to improve the quality and efficiency of the health system and to strengthen PHC. To date, the SGBP and the MHI have been functioning to promote financial affordability for the general public. In addition, a number of measures have been implemented to improve the practice of evidence-based modern medicine by skilled health personnel at all levels of health care. However, much remains to be done in order to improve access to and quality of prenatal and other health care services for vulnerable women.

There are considerable variations across regions and populations within Kyrgyzstan. In addition, there are significant disparities between urban and rural areas, with MMR trends decreasing in populated urban areas from 60.3 per 100,000 live births in 2000 to 32.1 per 100,000 live births in 2010. In contrast, in remote rural areas, the trend increased from 39.4 per 100,000 live births in 2000 to 61.3 per 100,000 live births by 2010.

⁶⁵ The World Bank. World Development Indicators, 2014.

⁶⁶ The World Bank. World Development Indicators and the Third National MDG Report (2013).

⁶⁷ UNDP. Human Development Report (2015).

⁶⁸ The maternal mortality ratio in 2000 was 45.5 (NCS data) per 100,000 live births (2000 is the more accurate/plausible year for baseline data for Kyrgyzstan, compared to the available data from 1990, due to many upheavals the country experienced in the 1990s due to the difficult restructuring process from the Soviet system to a free market system).

⁶⁹ The average annual pace of reducing maternal mortality ratio from 1990 to 2010 has been 0.2 percent, compared to an average 3.1 percent rate of reduction globally. Estimates have been calculated by WHO, UNICEF, UNFPA, and WB (2012).

⁷⁰ The Manas Taalimi Health Sector Reform Programme (2006-2011) aimed at solidifying health financing reforms, increasing effectiveness of PHC, improving access to specialized care, and improving the quality of health services and medical education.

⁷¹ The *Den Sooluk* Health Sector Reform Programme (2012-2016) aims to establish conditions for the protection and improvement of population health and individual health irrespective of gender and social status. It focuses on four priority areas: cardiovascular disease, maternal and child health, TB and HIV.

This means that the maternal mortality ratio among rural women across Kyrgyzstan is almost twice as high as that among women living in urban areas. A significant majority of maternal mortality occurs among vulnerable groups of women: internal labor migrants, women who are very poor and/or unemployed, and women who have no access to formal or informal social safety nets. For example, in the past three years, over 90 percent of women who died during pregnancy or childbirth were underemployed or unemployed poor women and women migrants. A major factor behind these deaths is the fact that the women were not enrolled in routine prenatal services and sought medical care only when significant complications occurred, often at late stages of pregnancy.

Most maternal deaths (about 78 percent) are attributed to direct obstetric causes, such as haemorrhage, hypertensive disorders, sepsis and other post-partum infections, and obstructed labor.

However, in recent years, over 22 percent of deaths have occurred due to indirect causes, including pre-existing medical conditions (such as TB, HIV, hepatitis and others) and inadequate care and support for women throughout pregnancy.⁷² Households in remote areas have little information and awareness to detect early warning signs of complications and do not practice family planning that could lead to greater birth spacing. In addition, poor nutrition among poor pregnant women and a lack of access to basic infrastructure, such as heating and water, exacerbates the situation.

BOTTLENECK ANALYSIS

Priority acceleration solutions identified through the MAF process

The MAF process builds on existing national processes and plans and advances the effective implementation of the maternal and child health (MCH) component of the new health reform programme, *Den Sooluk* (2012-2016). Since maternal health is a medical as well as a social issue dependent on many actors across the board, the MAF process enabled the involvement of a wide range of stakeholders, including the Parliament (*Jogorku Kenesh*), the MoH, the Ministry of Education and Science, the Ministry of Economy, the Ministry of Social Development, the Ministry of Labor, Migration and Youth, local governments, academia and civil society organizations. The United

Nations System, the World Bank Group and other international partners (such as KfW, GIZ, USAID and SDC) in Kyrgyzstan supported the Government in the application of the MAF methodology.

The MAF Action Plan seeks to improve existing interventions that address direct and indirect causes of maternal mortality. Priority intervention areas include: (i) expanding access to reproductive health care for rural and urban populations, especially youth; (ii) providing effective prenatal and birth care and emergency obstetric care; and (iii) providing social support for vulnerable women (migrants and poor households). The MAF analysis points to the need to continue addressing systemic health sector challenges. These challenges include: poor access to modern methods of family planning and reproductive health care services, especially for youth; the untimely referral and patient information exchange between primary and secondary health professionals; inadequate accessibility and usability of existing routine perinatal care through a patient-centred approach; lack of investment in the rehabilitation of the overall infrastructure and diagnostics equipment of health care facilities, many of which have not been refurbished for over 20 years; failure to adherence to established clinical protocols among the health care professionals; failure to improve the overall quality of emergency services during birth and post-partum to reduce sepsis and haemorrhage; the lack of well trained staff, the need to improve clinical practice, facilitate task shifting (including inclusion and empowerment of midwives and nurses), and the need to improve quality of care and improve clinical practices.

The main bottlenecks that contribute to poor maternal outcomes that were identified through this process also point to the issues that lie outside the health sector – for example, the lack of awareness and information among the public on addressing the danger signs of pregnancy and postnatal complications, and the lack of proper transportation and basic infrastructure, such as a steady supply of energy and heating, sanitation and clean water. The timely referral from the primary to the tertiary (emergency) level is especially problematic for rural areas. The lack of proper health and social support services targeted towards transient populations, such as labor migrants and internally displaced groups, is another key bottleneck. These groups often face prejudice and obstacles in accessing the free prenatal health

⁷² The Republic Medical Information Center 2015.

care packages, such as the state guaranteed benefits package (SGBP) sanctioned by the legal framework of the country. Thus, the solutions identified through the MAF process promote a 'beyond-the-health-sector' approach, with emphasis on providing social and medical support to vulnerable pregnant women, including the provision of quality prenatal care regardless of registration documents and the involvement of existing village health committees and local authorities to provide counselling and support throughout pregnancy.

Implementing the acceleration plan

The Government of Kyrgyzstan with development partners, has taken considerable steps to improve financing for the health sector.

This is evident through the continued increase of the national budget allocation for the health sector, with health expenditures as a percent of GDP increasing from 4.4 percent in 2000 to 6.0 percent in 2011.⁷³ The Office of the Vice Prime Minister for Social Affairs, the intergovernmental MDG Committee and the MoH committed to integrating the health part of the MAF Action Plan within the framework of *Den Sooluk* and other sectoral and local plans. The annual budgetary allocations for the period from 2013 to 2015⁷⁴ will consider the financing of specific measures identified by the MAF Action Plan, including some of the cross-cutting issues that lie outside the health sector.

Local governments, civil society organizations and academia have also committed to supporting the implementation of acceleration solutions in specific regions.

For example, the local governments of Talas and Naryn provinces worked closely towards revitalizing social support services for vulnerable households and women in their regions. Civil society organizations such as the NGO Alliance of Reproductive Health, the NGO *Mutakalim*, Civil Alliance of Food Security and Nutrition, Village Health Committees and other NGOs worked with vulnerable groups of women and helped to extend counselling services on reproductive health and family planning, danger signs of pregnancy and postnatal complications, child diseases, feeding and nutrition practices to rural women and their families. The Kyrgyz medical under- and post-graduate training institutions, along with the Associations of Obstetricians and Gynaecologists and Midwives helped to implement measures oriented toward improving the capacities of health personnel in rural and urban areas.

The UN System and the World Bank's support for the action plan includes the following: (i) ensuring access of adolescents and youth to sexual and reproductive health education and services; (ii) providing effective perinatal care through quality monitoring and care throughout pregnancy, delivery, and postpartum care with special emphasis on early detection of complications; (iii) raising awareness and education of the general population and migrants about existing state-guaranteed health care services; (iv) improving conditions for safe delivery through infrastructure investments; (v) developing emergency obstetric care, including timely referral and exchange of information; (vi) expanding existing pilot projects on social support; (vii) piloting the use of performance-based incentives and enhanced monitoring to improve the quality of maternal and newborn services; and (viii) improving nutritional awareness and practices of adolescents girls pregnant and lactating women.

International partners such as KfW, GIZ, USAID, and SDC provided support in gap areas

by extending reproductive health care to rural youth, improving the monitoring of procurement of contraceptives and essential medicines, reaching out to the general population through awareness and public information campaigns, and scaling up effective perinatal programmes that include nurses and other mid-level health personnel.

Addressing gaps by the UN System and the World Bank for sustaining and further accelerating progress

UN agencies and the World Bank, working together on the ground, have put forward the following elements necessary to close gaps in the implementation of the Action Plan, with a special focus on addressing disparities among regions and population groups:

- **Family Planning and Reproductive Health Care:**
 - Strengthen the policy and capacity of national partners with respect to family planning, reproductive health/rights and HIV (UNFPA, WHO)
 - Improve the procurement of contraceptives through a total market approach (UNFPA)
 - Conduct research and generate and synthesize evidence and data to design key interventions in reproductive, maternal, newborn, child and adolescent health (WHO, UNICEF, UNFPA)

⁷³ This amounts to an increase from KGS213.5 million (US\$4.4 million) in 2004 to KGS761.1 million (US\$15.7 million) in 2012.

⁷⁴ Including from the government budget and *Den Sooluk* SWAp support.

- **Effective Perinatal Care:**

- Institutionalize approaches aimed at improving existing maternal and newborn services by strengthening the capacity of health care providers and communities (WB, UNFPA, UNICEF)
- Support the MoH to improve monitoring of evidence-based practices to promote safe motherhood (WB, UNFPA, WHO, UNICEF)
- Equip and renovate health facilities for effective maternal and newborn care and timely referral (UNICEF, WB)

- **Emergency Obstetrics:**

- Strengthen the association of midwives and nurses in the emergency care of newborns (UNFPA, UNICEF, GIZ), in safe abortion (WHO)
- Support the MoH in the development of standards and clinical protocols/guidelines regarding emergency obstetric care and ensure compliance with them through the use of the Balanced Score Card with support of the Kyrgyz Health Results-Based Financing (HRBF) project; integrate the evidence-based programmes (Emergency Obstetric Care, Family Planning, Antenatal Care, Effective Perinatal Care, neonatal resuscitation) into the curriculum of under- and post-graduate medical education (UNFPA, WHO, UNICEF, GIZ)

- **Social Protection Services for Vulnerable Women:**

- Improve conditions for safe deliveries in hospitals and birthing centres by providing uninterrupted water supply, sanitation facilities, electricity and heating (UNDP, WB, UNICEF)
- Support access to safe and nutritious food for families, diet diversification through raising nutrition awareness and explore linkages to poverty reduction and safety net programmes (FAO, WFP, WB, UNICEF)
- Improve the livelihoods of vulnerable women by providing access to quality seeds to enhance yields so that women can have a more sustainable livelihood and promote off-farm skills development for rural women (WFP, JICA)
- Promote campaigns and outreach to end violence against women and girls (UNFPA, UN WOMEN, UNICEF)

- Facilitate the government's commitment to develop integrated data collection systems on vulnerable women (UNFPA, WHO)
- Complement government financing of the State-Guaranteed Benefits Package (WB, KfW, SDC)
- Support the expansion enrolment of pregnant women in the Mandatory Health Insurance Fund's free maternal care programme and advocate government support to ensure that poor and vulnerable women have better coverage for health services (UNICEF, UNFPA, WHO)
- Improve sanitary conditions in rural households by enabling access to clean drinking water systems (WFP)

- **Effective Management and Capacity Development:**

- Liaise with the MoH on review of the annual plan for implementation of the *Den Sooluk* Programme to ensure that the maternal and child health component and the State- Guaranteed Benefits Package is adequately financed (SWAP and *Den Sooluk* partners)
- Pilot the use of results-based financing for PHC and hospital personnel to improve maternal and newborn services (WB)
- Support the MoH in the development of an effective M&E system for maternal health care (WB, UNICEF, WHO, UNFPA, GIZ)
- Scale up integration of interactive e-health services across the country and support establishment of IT and communication infrastructure for the e-health system (UNDP, WB, WHO)
- Build a multi-sectoral platform to support the SUN movement in order to ensure high-level policy makers focus and integrate nutrition issues across all government activities (UNICEF, WFP, FAO, WB, UNFPA, WHO)
- Support the MoH in improving quality of care for mothers and newborns (UNFPA, UNICEF, WHO, WB, SDC, GIZ).
- Support the establishment and ongoing use of the coordination mechanism under the Food Security Council to improve food quality and to adopt measures aimed at reducing the burden of diseases (FAO, WFP, UNICEF, WB, WHO)

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

The timeframe for implementation of the acceleration action plan in the Kyrgyz Republic (2 years) was insufficient. It is important not to lose traction with the stakeholders mentioned above in order to ensure continued progress on improving maternal health and survival. From the partners' analysis of the MAF Action Plan, it is clear that some of the cross-cutting issues, such as providing targeted and integrated health and social support to underserved groups of women (internal and external migrants, destitute women, etc.) living in urban and rural areas, need prioritization in planning and resource allocation.

The following actions are identified as crucial to achieving measurable and high-impact results:

- **Building human resource capacity** through competency and skills-based training of medical students, residents and in-service medical personnel.
- **Investing in infrastructure** to improve structural aspects of quality of care.
- **Supporting a stronger inter-sectoral coordination mechanism** involving key ministries to help provide oversight and continuous inter-sectoral engagement. Continued advocacy by the UN Resident Coordinator and the WB Country Director is important for this effort.
- **Ensuring that health and non-health sector measures identified through the MAF Action Plan are financed through annual budgetary allocations in key sectors (health, economy, social welfare)** to ensure that prioritized solutions receive due attention and follow-up.
- **Investing in social protection care and support** is crucial to sustaining social and medical care for vulnerable women.
- **Tackling gender inequality and other socio-cultural issues at the community level remains important**, especially for family planning and reproductive health care.

- **Strengthening the system of monitoring of agreed actions by the various government agencies, NGOs and international partners is critical to achieving the set targets.**
- Finally, **improving the accuracy of data reporting on maternal mortality and morbidity** is important for monitoring the impact of the agreed actions over the next several years.

PROGRESS SINCE THE CEB REVIEW

Despite concerted efforts, maternal mortality remains high in the country (39.2 in 2013; 50.7 in 2014; 38.9 in 2015)⁷⁵, although there is limited progress with a slight decrease in the MMR trend when compared using a three-year moving average. Kyrgyzstan maintains high antenatal coverage with 95.8 percent of pregnant women receiving antenatal care⁷⁶. Almost all deliveries take place in health facilities and 98 percent of deliveries are attended by skilled health personnel⁷⁷. The contraceptive prevalence rate had declined from 60 in 1997 (DHS) to 36 in 2012 (DHS), but increased to 41 in 2014.

The improved effective perinatal care practices have been introduced in 90 percent of all maternity hospitals, where monitoring data indicated an increase in the active management of the third stage of labor and a decline in eclampsia and postpartum hemorrhage.

In 2015, the country adopted the law on reproductive rights which is the main legislation regulating reproductive health. The revised RH law contains two critical provisions that ensure access to SR services and information for young people in Kyrgyzstan. It sets the legal basis for sex education of young people. It also ensures access to SRH services for young people starting at age 16 without the consent of a legal guardian.

The Government has committed to providing subsidies for uninsured pregnant women. All uninsured pregnant women will now have access to discounted medicines under the Additional Drug Package at the PHC level and free diagnostic services under the State Guaranteed Benefit Package (SGBP).

⁷⁵ The Republic Medical information Centre 2015.

⁷⁶ Den Sooluk health care programme, M&E, 2012-2016.

⁷⁷ National Statistics Committee, 2014.

The first national report on Confidential Enquiry into Maternal Death (CEMD) contains critical recommendations to improve the quality of care for pregnant women and newborns. Implementing the recommendations of this report is a priority intervention for the next 2-3 years.

An agreement has been reached to reconstruct two regional perinatal centers starting in 2016.

The 2012 Demographic and Health Survey showed that 35 percent of women age 15-49 years were anemic and less than 2 percent of pregnant women took the recommended full course of iron supplements. The MOH, WFP and UNFPA, with financial support from Swiss Embassy and GIZ, conducted a knowledge, attitude and practice survey of nutritional awareness and practices of adolescent girls and pregnant and breastfeeding women of reproductive age. Following the recommendations in this study, awareness modules on nutrition were developed for the population with the support of WFP to increase public awareness on micronutrients and focus on the “1000 days approach”⁷⁸.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

The MoH demonstrated a strong leadership role and commitment towards the implementation of the MAF Action Plan. However, three years was not enough to make good progress in reducing MMR.

Limited resource mobilization for the implementation of the MAF action plan was a constraining factor in achieving better results. Efforts to improve maternal health in the context of the SDGs will need a clear strategy for resource mobilization, simplified country procedures, optimization of donor support for maternal and child health and well-defined coordination and functional responsibilities within ministries for it to be effective.

A number of socio-economic factors affect maternal health in general and access to timely and quality care during pregnancy and childbirth. Therefore greater attention needs to be paid to non-health sectors and to inter-sectoral collaboration.

Lack of quality data on indirect the causes of maternal mortality and urban-rural and other geographical disparities affecting the provision of and access to health care services is a constraining factor for better policy making. This information is crucial for developing informed policies, targeting resources more efficiently and measuring improvements in maternal health and universal access to SRH services.

Insufficient capacity for the management of maternity hospitals and decision-making processes using information systems and data analysis is a bottleneck to improving quality of healthcare services.

The unmet need for family planning is relatively high, possibly due to the lack of guaranteed supplies of contraceptives. The absence of a sustainable mechanism for ensuring access to contraceptive commodities is likely to have a negative impact on adoption of family planning and potentially on abortion rates.

Strong partnerships have been developed with UNDP, UNFPA, UNICEF, WHO, WFP, World Bank, UN Women, SDC, KfW, GIZ, FAO and USAID to support the implementation of the MAF action plan and based on further consultations with government and development partners. The support provided by multiple actors has facilitated implementation. Overall, the CEB MDG Acceleration Review helped in improving sharing information at a collective level among agencies and strengthened collaboration between health and non-health agencies.

The government needs to give greater priority to nutrition-sensitive interventions, such as routine micronutrient supplementation, flour fortification, nutrition education and behavioral change, as well as sustainable food security interventions. More advocacy around these issues is needed.

One other lesson learned that is also important is that partners should discuss MCH at the policy level as it is one of the priority areas under national health system reform program “Den Sooluk” that allows constant dialogue even if the results on decreasing maternal mortality are not yet achieved.

⁷⁸ This refers to the critical nutrition window for the first 1000 days of a child's life.



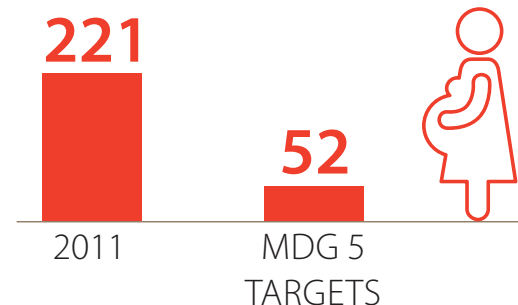
THE PHILIPPINES

Accelerating progress towards improving maternal health

CONTEXT

- MMR remains high (221 deaths per 100,000 live births in 2011) and MDG5 target of 52 per 100,000 was not reached in 2015. Inequality is evident across income groups and geographic areas.
- Out-of-pocket payment and prejudice discourage women from seeking facility-based health services.
- The country's decentralized health care system poses challenges in health care delivery and alignment to national and sub-national health policies.
- Frequent natural and man-made disasters diminish the capacity to deliver reproductive healthcare services, including maternal health services.

MATERNAL MORTALITY PER 100,000 LIVE BIRTHS



BOTTLENECKS

Limited supply side capacities and service readiness at the local level.



Scale up Reproductive Health (RH) services through improved access to quality and essential maternal and RH services including reaching 1.1 million women from the poorest quintiles with unmet family planning needs as part of the FP2020 initiative.

Poor service delivery.



Scale up provision of quality RH services and facilities to address unmet need of the bottom 2 quintiles.

Increase utilization of health facilities by making them rights-based and by improving the quality, affordability and accessibility of care.

Financial barriers and unsustainability for maternal and RH services.



Reduce out-of-pocket payments by re-costing the primary health care package and intensifying audits to ensure full compliance with the No-Balance-Billing policy.

Vulnerability to natural and man-made disasters and emergencies; poor planning not taking into account climate and geographic characteristics of the locale; insufficient focus on disaster preparedness.



Use the Service Availability and Readiness Assessment Tool together with geo-hazard mapping analysis in order to improve the resilience of the health care system to disasters.

INTRODUCTION

The Philippines has one of the highest rates of maternal mortality in the region and did not achieve the MDG 5 targets on reducing maternal mortality, and promoting universal access to reproductive health, including the contraceptive prevalence rate. All available methodologies used to measure maternal mortality show that there has been little improvement for the last ten years, hence the Maternal Mortality Ratio (MMR) target of 52 per 100,000 live births was not reached⁷⁹. While individual estimates differ, taken together, these demonstrate that maternal mortality remains unacceptably high, especially for a country with such high capacities as the Philippines. The Department of Health (DOH) identified the main causes of maternal mortality as follows: complications related to pregnancy occurring in the course of labor, delivery and postpartum; hypertensive complications; postpartum hemorrhage; pregnancy with abortive outcome and hemorrhage in early pregnancy.

Many of the interventions necessary for accelerating progress have limited reach. For example, data (Family Health Survey, 2011) reveal that 44.8 percent of all reported deliveries still occur at home; the contraceptive prevalence rate (CPR) remained only at 48.9 percent (a rate unchanged in the last decade) and the unmet need for family planning (FP) among married women in the Philippines is higher now, at 19.3 percent, compared to 15.7 percent last 2006. In addition, the 2013 Young Adult and Fertility and Sexuality Study (YAFSS) reports that one in every ten Filipina aged 15 to 19 was already a mother.

Inequality is evident across geographical areas and population groups. Urban households are significantly more likely to seek facility-based care than rural households. In areas where facilities are far from the community and transportation is either expensive, unavailable or sporadic, pregnant women are less likely to avail of antenatal care and facility-based delivery. The 2011 Family Health Survey shows that the main problems for accessing health care are: lack of money for treatment, distance of facilities and the need to take transport.

Differences in income and education are also associated with differences in demand for maternal and reproductive health services.

The 2011 Family Health Survey shows that only 48 percent of births in poor households were attended by health professionals compared to 80 percent of births in non-poor households; 87.1 percent of women with no education and 68.4 percent of women in poor households choose to deliver at home; total unmet need for FP for poor women is at 25.8 percent and only 16.6 percent for non-poor. Unmet need is highest for married women with no education at 29.2 percent and lowest for those with college or higher education at 17.6 percent. Furthermore, more educated women are also more likely to have influence in the family in terms of decision-making on the use of contraception and accessing facility-based health care.

There is a notable correlation across provinces between overall socio-economic development and health. Maternal health is undeniably related to social determinants. The 5th MDG Progress Report for the Philippines notes that it is typical for regions that lag behind in poverty reduction to also lag behind across several other MDGs. Provinces scoring low in the likelihood of achieving poverty reduction also scored low on universal primary education, gender equality, reducing child mortality and improving maternal health.

Frequent natural disasters can negatively affect maternal health.

According to the 2012 World Risk Index, the Philippines is the third most vulnerable country in the world in terms of typhoons, earthquakes and rising sea levels. The complicated terrain of the country exacerbates the situation. The National Disaster Risk Reduction and Management Council (NDRRMC) estimated that in the span of 12 years from 2000 to 2012, the total estimated amount of damages from natural disasters is about 184 billion pesos or about 4.1 billion US dollars. The impact of the Tropical Storm Haiyan alone in November 2013 affected 16 percent of the country's population. Of these, there were more than 3 million women of reproductive age and about 1 million of whom were displaced. The size and magnitude of this disaster and the possibility of a reoccurrence require a careful review of the preparatory, response and reintegration processes currently in place.

⁷⁹ The Joint WHO/UNFPA/UNICEF/WB estimates for Maternal Mortality Ratio (MMR) show a modest but not statistically significant decline from 110 to 99 in 2005 and 2010 respectively. The same statistically insignificant results are shown by the estimates through the 2011 Family Health Survey (FHS) which yielded 221 deaths per 100,000 live births from 162 per 100,000 live births in 2006. The Department of Health (DOH) through its Provincial Health Officers (PHO) Report for 2011-2012 records 68 deaths per 100,000 births. This figure is culled from the Field Health Services Information System (FHSIS), a facility-based data collection system. Data from private or non-government units, clinics, and institutions are not captured by the FHSIS.

Conflict also affects women's access to health care system. The armed conflict in the Autonomous Region of Muslim Mindanao (ARMM) between Moro groups, inter-clan factions and the government, which has continuously hampered development and resulted in poor education and healthcare services. In 2008, the National Statistics Office (NSO) estimated that 200 to 300 women die each year in the ARMM and in Northern Mindanao from pregnancy-related illnesses and childbirth. The region also has the highest unmet need for family planning at 35.8 percent. Only about 12 percent of all births in the region were delivered in a health facility and only 20 percent were delivered by a skilled health professional.

National support for maternal and reproductive health is growing.

Legislators passed the Responsible Parenthood and Reproductive Health Act (RH Law) in December 2012. This law guarantees universal access to family planning, sexual education, and maternal health. In April 2014, the Supreme Court upheld its constitutionality (barring some provisions dealing with consent and beliefs).

The Government is making long-term institutional investments to meet the challenges of reproductive and maternal health. It has strengthened supply side interventions such as emergency facilities and trained health care workers across the country. It increased coverage of universal health insurance from 34 percent of population in 2003 to 52 percent in 2011.

SITUATION ANALYSIS

MDG acceleration plan for reducing maternal mortality

The MDG Acceleration Framework (MAF) action plan on improving maternal health for the Philippines was updated to reflect the need to build up resilience to cope with natural disasters, while ensuring MDG progress is accelerated and sustainable. Led by the Department of Health and the National Economic and Development Authority, the action plan is bringing together UN agencies and the World Bank, as well as civil society organizations in support of national and local actions. The UN agencies and the WB are supporting the Department of Health and the Philippine Health Insurance Corporation in improving access to and quality of essential maternal and reproductive health services; to strengthen local government health systems and governance and service delivery capacities; and to engage at all levels to strengthen the resilience of the Philippine Maternal and Reproductive Health services to natural and man-made disasters.

BOTTLENECK ANALYSIS

Identified bottlenecks affecting maternal health in the Philippines

Maternal and reproductive health services along the continuum of care are not well integrated and not sufficiently focused on the needs, expectations and demands of women. This bottleneck derives from several factors: poor demand for reproductive health services among women; insufficient knowledge of the benefits of various reproductive health interventions; shortage of health care personnel; shortage of blood products, medicines and other essential health technologies; and poor implementation of protocols of care and referral.

- **Sub-optimal demand for RH Services.** Unmet family planning (FP) need is at an all-time high in the country, closely associated with poverty and education as noted earlier. Pregnant women are sometimes unwilling to seek facility-based care or a professional care provider. One reason is that although free health care is available in most parts of the country, families still have to shoulder the costs of transportation to the facilities and other related expenses. Moreover, some women feel like health professionals do not treat them with proper respect. Women who have undergone abortions are also apprehensive that they will be reported to the police, thus are more likely not to seek post-abortion care in a health facility. Thus, 44.8 percent of births are delivered at home, out of which 35 percent are performed by traditional birth attendants. Poor women are also more prone to domestic violence, including during pregnancy.
- **Limited supply-side capacities and service readiness at the local level.** The Department of Health (DOH) devolved the delivery of important public health service functions, including maternal and reproductive services; the supervision of service providers and ultimately the outcomes related to health status of the population to the Local Government Units (LGUs). At the local level, often times FP may not be regarded as a priority. As a result, commodities are not readily available at the LGUs. Although, there has been tangible progress in increasing the availability of skilled health workers at the community and district levels, there is still a lack of human resources in the community health facilities, and the district and provincial hospitals. Moreover, only about 20 percent of health service providers are trained on FP due to high staff turnover. Although blood loss is one of the

leading causes of maternal deaths, there is a lack of readily available and adequate blood supply in CEMONC facilities, notwithstanding Oxytocin availability at birthing facilities is uneven. The existing referral protocol under the BEMONC/CEMONC system for women with pregnancy-related complications is poorly implemented. Rural areas are clearly at a disadvantage when it comes to accessibility of health services. Thus there is a need to map out the location, accessibility, and level of functionality of all the BEMONC and CEMONC facilities at the local level in order to take stock of the current facility needs.

Lack of access to reproductive and maternal health services and the risk of fiscal space limitation for sustainable provision of these services under the universal health coverage (UHC) framework.

This bottleneck combines several issues: coverage gaps in UHC due to low awareness of health care benefits among the indigent population and low coverage of the informal sector; need for sustainable funding for scaling up service delivery capacities for reproductive and maternal health; the high out-of-pocket payment incurred at health care facilities.

- **Coverage gaps in the universal health insurance scheme.**

Even though population enrollment in the – a universal health insurance scheme – has nominally reached 80 percent, the actual coverage remains near 60 percent. This is due the fact that many enlisted in the universal scheme are not aware of their coverage status and benefits, and many are also not eligible for benefits as their health insurance premiums have not been paid. Although the enrollment of low-income households has been significantly scaled up, many remain ignorant about the benefits and how to access them. The informal sector is poorly covered by health insurance; and there is low uptake of PhilHealth accreditation among public health care facilities. At the same time, poor compliance with the ‘no balance billing’ policy for the poor renders access even more difficult among those who need it the most.

- **Fiscal allocation for health.** In the short- and medium term the fiscal space for health has been generously expanded with the introduction of ‘Sin Tax’ in 2013. However how the revenues from Sin Tax will be invested in the health system, prioritizing maternal and reproductive health services, remains to be seen.

Lack of alignment between national and sub-national priorities and planning.

The extensive decentralization of the health care system continues to create major challenges for implementing health care programmes. While a number of national policies governing the provision of FP and RH have been formulated, compliance at the local level is sporadic and sometimes not properly aligned with the national plans. Accountability for implementation is weak, and incentives are not well defined. This bottleneck combines several issues: lack of understanding among the LGUs of key policies promulgated by the central government and low buy-in for the priorities underpinning these policies; weak planning, budgeting and implementation capacities; and inadequate monitoring, evaluation and supportive supervision for implementation of national policies and protocols. For example, despite the Reproductive Health Law being deemed constitutional, the implementation challenge would lie in the ensuring compliance by the LGUs. In general, within most LGUs, there is inadequate prioritization of women’s needs and health resulting in a lack of allocation of funds for maternal health and poor provision of services to pregnant women especially in rural areas.

Vulnerability to natural and man-made disasters and emergencies.

This bottleneck is linked to several factors: lack of adequate architectural and functional standards for health facilities; poor planning which does not take into account climate and geographic characteristics of the locale; insufficient focus on disaster preparedness.

- **Inadequate infrastructure and poor organization of emergency response services.**

Most public service facilities are constructed at poorly surveyed sites (e.g. near the coast, where grounds are unstable) and most do not meet the standards of resilience that have recently been developed. LGUs are not aware of readily available funds to mitigate the impact of natural and man-made disasters and emergencies. Calamity funds are often used for disaster response and not for preparedness activities. During emergency, evacuation centers do not meet international standards, such as providing women-friendly spaces.

- **Ineffective policies and poor planning.** While significant attention is being given to disaster risk reduction in the aftermath of Typhoon Haiyan, it is still not sufficiently integrated into sustainable development

policies and planning. While the Department of Health has significant experience and capacities in disaster preparedness and response, the experience of Haiyan demonstrated that even these were inadequate to the challenges of a major disaster. In general, there is insufficient systematic incorporation of risk reduction approaches into the implementation of emergency preparedness, response and recovery programs. The government's disaster policies are more geared towards reactive approach to disaster, rather than preparative. Most LGUs do not have emergency protocols in place. As such, disaster response is often times uncoordinated and sporadic. Civil society organizations are left out even though they may be faster to respond.

- **Maternal health is not prioritized** in any of the Disaster Risk Reduction and Management Council (DRRMC) interventions. Likewise, Adolescent Sexual and Reproductive Health (ASRH) services are not included in disaster mitigation planning. Sexual violence prevention is also not part of the disaster preparedness plan. More importantly, the internationally approved Minimum Initial Service Package (MISP) for Reproductive Health is not fully integrated into the health management response to emergencies.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Identified interventions to accelerate maternal health in the Philippines

Based on the bottlenecks identified, the MAF action plan for the Philippines contains the following interventions, supported to varying degrees by the multilateral development system.

Improve the provision of continuum of quality care services based on agreed national standards by creating the enabling physical, policy, financial and cultural environment for their full implementation.

This action area includes a number of interventions targeted at the above identified demand and supply-side issues, and aims at scaling up delivery and utilization of effective reproductive health services.

- **Scale up reproductive health services.** The upholding of the constitutionality of the RPRH Law by the Supreme Court presents a unique opportunity to rapidly scale up services by national and local

governments so as to address unmet needs in the areas of family planning, maternal health, ASRH and STI-HIV. For example, support in the areas of capacity building, knowledge transfer, outreach services and RH commodity security shall be provided to reach 1.1 million women from the poorest quintiles with family planning unmet needs as part of the FP2020 initiative, a global partnership of governments, donors, multilaterals, civil society and others. Scaling up will also be facilitated through working on an enabling policy environment to address ASRH issues such as the passage in Congress of the Magna Carta for the Youth at the national level; and the development of ASRH policies and budget at the local government unit levels. Increasing the access of adolescents and youths (AY) to age-appropriate and accurate ASRH information through school-based Comprehensive Sexuality Education (CSE) and out-of-school based interventions such as the 'Youth Hub' consisting of the Teen Caravan and various social media platforms.

- **Open dialogue** between women in various communities, primary care providers (PCPs), and LGUs to address the reasons why women prefer to deliver at home. Participation in local health boards is one of the mechanisms through which women could voice their views and suggestions on how to improve delivery of services. While various partners are supporting individual components of this effort, there is a need to develop lower cost outreach materials.
- **Improve the quality of midwife services.** The World Bank supports an NGO (Populations Services Pilipinas, Inc - PSPI), to assist midwives attain PhilHealth accreditation by providing facility upgrades (physical and equipment) and training. UNFPA also currently facilitates accreditation by working with PhilHealth-DOH-LGUs. However, both these initiatives are limited in reach and need to be scaled up by national partners.
- **Strengthen service delivery.** Together with DOH, the UN Agencies and the World Bank will target their efforts to achieve rapid improvements in maternal and reproductive health services, focusing on upgrading maternal and newborn care skills, mapping access to basic and comprehensive emergency and newborn care, and addressing bottlenecks in supply chain management for lifesaving commodities and supplies. Several partners are engaged in improving practice guidelines, supervision, systematic monitoring and enforcement

of regulation at various levels, although the coverage remains limited to certain parts of the country. Similarly, several partners are working on transforming the existing referral system of the DOH into a two-way referral system at the LGU level, complemented by a modern information system, but the efforts need to be scaled up so as to cover the entire country.

- **Align LGU policies and plans.** LGUs are mandated to enact local RH ordinances to guarantee their constituent's access to contraception, RH information and maternal health services. Moreover, there are other policies that LGUs could enact that would directly influence maternal health, such as policies on gender equality, education, nutrition and livelihood. These social determinants contribute to improving the status of women in society and thereby guaranteeing the realization of their right to life and sexual and reproductive health. Technical support is currently being provided to a number of LGUs to help frame such policies, and to assist them in prioritizing maternal and child health in planning and budgeting – but this will need to be expanded to cover the entire country.
- **Increase financial sustainability of maternal and reproductive health services and reduce financial barriers to seeking care for the population.** This action area includes a number of interventions that will lead to improving the effective coverage of the population with UHC scheme by raising their awareness of benefits and entitlements, ensuring adequate financing of the health sector and primary health care in particular, and curbing out-of-pocket expenditures for maternal and reproductive health services.
- **Scale up effective coverage of the population under the universal health insurance scheme.** Support implementation of the Aquino Universal Health Care Agenda, or **Kalusugan Pangkalahatan**, to extend national health insurance to cover the entire population, including through links with conditional cash transfer programmes for improved targeting of the poor, advocacy and convening for strengthened collaboration between government agencies, strengthening cooperation at the sub-national level, and strengthening sub-national development of provider networks.

- **Ensure sustainable fiscal space for health, in particular maternal and reproductive health services.** The DOH will need to develop a medium-term expenditure framework (MTEF) before August 2014, which will outline the spending plan for the health system with clearly identified priorities. Also the DOH is finalizing monitoring framework for the implementation of the 'Sin Tax' (tax on liquor and cigarettes). The World Bank is supporting the the national government in developing a medium-term expenditure framework (MTEF) and Sin Tax implementation. Twice a year there will be a formal review of how Sin Tax revenues are invested in the health system and used for the benefits of the poor.
- **Reducing financial burden from seeking care.** Streamlining billing practices and incentives to comply will reduce the burden of unnecessary payments and therefore also help make PhilHealth more accessible to users. At the same time, expanding the content of the primary health care benefit package to include critical health interventions (which are currently fragmented) and ensuring their delivery in an integrated manner is needed. The revised package needs to be costed and the mechanism for paying the providers needs to be streamlined, so that providers are paid fairly and the population is not required to pay for additional services left outside the package, which is likely to lead to reduced out-of-pocket payments. While the package is under revision, additional efforts are likely to be required to ensure its adoption at all levels.

Enhance the effectiveness of national and subnational coordination in planning, implementation, and monitoring of maternal health services.

- This action area includes interventions that aim at improving the quality of governance at the LGU level and their accountability for outcomes.
- **Improving governance at the local levels and strengthening accountability for performance.** In partnership with DOH, Provincial, Municipal and City authorities, UN Agencies and the World Bank are strengthening subnational planning and implementation, including interventions related to reproductive and maternal health. This includes activation of and support for local health boards comprised of local government, DOH, Philippine Health Insurance Corporation,

Department of Social Welfare and Development, indigenous peoples' groups, and women's groups. Strengthening capacities for monitoring and supportive supervision, as well as reporting through sub-national health information systems are part of this effort. The existing LGU scorecard should be refined and used more effectively as a tool to keep the LGUs accountable for outcomes.

- **The Inter-Local Health Zone (ILHZ)**, which brings together several municipalities under a single collaborative district health planning system, is a promising initiative of the DOH aimed at strengthening referral systems as well as for developing service provider networks necessary for improving health insurance coverage. Scaling this up is expected to lead to greater efficiency and effectiveness.

Improve resilience of the health care system to natural and man-made disasters and emergencies.

- **Improve resilience.** A systematic, timely assessment and monitoring of disasters is needed, with disaster risk reduction streamlined into national and sub-national plans. LGUs need a comprehensive mapping of probable disasters so that protocols can be put in place to address emergency needs. This will help identify 'no-build' zones and safe areas for accessible health service delivery or health service provision points. To strengthen resilience, it must be ensured that new construction and renovation of health facilities, including in areas affected by earlier natural and manmade disasters, will follow the natural disaster resilient standards now in place. This requires close monitoring by the DOH and continuous coordination with LGUs. The exact way that the UN and World Bank can best support the DOH on this is yet to be determined.
- **Strengthen emergency preparedness and response.** Putting in place mechanisms (preparedness, response and recovery) to safeguard the delivery of health services in times of calamities and to minimize setbacks in maternal health progress during disasters is another area of intervention. One concrete and important step is the policy issuance that will require the inclusion of the Minimum Initial Service Package (MISP)⁸⁰ in the health emergency package of the DOH so health providers automatically provide MNCHN

services during emergencies in addition to rescue, surveillance and prevention of disease outbreaks. The LGUs should have set protocols in place to maintain the functionality of health service delivery in the event of a disaster. Another important element of preparedness and response is with respect to food and nutrition security where Early Warning Systems can help LGUs assess the situation at the municipal level and take corrective action. While FAO has a project providing this service in a small number of municipalities, it needs to be scaled up and institutionalized.

- **Promote peace-building.** Encouraging peace-building initiatives and policies on the national and decentralized level could reduce the likelihood of re-surgence of armed conflict and minimize the impact of conflict in Mindanao. Crucial in the setting up of the new Bangsamoro state is the formulation of Bangsamoro Development Plan that will provide the framework and directions for the development of the health sector plan, strategy and program. UN agencies have been requested to assist in the development and implementation of the plan. If developed and implemented successfully, it can contribute to peacebuilding by boosting development outcomes including those related to maternal and reproductive health. However, the resources required for this are likely to be significant. Other interventions can also play a complementary role, such as UNDP's work with the Regional Human Rights Commission to improve human rights situation in the Autonomous Region of Muslim Mindanao, including the welfare of pregnant women, especially the poor and the vulnerable, and internally displaced persons.

Guiding recommendations to the CEB

UN agencies together with the World Bank are recommending the pursuit of a dual strategy to assist the Philippine government in decreasing maternal deaths in the country by focusing on intermediate actions that have been proven to reduce maternal mortality given the high maternal mortality rate supplemented by longer term actions aimed at consolidating and further deepening the envisioned gains brought about in the short term.

⁸⁰ The internationally approved Minimum Initial Service Package (MISP) ensures that IDPs especially pregnant and lactating have access to life-saving RH services during emergencies. Provision of FP commodities is already part of these services.

Intermediate actions involve interventions that will accelerate the reduction of maternal deaths. This includes supporting the DOH and PhilHealth by:

- **Scaling up RH services** by improving access to quality and essential maternal and reproductive health care services including reaching 1.1 million women from the poorest quintiles with unmet family planning needs as part of the FP2020 initiative;
- **Strengthening service delivery** by addressing supply-side constraints;
- **Scaling up universal health care coverage** especially for the poor and the marginalized; and
- **Reducing the financial burden of seeking care** by reducing out-of-pocket payments.

Furthermore, immediate actions are proposed to **strengthen emergency preparedness and response** through the institutionalization of and scaling up of the Minimum Initial Service Package trainings, and the **promotion of peace-building** in the Bansamoro area.

Longer-term interventions include the following:

- **Aligning LGU policies and plans;**
- **Ensuring sustainable fiscal space for health**, particular maternal and RH services;
- **Improving governance at the local levels and strengthened accountability** for performance; and
- **Improving resilience** of the maternal and RH services to natural and man-made disasters.

While it is possible to fill some of the supply-side gaps in the short-run, the sustainable success in addressing the maternal and reproductive health issues in the Philippines will largely depend on the role of local governments. The need to prioritize maternal and reproductive health, allocate resources to these services and fully implement the national policies and guidelines, and improve M&E should be put in place and linked with stricter accountability of LGUs for outcomes.

PROGRESS SINCE THE CEB REVIEW

High maternal mortality rate has substantially remained the same and continues to be an issue in the country. Policies and initiatives are continuously being developed and implemented in order to improve access to health care services (including maternal health), to provide the necessary logistical support for these services, and to ensure the quality of health care delivery.

The UN system in the Philippines continued to assist the DOH, in its efforts to meet MDG 5 of reducing maternal mortality integrated with reducing newborn mortality to achieve MDG 4. From 2014 – 2016, the Joint Programme on Maternal and Neonatal Health (JPMNH) a concerted effort of the DOH, the United Nations Children’s Fund, United Nations Population Fund, and the World Health Organization, Phase 2 was implemented in targeted urban and rural project sites in the country. While MMR has not been substantially reduced, other key MNCHN indicators posted improvements. Facility-based deliveries rose from 75 percent in 2014 to 80 percent in 2015, still short of the 90 percent target set by the DOH (National Objectives for Health 2011-2016). For Modern Contraceptive Prevalence Rate (mCPR), while the target is set at 60 percent, it increased from 39 percent in 2013 to 44 percent in 2015⁸¹.

To ensure that gains are sustained, and address growing concerns such as the increase in teenage pregnancies and non-prioritization of sexual reproductive health services during emergencies, UN supported the development of a wide range of studies and technical assistance products, which were adopted into plans, policies, mechanisms and systems by the DOH, PhilHealth, and local governments. Furthermore, complementary supports were provided for capacity building of HSPs and health systems strengthening.

Development of policies. Landmark health policies in 2015-16 reinforced scaling up of MNCHN implementation in the country. These included, among others:

- DOH AO 2015-0020 Administration of Life-saving drugs during Maternal Care Emergencies by Nurses and Midwives in Birthing Centers;
- DOH AO 2015 – 0028 Guidelines on the Implementation of the UHC High Impact Five Strategy;

⁸¹ RH 2015 Annual Report.

- DOH AO 2016-0005 MISP for Sexual and Reproductive Health (MISP-RH) in Health Emergencies and Disasters;
- DOH AO 2015-0006 inclusion of subdermal implants as one of the modern methods recognized by the National Family Planning Program.
- PhilHealth Circular No. 038-2015 PhilHealth Subdermal Contraceptive Implant Package
- PhilHealth Circular No. 040-2015 entitlement to NHIP Benefits of MCCT Beneficiaries Under the Pantawid Program of the DSWD
- PhilHealth Circular No. 032-2015 Enrolment and Coverage of Emancipated Individuals and/or Single Parents Below 21 Years Old from the NHTSPR-identified Poor Families as Indigent Members
- PhilHealth Circular No. 025-2015 Social Health Insurance Coverage and Benefits for Women About to Give Birth Revision 1

Capacity building. DOH with support of development partners, improved the capacity of HSPs in providing services for BEmONC, Adolescent Health Care, EINC, Infant and Young Child Feeding (IYCF), newborn screening, lactation management, and conducting pregnancy tracking and maternal death review. Referral hospitals in Region 12/ South Central Mindana were also trained in Care for the Small Babies, a comprehensive Training of Trainers combining EINC and Kangaroo Mother Care (KMC). This facilitated accreditation of these hospitals as Centers for Excellence for Care for the Small Babies. HSPs were also trained in various FP skills, including FP Competency Based Training Levels 1 and 2 (IUD insertion/removal, ligation, vasectomy, PSI insertion and removal). Systematic support is likewise provided in FP logistics management, including the pilot implementation of a barcoding system for tracking and tracing commodity distribution and utilization.

These trainings complemented the DOH Health Facility Enhancement Programme (HFEP) that provided infrastructure and equipment upgrading support to LGUs, amounting to Php 11B.⁸²

Improved service delivery. Facility-based deliveries rose from 75 percent in 2014 to 80 percent in 2015. Skilled birth attendance was reported at close to 80 percent of all deliveries. Though Modern Contraceptive Prevalence Rate increased to 44 percent in 2015 from 39 percent in 2013, it was still

short of the 60 percent target in the National Objectives for Health⁸³. The Philippine National Health Insurance Corporation (PhilHealth) database reported that for the end of 2015, 80 percent of LGUs had a facility capable of delivering the services under its Maternity Care Package. PhilHealth also reports that in CY2015, it paid out a total of almost PHP 2.8 billion for 559,998 Maternity Care Package services provided in 2015.

Health systems strengthening. Under Phase 2 the JPMNH focused on building models for organizing and strengthening a functional MNCHN Service Delivery Network. It supported the Health Leadership and Governance Program (HLGP) for local chief executives; and the drafting of Adolescent Health and Development Manual of Operations for Primary Level Program Managers.

Improved fealth financing. The second Consolidated Report on the Implementation of the RPRH Act of 2012, reported the total budget made available for RPRH in 2015 amounted to approximately Php 40.7B from the public sector and development partners. DOH budget allocation for RPRH increased from Php 2.5B in 2014 to Php 3.2B in 2015.

Public-Private Partnerships. The DOH continued its partnership with the Zuellig Family Foundation (ZFF) and academic institutions in the implementation of ZFF's Health Leadership and Governance Program (health change model) for local chief executives and local health officers. The program tracks changes in MMR, infant mortality rate, FBDs, SBA and malnutrition rates. This program is also being supported by both USAID and the UN's JPMNH. The program is in 121 LGUs all over the country. The increase in investment for MNCHN resulted from joint efforts of development partners with the DOH, fueled by resources from the national budget, PHIC benefit claims payments, development partners, and CSOs.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

Delivering as One. To accelerate progress towards reducing maternal mortality, the UN system banked on the collaborative platform of the JPMNH, where the UN agencies; DOH counterparts; national oversight agencies – National Economic Development Authority (NEDA); Department of Finance (DOF); and Department of Budget and Management (DBM); the Australian Government; and civil society

⁸² The DOH Health Facility Enhancement Program accounted for 48% of the total DOH budget, amounting to 11 billion pesos, appropriated for RPRH-related programs in 2015.

⁸³ RPRH 2015 Annual Report

THE IMPACT OF THE PANTAWID PAMILYA PILIPINO CCT PROGRAM ON MATERNAL HEALTH

Pantawid Pamilyang Pilipino Program (Pantawid) is a conditional cash transfer (CCT) program aimed at improving utilization of health and education services among poor households with children and pregnant women. The program provides cash grants to households on condition that they comply with the program requirements related to health and education. The program expanded from 0.7 million households in 2010 to 4.4 million in 2015, covering about 25 million poor Filipinos. The Program beneficiary households are automatically enrolled in the subsidized health insurance program with PhilHealth. The CCT program is subject to a rigorous impact evaluation. The evaluation that was conducted in 2014, found the following:

The program appears to encourage women to try modern family planning methods at least once. Findings show that among 15-49 year old women who gave birth in the last five years, 74% of those from *Pantawid* households indicated using any modern family planning method compared to 68% of their non-*Pantawid* counterparts. The higher incidence of trial use, however, is not translating into sustained use of modern family planning methods. *Pantawid* grantees are required to attend Family Development Sessions (FDS) monthly. FDS, which include lectures on family planning, might have influenced parents' knowledge of the benefits of modern family planning that could have led to changes in attitudes and practices concerning reproductive health. Frequent visits to health center by *Pantawid* mothers may also have increased their access to information on modern family planning methods.

Findings of the study also reveal that almost all mothers (99%)—both *Pantawid* and non-*Pantawid*—are aware of at least one modern family planning method. On the other hand, contraceptive prevalence rate (CPR),

which is defined among in-union women, is 43% and 39% for *Pantawid* and non-*Pantawid* mothers, respectively. The difference, however, is not statistically significant.

Pantawid Pamilya improves mothers' access to maternal care. The IE found that the incidence of at least one antenatal checkup (ANC) with live births in the past five years is high for both beneficiaries (98%) and non-beneficiaries (95%). The incidence of antenatal care by a skilled health professional is also high for *Pantawid* mothers (93%). Estimates show that 80% of *Pantawid* mothers had at least four antenatal check-ups, which is close to the national average of 84% (NDHS, 2013).

A key impact of the program is that more *Pantawid* mothers delivered in health facilities. At the threshold, 7 in 10 live births in the past five years by *Pantawid* mothers were delivered in a health facility, compared to 5.5 in 10 births among non-beneficiary mothers. The national average is 6 in 10 births (NDHS, 2013).

The incidence of having postnatal check-up within 72 hours after birth is not statistically different between *Pantawid* and non-*Pantawid* mothers. While there is no observed impact on incidence of postnatal check-ups, there is marked improvement on having these check-ups by a skilled health professional and in a health facility. Results of the study reveal that 80% of beneficiary mothers are checked by a skilled health professional after giving birth, compared to 59% of non-beneficiaries. More *Pantawid* mothers (72%) also had their postnatal check-up in health facilities, much higher than their non-beneficiary counterparts (55%).

Source: DSWD, 2014. *Keeping children healthy and in school*. Evaluating the Pantawid Pamilya Using Regression Discontinuity Design. Second Wave Impact Evaluation Results. Manila.

Organizations, form part of a National Steering Committee, which serves as a venue for high-level policy discussion and recommendations, including sustainability mechanisms for MNCHN initiatives.

Institutionalizing this joint working approach is also present in parallel bodies, such as the RPRH National Implementation Team (NIT) and the MNCHN SDN Technical Working Group. These coordinative mechanisms were also mirrored in the regions, with the RPRH Regional Implementation Teams (RITs) and the Regional Implementation and Coordination Team (RICT), which ensures harmonization and alignment, minimizing the duplication of efforts of MNCHN activities at the local level.

In terms of working with other line agencies – the RPRH NIT provided a mechanism for other sectoral partners, such as the Department of Social Welfare and Development (DSWD), Department of Education (DepEd), Department of Interior and Local Government (DILG), National Anti-Poverty Commission (NAPC), PHIC and PopCom, and reviewed DOH MNCHN-FP policies in 2015 for consistency with the Implementing Rules and Regulations of the RPRH Law. This resulted to actual commitments from the agencies, including DepEd’s work towards the implementation of Comprehensive Sexuality Education (CSE), DSWDs work on incorporating Maternal Health and FP in the CCT programme and DILGs oversight over LGUs responsibilities under the RPRH Law.

Private sector support. While the Supreme Court resolution⁸⁴ prohibiting DOH from “procuring, selling, distributing, dispensing or administering, advertising and promoting the hormonal contraceptive ‘Implanon’ and ‘Implanon NXT’ remains in effect, private sector organizations such as the Philippine Society for Responsible Parenthood (PRSP) scaled up its engagement with NGOs for the provision of Sub-Dermal Implants to ensure availability of SDI.

Models for engaging the private sector for family planning services had been developed with the Business Action for Family Planning (BAFP) project, leveraging what has been mandated under labor laws and as part of a Public-Private Partnership within a service delivery network for family planning. In partnership with the Employers Confederation of the Philippines (ECOP) and other private companies, information sessions for family planning have been conducted for their employees, linking them to actual FP services.

Other professional organizations such as the Association of Deans of Philippine Colleges of Nursing (ADPCN), Integrated Midwives Association of the Philippines (IMAP), and Association of Philippine Schools of Midwifery were also tapped in the integration of EINC in the pre-service curricula.

Innovative approaches to demand generation. Unique and targeted approaches were also implemented to ensure gender and cultural-sensitivity in the provision of MNCHN services. This was demonstrated in the Indigenous Peoples MNCHN Project, a joint project with the National Commission on Indigenous People, the DOH, EU and UNFPA, enhancing the access and utilization of quality essential RH services in selected indigenous people communities in Mindanao through a comprehensive and culturally acceptable implementation of the MNCHN strategy.

Operational research on male involvement in FP, promotion of shared responsibility in child care through EINC, communication research on community behaviors on MNCHN services, FP demand generation through Family Development Sessions with immediate service delivery, and corresponding Communication for Development (C4D) interventions to develop strategic and context-specific communication interventions, were also implemented.

Capitalizing on existing non-health programmes to enhance maternal health outcomes. The government’s Conditional Cash Transfer Program (CCT or *Pantawid Pamilya*) being implemented by the Department of Social Welfare and Development has contributed to improvements in the delivery of maternity care-related services specifically to increases in facility-based deliveries and skilled birth attendance (see Box). The *Pantawid Pamilya* utilizes Family Development Sessions (FDS) as a means of conveying critical programme information to its beneficiaries. It is also an avenue by which other agencies like the DOH and PhilHealth are able to reach their target clientele. Through the FDS, the DOH has been able to reach pregnant programme beneficiaries and reinforce the need for them to avail of the services at the health facilities. It is also an avenue by which PhilHealth imparts the information that they are all insured and of the different service packages that they can avail of. The programme helped ensure that the poorest segments of the population are being reached by much needed health services.

⁸⁴ Supreme Court resolution dated June 17, 2015, temporary restraining order (TRO), prohibiting DOH from “procuring, selling, distributing, dispensing or administering, advertising and promoting the hormonal contraceptive ‘Implanon’ and ‘Implanon NXT.’” It also prohibited the Food and Drug Administration (FDA) from “granting any and all pending application for reproductive products and supplies, including contraceptive drugs and devices.

Piloting service utilization incentives through an electronic voucher system. The recently concluded Bank OBA-funded Philippines Public Health Project in Region 8 has demonstrated that the implementation of an electronic maternal voucher system could work even in poor provinces and in difficult to reach areas. The maternal health voucher system (marketed as Mothers Bonus) that was implemented for a little more than a year in Samar and Northern Samar provinces in Region 8 was able to demonstrate that financial incentives can improve access to and utilization of maternal care services. The vouchers were electronic in nature and were transmitted to the mobile phones of the clients and the sellers upon purchase. An electronic voucher bought for PHP50 would then be redeemed for a total amount of PHP1,500 if all the required maternal care services for antenatal, natal and postpartum care were received by the client. Cash payouts under the voucher was dependent on the health service received. During the pilot period, a total of 9,828 vouchers were sold to pregnant women (meeting the expected project uptake of 50 percent of the total expected pregnancies) and of these, 7,144 vouchers were redeemed for various maternal care services. Of note is that there were 2,822 vouchers that were redeemed for a complete set of antenatal, natal and postnatal services. Of the expected 21,818 deliveries in both provinces for 2015 (13,827 in Samar and 7,991 in Northern Samar) the Mothers Bonus supported deliveries accounted for 22 percent of the total (4,637). The total amount paid to clients for the redeemed voucher services was PHP10.7 million (approximately USD 228,000).

Enhanced collaboration and coordination. Development partners in the Philippines have both formal and non-formal venues for dialogue and consultation. The Department of Health hosts a semi-annual meeting with development partners that is chaired by the Secretary or an Undersecretary (UN agencies and the WB are individually represented in these meetings). The meeting is a venue to share information and discuss policy issues. Though less frequent as desired and in an informal manner, the development partners also meet amongst themselves to discuss policy issues and common agendas to push forward with government. That being said, the joint work by the UN and WB for the CEB has strengthened existing collaborations and facilitated more

open dialogue within the UN family. The collaboration has enhanced joint analysis of the problem and stocktaking of current and future initiatives that resulted in a more “focused” implementation of previously independently planned actions. In preparation for undertaking the CEB work, a previously accomplished MAF with the Government was updated and further enhanced through a wider consultation and collaborative process. The exercise also allowed the UN and WB to work with the NEDA (state planning body) and other government agencies as a single organization with a common purpose. The resources of all agencies were brought to bear in tackling a significant issue for the Government. There was constant communication and coordination between the UNCT and the WB during the whole exercise.

Improving Resilience. Capacity was built in HSPs to equip them with the knowledge and to provide sexual and reproductive health care services during emergencies. To ensure that MISP is integrated in local Disaster Risk Reduction and Management plans, local officials were also trained in the Minimum Initial Service Package (MISP) Level 2. The issuance of AO 2016-0005 Minimum Initial Service Package of Sexual and Reproductive Health (MISP-RH) in Health Emergencies and Disasters, provided an enabling mechanism for mainstreaming SRH activities into the humanitarian response.

CHAPTER 4

ACCELERATING PROGRESS TOWARDS REDUCING THE INCIDENCE OF MALARIA, HIV/AIDS, TB, AND NON-COMMUNICABLE DISEASES



HIV/AIDS, malaria, and tuberculosis are among the world's deadliest infectious diseases. The targets were to halt and begin to reverse the spread and incidence of these diseases by 2015.

An estimated 37 million people were living with HIV/AIDS in 2014. The number of people newly infected with HIV is continuing to decline in most parts of the world: 2 million people contracted the disease in 2014, down 33 percent from 2001 and 13 percent from 2011. The spread of new infections has slowed, in line with the target of halting and reversing the spread, however the proportion of adults living with HIV has stayed around 0.8 percent since 2000.

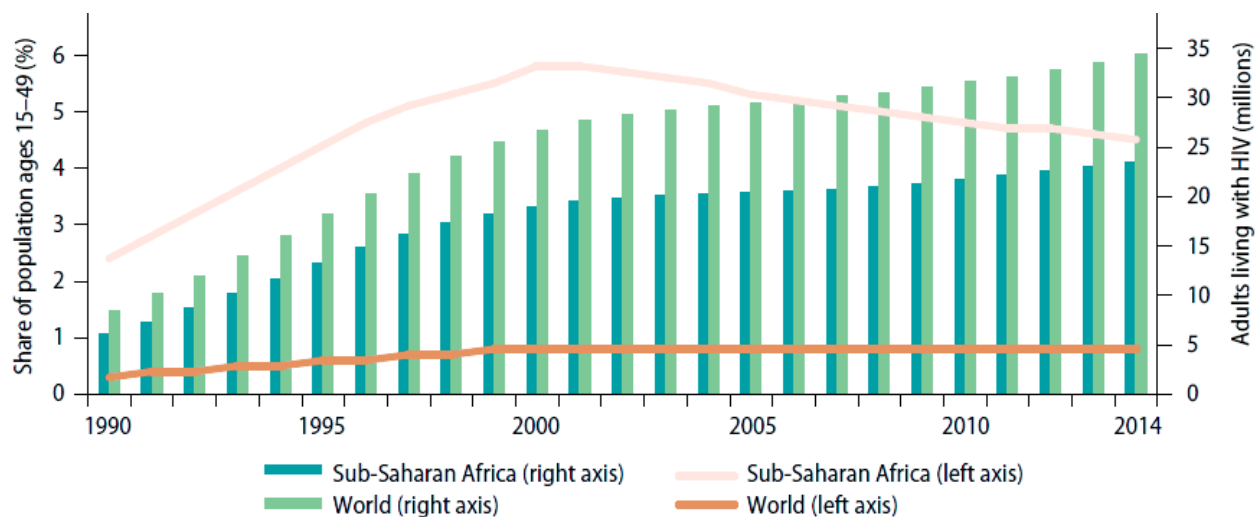
Sub-Saharan Africa remains the center of the epidemic, comprising about 70 percent of the world's adults living with HIV. The prevalence rate was 4.5 percent in 2014, compared with less than 1 percent in other regions with available data. Despite progress in stabilizing the proportion of adults living with HIV worldwide, the absolute number of adults with HIV is increasing: from 29 million in 2005 to 34 million in 2014 worldwide, and from 20 million to 24 million in Sub-Saharan Africa. The increase poses additional challenges to expanding access to antiretroviral drugs, which have dramatically improved survival rates. Addressing the HIV epidemic requires changes in behaviors based on better understanding of the disease and effective steps to avoid infection.

In 2013, there were 9 million new tuberculosis cases in the world and 1.1 million deaths. However, the incidence and prevalence, as well as the rate of deaths, are falling: incidence fell 41 percent between 1990 and 2013, and the death rate fell 45 percent⁸⁵. Globally, the target of halting and reversing tuberculosis incidence by 2015 has been achieved. Despite population growth, the absolute numbers of tuberculosis cases and deaths have dropped.

Malaria is one of the leading causes of death of young children and undermines the health of millions of adults. An estimated 214 million cases of malaria occurred in 2015, which led to 438,000 deaths. An estimated 3.2 billion people are at risk of being infected. Since 2000, there have been substantial reductions in the number of cases and deaths. The target of halting and reversing the incidence of malaria has been met⁸⁶.

Malaria occurs in all regions, but the most lethal form of the parasite is concentrated mainly in Sub-Saharan Africa. Insecticide-treated bed nets have proven an effective preventative. Better testing and the use of combination drug therapies are improving the effectiveness of treatment.

PREVALENCE OF HIV IN ADULTS AND NUMBER OF ADULTS LIVING WITH HIV, BY REGION, 1990-2014



Source: World Bank, 2015. Global Monitoring Report 2015/2016: Development Goals in an Era of Demographic Change.

⁸⁵ WHO.

⁸⁶ WHO and UNICEF.

BANGLADESH

Reduce the incidence, prevalence and mortality caused by tuberculosis

CONTEXT

- Bangladesh was off-track on the MDG-6 TB targets/indicators of (1) falling incidence rate; (2) 50% reduction in the prevalence rate by 2015 compared with 1990; (3) 50% reduction in the mortality rate by 2015 compared with 1990; and (4) at least a 70% case detection rate.
- In its fight against TB, the country has also attained remarkable progress such as a high success rate for treatment, the third highest (92%, behind only China and Cambodia) among the 22 high TB burden countries in the world.
- Bangladesh has the world's third-highest prevalence rate (404 per 100,000 people), the fourth-highest mortality rate (51 per 100,000 people), and the seventh-highest incidence (227 per 100,000 people).
- The National TB Control Programmed successfully treated 93% of the 184,077 cases in 2013.

TB MORTALITY

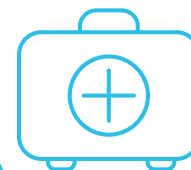
51/100,000

PREVALENCE

404/100,000

INCIDENCE

227/100,000



BOTTLENECKS

Low case detection — it is estimated that 47% of all TB cases and three quarters of multi-drug resistant TB (MDRTB) cases remain undetected.



Low quality and availability of diagnostic services (only half of total estimated TB cases are detected and notified).



Inadequate systems, supervision and monitoring of drugs.



Lack of integrity and effective supporting schemes in delivering services and allocating in-kind contributions.



SOLUTIONS/EFFORTS

Increase number of microscopy labs; gradually expand LED FM (advanced microscope technology) to 200 centres; and increase usage of Xpert MTB/RIF machines.

Social support is being provided for the investigation of highly suspicious smear-negative and extra-pulmonary cases. Yearly notification of all forms of TB has increased.

Drug storage facilities have been improved and the electronic registration of TB data using e-TB manager software has been expanded to 255 DOTS (directly observed treatment, short-course) centres.

Completion of the ongoing prevalence survey, initiation and completion of the analytical work on urban health and studies analyzing factors such as smoking, crowding, occupational hazard for garment workers and other conditions would help address key determinants of TB.

INTRODUCTION

Despite the Government of Bangladesh's efforts and support by bilateral and multilateral development partners, Tuberculosis (TB) continues to be a major development challenge in the country. The following summarizes the prevailing bottlenecks faced by the country, and proposes measures to accelerate progress to effectively provide a development response to TB.

SITUATION ANALYSIS

Bangladesh, a low-income South Asian country of about 157 million people, has made impressive economic and social progress in recent years. Since 2000, GDP has grown by nearly 6 percent annually and the percentage of people living on less than \$1.25 per day has fallen from 58.6 percent to 43.3 percent in 2010. The country is expected to partially achieve the MDGs for poverty reduction and primary school enrolment, and is on track to achieve the MDGs for gender parity in education, child mortality, and maternal health. The main reasons behind this achievement include Bangladesh's attention to health outcomes, elementary education, family planning, and gender equality (especially in education and workforce participation), which often stem from a strong community network of health providers, supported by the government and NGOs.

Bangladesh has made remarkable health achievements in the last few decades and has been described as "an exceptional health performer."⁸⁷ In its fight against TB, the country has also attained significant progress. The country records an impressive treatment success rate – the third highest (92 percent, behind only China and Cambodia) among the 22 high TB burden countries in the world.⁸⁸

Despite progress, significant challenges remain. According to the latest WHO global TB report,⁸⁹ Bangladesh is off-track to achieve MDG 6 TB targets/indicators with regards to (1) incidence rate falling; (2) 50 percent reduction in prevalence rate by 2015 compared with 1990; (3) 50 percent reduction in mortality rate by 2015 compared with 1990; and (4) at least 70 percent TB case detection rate.

Bangladesh's estimated TB mortality (80,000 or 51/100,000), prevalence (640,000 or 404/100,000), and incidence (360,000 or 227/100,000) rates in 2014 to be respectively 4th, 3rd, and 7th highest in the world. While the TB mortality rate has been steadily declining with a high treatment success rate, the incidence rate has remained constant since 1990, mainly due to unfavorable socio-economic and demographic changes. The country is reported to be the 4th country with the highest estimated rate of 'missed' or undetected cases, as only 53 percent of the total estimated TB cases are actually detected and notified.

If current trends persist, Bangladesh is unlikely to achieve the targets for prevalence and mortality of TB. Although overall progress appears promising, particularly for case notification, treatment coverage and success, concerns remain about data quality. It is generally accepted that targets related to TB mortality and TB prevalence will not be achieved, but experts often dispute estimates on the TB situation in Bangladesh⁹⁰.

Epidemiological evidence on TB in urban slums is still limited, and yet limited available data suggests a very high TB prevalence in slum settings. Despite the presence of favorable conditions for TB infection/activation (poverty, malnutrition, high population density, inadequate ventilation in crowded housing conditions, and exclusion from public services including health, among others). Limited available data suggests a very high TB prevalence in slum settings.

BOTTLENECK ANALYSIS

Bottleneck analysis and existing gaps

TB remains a disease of poverty, and the incidence of TB is likely to be higher among populations living in poorer socioeconomic conditions (e.g., the extreme poor, slum dwellers, char dwellers, people living in the Chittagong Hill Tracts, indigenous populations, refugees, migrant workers, prisoners and garment workers). In 2011, the World Bank estimated that TB mortality in the poorest quintile is twelve times higher than in the richest. Growing consensus indicates that progress in TB control will require not only investment to strengthen control programmes, diagnostics, and treatment, but also necessitate to take

⁸⁷ Chowdhury, A.M.R., Bhuiya, A. et al (2013). The Bangladesh paradox: exceptional health achievement despite economic poverty. *The Lancet*, Vol 382, November 23, 1734-1745.

⁸⁸ WHO Global Tuberculosis Report 2015.

⁸⁹ Ibid.

⁹⁰ The field activities of TB Prevalence Survey, completed in April 2016.

action on social determinants. Interventions from outside the health sector – specifically, in social protection and urban planning – have the potential to strengthen TB control. Furthermore, burgeoning urban slums caused by rapid urbanization, high smoking prevalence, and the growing number of people with diabetes in Bangladesh together with the growing emergence of multi-drug resistant (MDR)/extensively drug-resistant (XDR) TB cases⁹¹ could exacerbate the TB landscape with tremendous human development, health, poverty, and economic implications, thereby slowing the progress towards achieving other MDG targets.

Bottleneck area 1: Active screening among high-risk groups, contact-tracing and quality-assured diagnostic services

A key challenge for TB control in Bangladesh is low case detection. It is estimated that 47 percent of all TB cases and three-quarters of multi-drug resistant TB (MDRTB) cases remain undetected. Given the extreme difficulty in containing outbreaks of MDRTB, increasing the MDRTB case detection rate is an urgent priority.

Three initiatives will help increase detection rates:

Promoting active screening and case detection in high-risk groups and contact-tracing. The goal of contact tracing is to reduce the time required to detect and treat a case and hence reduce the transmission. In addition, active screening for co-infection such as HIV/TB co-morbidity should be introduced as around 20 percent of detected HIV cases have TB co-infection.

Improving the quality and availability of diagnostic services for smear positive, smear negative and MDRTB cases. To date, the Government has not achieved its target of having one smear microscopy laboratory per 100,000 population. Even when diagnostic facilities are in place, they are often not appropriately staffed and supervised, and do not have adequately-functioning diagnostic equipment. The quality of smear microscopy services is suboptimal. Moreover, access to quality diagnostic services for smear negative cases, MDRTB, child TB and extra-pulmonary cases remains insufficient. Therefore, providing quality diagnostic services for TB control to enhance detection rates should be a priority for Bangladesh.

Operationalizing mandatory TB notification. Recent legislation concerning mandatory notification is still not operationalized, especially in the private sector. Given there are no recording and reporting forms for private practitioners, detected cases in such facilities are usually communicated orally to the public sector. The existing case notification software used in the public sector requires further operationalization and specific training for staff responsible for using the system.

Bottleneck area 2: Standardized treatment, with supervision and patient support

In Bangladesh, patients with TB diagnosed in the public sector will have high treatment success, due to the effective use of the DOTS strategy, implemented jointly by the public sector and NGOs. The public sector provides essential diagnostic, medicinal, and initial hospital treatment services, while a network of NGOs delivers community-based treatment for all identified cases following the DOTS strategy. High treatment success rates were achieved from the beginning, with the target of achieving an 85 percent treatment success rate for new smear-positive cases first met in 2003. The NTP has been maintaining a treatment success rate exceeding 90 percent since 2006, and it successfully treated 93 percent of the 184,077 new and relapse cases registered in 2013.

By contrast, TB patients that have not been detected and treated through the public sector are believed to have much lower treatment success. Private for-profit health-care providers and pharmacists are not formally engaged in Bangladesh's National TB Control Programme (NTP). Misdiagnosis may result in cases being treated with cough medicines, antihistamines and antibiotics first. Even when proper diagnosis is established, it may be followed by incomplete treatments, use of variable regimens outside the DOTS protocol, and failure to be captured in the standardized NTP recording and reporting system. As a result, new cases and defaulters may not receive follow-up and contacts may not be detected or traced.

Within the public sector, Bangladesh has a reasonably strong TB recording and reporting system, but private treatment is not adequately captured. Individual patient data, including information on treatment outcomes, is captured at the central and peripheral levels of the

⁹¹ See Noor, R. et al. (2012). Frequency of extensively drug-resistant tuberculosis (XDR-TB) among re-treatment cases in NIHCH, Dhaka, Bangladesh. *J Infect Chemother*, 10 October 2012; Falzon, D. et al (2013). Universal access to care for multidrug-resistant tuberculosis: an analysis of surveillance data. *The Lancet*, Vol 13, August 2013; and Kamal, S.M.M. et al (2015). Anti-tuberculosis drug resistance in Bangladesh: Reflections from the first nationwide survey. *Int J Tuberc Lung Dis*. 2015 Feb;19(2):151-6

public health system and used to compile treatment outcomes in cohorts of patients, to monitor treatment outcomes and identify local problems as they arise, and to ensure quality TB control across the country. That said, TB patients who are not properly diagnosed or who receive treatment from private care providers who are not directly linked to the NTP are often not captured in the notification system. Moreover, experts often dispute estimates of the epidemiological situation and of progress in TB control; hence, regular and more frequent surveys should be implemented better to understand progress in TB control and the social dynamics that contribute to high TB rates.

Bottleneck area 3: Funding for TB

In Bangladesh, there is political commitment to control TB, with strong public-NGO partnerships, but financing is inadequate. At the central level, the NTP is responsible for policy, planning, management, training, supply, coordination, supervision and monitoring of the implementation of TB services. The public sector provides essential diagnostic, medicines, and initial and hospital treatment services, while a network of NGOs, led by BRAC, provides community-based treatment for all identified cases following the WHO-recommended DOTS strategy, which initiated field implementation in November 1993. Bangladesh achieved a treatment success rate exceeding 90 percent in 2005, and has maintained that success rate. However, Bangladesh is a low-income country with a limited tax base and revenues, and while there is huge demand for services, competing funding priorities for the government cannot ensure funding for basic package of services.

Low public funding for health care means that many poor people who are sick do not seek treatment, or settle for treatment that is less than adequate. With out-of-pocket expenditures averaging more than 63 percent of total health expenditures in 2012-2013, many people, especially the poor, underutilize health services, self-medicate or limit their search for medical advice to pharmacists or other private providers, often with unsuccessful outcomes. Additionally, human resources are critically deficient, with poor terms of services negatively impacting the availability, distribution and motivation of competent health workers.

Enhancing public spending and ensuring the availability of adequate and competent human resources for TB care must be part of any scaled-up effort in Bangladesh. To date, most NTP

funding comes from external sources, putting the sustainability of the programme at high risk. Further resources need to be mobilized, from international as well as (progressively more) domestic sources. Although Bangladesh is experiencing a general crisis related to human resources for health, it is possible to prioritize some services and fill staffing needs (like mid-level managers and community-level health workers) through special measures that can be implemented immediately or outsourced (e.g., through new funding under discussion with the Global Fund) and that can serve as a bridge while long-term sustainable solutions.

Bottleneck Area 4: Multi-sectoral approach to tackle determinants of TB

Sustaining successful treatment rates exceeding 90 percent will require emphasis on continuing Government/NGO partnerships, reducing variable TB treatment practices within the private sector, and supporting the poor who contract TB. To prevent the spread of MDRTB in Bangladesh, a priority must be the development and implementation of regulations and of a mandatory notification system which includes NGOs and for-profit providers in the NTP.

While TB is closely associated with poverty and the relationship is bidirectional, the current TB response in Bangladesh appears not to have comprehensively engaged non-health relevant stakeholders. Poor people diagnosed with TB will need to receive better support. Stronger cooperation is needed among the social services, NGOs and international organizations to provide assistance to poor TB patients to seek care, adhere to treatment, receive social assistance and address behavior patterns that contribute to higher TB rates.

Stigma and discrimination associated with TB are also part of social determinants and consequences of TB, impacting the effectiveness of a TB response. They can, for example, deter people from coming forward for TB test and treatment, as well as reducing economic opportunities (e.g. loss of jobs, avoidance of businesses owned by people living with/or affected by TB).⁹² These issues need to be addressed through multiple pathways and agencies, including the justice and law enforcement sectors.

⁹² See Hatherall, B. (2009). Understanding TB-related stigma in Asia: Bangladesh; Somma, D. et al. (2008). Gender and socio-cultural determinants of TB-related stigma in Bangladesh, India, Malawi and Colombia. *Int J Tuberc Lung Dis*, 12 (7): 856-866; and UNAID (2012). Reducing TB Delays: Evaluating the Frequency and Causes of Delays in Bangladesh and Swaziland. July 2012.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

It is imperative to better understand the causes of the high and unchanged incidence of TB despite very high treatment success rates and poverty reduction achieved in Bangladesh in the last 20 years.

Completion of the ongoing Prevalence Survey as well as initiation and completion of the analytical work on Urban Health and studies analyzing factors such as smoking, crowding, occupational hazard for garment workers and other conditions contributing to sustain unchanged and high incidence would help address key determinants of TB in Bangladesh. This could include efforts to address urban planning, urban transport, housing and control of air pollution, develop and implement occupational hazard regulations and safety measures, tighten tobacco control efforts.

- Even before analytical work is completed and appropriate action plan is developed by UN and partner agencies, several interventions should be implemented, especially focusing on **accelerating efforts to improve Bangladesh's case-detection rates**, through active screening and improved access to quality diagnostic services, to reach at least 70 percent case detection rate by 2018. This will cost an estimated US\$80m in capital investments, and an additional US\$12m per year in running costs. It would include **filling urgent vacancies in human resources and outsourcing** through short-term measures while transitioning towards a fully-staffed health workforce (US\$7m per year).
- Increasing detection rate but also preventing drop outs from the DOTS programme can be achieved by **strengthening the regulatory and stewardship role of the Government for effective engagement with private sector health-care providers in expanding TB control efforts and developing and enforcing adequate case notification system in the private sector** (costing US\$12m for MIS and supervision). These efforts can start immediately and would require additional support to expand community coverage provided by NGOs.
- As the Government of Bangladesh has already developed solid national TB strategy for 2015-2020, it would be important to support **full implementation of this strategy with an additional 5 percent annual increase in the Government contribution.** (Funds will be sought in the next round of Global Fund grants and government funding).

- And finally, continuing and accelerating efforts to achieve poverty reduction, while introducing **targeted programs for vulnerable and susceptible groups including people living with HIV, through policies, and especially through social support and services that can contribute to TB control** can create demand for higher utilization of TB services and contribute to even higher recovery rates and prevent unnecessary deaths (social assistance targeting TB patients would cost about US\$16 million per year).

PROGRESS SINCE THE CEB REVIEW

In the six months after finalization of the CEB report some significant progress in the prioritized areas are evident:

- **TB prevalence survey:** following completion of field implementation in April, the lab results will be ready by July and the draft report by end of October 2016. The epidemiological analysis will be completed by the end of the year.
- **Initiatives to enhance detection rates:**
 - Increased number of microscopy labs from 1089 to 1104; gradually expanding LED FM (advanced microscope technology) in 200 centers; and usage of XPERT MTB/RIF machines increased from 27 to 39.
 - Accelerated TB awareness raising programmes with special attention to Child TB. The impact is evident in the increase of Child TB case detection rate i.e. <2 percent in 2005 to 3.9 percent in 2015
 - Introduced contract Tracing and Isoniazid Preventive Therapy for children and active screening in some hard to reach areas.
 - Community based drug resistant (DR) TB management is available throughout the country as a result of which multi drug resistant treatment success rate has increased to about 73 percent.
- **Improving quality and availability of diagnostic services:**
 - NTP is providing LED microscope in exchange of conventional microscope to improve the diagnosis.
 - Social support is being provided for the investigation of highly suspicious smear negative and extra-pulmonary cases. As a result, yearly notification of all forms of TB has increased to 205,898.

- **Filling urgent vacancies in human resources and outsourcing:**
 - NTP completed recruitment of new staff/filling up of vacant positions under Global Fund support. NTP also recruited one international procurement and supply management consultant.
- **System strengthening, supervision and monitoring:**
 - National guidelines and operational manual on the Public Private Mix (PPM) is in process of finalization. The objective of the PPM TB is to achieve set targets for case detection and to sustain treatment outcomes during the NSP 2016-2020, that is in line with the END TB Strategy. It will also enhance access to services among the poor including the reduction of financial burden on patients for TB treatment.
 - National guidelines and an operational manual on childhood TB (2nd edition) and national guidelines on TB/HIV managements and the programme collaboration and implementation manual (2nd edition) were finalized and approved by NTP.
 - A joint monitoring mission will be undertaken in early 2017 to assess the current situation and support the update of the Strategic Plan as well as the development of a concept note for submission to the Global Fund (the current support from the Global Fund is until end of 2017). The results of the prevalence survey and epidemiological analysis will also be used in this case.
 - Drug storage facilities have been improved and the electronic registration of TB data using e-TB manager software expanded to 255 DOTS Centers.

Nevertheless, despite the likely increase in public budgetary allocation, the recommendations to address prioritized bottlenecks and achieve the targets will have to be met with additional resources from development partners.

- One specific lesson learned with regard to case detection is the strengthening of “mandatory case notification” through public-private partnership. Having a legislation does not naturally translate into implementation. Such initiatives need to be followed through with the Government and the partners for operationalization.
- The CEB experience has helped to generate awareness among partners and particularly the UN agencies and the World Bank on the need to promote joint and multi-sectoral actions as key to control TB. It generated stronger partnerships across the relevant UN agencies to better understand and support the national TB programme. Better initiatives include a rejuvenated focus on quality services to increase service demand. The CEB process contributed to facilitate better inter-agency collaboration particularly on the diagnostic part of reasons for the TB epidemic, and socio-determinant factors. For instance, an urban health study was initiated to identify cases of poor health in urban areas. Concerned agencies are exploring existing inter-agency programmatic frameworks to provide TB services to the hard to reach population. New partners in the intervention area such as ILO will look into the use of OSH measures and enterprise infirmaries and doctors to combat and contain communicable diseases like TB in the garments sector.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

- Overall, the CEB led MAF review of MDG 6 has helped to accelerate the momentum of meeting the TB target among partners locally. The Government has committed to a significant increase in domestic budget from USD \$1.8 million of almost \$6 million for NTP. The Government is working with relevant partners to put together a concrete plan to maximize the utilization of available resources.

DEMOCRATIC REPUBLIC OF CONGO

Accelerating progress towards MDG-6 combating HIV/AIDS and malaria

CONTEXT

- DRC ranks among the poorest countries in the world. It is the third largest country in sub-Saharan Africa by population (67.5 million). DRC's national MDG progress report in 2012 indicated that it was unlikely to attain any of MDGs by 2015.
- However, accelerated results have been made, including a reduction in the prevalence of the malaria down from 31% (2007) to 23% (2013). Increase in the use of long-lasting insecticidal mosquito nets up from 5.8% (2007) to 55.8% (2013).
- Percentage of HIV/AIDS patients treated with antiretroviral therapy (ARV) rose from 4.3% (2007) to 46% (2014). But there is still limited knowledge about the disease (19%) and condom use remains low (12.2%). The prevalence of HIV/AIDS has stagnated from 1.3% (2007) to 1.2% in (2013–2014).

MALARIA REDUCTION

2007	2013
31%	23%



HIV/AIDS PATIENTS TREATED (ARV)

2007	2014
4.3%	46%



BOTTLENECKS

Insufficient coordination between health care systems and multisector community platforms limits the implementation of HIV/AIDS and malaria control actions at the community level.



Users and communities have inadequate knowledge of HIV/AIDS and malaria control standards, strategies and guidelines.



Lack of well-structured, high-quality data makes it difficult to monitor progress.



Sector and multisector funding for HIV and malaria remains insufficient.



SOLUTIONS/EFFORTS

Partnerships could be harmonized through an integrated approach (e.g. the partnership between the World Bank, UNICEF, GAVI, Global Fund and UNFPA will provide an integrated approach and cover around 25% of the country's population in four provinces. This is based on Performance-Based Financing and focused on a package of high-impact maternal and infant health interventions.

At least 75% of health officials involved in delivery of the comprehensive service package to be equipped with the necessary skills to treat HIV/AIDS and malaria through ongoing training.

Accelerate modernization of the national Health Management Information System and develop a national real-time monitoring system.

External assistance is the main source of health funding (accounting for about 40% of the total expenditure per year from 2008 to 2013). The implementation of the Global Financing Facility, can provide an important source of additional funding for the sector.

INTRODUCTION

Efforts by the Democratic Republic of the Congo (DRC) to control HIV/AIDS and malaria, towards achieving the targets of MDG 6 by 2015, have delivered mixed results. Improvements have been made in certain areas, including a reduction in the prevalence of the malaria parasite (down from 31 percent in 2007 to 23 percent in 2013), and an increase in the use of long-lasting insecticidal mosquito nets (up from 5.8 percent in 2007 to 55.8 percent in 2013, with a target of 80 percent). Similarly, the percentage of HIV/AIDS patients treated with ARVs rose from 4.3 percent in 2007 to 46 percent in 2014. Despite this progress, challenges remain in terms of both HIV/AIDS and malaria. The prevalence of HIV/AIDS has stagnated, falling from 1.3 percent in 2007 to 1.2 percent in 2013–2014. Yet, there is still limited knowledge about the disease among the population (19 percent), and condom use remains low (12.2 percent). The prevalence of malaria remains one of the highest in the world. An analysis of the situation identified the main bottlenecks, and a range of strategic actions have been proposed in order to overcome, or at least reduce, these bottlenecks. These actions focus primarily on improving greater harmonization and coordination of interventions, increased health funding, greater availability of drugs and other high-quality inputs, and improvements to the community system.

DRC is the seventh poorest country in the world and the third-largest in sub-Saharan Africa by population (67.5 million). Two thirds of its population live below the national poverty line. The under-five mortality rate (104 per 1,000 live births) and malnutrition rate (43 percent of children with stunted growth) remain high. In the 2013–2014 period, DRC's Gini coefficient stood at 0.40.⁹³ With regard to the MDGs, DRC's national evaluation report (published in 2012) indicated that it was unlikely to attain any of them by 2015. Having initially adopted a vertical approach to disease control, DRC has begun implementing a horizontal approach with a view to providing universal health coverage. Donor funding for the health sector almost doubled between 2007 and 2012, rising from \$255 million to \$530 million.⁹⁴ As a result of these efforts, an assessment conducted in 2010 indicated that some of the MDG targets may be attained by 2015

(namely the targets of MDGs 2, 3 and 6). However, given that only eight months remain until the deadline, DRC will no longer be able to meet the targets of MDG 6. Innovative acceleration strategies will therefore be required within the framework of the 2030 Sustainable Development Agenda.

COUNTRY CONTEXT

DRC is a fragile, post-conflict country that is currently undergoing a process of political and socio-economic stabilization. The country has experienced social and political unrest, which has destabilized its institutions and devastated its fragile economy. Following years of political instability, it is now engaged in a process of democratization, with efforts to restore the government's authority across the entire nation. Following the resumption of development cooperation in 2002 and government-led efforts to trigger an economic recovery through ambitious policies and reforms, the country now enjoys a more stable macro-economic framework and is back on the road to growth. Nevertheless, the eastern region of the country continues to face recurring periods of instability, combined with vast population displacement.⁹⁵ Certain health indicators have improved as a result of humanitarian responses to this situation.⁹⁶ DRC ranks among the top four countries in West and Central Africa in terms of morbidity and mortality from HIV/AIDS and malaria.

The health care system, once one of the best in Africa, has deteriorated over the years. Under the ongoing decentralization reforms, the healthcare system comprises 26 provincial health divisions (DPSs) and 516 health zones, each containing around 20 health districts and one lead general hospital (HDR). Patients may be referred from health centres to hospitals and vice versa. The healthcare system includes both structures formally recognized by the health zone (public, private or accredited⁹⁷) and other structures operating in parallel with minimal regulation. Health centres deliver a minimum package of priority activities, while hospitals cover an additional package, as defined by the Ministry for Public Health (MSP). Each of these two packages includes specific HIV/AIDS and malaria activities. In addition to these two packages, some

⁹³ Demographic and Health Surveys 2013–2014. DRC

⁹⁴ World Bank survey, DRC section: The HIV target of 3.1% for MDG6 was based on zero-surveillance surveys, which reported higher figures. Following a consensus on the DHS 2007 data, the target should have been reduced by 50% at least. The new target will therefore not be attained in seven years' time.

⁹⁵ 221,737 refugees and 2,756,585 internally displaced persons (IDPs) in September 2014 according to OCHA, and 467,102 Congolese refugees in neighbouring countries, of which 92,849 returned refugees.

⁹⁶ OCHA, HCR and humanitarian funding mechanisms.

⁹⁷ Accredited: these are structures that have signed an agreement with the government, making them a formal part of the system, in order to overcome existing deficiencies. These may be either religious bodies or structures belonging to NGOs.

activities are managed at the community level (either in conjunction with or separately from the health centre). These include humanitarian actors in conflict zones, NGOs, alternative medicine providers and churches, which play an important role in health. Although the existing essential medicines supply system is well defined, it does not function adequately and is only used by a very small percentage of partners. It includes decentralized, provincial procurement and supply offices, as well as a comprehensive reporting system that runs vertically through the entire system, from the front line to the MSP. The overall health management information system currently receives substantial support, with a view to creating a more robust, electronic, web-based system.

Health funding is highly dependent on external assistance, despite high-level commitments. DRC spends \$13 per capita on health, a level 10 times lower than the rest of Africa. Health spending has fallen from 4.6 percent of GDP in 2008 to 3.8 percent of GDP in 2011–2012. External assistance is the main source of health funding in DRC, accounting for an average of 40 percent of total expenditure per year in 2008–2013. Although the total amount of external health assistance has been rising, it remains lower, per capita, than in the rest of the African region (between \$5.7 and \$7 compared with \$11 in the region, in 2012). Household expenditure is the second highest source of health funding (39.3 percent on average in 2008–2013).

More than 90 percent of this expenditure is made through direct payments, with the exception of a few districts that have implemented a subsidized fixed rate payment. Central Government funding for the health sector remains limited, accounting for less than 15 percent of total expenditure on health. The amount of money spent on health by the Central Government continues to fall. Furthermore, the Government allocated an average of just 4 percent of its total budget to health between 2007 and 2013, representing an expenditure of less than \$1 per capita. The nature of public health spending has changed over recent years, with a rise in expenditure on personnel costs and a reduction in spending on operating costs and capital investment. The percentage of total spending allocated to personnel doubled over the period, rising from 42 percent in 2007 to more than 80 percent since 2010. In 2014, the government launched a Health Structure Equipment Project (Projet d'Équipement des

Structures Sanitaires), with a budget of \$80 million from government funds to increase capital investment expenditure. Other than personnel costs, the MSP's total budget is falling. This imbalance has had an adverse effect on health training programmes, which are now mainly funded through private expenditure. The implementation of the Global Financing Facility⁹⁸ would provide an important source of additional funding for the sector.⁹⁹ Furthermore, the introduction of a provincial 'single performance-based contract' would ensure that external assistance is used more effectively and more efficiently, helping to release more resources and ultimately increasing the overall budget assigned to health.

SITUATION ANALYSIS

Some general improvements have been made in DRC in terms of controlling HIV/AIDS and malaria, but the country is far from attaining the targets of MDG 6. The country has developed a range of specific coordination programmes designed to improve disease control. These are described in various formal plans, including the National Health Development Plan (PNDS), the Malaria Strategic Plan 2011–2015, and the National HIV Strategic Plan 2014–2017. These plans have helped to mobilize substantial resources from technical and financial partners¹⁰⁰ such as the Global Fund, as outlined in two recent concept notes (malaria and HIV/TB). In 2012, the total current expenditure on health stood at an estimated \$1 billion, 12 percent of which related to controlling HIV/AIDS. The UNDAF 2013–2017 is providing significant implementation assistance for the PNDS. In a similar vein, there are various ongoing harmonization and alignment initiatives, including the Health Donor Coordination Group (GIBS), the Joint UN Team on HIV/AIDS, the Global Fund National Country Coordination Mechanism (CCM) and the multi-partner National Malaria Task Force. However, given the scale of the existing harmonization and coordination challenges and the MSP's stated intention to strengthen harmonization, initiatives to harmonize at the operational level should be rolled out on a wider scale.

Since 2012, HIV prevalence in DRC has stagnated at around 1.2 percent in the general population (DHS 2013–2014), following a reversal of the figures seen in the 1990s. However, this stagnation masks a reduction in new infections (from 41,000 in 2009 to 34,000 in 2013) and a reduction in deaths (from 39,000 in 2009 to 25,000 in

⁹⁸ In which DRC could become one of the first participating countries.

⁹⁹ DRC is one of the four GFF pioneer countries for maternal and child health.

¹⁰⁰ Technical and financial partners: World Bank, UNAIDS, UNDP, UNFPA, UNICEF, WHO, WFP, GAVI, Global Fund, USAID, DFID, PEPFAR, GIZ, CTB, KOICA, JICA, Belgian cooperation, French cooperation, German cooperation, Canadian cooperation, Swedish cooperation, Japanese cooperation, Dutch cooperation, etc.

2013). The figures at the end of 2014 also show progress in terms of access to ARVs, with the total number of pregnant women receiving ARVs to prevent mother-to-child transmission having doubled, from 4,176 (20 percent) in 2012 to 10,560 (40 percent) in 2014, and the total number of qualifying patients receiving ARV treatment rising from 64,219 (25 percent) to 101,089 (46 percent). Further efforts will therefore be needed to consolidate and accelerate this progress.

Having fallen from 1.5 percent in 2001, the HIV/AIDS prevalence rate has remained stagnant at around 1.2 percent since 2012.¹⁰¹ The estimated number of people living with HIV (PLHIVs) was 409,769 in 2014. The figures reveal significant disparities by age and gender, with prevalence rates among young people (15–24 years old) of 0.7 percent in 2007 and 0.8 percent in 2013, among women of 1.6 percent in both 2007 and 2013, and among men of 0.9 percent in 2007 and 0.6 percent in 2013. HIV/AIDS remains an epidemic throughout the population in DRC, with a large proportion of new infections transmitted by a core group consisting primarily of sex workers (prevalence of 6.9 percent) and men who have sex with men (prevalence of 16.9 percent). Most new infections occur within stable couples.¹⁰²

In addition to these stagnating prevalence figures, several key indicators reveal that existing interventions are insufficient. Only 44 percent of health zones are covered by HIV activities. Condom use remains low among women in the 15–49 age bracket. Although this figure rose from 7.7 percent in 2007 to 12.2 percent in 2013–2014 (according to DHS), the national target stands at 100 percent. The percentage of the population with in-depth knowledge about HIV rose from around 4 percent in 2007 to around 19.2 percent in 2013. This situation leads not only to risk-taking through ignorance, but also to stigmatization and discrimination. These factors limit access to and use of health care and education services, reinforcing social barriers and contributing to social exclusion, loss of employment and loss of income. At present, only 46 percent of qualifying PLHIVs currently receive ARVs, representing a substantial shortfall¹⁰³.

Furthermore, malnutrition poses a barrier to treatment compliance and is one of the reasons behind the attrition rate among patients receiving

ARVs. More than 51.9 percent of PLHIVs are already malnourished upon admission. Some 25 percent of these present in a condition of severe wasting, and 26.9 percent in a condition of moderate acute malnutrition.¹⁰⁴ In order to combat this problem, DRC incorporated nutrition into its PLHIV treatment strategy in 2012. However, this strategy has not delivered the expected outcomes to date due to shortcomings in the mobilization of funding.

The malaria parasite prevalence rate remains high and the number of malaria-related cases and deaths, in absolute terms, is on the rise. The parasite prevalence rate fell from 31 percent in 2007 to 23 percent in 2013,¹⁰⁵ indicating a slight downward trend. This fall is the outcome of considerable coordinated efforts to promote the use of long-lasting insecticide al mosquito nets (LLINs). In 2013, LLIN availability reached 72 percent (compared with a national target of 80 percent). These efforts have also focused on intermittent preventive treatment (IPT), with coverage rising from 5 percent in 2007 to 14 percent in 2013–2014, as well as increasing access to artemisinin-based combination therapies (ACTs). Between 2007 and 2013, LLIN availability rose from 9.2 percent to 72 percent, and its usage rate rose from 5.8 percent to 55.8 percent;¹⁰⁶ although these figures are below the national target of 80 percent. According to a recent UNICEF analysis of DHS data from 2013 to 2014, LLINs have been responsible for 33 percent of the total reduction in infant and child mortality from 148 per 1,000 live births in 2010 to 104 in 2013–2014.¹⁰⁷

The figures also reveal significant disparities between provinces, due to a lack of synchronization of the campaigns, the sheer size of the country and insufficient resources to cover all provinces in a single, mass campaign. Although ACT availability is high, it fell from 91 percent in 2010 to 62 percent in 2013. Here too, the figures show disparities between provinces. Older surveys (WATCH 2009) indicate that ACT quality was poor in 30 percent of cases, in both the public and private sectors. Furthermore, not all patients who take ACTs have been subject to parasite-based diagnosis by microscopy or rapid diagnostic testing, as recommended by the National Malaria Control Programme (PNLP). The same applies

¹⁰¹ UNAIDS report and DHS data (2007–2013–2014).

¹⁰² MOT report 2013.

¹⁰³ UNAIDS GAP Report, 2015.

¹⁰⁴ Nutritional treatment of PLHIVs in DRC: Update and outlook PNLs 2013. UNGASS/GARPR Report 2008 to 2014.

¹⁰⁵ DHS 2013–14.

¹⁰⁶ RDC Demographic and Health Survey 2013–2014.

¹⁰⁷ UNICEF, DHS II 2013–2014 analysis report.

to the diagnosis and treatment of fever in the home to reduce morbidity and mortality. In light of these difficulties, it is not possible, from the routine data currently collected, to determine malaria-related morbidity and mortality to a satisfactory degree of confidence.

BOTTLENECK ASSESSMENT

The identification and analysis of bottlenecks focused on priority intervention indicators, since these have a significant knock-on effect on the others.

Major challenges remain, particularly at the operational level, in terms of coordination between the various health stakeholders (government and development partners) involved in combating malaria and HIV/AIDS. Although the MSP possesses significant capacities, the sheer number of stakeholders involved makes coordination difficult at all levels of the health care system. As a result, interventions are fragmented and resources are not used efficiently.

There is insufficient coordination between health care provision systems and multi-sector community platforms, thereby limiting the implementation of HIV/AIDS and malaria control actions at the community level. The health care system in DRC is well organized down to the health centre level. However, below this level, guidelines are nonexistent or rudimentary at best. More effective organization and coordination at the community level would encourage multisector activities and reduce mortality. Examples of these activities include voluntary HIV screening, home treatment of malaria prior to referral, and environmental and collective prevention initiatives.

Users and communities lack sufficient knowledge of HIV/AIDS and malaria control standards, strategies and guidelines. The DHS 2013–2014 survey revealed insufficient knowledge on HIV/AIDS among communities. Similarly, ACTwatch surveys have revealed that medical prescription practices do not always comply with the guidelines of the PNLP.

Human resources are deployed inefficiently. Although DRC has a significant number of qualified human resources, certain categories are oversubscribed, while others lack resources. Furthermore, resources are distributed unevenly, there is a general lack of motivation, and there are also shortfalls in terms of specific HIV/AIDS and malaria skills and knowledge.

Well-structured, high-quality data is lacking, making it difficult to monitor progress. Due to shortcomings in the health care information system, it is not possible to access regular, high-quality routine data, collect survey data on an ongoing basis or conduct in-depth key indicator analyses. This causes problems in terms of scheduling, managing and monitoring interventions and progress.

Sector and multisector funding for HIV and malaria remains insufficient, echoing the general funding problem affecting the health sector as a whole. Although the health sector in DRC has established multiple funding partnerships;¹⁰⁸ around one third of total health expenditure still comes from household budgets. The majority of these households are poor and live below the national poverty line. This compromises fair access to high-quality healthcare services. Expenditure by households with sufficient resources to access these services (30 percent)¹⁰⁹ accounts for 10 percent of total expenditure on HIV/AIDS control.

Coverage of specific HIV services remains low. Around 53 percent of targeted health care training programmes do not offer the full package of HIV interventions as specified by the National AIDS Control Programme (PNLS), which states that there should be two antiretroviral therapy structures per health zone. Only 44 percent of the 516 health zones in the country offer the complete package¹¹⁰.

The social and legal context in DRC is not conducive to social integration and access to services for people living with HIV and most-at-risk populations. The existing legal framework seeks to protect the rights of PLHIVs through a series of punitive and restrictive measures concerning the disclosure of HIV-positive status. The PLHIV Stigma Index survey conducted in 2012 reveals that discrimination and

¹⁰⁸ World Bank, UNAIDS, UNDP, UNFPA, UNICEF, WHO, WFP, GAVI, Global Fund, USAID, DFID, PEPFAR, GIZ, CTB, KOICA, JICA, Belgian cooperation, German cooperation, French cooperation, Canadian cooperation, Swedish cooperation, Japanese cooperation.

¹⁰⁹ PNMLS, Report on estimated expenditure on HIV/AIDS control, 2012.

¹¹⁰ PNLS report 2013.

stigmatization remain extremely widespread in DRC. Furthermore, efforts by the country's parliament to legislate against homosexuality are proving counterproductive in terms of access to HIV prevention, education and treatment services. Prisoners and injecting drug users do not have access to suitable HIV services. The rights of women and young girls living with HIV, as well as the victims of violence, are not respected.

Insecurity and the displacement of conflict-affected populations are barriers to accessing prevention, care and treatment services, particularly in the provinces of Sud Kivu, Nord Kivu, Maniema and Equateur. The humanitarian crisis in these provinces is likely to intensify risks and vulnerabilities associated with HIV/AIDS and malaria. Existing treatment facilities are unable to cope with the additional demands of conflict-affected populations.

Access to HIV/AIDS and malaria prevention, diagnosis and treatment inputs remains insufficient. The supply of inputs — LLINs, condoms, ACTs, rapid diagnostic tests (RDTs), nutritional products — is insufficient to meet the country's needs. Access is limited by a number of factors, including: (i) the fact that the private sector is not included in the supply and distribution circuit; (ii) insufficient household purchasing power; (iii) cultural barriers; and (iv) inadequate logistics facilities due to a lack of distribution infrastructure.

The service usage rate is low, hindering the deployment of morbidity and mortality reduction activities within the community. The high cost of health care has been identified as a major obstacle to service usage. There are also problems with the quality of care, which not only limits access but also aggravates mortality.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

During the course of this analysis, a number of actions were identified to overcome the observed bottlenecks. Priority has been given to those actions that will have the greatest short-term and medium-term impacts, and that will be efficient, achievable and measurable. These actions, which will need to be implemented by the government with the support of its partners, are organized into four areas of intervention.

Area of intervention 1: Improving provision of comprehensive services through greater harmonization and coordination of interventions

Extend partnership activities to ensure that at least 80 percent of the population has access to a comprehensive package of services, drawing inspiration from the existing health system improvement platform and focusing on the use of 'Performance-Based Financing' (PBF). The fragmentation of the health system is a significant bottleneck, with major adverse impacts on health intervention effectiveness, efficiency, fairness and opportunities. Partnerships could be harmonized through an integrated approach, inspired by the model deployed in the existing partnership between the World Bank, UNICEF, GAVI, Global Fund and UNFPA. This partnership, based on PBF and focusing on a package of high-impact maternal and infant health interventions as defined by the PNDS, will cover around 25 percent of the country's population in four provinces. In addition to targeting healthcare services, this arrangement will deliver operational improvements within provincial health directorates and within key central government departments, with an emphasis on quality, fairness and personnel motivation. This partnership will provide an initial platform, and may subsequently be joined by other partners, targeting other provinces. This, in turn, could help DRC achieve its set target of universal health coverage.

Under the terms of the structural financing mechanism, the administrative and healthcare departments of health centres and lead general hospitals are subject to performance contracts. The Provincial Health Divisions are also bound by performance obligations, and are required to manage and supervise health training programmes to ensure that they deliver high-quality health care that also includes HIV and malaria services. Services are produced according to a dedicated management plan, which clearly indicates how funding is linked to performance in terms of both quantity and quality. In addition to the provision of inputs, the arrangement also includes a series of incentives for health training programmes to offer additional care and treatment services through the elimination of bottlenecks.

Request to CEB: (i) Call on UN agencies to harmonize the coordination framework and intervention approach, based on the PFB model. (ii) Encourage other agencies (e.g., bilateral agencies) to join the partnership.

Accelerate modernization of the national Health Management Information System (HMIS) and develop a national real-time monitoring system. A group of partners is currently supporting work to integrate the DHIS 2 software into the HMIS. This will facilitate more effective real-time data usage and support decision-making. The agencies recommend accelerating modernization of the HMIS, with a particular emphasis on the integrated surveillance component.

Request to CEB: Ask partners to accelerate the implementation and ensure that the HMIS includes surveillance and nutrition modules.

Support capacity-building among human resources involved in HIV and malaria control efforts. At least 75 percent of health officials involved in the delivery of the comprehensive service package are expected to learn the necessary skills to treat HIV/AIDS and malaria through ongoing training, via recycling and supervision.

Request to CEB: None

Area of intervention 2: Increasing health funding

Increase investment in the health sector in terms of both domestic financing and international assistance. Insufficient investment in the health system is one of the main bottlenecks in DRC. Implementation of the actions proposed in this note will require a commitment from the government and its partners to increase the health budget. Although many of the actions proposed will help to improve intervention efficiency, the desired impact can only be achieved through greater investment in the health sector. This, in turn, will deliver significant improvements for both HIV and malaria, as well as for other interventions related to the attainment of universal health coverage.

Request to CEB, within the framework of the Global Financing Facility (GFF): (i) Call on agencies to remind the government of its duty to respect international commitments, particularly its obligation to allocate a certain percentage of public funding to priority sectors, including health (15 percent). (ii) Increase

international investment from agencies in the health sector. (iii) Advocate further for the introduction of universal health coverage and accelerate its implementation.

Area of intervention 3: Increasing the availability of drugs and other high-quality inputs

Guarantee the availability of essential drugs and inputs, including food, and improve the national supply system. The agencies are determined that the National Essential Drug Supply System (SNAME) should be the exclusive supply and distribution system. They are also committed to ensuring that it has sufficient resources and technical capacities to provide all essential HIV/AIDS and malaria prevention and treatment inputs. More specifically, access to ARVs will need to increase significantly in order to reach the target of 80 percent (compared with 46 percent at present).

Request to CEB: Ensure that UN agencies (at head office level) undertake: (i) to use the SNAME for the supply and distribution of inputs in DRC; and (ii) to reinforce the SNAME.

Conduct a wide-scale impregnated mosquito net distribution campaign every three years. The aim is to have more than 80 percent of the population sleeping beneath impregnated mosquito nets. These mass mosquito net distribution campaigns will draw on the lessons learned from other, recent distribution activities, and will address the reasons why certain health zones have lower levels of coverage than others.

Request to CEB: Overcome the funding gap to guarantee regular distribution and replenishment cycles.

Area of intervention 4: Prioritizing coordination and build closer relationships between the community system and health services

Support a community mobilization strategy in at least half of the country's health zones. Stronger community engagement will help to boost demand for, and use of, preventive and remedial treatments, as well as fostering the behavioral changes necessary to reduce the prevalence of HIV/AIDS and malaria. Similarly, community-led education on nutritional practices and the use of local food products will help to improve treatment for PLHIVs. The agencies are committed to documenting the various community approaches across DRC and to developing a joint strategy to achieve greater community platform involvement.

Request to CEB: Secure additional resources to support community-led approaches.

Build the capacities of civil society organizations, young people, members of parliament and the justice sector on human rights and HIV/AIDS. Capacity-building will help advocacy efforts surrounding legislation to protect the rights of PLHIVs. It will also help to reduce

stigmatization and discrimination, and will allow PLHIVs to play a greater role in mobilizing financial resources.

Request to CEB: (i) Secure high-level political support on human rights and HIV issues. (ii) Provide additional resources for education activities.

DEMOCRATIC REPUBLIC OF CONGO – TREND ANALYSIS DATA TABLES

I. HIV/AIDS

KEY INDICATORS	2007	2008	2009	2010	2011	2012	2013	2014	MDG-6
HIV prevalence in the general population	1.3% (DHS)						1.2% (DHS)		Stop and reverse the trend
HIV prevalence among pregnant women	4%			3.5%			1.8% (2012)		Stop and reverse the trend
HIV prevalence among young people (15-24 years old)							0.7%		Stop and reverse the trend
Number of new infections			41,000				34,000		Stop and reverse the trend
Number of deaths linked to HIV/AIDS each year	30,000		39,000	40,000	35,000	32,000	25,000		Stop and reverse the trend
Number/percentage of HIV-positive women receiving antiretrovirals to reduce the risk of mother-to-child transmission	2,154	2,664	2,881	1,116	2,098	4,176	8,575 (33%)	10,506 (40%)	Universal access
Number/percentage of adults and children eligible for antiretrovirals (CD4 < 350) who have access to this treatment	21,960	28,576	39,224	43,878	59,792	64,219	79,978 (39.1%)	101,089 (46%)	Universal access
• Children	1,632	4,053	5,735	5,937	6,238	4,751	5,055	8,471	
• Adults	20,328	24,523	33,489	37,941	53,554	59,468	74,923	92,618	
Laws									Although gender-based violence and discrimination against PLHIVs and key populations (particularly MSMs) exist
• Entry-related HIV restrictions	No	No	No	No	No	No	No	No	
• That make transmission of HIV a criminal offence	No	No	No	No	No	No	No	No	
• That make homosexual relationships a criminal offence	No	No	No	No	No	No	No	No	

II. MALARIA

KEY INDICATORS	2007	2010	2013	MDG-6
Key indicators	31%		23%	Reverse the trend
Malaria prevalence (DHS) among under-fives	31%		23%	Reverse the trend
Availability of LLINs	9.2% (DHS)	51.0% (MICS)	72% (DHS)	100% (80% PNLP)
Proportion of under-fives sleeping beneath LLINs	5.8% (DHS)	38.1% (MICS)	55.8% (DHS)	100% (80% PNLP)
Availability of ACTs (WHO source)	26%	91%	62%	100%

Sources: DHS 2007, World Malaria Report 2009-2010-2011-2012-2013-2014, DHS 2013-2014, MICS 2010, PNLP Annual Report 2007, 2008, 2009, 2010, 2011, 2012

PROGRESS SINCE THE CEB REVIEW

Improved provision of services through greater harmonization and coordination of interventions

- Good progress has been made in this area, as a result of effective partner coordination and support from WHO, UNDP and the WB. Efforts to harmonize the intervention approaches of different partners have been successful, with an emphasis on PBF. Now that implementation of the PDSS has commenced, scale-up of this approach will be further strengthened.
- Preparations for implementation of DHIS 2 are on schedule, with support from the WB, the Global Fund, GAVI and DFID.
- Efforts to implement the 90-90-90 target in DRC have been strengthened through a strong, dynamic, strategic partnership at the national and provincial authority level. This partnership – involving UN agencies and coordinated by UNAIDS – has received support from UNDP, civil society organizations, the National Multisectoral AIDS Control Programme (PNMLS), the Ministry of Health's PNLS and sectoral ministries. At the municipal level, mayors have begun implementing local strategies in accordance with the principles of human rights.
- The capacities of stakeholders at all levels have been strengthened, and PMTCT of HIV action plans have been developed for the medium term (2016–2020). Health service providers have also received capacity-building training as part of efforts to reduce stigma and discrimination and to protect the confidentiality of HIV test results under the fast-track strategy. Some 13,529 teachers have also received training on reproductive health and HIV education (2013–2015). The capacities of managerial staff across multiple sectors at the national level (youth, health, education, etc.) have also been strengthened under the All strategy.

Increased health funding

UN partners have helped the Government to create the Global Financing Facility Investment Framework. Once finalized, the framework will provide much-needed financial support for the health sector. In 2016, the health budget rose to 7.5 percent, from 4.5 percent in 2015. As a result of more robust advocacy efforts in favour of universal health coverage, this has now become one of the strategic priorities of the 2016–2020 PNDS, a plan adopted at the national level. Universal health coverage is also one of the pillars of the public health bill under debate in parliament.

Increased availability of drugs and other high-quality inputs

- Efforts are ongoing to revitalize the SNAME. Some partners (such as the WB) are already using the system for procurement purposes, while others (UNICEF, WHO, UNFPA, Global Fund, etc.) are using it for distribution. The WB, WHO, UNICEF and other partners are providing technical assistance to strengthen the system's capacities in areas such as quality control and supply chain management.
- Support for the AIDS control programme from the Global Fund, USAID-PMI, UNICEF and DFID has helped to address LLIN gaps for 2016–2017. The mass distribution plans have been developed and LLIN distribution campaigns are currently ongoing in the target provinces.

Community system support initiatives underway

A number of community system support initiatives are ongoing. In particular: (i) the community health guide has been produced and work has started to develop the strategy; (ii) the new primary and secondary-level family life education curricula have been developed for the formal sector, and the sexual health self-study guide for young people in the informal sector has been finalized; (iii) a consultant has been recruited to conduct an analysis of nutrition in health; (iv) work has begun on analysing community indicators to ensure effective alignment of the interventions of health care facilities; (v) in terms of HIV/AIDS, efforts are ongoing to identify examples of best practices within communities under the Stepping Stones approach, with a view

to adapting these practices; (vi) a behaviour change communication strategy document has been developed as part of efforts to prevent sexual violence and HIV transmission.

- All stakeholders, including those at the highest level, have received advocacy capacity-building interventions. Human rights, HIV/AIDS, and HIV/AIDS domestic resource mobilization training has been delivered to the Government, political and administrative authorities; 150 members of parliament; 1,550 officials (judges, police and armed forces) and 750 civil society networks and organizations. Gender-based sexual violence (GBSV) training has been delivered to 3,878 people including senior politicians and civil servants, defense staff, military personnel, religious leaders and managers of NGOs and human rights organizations, as well as 150 traditional leaders and 100 university academics. As a result of these interventions: (i) the proposed amendment to the law protecting PLHIV and people affected by HIV is currently being debated in parliament; (ii) the country has a national strategy for 2014–2017 that includes the needs of key populations (LGBTI, prisoners and sex workers); (iii) parliamentary forums have been held to mobilize resources from provincial budgets; and (iv) plans to revise the National Sexual and Gender-based Violence Prevention Strategy.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

The MAF process for MDG 6 has been a particularly enriching experience for DRC. As a result of this process, the country has been able to: (i) harmonize data for these diseases and learn more about the reference framework, through a better understanding of the roles and capacities of different UN agencies; (ii) benefit from recommendations and actions to control the two diseases and help strengthen the country's health system; (iii) strengthen coordination, synergy and alignment of stakeholder interventions; (iv) bring together the health and education sectors to develop a joint response to the HIV/AIDS pandemic and GBSV in schools and other educational and community settings; and (v) plan, implement and accelerate its interventions more effectively through the impetus and mobilization obtained at the international (CEB) and regional levels.

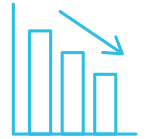
PACIFIC ISLANDS COUNTRIES (PICs)

Accelerating progress on MDG 6 and sustaining results: reduce the incidence, prevalence and mortality by non-communicable diseases (NCDs)

CONTEXT

- NCDs are not diseases of affluence or ageing populations. The top 7 most overweight countries in the world are PICs. Eight PICs are amongst the top ten for highest diabetes prevalence.
- The NCD epidemic is a relatively new phenomenon in the Pacific. However, it is expanding at an alarming rate (e.g. double disease burden: malnutrition and obesity).
- In 2010, PICs incorporated NCDs as part of the MDG framework. The implementation of the Health SDG will build on the current efforts.
- NCD Action Plan (2013-2020) calls for a global reduction of NCDs by 25% by 2025.

**NCD ACTION PLAN
ON 2025 REDUCTION
25%**



BOTTLENECKS

SOLUTIONS/EFFORTS

Health systems unfit for purpose



The 2011 UN Political Declaration and 2014 Outcome Document on NCDs include a road map of concrete commitments to address the prevention and control of NCDs through people-centred primary health care.

**NCDs response has been focused on the health sector alone.
Difficulties in operationalizing a multisectoral response**



Development partners are working together to strengthen the capacity of PICs for greater coherence between trade and health policies.

Most countries have limited options for increasing fiscal space for health



Establishment of an NCD Trust Fund Facility (supported by a range of donors). Components of the trust fund include: (i) small grants; (ii) a results-based disbursement component against actions in the NCD crisis response plans; (iii) a research and impact evaluation component; and (iv) an investment component to provide incentive financing for infrastructure development.

Difficulties in managing cross-cutting issues



Some donors are moving away from disease-specific programme support to greater investment in strengthening health systems. Greater synergies and integration between disease-specific programmes with NCDs can lead to mutual benefits and results.

INTRODUCTION

Cardiovascular diseases (CVD), cancers, chronic respiratory diseases and diabetes are no longer unique to wealthy countries and aging populations. No region of the world embodies this more dramatically than the Pacific Islands Countries (PICs). Despite demographic ‘youth bulges’, 40 percent of the region’s population of 9.7 million have been diagnosed with a Non-Communicable Diseases (NCDs)¹¹¹. Almost two out of every three Pacific Islanders¹¹² who die from an NCD, die before the age of 70 and the probability of dying from an NCD between the ages of 30 and 70 in the PICs is three times higher than in neighboring Australia and New Zealand. At the same time, there are still challenges pertaining to maternal, pediatric and infectious disease, which profoundly affects economies and communities and requires PICs to speedily address those challenges with limited resources. Leaders of the region have declared NCDs “a health and economic crisis and a threat to human development” in 2011.

In 2010, 22 PICs and territories called upon their heads of governments and the United Nations to specifically include non-communicable diseases as one of the MDGs. This call aimed to accelerate efforts and attract the partnerships needed to tackle NCDs as an emergency development priority for the region. The unfinished business of the MDGs is expected to carry forward into the implementation of the Sustainable Development Goals (SDGs). For most countries, NCDs are part of the new health agenda covered under the SDG-3 on health. For the PICs, this will build on their current efforts of implementation and monitoring.

Health gains for NCDs can be achieved much more readily by influencing public policies in sectors like trade, taxation, education, agriculture, urban development, food and pharmaceutical production than by making changes in health policy alone.

It is estimated that up to two thirds of premature deaths from NCDs are linked to exposure to four common risk factors (tobacco use, harmful use of alcohol, unhealthy diets and physical inactivity) and that up to half of all premature deaths are linked to weak health systems that do not respond effectively and equitably to the health care needs of people with NCDs.

This note surveys the NCD situation in Pacific Island Countries from a health and development perspective. It also analyses some of the prominent bottlenecks in the current response and how those are being addressed and makes recommendations for the CEB to consider in support of a scaled-up, more coherent and collective effort to address this ‘long-wave’ disaster.

SITUATION ANALYSIS

REGIONAL CONTEXT

“NCDs in the Pacific have reached crisis level with no signs of abatement”

NCD statistics in the region are alarming. The seven most overweight countries in the world are from the region, while eight Pacific Island Countries are amongst the top 10 for diabetes prevalence. Close to 40 percent of Micronesians and Palauans, nearly one third of Marshall Islanders and one quarter of I-Kiribati suffer from the chronic condition. These figures represent three to five times the global average. Every 12 hours, a Fijian loses part of his or her lower limbs to diabetes. Cardiovascular disease alone accounts for between 29 percent and 38 percent of all causes of death combined. The burden of lung cancers attributable to smoking is also growing rapidly.

The NCD epidemic is a relatively new phenomenon in the Pacific. However, it is expanding at an alarming rate. Obesity was uncommon in the mid-20th Century, but, between 1980 and 2008, the body mass index (BMI) of females in nine Pacific countries increased by more than four times the global average. Childhood and adolescent obesity is high and rising. A double burden of malnutrition is also observed in the Pacific, where undernutrition exists concomitantly with obesity. Micronutrient deficiencies are also an issue and often related to an increased intake of calorie-rich, nutrient-poor, ultra-processed foods. Diabetes was virtually absent from the region in the 1960s. It now accounts for an extremely large fraction of mortality and disability, particularly amongst middle-aged women. The number of diabetic patients in Tonga, for example, has doubled in just eight years, while related amputations have increased three fold in the last five years.

¹¹¹ All references in brackets are included in Annex III (CEB Matrix for Pacific Island Countries).

¹¹² Compared to one in five in neighbouring Australia and New Zealand.

The present extent and distribution of behavioral risk factors suggest that the situation will worsen in the years to come. Male smoking prevalence ranges from 20 percent in Fiji to over 70 percent in Kiribati and is increasing among girls (62 percent in Palau, 57 percent in Northern Marianas). Physical inactivity reaches alarming levels particularly among women (75 percent in Micronesia) and unhealthy diets are widespread, with all countries reporting over 70 percent (ranging from 70 to 95 percent) of their populations having low fruit and vegetable consumption.

These modifiable risk factors are strongly influenced by other sectors' policies. Rapid social and cultural change linked to relatively recent shifts from subsistence- to market-based economies; poorly planned urbanization; and increasing international trade integration (globalization) constitute major determinants of NCD epidemics in the region. Trade liberalization combined with the promotion of export-oriented agriculture, in particular, are greatly contributing to profoundly modified food environments. At the same time, governments and development assistance agencies have tended to neglect the producers who sell food on local markets. Energy-dense foods high in fat (e.g., butter, oils, and fried foods), sugars or starch have largely displaced fruits and vegetables in Pacific diets. Evidence suggests that these changes are driven by marketing, affordability, convenience and availability. Price differences between fatty imported meat parts and healthier sources of protein such as local fish often range between 20 percent and 50 percent. The total available energy and fat supply has increased in all PICs by as much as 64 percent since 1965. In Fiji, per capita yearly consumption of sugar- sweetened beverages and butter has doubled in just 10 years. Household expenditure on imported foods is considerably high in all countries, ranging from above 50 percent in Kiribati and Tonga to 30 percent in Vanuatu and Solomon Islands.

Pacific Island people are developing NCDs at an increasingly younger age, switching from over- 50 to under-40. Compared to everywhere else in the world, premature (preventable) mortality rates before the age of 70 are higher and a greater share of premature deaths in most PICs is attributable to NCDs. While the data quality of cause of death is an ongoing area of work, existing data show that the share of NCD deaths before age 60 as a percentage of all premature death ranges from 38

percent in Papua New Guinea to 65.4 percent in Tonga, with all remaining PICs above 50 percent. Life expectancy is impacted and stagnates at a relatively low level despite significant declines in infant and child mortality.

Health-related costs are rising and expected to become untenable.

Per capita health expenditure has increased substantially over the years and is consistently higher than the average for lower middle-income countries (LMICs) in most PICs. These investments have translated into good progress toward addressing some communicable diseases and most PICs achieved MDGs 4 and 5.¹¹³ Unfortunately, similar health outcomes are not realized for NCDs, although some estimates claim that 40 percent to 60 percent of government spending on health is expended on tackling NCDs (essentially curative and palliative care). The current situation is already unsustainable. The World Bank, for example, estimates that the average cost of dialysis in Samoa is more than 12 times the per capita gross national income.

Indirect social costs are less accounted for, but believed to be considerable.

In 2001, the negative impact on national income was as high as 1.62 percent in Samoa, 1.50 percent in Fiji and 0.80 percent in Tonga and reaching up to 6.5 percent of GDP in Nauru. These figures are undervalued because they are calculated only for the economically active population in the formal sector. They also do not account for social costs such as unpaid care work by family members, principally women and young girls (some of whom must be pulled out of school to care for bedridden or disabled relatives). This situation exacerbates poverty and vulnerability in Pacific communities. The cost of pain, suffering or insecurity associated with a lack of knowledge about one's condition or its future prognosis is also largely ignored.

BOTTLENECK ANALYSIS

BOTTLENECKS AND CURRENT REMEDY ACTIONS

Bottleneck Area 1: "Health systems unfit for purpose"

Despite early recognition of the underlying social determinants of NCD epidemics, the response has essentially been resting on the health sector alone. Current health systems are unable to respond to the health care needs of people with NCDs, as they were primarily designed to address communicable diseases. The primary health care level is not

¹¹³ As mentioned in the introduction, communicable diseases have not disappeared and many parts of the region face a double burden of communicable and non-communicable diseases. TB, malaria and emerging or re-emerging vector borne diseases (e.g., dengue) remain a problem. Papua New Guinea is grappling with a serious HIV epidemic and the virus remains a region-wide threat given the high prevalence of sexually transmitted diseases and increasing mobility.

ensuring the availability of NCD services such as basic screening and early treatment of conditions before they progress to diseases and is not meeting the needs for long-term care of people with NCD-related disabilities and co-morbidities (several diseases occurring at the same time). The bulk of patients then end up at secondary- or tertiary-level hospitals, often with worse prognoses and sometimes rapidly increasing cost implications, including through increased rates of referral to overseas treatment schemes. WHO estimates that 75 percent to 80 percent of adult admissions to general hospital wards and surgery in the region are related to NCDs. Disease-specific approaches, externally funded and often uncoordinated, also contribute to fragmented services and inequitable distribution. Health facilities are often ill equipped. There are shortages in or poor distribution of staff. Capacities are inadequate and service delivery models are often inappropriate. Surveillance systems remain relatively weak and ill-adapted to inform adequate decision-making and to evaluate the impact of interventions.

Current remedy actions

- The 2011 UN Political Declaration and 2014 Outcome Document on NCDs include a roadmap of concrete commitments from heads of state and government, including a **time-bound commitment to strengthen and orient health systems in 2016 to address the prevention and control of NCDs through people-centered primary health care**, taking into account the set of 'best buys' included in the WHO Global NCD Action Plan 2013-2020 that will enable health systems to respond to the health care needs of people with NCDs.
- An evolving **package of evidence-based and cost-effective interventions** (PEN) is helping to strengthen NCD management in the PICs. Most countries are adapting the package to their national context and two countries have nationally rolled out the package. Initial costing has been done in five countries.
- Great strides to **improve NCD surveillance** have been made lately and STEPS surveys for NCDs have been undertaken in 17 countries, with three countries completing two rounds. Youth-based surveys with a focus on tobacco and schools-based surveys have also been completed in 17 and 10 countries, respectively.

- Significant efforts supported by bilateral and multilateral partners are underway to **improve health care infrastructure, service delivery and workforce**, with greater focus on equitable distribution. However, given the needs and limited resources, this area requires considerably more technical and financial support.
- In some countries, efforts are also being made to create **greater coordination and synergies** between programmes, including with respect to HIV, TB and NCDs. There needs to be more emphasis on integration and on strengthening people-centered primary and secondary health care based on universal health coverage (UHC) as well as better performing governance structures.
- There is scope to **better leverage donor-funded initiatives** such as the Global Fund for AIDS Tuberculosis and Malaria, among others, to strengthen health systems and to manage co-morbidities. There is also a **need to demonstrate greater synergies between TB and HIV programmes and broader health and development issues** in SIDS, in particular in relation to NCDs; there is also a need for progress on HIV to have multiplier effects across NCDs and vice versa.¹¹⁴
- Only one Pacific Island Country – Tonga – has used the MDG Acceleration Framework (MAF) to identify bottlenecks and to develop an ambitious intersectoral MAF plan to address NCDs more holistically. Although the plan could not attract sufficient resources to be fully implemented, it has **helped raise awareness about the social determinants of NCDs, mobilized non-health sectors in the national response and top leadership commitment and strengthened intersectoral coordination across government**.¹¹⁵

Bottleneck Area 2: “Difficulties in operationalizing a multi-sectoral response”

Decades of prevention efforts aimed at reducing the exposure of individuals to the common risk factors for NCDs through individual interventions (e.g., public awareness programmes) rather than population-based interventions (e.g., increasing tobacco taxes, regulate availability of alcohol, replacing trans fats through legislation) have had little impact. The broader determinants

¹¹⁴ Research shows that HIV and NCDs have many things in common: both are chronic and preventable; both disproportionately affect the poor; both require a response that goes well beyond the health sector (including the need to address the social and political determinants and inequalities); and both require strong political leadership and commitment as well as social mobilization and public support. Creating such synergies benefits everyone and is a more efficient use of resources and services focusing on people rather than on disease.

¹¹⁵ Tonga has raised the profile of NCDs as a major development challenge reflected as such in the Country's Strategic Development Frameworks for 2011-2015 and 2015-2025.

have so far been left largely unchanged. There needs to be more focus on implementing the set of very cost-effective and affordable multi-sectoral population-based interventions for all Member States ('best buys') to reduce risk factors and to create environments that promote health. Trade agreements complicate the policy space for regulatory approaches and hinder access to affordable medicines. WTO accession also restricts the use of subsidies and support for local farmers and fishermen.

- **The lack of effective national multi-sectoral mechanisms – a high-level commission, agency or task force – for engagement, policy coherence and mutual accountability of different spheres of policy making that have a bearing on NCDs is a major impediment for multisectoral action.** Although nearly all countries have developed National Strategic Plans to address NCDs -some of them multi- sectoral 'on paper', the majority of these plans do not set national targets for NCDs (taking into account the global NCD targets for 2025) and are not or insufficiently costed to be operationalized. There is little involvement of sectors beyond health in the development and implementation of these plans, e.g. education, agriculture, transport and infrastructure, finance etc. as well as limited engagement with civil society, communities, and the private sector. This may be attributed to a range of factors including: limited national capacities, sub-optimal understanding of the wide ranging socio-economic consequences of NCDs across sectors other than health. Most PICs also lack expertise in protecting public health policies for the prevention and control of NCDs from undue influence by any form of vested interest from the private sector.

Current remedy actions

- **There is political support for a Social Determinants of Health approach as proposed in the Healthy Islands Vision** that was adopted at the first Ministerial Conference on Health for Pacific Islands Countries in Fiji in 1995.
- The Vision's implementation remains fragmented due to the vertical approach mentioned earlier. There are ongoing efforts to revive the Healthy Islands Vision and to give it a new impetus (the Pacific Health Ministers' Meeting which took place in

Fiji in April 2015). **This was also reflected in recent Pacific Island Forum Leaders' communiqués and the Samoa Pathway adopted at the 2014 SIDS conference.**

- The implementation of the WHO Framework Convention for Tobacco Control in the region is well advanced, with all PICs being parties to the Convention. Almost all have legislation in place and there have been tobacco tax increases in 11 PICs over the past year. **The region has also developed an ambitious Tobacco-Free Pacific initiative with a target of less than 5 percent adult tobacco use by 2025.**
- 12 PICs have **raised taxes on sugar and sugar-sweetened beverages while a number have decreased taxes on fresh produce.** Some are developing voluntary new labelling standards and salt- reduction in consultation with the private sector. More needs to be done to understand the impact of these taxes on consumption.
- Development partners (UN, World Bank, Secretariat of the Pacific Community) **are working together to strengthen PICs' capacity for greater coherence between trade and health policies.** A regional workshop on health and trade took place in 2013 and has helped countries to develop and implement policy responses. **A Pacific NCD Roadmap to operationalize cost-effective approaches beyond the health sector was formally adopted by the Pacific finance and health ministers in July 2014;** its progress is monitored annually at the Pacific Forum Economic Ministers' Meeting.
- In the past two years (2013-2014), **Helen Clark and Margaret Chan have written twice to UN Country Teams to integrate NCDs into the United Nations Development Assistance Framework (UNDAF)** design processes and implementation and to bring attention to the Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013-2020.¹¹⁶
- UNDP and WHO co-authored and launched the **Guidance Note on the Integration of NCDs into UN Development Assistance Frameworks.** The Guidance Note highlights the importance of ensuring that linkages are made between the prevention and control of NCDs and broader development issues, such as universal health coverage, social protection, governance and the social determinants of health.

¹¹⁶ www.who.int/nmh/UNDP_WHO_Joint_letter_on_NCDs_24Feb2014.pdf

- **New partnerships are also emerging, bringing a range of actors from donors to technical partners across the development spectrum.** The Pacific Partnership for a Multi-sector Approach to Prevent and Control NCDs was launched at the SIDS conference in 2014, building on the Pacific NCD Roadmap.
- For example, the **US Government announced support for the Pacific Partnership on NCDs at the SIDS conference in Samoa.** It also announced an additional, but complementary partnership – the Regional Non-Communicable Diseases Control (RNCDC) Project – to build Pacific SIDS' sustainable capacity to address NCDs with funding from the United States Pacific Command (PACOM). The project will assist PICs in developing and implementing the country NCD roadmaps as endorsed at the Joint Economic and Health Ministers' Meeting in the Solomon Islands in July 2014.
- Another example is the partnership initiative for better food security and nutrition focusing on investments for more production, consumption and marketing of local foods. Under this, Fiji and Kiribati have designed programmes connecting partners and resources (e.g., IFAD, the Taiwan Technical Mission, the Australian Centre for International Agricultural Research, the Pacific Islands Farmer Organisations Network and the Pacific Organic and Ethical Trade Community).
- **The UN Inter-Agency Task Force on NCDs**, which the Secretary-General established in 2013 and placed under the leadership of WHO, **has developed a number of global joint programmes that provide technical assistance to support national NCD efforts in PICs.** A joint programming mission of the Task Force and the Pacific Regional UN Thematic Group on NCDs (see below) was fielded to Tonga in March 2015.
- **A Pacific Regional UN Thematic Group on NCDs¹¹⁷ that further coordinates the efforts of the UN system on NCDs in the region was established in 2014.** It is chaired by the UN Resident Coordinator and is based in the Fiji Islands, the regional hub. The Thematic Group raises awareness about the regional and national public health burden

caused by NCDs and the relationship among NCDs, poverty and socio-economic development. **The group works to integrate NCDs as a cross-cutting theme into the work of the UN Regional and Country Teams**, promotes dialogue and cooperation and develops joint action among the UN Regional and Country Team members that would contribute to realizing the national commitments included in the 2011 UN Political Declaration and the 2014 UN Outcome Document on NCDs.

- In some countries, citizens' movements for improved food and living environments are also nascent and need support. **For example, greater engagement with parliamentarians through UNDP governance-strengthening programmes aims at better employing the human rights frameworks for improved accountability, greater policy coherence as well as addressing equity issues in service delivery.**
- Lessons learned from the multi-sectoral response to AIDS and the Joint United Nations Programme on HIV/AIDS are also strengthening multi-sectoral responses to NCDs.¹¹⁸

Bottleneck Area 3: "Financing health care and fiscal squeeze: between a rock and a hard place"

The rapidly increasing NCD burden of disease and its impact on acquired disability and reduced productivity will additionally pressure governments' health and general budgets. This is a major and growing challenge for Pacific countries. **Macroeconomic forecasts for most countries are modest and aid funding from traditional donors is also decreasing, which leaves most countries in the Pacific with limited options for increasing fiscal space for health.** Many countries already have high levels of health spending relative to income, financed through government general revenues and external donor resources. Most have small private sectors and low out-of-pocket spending. Most countries allocate more than 10 percent of their annual domestic government recurrent budgets for health. When coupled with funding from donor partners, this takes total health expenditure well over 10 percent for most,

¹¹⁷ The Pacific Regional UN Thematic Group on NCDs is an informal collaborative arrangement of UN agencies. It liaises with the Global UN Interagency Task Force on NCDs, which the Secretary-General established pursuant to ECOSOC resolution E/2013/12 (available at www.who.int/nmh/ncd-task-force/tf-2013.pdf) and which is placed under the leadership of WHO. The Pacific is the second region in the world to establish such a Thematic Group, after Europe. The group meets regularly and is chaired by the UNRC. The creation of the group was announced at the 2014 SIDS conference.

¹¹⁸ There are many programmatic aspects where lessons can be shared and common approaches developed, particularly with regards to community mobilization and building civil society networks and their inclusion in decision-making and accountability processes.

if not all, countries (average 14 percent). In spite of this, there is anecdotal evidence that the inability of health systems to deliver adequate services free or at subsidized cost may push vulnerable households deeper into poverty, with greater impact on women and girls. Inequities are also evident between underserved rural populations and those living in or near urban centers.

Similar to global trends, funding support from donors is disproportionately in favor of communicable and infectious diseases and certainly not commensurate with the disease burden.

From 2002 to 2009, donor support for HIV alone amounted nearly US\$70 million, while funding for all NCDs amounted to US\$33 million including a notable increase toward the end of the period due to a single programme funded by New Zealand and Australia. As an indication, cumulative AIDS deaths per 100,000 population in the region was approximately 50 in 2005 compared to in excess of 10,615 NCD deaths per 100,000 population across 13 Pacific countries in 2002.

Current remedy actions

- The potential to further increase taxation on tobacco and alcohol exists in many countries. Even if only a portion of the proceeds were allocated to health, access to services would be greatly enhanced. PICs are also increasingly implementing or considering taxes on other harmful products such as sugary drinks and foods high in salt or trans fats. These taxes reduce consumption, improve health and increase the resources that the government can spend on health.
- Some Pacific countries are starting to focus on efforts to improve both the allocative and technical efficiency of health spending. This includes efforts to redistribute resources more equitably and towards NCD prevention and early treatment. It also requires improvement in public financial management as a means to increase value for money and accountability.
- Some donors are moving away from disease-specific programme support and providing greater investment in health systems strengthening. As outlined earlier for HIV and TB, greater synergies

and integration between disease-specific programmes with NCDs can lead to mutual benefits and results.

Bottleneck Area 4: Cross-cutting issues

Myths and misconceptions about premature deaths from NCDs persist at all levels from patients to health care workers to decision makers and donors. Those misconceptions include the notions that NCDs affect mainly high-income nations, high-income quintiles in developing countries or the elderly; that they are unavoidable; that they are caused by 'unhealthy lifestyles' and individual choices; and that prevention and control are too difficult and expensive.

Dietary and 'lifestyle changes' reflect the increased stakes of the global food industry, but also have social and cultural dimensions. Specific attention to the gendered (and age-related) norms and expectations around risk factors, socio-economic status and health-seeking behaviors are critical in shaping an effective response. These dimensions are important, often complex and at times counterintuitive. For example, NCD STEPS survey data reveals marked variations in the associations between risk factors and socio-economic status and gender.¹¹⁹

Transnational food and beverages corporations, including those based in the Pacific, are actively lobbying governments against policy or regulatory interventions that could reduce production and profits. This is a global phenomenon.

Most governments have not yet adopted agricultural policies that favor the increased production of nutritious local food that would increase the availability and domestic supply of healthy food for consumers.

The commitments from the Millennium Declaration, the 2011 UN Political Declaration and the 2014 Outcome Document on NCDs are expected to carry forward as part of the implementation of the goal on health under the Sustainable Development Goals.

¹¹⁹ In Fiji, for example, having a tertiary education and living in an urban area are associated with reduced odds of being a smoker, for men and women. While Fijian men with secondary and tertiary education are more likely to be obese, Fijian women with secondary and tertiary education are less likely to be obese than those with only primary education. A similar pattern is observed with diabetes: while it was more prevalent among men with tertiary education, an inverse relationship with educational level is observed for women. Living in an urban area in Fiji increased the odds of not consuming enough fruits and vegetables, while having a tertiary level education reduced these odds, for men and women. In Nauru, the prevalence of obesity was very high for men and women across all educational levels. However, diabetes was most prevalent among those with high educational attainment. The prevalence of current smoking was generally higher in women than men across all age groups in Nauru, and smoking was also more prevalent among those with low educational levels [35].

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

GUIDING RECOMMENDATIONS FOR THE CEB

- 1. Mandate and support the different UN system agencies that are present in the Pacific to operationalize the national commitments included in the 2011 UN Political Declaration on NCDs¹²⁰ and the 2014 UN Outcome Document on NCDs¹²¹ and through the newly established UN Inter-Agency Task Force on NCDs, in full collaboration with the Pacific Regional UN Thematic Group on NCDs.** This includes (in accordance with its terms-of-reference endorsed by ECOSOC¹²²) joint work plans and joint programming missions where relevant to harmonize and maximize the value-added of each agency; mainstreaming NCD work through agencies' existing and related projects; development of joint projects with a strong focus on 'impact investment'; greater emphasis on NCDs in UNDAF processes; specific agency resources allocations to be considered; the establishment of resident UN Thematic Groups on NCDs, as well as high-level representation in NCD-related meetings.
- 2. Because other development efforts and international trade significantly affect NCD incidence and prevalence amongst the PICs and there is a disproportionately low allocation of donor and national resources for addressing NCDs, we recommend the establishment of an NCD Trust Fund Facility (supported by a range of donors) to offset these effects.** The Trust Fund might have a number of components, e.g., (1) a small grants component that would finance community initiatives to fight NCDs; (2) a results-based disbursement component against actions in the NCD crisis response plans; (3) a research and impact evaluation component; and (4) an investment component to provide incentive financing for infrastructure investments that promote availability of affordable locally produced food and healthy lifestyles (e.g., lowering transport and storage costs, constructing bike paths and sidewalks, etc.).

- 3. Host special NCD sessions around key annual meetings for respective agencies, e.g., World Bank Annual Meetings (with finance ministers), World Health Assembly (with health ministers) and others where the UN system may be engaged in - agriculture, trade, education, development in preparation for the third High-Level Meeting of the UN General Assembly on NCDs in 2018.** Given the disproportionate burden and their heightened socio-economic vulnerability, SIDS and the Pacific Islands need special attention.

PROGRESS SINCE THE CEB REVIEW

Progress on the first CEB recommendation: Support the different UN agencies present in the Pacific to operationalize the national commitments included in both the 2011 UN Political Declaration on NCDs¹²³ and the 2014 UN Outcome Document on NCDs¹²⁴, by working with the newly established UN Inter-Agency Task Force on NCDs and the Pacific Regional UN Thematic Group on NCDs.

Interagency collaboration and coordination has continued and intensified, facilitated by the Pacific Regional UN Thematic Group on NCDs. This is chaired by the UNRC, with WHO acting as the Secretariat. A number of projects with a regional or multi-country scope have been developed and are being implemented. These include: (i) a project led by UNDP in collaboration with WHO to develop technical capacity for legal and health professionals in achieving coherence between health, trade and investment; (ii) a project led by IFAD leveraging the development of local food crops and Fisheries Value Chain for improved nutrition and sustainable food systems in PICs; (iii) ILO has developed and started rolling out a workplace NCD prevention programme using occupational health and safety entry point; (iv) The World Bank is undertaking an analysis of the burden of NCDs in select countries over the medium to long term, while UNDP and WHO are providing support for a more detailed analysis of the cost burden on the Fijian economy, and (v) FAO and WHO are undertaking secondary analysis of HIEC/HCES data to estimate dietary intake the impact of a price increase on unhealthy foods (vi) UNICEF supports Fiji, Vanuatu, Kiribati, Solomon Islands and Federated State

¹²⁰ Resolution A/RES/66/2, available at www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1

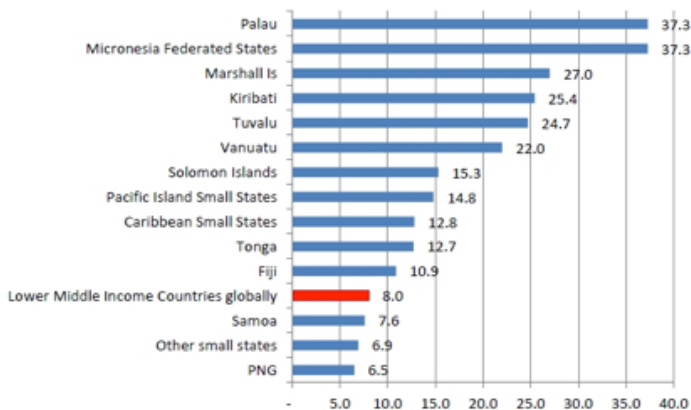
¹²¹ Resolution A/RES/68/300, available at www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1

¹²² www.who.int/nmh/events/2014/ecosoc-20140401.pdf

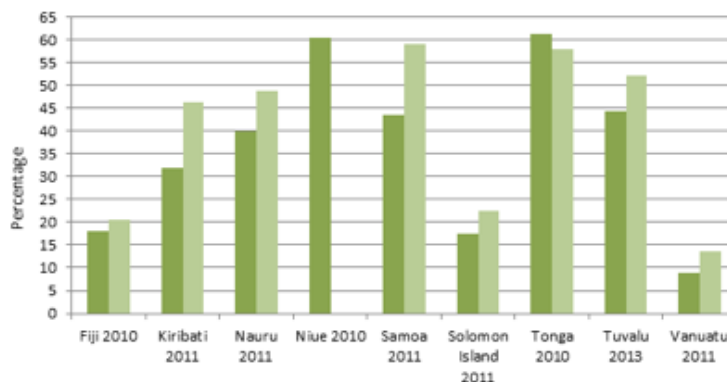
¹²³ Resolution A/RES/66/2, available at www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1

¹²⁴ Resolution A/RES/68/300, available at www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1

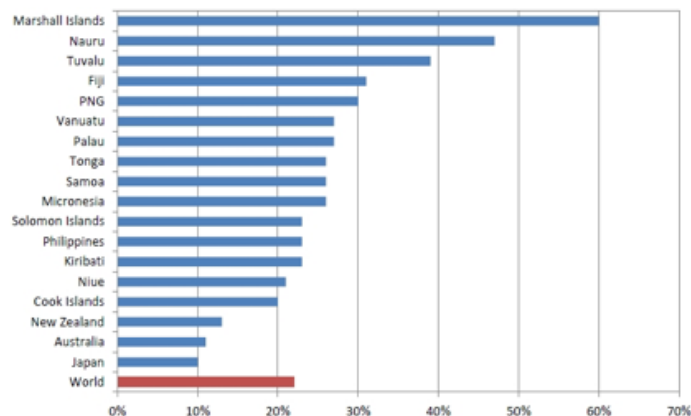
GRAPH 1: DIABETES PREVALENCE
(% AGED 20-79)



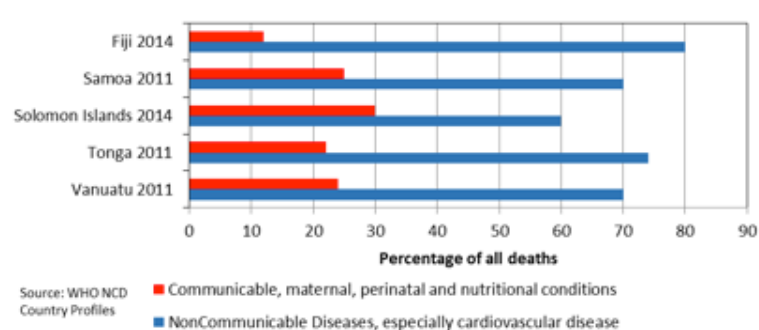
GRAPH 2: OBESITY
(% AGED 13-15 *FEMALES LIGHTER SHADE)



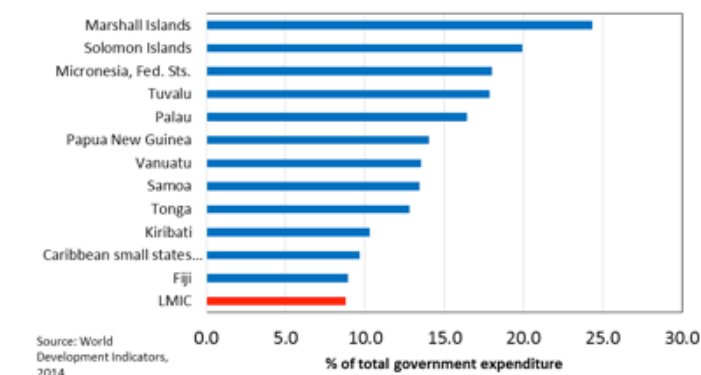
GRAPH 3: PREMATURE DEATH
(% AGED 30-69)



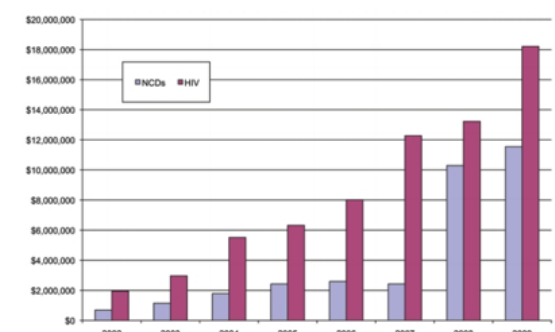
GRAPH 4: PERCENTAGE OF DEATHS
(NCD VS. COMMUNICABLE DISEASES & MNCH)



GRAPH 5: PUBLIC HEALTH EXPENDITURE
(% OF TOTAL GOVERNMENT EXPENDITURE)



GRAPH 6: EXTERNAL FUNDING FOR HIV Vs. NCDs IN PICs
(2002-2009)



Additional sources: Graphs 1-3: WHO NCD Country Profiles; Graph 6: Khaleghian, P. Noncommunicable diseases in Pacific Island Countries: disease burden, economic costs and policy options. SPC. 2001

of Micronesia through lifecycle approach, from pregnancy to early childhood, to promote appropriate maternal, infant and young child feeding, starting with breastfeeding and appropriate complementary feeding and micronutrients, for the current and future health and well-being, including minimizing the risk of NCDs. (vii) A project, Sports for Development (S4D) led by UNICEF that aims at promoting healthy lifestyle among young people in Tonga, Samoa and Fiji with plans to extend to other Pacific Island countries. The aim is to influence young people aged 6 to 16 years in schools to make lifestyle choices in order to help them avoid risks, be active and stay healthy. This will inform the development of accompanying policies to improve access to nutritious substitutes. At the global level a joint WHO-UNDP programme has been developed for which funding is being sought. The programme will undertake national investment cases, develop national coordination mechanisms and strengthen municipal action and integration of NCDs in national SDG frameworks in 24 countries.

In addition to this, a subset of development partners (including DFAT, MFAT-who play an extremely important role in the Pacific Region – WHO, SPC and the World Bank) – regularly discuss NCD issues in the Pacific through the Quints forum.

Progress on the second CEB recommendation include: Because other development efforts and international trade significantly affect NCD incidence and prevalence amongst the PICs and there is a disproportionately low allocation of donor and national resources for addressing NCDs, we recommend the establishment of an NCD Trust Fund Facility (supported by a range of donors) to offset these effects.

The World Bank and UNDP have sent joint letters to the governments of Australia, Korea and New Zealand asking for their consideration and support to help establish a regional Trust Fund Facility for

Non-Communicable Diseases. There are several concerns about the establishment of a Trust Fund: (i) sluggishness in the global economy, (ii) emerging global hotspots garnering greater attention, and (iii) a continued concern that such a Trust Fund Facility for Non-Communicable Diseases is not likely to be more successful in addressing the NCD crisis in the region compared to the significant amounts of bilateral aid currently being channeled to these countries. Whether or not a Trust Fund Facility of the nature mentioned is established or not, there is a clear recognition and understanding that financing for NCDs has to be increased and that failure to act now could lead to significantly higher costs in the medium to long term. A high level NCD Summit will take place in Tonga in June 2016.

Progress on the third CEB recommendation include: Host special NCD sessions around key annual meetings for respective agencies, e.g., WB annual meetings (with finance ministers), WHA (with health ministers) and others that other UN agencies.

In September 2015, the Pacific Islands Forum leaders endorsed a new framework for Pacific regionalism. They noted the substantial burden that cervical cancer places on women and girls in the Pacific region as well as the insufficient response to address it across the region and agreed to prioritize action and resource allocation to address the disease. More discussions are underway. A high level NCD summit took place in June 2016 in Tonga and was attended by several heads of state and the UNDP Administrator. It was part of a push to galvanize political will at the highest level. The meeting also helped review the progress made by countries on implementing the recommendations found in the NCD Roadmap. These include - tackling tobacco use and limiting the consumption of sugary drinks and fatty foods, by increasing taxes to support behavioral change and support effective interventions.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

There is a high demand for cross sectoral approaches to address health issues, and in particular, NCDs given the nature of the diseases' etiology. Operationalizing multisectoral actions however remains a challenge in the Pacific, as it is elsewhere in the world. There is a whole host of reasons for that – including institutional structures in governments where ministries tend to function in silos, donor priorities, aid culture built to deliver 'projects' with short to medium term results prioritized, and weak or lack of coordination mechanisms at country level.

The MDG Acceleration framework adopted in some countries to tackle NCDs (for example, Tonga) has had a catalytic role in pulling several sectors together to address and deal with NCDs in a more holistic fashion and to offset the trend described above.

Furthermore, the NCD roadmap endorsed by the Pacific Finance and Economic Ministers intended to galvanize intersectoral planning and action. It emphasizes the non-health sectors' role and promotes population approaches to NCDs (through taxation for example), partnerships and improved efficiency. The roadmap has become a standing agenda item at the region's Finance and Economic Ministers' annual meeting. An update was discussed at the last meeting in October 2015 with an agreement to develop specific targets for progress review at each meeting. Specific country roadmaps, consistent with their existing policies and programmes are now under development.

The SDG framework and the process of SDG localization is providing significant new opportunities for addressing health issues across goals, especially given the high number of goals directly or indirectly impacting health outcomes, as well as the high number of shared targets and indicators between these goals. To successfully seize this opportunity, a number of actions should be taken to strengthen accountability, transparency, coherence, monitoring, reporting, as well as knowledge sharing through cross-sectoral multi-stakeholder partnerships.

CHAPTER 5

MDG-7 ACCELERATING PROGRESS TO INCREASE ACCESS TO WATER AND SANITATION



BENIN

Accelerating access to safe drinking water and basic sanitation

CONTEXT

- About 68.1% of the population in rural areas and 72.1% in urban areas had access to drinking water in 2014.
- The proportion of the urban population using an improved sanitation facility rose from 35.4% in 2007 to 53% in 2015 (MDG target for 2015 was 69.1%).
- 2014 ICS survey notes only 23% of rural households had access to a latrine or a toilet.

**RURAL HOUSEHOLDS
HAD ACCESS TO A
LATRINE OR A TOILET**

23%



**URBAN IMPROVED
SANITATION FACILITY (%)**

35.4

53.0



2007

2015

BOTTLENECKS

Persistent problems of access to drinking water in some parts of the country.



Lack of financing and human resources capacity to promote awareness on hygiene and clean sanitation.



Lack of awareness and communication on the importance of safe drinking water and sanitation.



Uncoordinated efforts to improve service delivery on hygiene and sanitation at the community-level.



SOLUTIONS/EFFORTS

Scale-up a National Programme of Drinking Water Supply in Rural Areas to improve access to safe water for nearly 77,000 people living in rural Benin and other programmes.

Technical and financial support to certify rural localities as open defecation-free (ODF) (e.g. by December 2015, covered 350,837 people in 60,538 households in 9 communes).

Roll-out a community-driven total sanitation (ATCP) to off-track rural districts (e.g. In Ouémé department, 30 out of the 57 localities where this approach was tried saw an end to open defecation).

Increase the collaboration among UN system, bilateral partners, and the private sector to strengthen systems for monitoring, information sharing, and evaluation of water and sanitation.

INTRODUCTION

Benin has a low human development index, estimated to have been at 0.480 in 2014 (‘Human Development Report’, 2015). Since 2000, the average economic growth rate has been around 3 percent, which is below the estimated population growth rate of 3.5 percent as reported in the population census of 2013. According to the 2015 results of the Integrated Modular Survey on Household Living Conditions, 40.1 percent of Benin’s population was living below the national poverty threshold, compared to 35.2 percent in 2009.

Access to drinking water and basic sanitation continues to be a major concern. According to the Government, about 68.1¹²⁵ percent of the population in rural areas and 72.1 percent in urban areas had access to drinking water in 2014¹²⁶ (MDG target: 75 percent by 2015). In sanitation, the proportion of the urban population using an improved sanitation facility rose from 35.4 percent in 2007 to 53.0 percent in 2015 (MDG target: 69.1 percent). According to the 2014 ICS survey, only 23 percent of rural households had access to a latrine or a toilet.

The Government of Benin (GoB) decided to apply the MDG Acceleration Framework (MAF) to MDG 7C (halving the proportion of people without sustainable access to safe drinking water and basic sanitation). The choice of MDG 7C was guided by: (i) the cross-cutting nature of the impact of improving access to water and basic sanitation on all MDGs, particularly poverty reduction, education and health; and (ii) the UNDP 2010 report on MDG implementation that showed that the 2015 targets could still be achieved in these two sectors.

Accelerating progress towards MDG 7C was expected to lead to attendant gains for the other MDGs. Clean drinking water, decent sanitation and hygiene are central to combating diarrhoea and debilitating diseases that lead to child illnesses and deaths, reduce productivity and inhibit nutrition outcomes. Availability of water close to the household saves time and energy that people – especially women and girls – would otherwise spend fetching water over long distances. The resulting time saved can be put to more productive uses – attending

school, or improving household food security and income. Access to drinking water and decent sanitary facilities are intended to boost the enrolment and retention of girls in schools. Involving women (and other marginalized groups) in community-level decision-making regarding access to water and sanitation results in more equitable outcomes as well as greater confidence and empowerment. Managing and maintaining these facilities can also impart skills that can be put to use in other areas of life.

The Government has demonstrated continuing commitment to achieving the MDGs that go beyond its efforts directed at MDG 7c. In 2013, the Government adopted an Action Plan in response to the UN Secretary General’s initiative to accelerate progress over the last 1,000 days for the MDGs. A Ministry in charge of the MDGs and Sustainable Development Goals (SDGs) has been appointed to monitor the implementation of the Action Plan that has been integrated in the 2014 Budget Law. The monitoring mechanism drills down to the level of the Annual Work Plan (AWP) of the ministries, making sure that each intervention is properly articulated and monitoring budget disbursement and sectoral procurement are properly planned. A reviewing process was started in April 2014 to monitor how the 1000 Days Initiative Action Plan is being implemented through the work plans of associated MDG ministries. A report will be submitted each trimester to the Cabinet to allow the President of the Republic to discuss with MDG ministries the bottlenecks in the implementation of the Action Plans, and to take steps for their resolution.

SITUATION ANALYSIS

Drinking water and basic sanitation policies and strategies

The Government’s Accelerated Growth Strategy for Poverty Reduction (SCRIP) 2011–2015 further points to its commitment to reaching the MDG targets for drinking water and basic sanitation.

This strategy articulates the two key elements in expanding access to water in a sustainable manner in rural areas: transferring the management of water facilities to the communes and mainstreaming the principle

¹²⁵ At the national level, the statistic used is the water coverage rate developed by the Ministry of Water Affairs for programming the implementation of water facilities, while the disaggregated statistic used for rural and urban areas calculated by the National Statistic Institution (INSAE) is the water access rate. Some data used in this paper are from the 2013 sectoral review. It should be noted that the Joint Monitoring Program (JMP) has produced a different set of coverage rates and MDG targets. The JMP target for rural water is 74 percent and urban water is 86 percent for 2015; for urban sanitation, the target is 51 percent. These differences stem from the different assumptions made by the Government and the JMP on the number of persons living in a beneficiary household and the number of people using a standpost or a well.

¹²⁶ MICS Benin was implemented in 2014.

of paying for water services. This principle is now well accepted by the population and water prices are set to cover operating, maintenance, partial equipment renewal and service extension costs. Moreover, new facilities such as small-town piped water schemes, are systematically leased to domestic private operators who are responsible for their operation and maintenance. The management of basic facilities (hand pumps) is generally entrusted to local communities.

A number of policies, plans and implementation frameworks articulate the approaches being taken in the field of sanitation.

These include the National Sanitation Policy (NSP, 1995), the National Sanitation Development Plan (NSDP, 2009–2018), the National Strategy for Hygiene and Sanitation Promotion (NSHSP, 2013), and the manual on Promoting Hygiene and Basic Sanitation (PHBS, 2005) that provide the reference framework for the coordination of multiple interventions in the sector. UNICEF and UNFPA contribute actively to the harmonization of the strategies on sanitation. The National Health Development Plan (2009–2018) of the MoH includes priorities related to hygiene and basic sanitation. Communication on behavioural change regarding sanitation is an intrinsic part of the proposed approach. WHO contributes to the Government's efforts to improve sanitation standards through its support to the implementation of the National Sanitation Development Plan, while UNFPA contributes actively to the mainstreaming of gender issues in the policies of the sector.

Since the adoption of the MAF action plan, new policy reforms have been implemented well. These included the implementation of a Rural Water Sector-wide and programmatic approach, with related performance targets, and planning and budgeting processes; the decentralization and devolution of responsibilities to municipalities; the involvement of consumer associations; and the introduction of private-sector participation in the management of water supply facilities. These policies clarify needs, bottlenecks and solutions involving access to drinking water and sanitation sectors. Their successful implementation has made a good contribution to the gains achieved in the two sectors toward the MDGs.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Accelerating solutions for progress toward MDG 7C

The ownership and subcontracting model is set to become the standard approach of the communes as far as the provision of water services is concerned. Since 2008, the ownership of water facilities has been transferred to 74 of 77 communes. It is expected that the communes will significantly improve their technical and financial capabilities in the monitoring of leased facilities and thus enhance the sustainability of the system.

This should be combined with efforts to consolidate gender-related progress in capacity-building to manage water facilities. Emphasizing the role of women in the leasing and management of these facilities can be expected to further accelerate progress.

The Government, in collaboration with development partners, is promoting the adoption of low-cost connections to improve access to water for disadvantaged populations in urban and peri-urban areas. Introducing flexibility in the payments for water connections for poor people in peripheral areas, especially women and women-headed households, together with the formulation of a national policy on the provision of services in peri-urban areas, would help accelerate progress and sustain results.

The national hygiene and sanitation strategy emphasizes the use of education and communication programmes to raise awareness of the benefits of hygiene and basic sanitation and assigns a central role to hygiene assistants and community workers in the implementation phase. Awareness-raising campaigns have already been run in five departments: Atlantique, Zou, Alibori, Borgou and Collines. In four years, the intervention enabled a 20 percent increase in the proportion of people who have access to improved sanitation facilities. A UNICEF programme called Community-driven Total Sanitation is currently being piloted in three departments in order to strengthen the national hygiene and sanitation strategy approach and results have been promising. In Ouémé department, 30 of the 57 localities where this approach was tried saw an end to open defecation, and even in the others there was an appreciable increase in the number of latrines built.

The national hygiene and sanitation strategy emphasizes the preparation and implementation of commune-level hygiene and sanitation plans that directly meet beneficiaries' needs. In 2012, only 14 of the 74 rural communes had a commune-based hygiene and sanitation plan. By 2014, that number had risen to 68. The commune-based plans include, inter alia, building latrines for schools and families and educating people about hygiene.

Systems for monitoring, information sharing, and evaluation in the areas of water and sanitation have also been strengthened over time. Overall, UNICEF, UNDP, WHO, the WB, several bilateral partners, and the Beninese private sector are cooperating to accelerate the momentum of the gains that have been achieved, documenting them, and making training and community ownership of water facilities paramount in their support to the Government. Partners are also supporting efforts to set up and sustain small-scale public-private partnerships involving domestic private-sector participation in the rural water and sanitation sector. This approach is expected to foster the expansion and delivery of water services.

As part of the acceleration efforts, the tested and proven operating/management model for piped water schemes is being expanded to small towns across the country. This initiative combines the mobilization of private investments with targeted public subsidies so that access to safe drinking water becomes sustainable and affordable. The country has already made significant progress in this direction. Indeed, as of the end of 2013 and through the country's accelerated MAF implementation, more than 85 percent of the water supply systems in Benin included private sector participation in delivering and managing services and professional operators were managing more than 50 percent of the water supply distribution systems. The UN and the WB are working closely with the Government of Benin to enhance this grassroots approach to water resources management and to increase private sector participation to 97 percent by the end of 2015, thereby significantly contributing to the achievement of MDG 7c.

Strengthening institutional capacity at the central as well as decentralized levels is an essential component of accelerating progress and sustaining gains. Principal efforts in this regard include: (i) mainstreaming of MDG 7c objectives in budget programming in cooperation with other water supply and sanitation partners; (ii) strengthening implementation capacity of decentralized communes, including training for water and sanitation management and resource development in the local administrative bodies; and (iii) improving monitoring capacity.

Adequate and assured resources are crucial to the effort. The data gathered from the country's technical services suggest that \$57 million per annum for water and \$196 million for sanitation were needed. Given the past investments in the sector, and as a result of the programmatic funding approach supported by all technical and financial partners, Benin had a minor funding gap of \$4 million per year in achieving the water target.¹²⁷ Substantial financial support was needed in the sanitation sector to achieve the target.

The sustainability of the systems depends on scaling up the delegated management approach. On the basis of the joint pilot project, the WBG and other bilateral donors are coordinating a range of instruments to deepen domestic private sector engagement in water and sanitation service delivery in rural areas and small towns. Adequate funding of the capital expenditure fund for the rehabilitation and expansion of rural and small-town water schemes is necessary to increase the number of affordable connections for low-income households. The WBG is working on an innovative financing mechanism and on risk management instruments to enhance the viability of commercial lending to private operators for infrastructure investment.

¹²⁷ Bilateral donors contribute significantly to the water sector – to the extent of US\$ 25 million in rural areas, and US\$ 25 million in urban areas. The national budget itself commits US\$ 7 million per year. In the context of the programmatic approach developed with technical and financial partners it is expected that this funding arrangement will continue through 2015.

GUIDING RECOMMENDATIONS FOR THE CEB

In order to help the Government achieve its water and sanitation coverage targets, the UN agencies and the WB need to continue to strengthen the implementation of the delegated management approach to guarantee the sustainability of the systems. In particular, for ensuring coverage of the poor and disadvantaged, there needs to be a continuing emphasis, accompanied by the mobilization of resources, on the expansion of rural and small-town water schemes to provide affordable connections to more households.

Integrated responses from UN agencies and the WBG through diverse programmes will strengthen its interventions in the water and sanitation sector, and ensure that these are translated into gains for other MDGs as well. Such interventions could include: the school feeding programme and the development of community ownership of school canteens (WFP); the Millennium Villages Project, which builds classrooms and latrines in schools; multifunctional platforms for energy and drilling wells (UNDP); and maternity and reproductive health programmes (UNFPA). An integrated approach in common priority areas for intervention for the new cycle of UNDAF (2014–2018) could allow the development of a joint project on water and sanitation where the building of water facilities by one agency would go hand in hand with the implementation of total sanitation activities.

UN agencies, particularly UNICEF, UNFPA, WFP, WHO and UNDP will strengthen their support to the Government to ensure the operationalization of the National Strategy for the Promotion of Hygiene and Basic Sanitation especially by strengthening community approaches to total sanitation, hand washing with soap or ash and household water treatment. To end open defecation, specific interventions will be dedicated to strengthening the human resource capacity of civil society and the mainstreaming of water, hygiene, and sanitation aspects in the curricula of schools benefiting from UNDP's diverse programmes.

A partnership led by WFP with UNICEF, GIZ, Dutch cooperation and other institutions specialized in WATSAN could be developed to implement water supply systems for vulnerable populations in rural areas targeted to receive WFP school canteens. Women and girls would particular benefit from expanded access to water sources

and potable water, as traditionally women and girls are responsible for collecting water and often have to walk long distances to locate a water source.

Agencies and other partners can benefit from the national coordination mechanism set up under the MDG/SDG ministry to strengthen the coordination of implementation efforts. The WB could revise its Country Partnership Strategy at its mid-term review of the integration of water and sanitation as a prioritized sector which would direct investments dedicated to the sector. UNDP could strengthen its support to the MDG/SDG Ministry to enhance its functioning through additional global support and partnerships.

A joint project of UNFPA and FAO under formulation to support the promotion of hygiene and basic sanitation, food security and the empowerment of women in rural areas could benefit from global support to mobilize the resources needed to finance the gap of \$1 million. The project aims to enhance maternal health and reduce infant mortality through more nutritional food, better water quality and the empowerment of women through activities generating revenue for them.

PROGRESS SINCE THE CEB REVIEW

In 2016, UNDP has signed with the Government of Benin an emergency programme for the implementation of the National Programme of Drinking Water Supply in Rural Areas. This programme aims to serve some areas of the country with persistent serious problems of access to drinking water. It will increase the level of service and access to clean water for populations in 54 municipalities of Benin, covering 307 villages in order to contribute to improving their living conditions and the full realization of target C of MDG 7. It will also strengthen the management capacity of delegates for the sustainable management of water points and on the observation of hygienic measures. Activities to be undertaken in the areas of intervention are as follows:

- Awareness-raising, studies, control and completion of 307 boreholes fitted with hand pumps;
- Capacity-building of local stakeholders involved in the management of village water projects including the capacity of communal social intermediation.

Funded by the Government of Benin for a total cost of \$6 million, the emergency programme is planned for a period of one year and will improve access to safe water for nearly 77,000 rural Benin. A partnership agreement and project management delegation between the Ministry of Water and UNDP serves as a reference framework for the project. The results obtained in May 2016 show that 47 of the 53 boreholes were launched in the subregion Les Collines, studies have begun on the implementation of the remaining 264 wells and the opening of bids for drilling the remaining 264 is near completion.

On sanitation, civil society organizations with technical and financial support from UNICEF triggered 1,523 rural localities among which 1,383 were certified Open Defecation Free on 31 December 2015, covering 350,837 people in 60,538 households in nine communes of Benin. To achieve this result, the funding provided by UNICEF amounted to \$2,820,995.

In the rural water sector, WBG has been supporting the GoB in carrying out reforms to improve the management of rural and small-town piped water schemes. Working together, IFC and the WB helped develop public-private partnerships to extend water supply into rural areas in Benin. For the first time in Benin, bankable long-term commercial agreements allowed private operators to raise funding to undertake the necessary capital investments. A pilot project led to the implementation of four 8-year subsidized concession contracts for 10 piped water schemes in three municipalities with three different private operators. Private operator contributions to capital expenditure exceeded the contribution expected by nearly 17 percent. In total, an estimated 48,500 people have improved access to water services through these pilot project contracts. These achievements provide a strong basis for the design of the scale-up phase that is already underway with WBG support. It will have a significant impact on drinking water supply for small towns (localities of less than 20,000 inhabitants) outside the perimeter of the Urban Water Utility.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

The implementation mechanisms for MDGs had been designed progressively when the achievement was becoming problematic. The timeline of the MDG implementation shows especially how the MDGs have been slow to be appropriated by counties, how the international community, through the UN system, has been slow to find the appropriate instruments to facilitate their implementation (MDG assessment, planning

and costing tools, localization of MDGs, the Gleneagles scenarios and MAF) and finally how the issue of funding has never found a completely satisfactory answer.

The MAF, and ultimately the CEB process, have been instrumental to accelerating progress on specific targets by forging partnerships, first with the Government, then with donors at the sectoral level and later with the WB and UN agencies.

On sanitation, the major lesson learned is that partnerships between all stakeholders work. Indeed, the partnership between civil society, the Government and UNICEF showed that the CLTS is possible in Benin and can earn tangible results. CLTS combined with hygiene promotion and household water treatment results in major changes in behaviour and social norms among communities who still face sustainability challenges.¹²⁸

With regard to water access, it appears that creating and implementing reforms has been a difficult process as expected. Changing the rules of business in the water sector has not been easy. Indeed, reforming the rural water sector in Benin involved five different categories of actions: (i) enhancing knowledge of the condition of the asset; (ii) defining the responsibility for operation and maintenance of assets at each local government affected; (iii) clarifying how to delegate management to private operators; (iv) organizing private regulations at the national level; and (v) allowing private operators to use financing to develop services. These reforms needed a theory of business that has been applied to move the process forward and gain results.

One of the main lessons for the UN Country Team to consider for the Sustainable Development Goals is the necessity to strengthen UNDP joint programming and coordination instruments in synergy with a joint mechanism for consultation and dialogue with governments. This would promote an integrated approach to solving the diverse issues addressed by the Sustainable Development Goals. Breaking the silos both within the UN System as well as in governments in promoting joint intervention platforms open to other stakeholders, including donors, civil society and NGOs, and the private sector, will be crucial. An integrated approach in common priority areas for intervention for the new UNDAF cycle (2014–2018) could allow the development of a joint project on water and sanitation where the building of water facilities by one agency would go hand in hand with the implementation of sanitation activities.

¹²⁸ Rapport du contrôle de la durabilité – Unicef 2015.

NEPAL

Accelerating progress towards reaching universal sanitation coverage

CONTEXT

- In 2011, basic sanitation coverage was 62% of the population and improved sanitation coverage was 48%. Socio-economic inequities exist across the country. Disparities in access exist across caste and ethnic groups.
- The MDG target for sanitation in Nepal, Target 7 C, was to halve the population without sustainable access to improved sanitation, from 94% to 47%. It reached 53% in 2015.
- The earthquake on April 2015 set back the country's progress on sanitation. It was estimated that about 390,000 toilets; 7,700 water supply systems and 750,000 houses were destroyed (partially or fully) in 31 out of the 75 districts in the country struck by the earthquake.

EARTHQUAKE DAMAGE



390,000
TOILETS



7,700
WATER SUPPLY
SYSTEMS



750,000
HOUSES

BOTTLENECKS

Functional status of school facilities is relatively poor and inadequate (e.g. only 76.8% of schools have water supply facilities, only 80% have sanitation facilities, and only 65% have separate toilets for girls).



Inadequate WASH capacity building programmes at various level.



Inadequate coordination and alignment of WASH initiatives.



Inadequate sanitation and hygiene facilities in many schools lead to greater absenteeism and drop-outs, especially among girls.



SOLUTIONS/EFFORTS

Support the Government campaign to build 3-5,000 toilets in schools country-wide.

Implement Water and Sanitation and Hygiene (WASH) in school programmes with full community ownership and municipal/village committee collaboration.

Develop WASH School Guidelines with the view that schools are an important element of declaring and sustaining the Open Defecation Free (ODF) movement in Nepal (e.g. WASH in school guidelines are being developed under the leadership of the Department of Education with support from local and international NGOs including UN agencies).

Coordination resulted in a timely and coherent WASH Sector Plan under the Post Disaster Recovery Framework.

Advocate sanitation as a development priority, stressing impacts on health and education.

Support institutional sanitation programs, especially in schools to increase girls enrollment and retention.

INTRODUCTION

Nepal has set itself an ambitious target of universal access to basic sanitation by 2017, in line with national development priorities. The MDG target for sanitation in Nepal, which is about halving the population without sustainable access to improved sanitation, was calculated to be up to 53 percent by 2015. The 2015 Multiple Indicators Cluster Survey (MICS) shows that the improved sanitation coverage in Nepal reached 60 percent, whereas the government's self-reporting data shows the sanitation coverage reached to 81 percent in 2015. A significant increase in sanitation after formulation of MAF for improving sanitation access in 2012 is noted. The Government of Nepal (GON) has set to achieve 80 percent improved sanitation coverage by 2015 and 100 percent by 2017.¹²⁹ There has been much improvement in the sanitation coverage due to a massive Open Defecation Free (ODF) campaign in the communities and schools with the leadership of local bodies and enhanced coordination of various stakeholders in the country. Local sanitation triggers who were developed country wide also played significant roles to trigger the ODF campaigning in the districts, villages and schools. The MAF had four major interventions: (1) strengthening the coordination of multistakeholders committees on water and sanitation with the leadership of local bodies; (2) development of sanitation triggers; (3) schools sanitation; and (4) strengthening ODF campaigning. Though the synergy of the prioritized interventions yielded the accelerated sanitation coverage, it is still a challenge to maintain and accelerate the present trend of achievement nationwide, across districts, ecological belts and rural and urban communities, and among all segments of people, particularly in the aftermath of the devastating earthquake of April 2015.

Nepal is also among the poorest countries in the world and currently ranks 145th among 188 countries on the Human Development Index.

The population of Nepal is estimated at about 27 million in the 2011 Census, with a growth rate of 1.35 percent per annum. The economic growth rate remains below four percent for last several years. Poverty is more severe in rural areas (27 percent) compared to urban areas (15 percent) and particularly severe in mountainous areas (42 percent), with ethnicity a dominant factor in these differences.

Nepal is also one of the most rapidly and haphazardly urbanizing countries in South Asia – the urban population is estimated to be 38.5 percent (MoFALD, 2014), up from 17 percent (2011). The number of municipalities has increased to 217 (2015) from 58 (2011). Nepal's population is projected an equal rural-urban split by 2030 (NUDS, 2015). This has a significant bearing on governance, programming and management for urban water supply and sanitation services.

The devastating 2015 Earthquake followed by fuel crisis and shortage of goods and materials as a result of the blockade in southern border have negatively impacted Nepal's economic growth and poverty reduction efforts. According to the Post Disaster Needs Assessment, the earthquake will end up pushing an additional 2.5 to 3.5 percent Nepali to poverty in FY 2015/16 which translate into at least 700,000 additional poor. GDP growth rate is expected to be reduced to 0.77 percent¹³⁰. It is estimated that approximately USD 7 billion is required for the recovery.

The earthquake also set back the country's progress on sanitation. It was estimated that about 390,000 toilets, 7,700 water supply systems, and 750,000 houses were destroyed (partially and fully) in 31 districts out of 75 districts in the country by the earthquake struck in April 2015. Moreover there were also about 8,800 human casualties and 22,000 injuries. It is estimated that the lives of eight million people, almost one-third of the population of Nepal, have been impacted by this earthquake. The recent Post Disaster Recovery Framework (PDRF) developed by the Government of Nepal has estimated that additional USD 15 million is required to reconstruct sanitation infrastructures and revive the ODF status in the earthquake affected districts. This amount is about 7.4 percent of the total WASH recovery cost. As the foremost priority of the people is to build their houses and resume their livelihood, they may not give priority to or have resources to contribute and get involved in the rehabilitation and reconstruction of the damaged water and sanitation facilities. There is an urgent need to fill this gap which requires about 70 percent of the total sanitation recovery cost for the initial years to meet the urgent needs of people, to resume the water supply and sanitation systems and also to revive the Open Defecation Free status in the ODF declared VDCs, municipalities and districts.

¹²⁹ *Basic sanitation* is the lowest-cost technology ensuring hygienic excreta and sillage disposal and a clean and healthful living environment at home and in the neighborhood of users. Access to basic sanitation includes safety and privacy in the use of these services. Access to improved sanitation facilities refers to the percentage of the population using improved sanitation facilities. The improved sanitation facilities include flush/pour flush (to piped sewer system, septic tank, pit latrine), ventilated improved pit (VIP) latrine, pit latrine with slab, and composting toilet. (Source: WHO/UNICEF Joint Monitoring Program (JMP) for Water Supply and Sanitation (www.wssinfo.org). However, the Nepal Sanitation and Hygiene Master Plan has adopted only flush/pour flush toilets as the improved sanitation.

¹³⁰ Central Bureau of Statistics/National Planning Commission.

After the introduction of Sustainable Development Goals (SDGs), water and sanitation have received significant importance. Unlike with the MDGs, the SDGs have a dedicated goal on water and sanitation. SDG 6 is about ensuring the availability and sustainable management of water and sanitation for all. According to the SDG national report prepared by the National Planning Commission, the sanitation has reached 70.3 percent of the population in Nepal. Two-thirds of the Nepali population now use latrines and 30 percent of urban households are connected to sewerage systems. The proposed targets for 2030 include 95 percent of households having access to piped water supplies and improved sanitation, all communities being free of open defecation, and all urban households being connected to a sewerage system¹³¹.

The Government has emphasized the sector by creating a dedicated Ministry for Water Supply and Sanitation early in 2016. Previously Ministry of Urban Development used to undertake the WASH sector.

SITUATION ANALYSIS

The National Planning Commission (NPC), in collaboration with sectoral ministries and development partners, prioritized sanitation (target MDG 7C) in order to develop an MDG Acceleration Framework Action Plan, given the uneven progress across subnational regions and population groups and its direct implication to other MDGs and achievement of national targets beyond MDG targets. Sanitation is a cross-cutting issue and has a direct positive impact on other goals, particularly on education and health. The MAF process highlighted the linkages to MDGs 2 (education), 3 (gender equality and women empowerment) and 4 (reduction of child mortality). For example, the availability of separate latrines and toilets for girls, especially adolescent girls, improves school attendance. Lack of facilities and hygiene required by menstruating girls leads to a high level of absenteeism (four days per month) among adolescent girls. Over a period of one year, absence from school by girls due to lack of toilet facilities is significant, being estimated at about 25 percent of the school year. Poor sanitation facilities have also led to several health risks, directly linked to diarrheal diseases and child mortality. A staggering 75 percent of hospital outpatient department visits are due to water and sanitation related diseases.

The government has promulgated a number of plans and policies on sanitation. The existing policies and strategies related to hygiene and sanitation in the country are the National Sanitation Policy – 1994, Rural Water Supply and Sanitation National Policy, Strategies and the Sectoral Strategic Action Plan (RWSSNSP) – 2004, Nepal Water Plan-2005, National Urban Water Supply and Sanitation Policy-2009. The most recent National Sanitation and Hygiene Master Plan enforced in (2011) harmonizes all existing policies to promote action at the local and national levels in order to meet the MDG and national targets. WASH Sector Development Plan (SDP) is under preparation by the Ministry of Water Supply and Sanitation (MoWSS) for a period of 15 years from 2016 to 2030 for the achievement of national targets and Sustainable Development Goals by 2030.

The National Sanitation and Hygiene Master Plan (NSHMP) envisions sanitation as going beyond the construction of toilets and declaration of ODF. It also envisages upgrading of toilets and sustained hygiene behaviors, including upgrading, use and maintenance of toilets with water facilities, hand washing with soap at critical times, waste management and food hygiene, and safe drinking water. **As of March 2016, 2,087 of the total 3,157 village development committees (VDCs), 85 of the 217 municipalities and 34 of the 75 districts have achieved 100 percent sanitation coverage and been declared ODF** District-level strategic plans have been drafted by 62 districts; VDC-level strategic plans are being prepared and implemented by 2,900 VDCs; and post-ODF strategies have been drafted and are being implemented by two districts. Fifteen pilot ODF VDCs are implementing Total Sanitation Programmes (five household level indicators plus one indicator on clean environment) and two VDCs have been declared total sanitation VDC. However, moving beyond declaration of ODF and onto the achievement and sustainability of total sanitation coverage remains a big challenge. A good monitoring mechanism needs to be in place for adequate learning and post-ODF declaration support inputs to ensure that people really climb up the 'sanitation ladder' by stopping open defecation and using shared sanitation and improved sanitation facilities.

¹³¹ Sustainable Development Goals (2016-2030): National report/National Planning Commission.

NSHMP puts the local bodies in the driver's seat to steer the sanitation campaign with decentralized actions and enhanced accountability at the local level. At the national level, the Ministry of Water Supply and Sanitation is responsible for ensuring access to water supply and sanitation coverage throughout the country. The local bodies- VDCs, DDCs and municipalities, with technical support from the technical agencies, are responsible for planning and implementing the sanitation campaigns. This includes formation of coordination committees at the national, district and village levels of government. The District Water, Sanitation and Hygiene Coordination Committees (D-WASH-CC) and Village/Municipality WASH Coordination Committees (V-WASH-CC/M-WASH-CC) are responsible for promoting and ensuring sanitation coverage in their constituencies. The NSHMP has laid down nine guiding principles to be adopted by all WASH-related stakeholders when providing sanitation support. At the household level, the individual households are responsible for funding the sanitation facilities (toilets).

Similarly, the MAF process identified high impact interventions, key bottlenecks and solutions to unlock these bottlenecks that are in line with the NSHMP principles. Four key interventions were prioritized that seek to address the critical issues to ensure that improvement in sanitation coverage happens across the geographical, ecological and ethnic divides under a coherent approach that can be sustainable in the country context. These include: enabling effective and functional WASH coordination committees; formulating and systematically implementing programmes (minimum common modules/tools) at various levels to strengthen the capacity of triggers¹³² to support ODF campaigns; expediting sustainable ODF campaigns at the district, VDC and municipality levels by adopting sanitation marketing strategies; and implementing WASH in school programmes with full community ownership M-VWASH- CC and D-WASH-CC collaboration. Although the policy environment for sanitation is favourable, implementation of key interventions has proven to be a real challenge. Coordination mechanisms need to be strengthened and institutional capacity built. In addition, WASH programs tend to be poorly funded.

BOTTLENECK ANALYSIS

Sanitation Challenges: Prioritizing Acceleration Solutions

Despite promising achievements in the sanitation and hygiene sector in recent years, visible disparities can be seen between the regions and ecological zones as well as between rural and urban areas. Of the 75 districts, eight densely populated districts in the Terai had coverage below 30 percent and one third of all districts had less than 50 percent coverage, far below the national average of 62 percent in 2012. Access to toilets was also uneven and mostly based on economic status: 97 percent of the richest quintile had access to improved toilets, but, among the poorest quintile, only 4 percent had access to improved toilets.¹³³ By 2015, the Terai sanitation coverage increased from 30 to 47 percent from 30 percent; the disparity between the rich quintile and poor quintile is reduced from 93 percent to 1 percent due to universal coverage approach in the country as per the MICS 2015. Rural and urban disparity has also decreased from 31 percent to 3 percent in the last three years after promulgation of MAF.

Only 76.8 percent of schools have water supply facilities and only 80 percent have sanitation facilities, while only 65 percent have separate toilets for girls. Furthermore, the functional status of these facilities is relatively poor and inadequate. This has affected the school attendance, completion and performance of children, particularly girls. While commitment has been made to ensure the presence of toilet facilities in all 34,000 schools, software programmes such as WASH in School/Children need to be added to ensure the regular use, operation and maintenance of the installed WASH facilities.

Though the toilet coverage in urban areas seems very high when compared to that in rural settlements, achieving ODF status in urban areas will require innovative approaches and the active engagement of partners and local communities. Sanitation coverage in urban areas is as high as 90 percent. However, extending coverage to the remaining 10 percent poses a challenge, as it comprises the poor and residents of slums and squatter areas. Rapid urbanization of the municipalities is the major reason behind

¹³² Triggers are the community mobilizers trained in the tools of triggering change in the community behavior toward improved sanitation practices by encouraging innovation, mutual support and appropriate local solutions under the Community-Led Total Sanitation approach.

¹³³ National Planning Commission and United Nations Development Programmes (UNDP). 2011. Millennium Development Goals, Needs Assessment for Nepal – 2010. Kathmandu: National Planning Commission, Government of Nepal and UNDP.

this phenomenon,, particularly in slums and squatters, where a lack of space, affordability, and uncertainty about tenure have resulted in a lack of adequate toilets. The faecal sludge management is becoming a critical issue especially in the urban areas.

While national and local-level programmes are being implemented to address the sanitation challenge, particularly trying to reach the yet unreached pockets of population, the coordination mechanisms set at the various levels to accelerate sanitation coverage are not yet fully functional everywhere. The NSHMP set up a steering committee and various coordination committees at the national, regional, district, village and municipality levels and has defined their composition and functions. However, a lack of human and financial resources and a lack of vertical and horizontal institutional linkages to effectively plan, coordinate and monitor the WASH activities have resulted in poor compliance of the policies at all levels, which has impeded progress toward sanitation coverage, especially in some geographical areas and among those segments of society that have traditionally lagged behind.

Urban sanitation continues to receive low priority in the policies and programs. Poor environmental sanitation services and highly degraded urban environments are the most visible consequences in the municipalities. Due to lack of an effective regulation, untreated sewerage, septage and fecal sludge contaminate groundwater and empty into rivers, polluting water sources and jeopardizing public health. To address the growing challenges in towns and municipalities, the 2009 Urban Water Supply and Sanitation Policy provides direction and strategies for effective programming and implementation through integrated urban water supply and sanitation sector projects. The challenge now is to build local capacity and prepare an investment plan to implement these policies.

The devastating earthquake of April 2015 set back the country's progress on sanitation. It was estimated that about 25 per cent of households in the 31 districts lost their toilets. People have lost their houses and livelihoods due to the earthquake, and as their foremost priority is to build their houses and resume their livelihood, they may not give priority to or have resources to contribute and get involved in the rehabilitation and reconstruction of the damaged water and

sanitation facilities. There is an urgent need to fill this gap for the initial years to meet the urgent needs of people, to resume the water supply and sanitation systems and also to revive the Open Defecation Free status in the ODF declared VDCs, municipalities and districts.

PROPOSALS TO ADDRESS PRIORITIZED BOTTLENECKS

Implementing the MAF: Priorities for Acceleration and Sustaining Progress

To address the challenges, the MDG Acceleration Framework (MAF) on sanitation lays down practical recommendations for high-yielding actions in four areas. These are in line with the guiding principles laid down in the NSHMP:

- **Enabling effective and functional WASH coordination committees.** A High-Level Sanitation Advisory Board chaired by NPC has been created to oversee the overall MAF implementation and monitoring and also to facilitate coordination across the various line ministries. The national-level and regional coordination committees have already been formed, whereas the formation of district- and VDC/municipality-level coordination committees is still taking place. These committees need to enhance their effectiveness by redefining roles, enhancing human capacity and mobilizing financing.
- **Formulate and systematically implement capacity-building programmes (minimum common modules/tools) at various levels.** Increasing sanitation coverage is based on ODF/total sanitation campaigning to create demand and to improve sanitation behaviours through the mobilization and training of triggers¹³⁴ that have the potential to help sanitation initiatives across designated programme areas cost-effectively, primarily at the district and VDC/municipality levels.
- **Expedite sustainable ODF campaigning at the district, VDC and municipality levels.** The NSHMP states that ODF status is the minimum requirement of any sanitation and hygiene promotion programme. It also states that the VDC is the smallest unit area for any ODF programme. The core principle of ODF is a total sanitation approach

¹³⁴ This includes providing community mobilizers with training on tools of triggering developed under the Community-Led Total Sanitation model.

without external support for building toilets. However, a safety net is applied to the ultra-poor and other disadvantaged people. Generally, a sanitation strategic action plan is developed and the D-WASH-CC and V-WASH-CC/M-WASH-CC coordinate among themselves for the ODF campaign. This will require greater attention on sanitation marketing approaches, particularly in the Terai- and flood-prone areas, and in urban areas.

- **Implement WASH in school programmes with full community ownership and municipal/VWASHCC and DWASHCC collaboration.**

School sanitation is an important element of sanitation coverage under MAF and seeks to maximize the impact of school feeding programmes,¹³⁵ which are being implemented in over 29 districts. WFP has been supporting the government to implement WASH in school program in 10 out of 29 school Meals programme districts in mid and far- western region. The government has a countrywide programme to build toilets in schools. Each year, 3,000 to 5,000 toilets are planned for construction in the country and each school is given between NRs. 150,000 to NRs. 200,000 to build a toilet facility. Recently, a girl- friendly toilet programme has been introduced to provide separate toilets for girls, because only 34 percent of the schools have such a facility. Some 64 percent of community schools have only one toilet. School teachers, children's clubs and other local groups, including children as change agents for School-Led Total Sanitation approach, are being massively mobilized to support this campaign.

- **Development of WASH in school guideline** – considering school an important element of declaring and sustaining ODF movement in Nepal, WASH in school guidelines is being developed under the leadership of Department of Education with the support from local and international NGOs including UN agencies in order to give a basic direction to unify and harmonise working processes through adoption of standard norms, process and results framework.

Coordination and alignment of initiatives among the government agencies and other stakeholders is key to the achievement of sanitation coverage targets. The linkages and coordination among inter and intra-sectoral stakeholders are being reinforced through joint planning, financing and implementation arrangements and alignment of stakeholder programmes, in line with NSHMP guidelines/principles. For this, the multilateral banks¹³⁶ have taken the responsibility mostly for the financing of the interventions, while UN agencies are involved more deeply in the software aspects. This collaboration over the MAF period resulted in the establishment of sound systems at the local level which were instrumental in quick mobilization of resources during the post-earthquake situation. The coordination also resulted in an on-time and coherent WASH sector plan under the Post Disaster Recovery Framework.

In order to support the government in achieving the sanitation coverage targets, the following potential areas for collaboration between UN agencies and the World Bank have been identified. Supporting capacity development activities in line with the guidelines of NSHMP. These will include:

- **Strengthening of coordination committees at various levels** by supporting the role of national- and local-level coordination committees in the various programmes/projects supported by agencies in the water supply and sanitation sector and providing necessary training and capacity- building support to them.
- **Capacity-building of the local-level resources**, including the training of the triggers and development of planning and monitoring mechanisms in the local bodies in those areas where the agencies are operating. This could be based on a package of agreed minimum common modules/tools for capacity development for use by all agencies. Also agencies need to build in their programmes the scope for strengthening the executing agencies' systems for the effective use of the resources that are allocated for improving sanitation by various stakeholders.
- **Better targeting of interventions in hard-to-reach areas** by engaging in common exercise/approach at the district and central levels to identify the pockets where sanitation coverage is low and

¹³⁵ School feeding programmes are often integrated with health and nutrition education, parasite treatment, health screening, and provision of water and sanitation.

¹³⁶ The Asian Development Bank's programmes are focused in urban and semi-urban areas, while the World Bank has a more rural focus in integrated water supply and sanitation programmes.

by supporting local bodies to improve coverage to those still without sanitation facilities in order to reduce disparities of access to services across different segments of the population. Project/programme interventions will then build on the interventions already made by other agencies or design common programmes, components of which can be implemented/supported by multiple agencies.

- **Collaborating with other agencies to link basic sanitation coverage achievements to initiatives beyond the declaration of ODF** to ensure sustained sanitation behaviour. This would include coordinating with other agencies to link their programmes for support to communities/VDCs/municipalities in the development and implementation of post-ODF interventions. This will include, for example, WB-supported projects providing assistance for water supply improvement in the VDC that has achieved ODF status, supported by UNICEF. Duplication of activities/support in particular areas will be avoided through integrated planning processes at the district and central levels.

GUIDING RECOMMENDATIONS FOR THE CEB

There is a good policy environment for increasing access to improved sanitation, but implementation is at a challenging stage due to a number of reasons that constrain the performance of the various stakeholders in the WASH coordination committees at all levels. Each district, in hilly and mountainous environment, has developed a sanitation strategy plan, but institutional coordination arrangements and resources need to be provided to implement them. For eight Terai districts that have very low sanitation coverage, the GON is collaborating with UN agencies¹³⁷ to develop a special Terai sanitation programme to address these challenges. The agencies need to continue to better align their efforts in supporting institutional and systemic capacity-building, focusing on lagging areas.

The challenge of providing universal access to sanitation is exacerbated due to the situation of poor people living in remote areas, marginalized communities, low-income families living on rent, informal settlers in urban areas, girl students, senior citizens and the physically challenged. This calls for the agencies to complement others' programmes around the priorities set by the MAF.

Functioning of local-level coordination and support mechanisms as well as financial and technical planning are suffering due to a lack of reliable data and information on the communities that have no sanitation facility services. To achieve the sanitation coverage target, it is critical to support the strengthening of monitoring and reporting systems at the local and national levels by all agencies, based on which programing can be achieved to reach the remote areas.

There is a risk that people may go back to open defecation after a period if institutional and financial support is lacking for post-ODF activities, after the ODF declaration. Improving and sustaining urban sanitation is a challenge due to municipal authorities' limited attention to the promotion of public toilets (public places, highways, local institutions). In order to sustain sanitation coverage and continue the changes in hygiene behaviour, agencies should also start focusing their attention on developing of programmes to support post-ODF activities in urban and rural areas.

The focus of sanitation also needs to shift towards the implementation of a comprehensive sanitation, extending beyond the current campaign on ODF, in line with the SDG indicators for sanitation. Moving from open defecation at one extreme to the safe collection, storage and disposal of human excreta and the treatment or recycling of sewage effluents poses different challenges in different contexts. The SDP envisages that the sanitation programs will graduate to the implementation of the Total Sanitation Guidelines which includes clear approaches and indicators for the clean house, community, village municipality and district, will be uniformly applied across the country to support the communities to improve sanitation ladder through inclusive, effective and sustainable approaches and realize total sanitation outcomes. In the urban area, sanitation activities will include systematic planning for sewerage network in all large and medium cities; construction and expansion of sewerage system (including network and connections with modern wastewater treatment plants and treatment facilities); energy generation, through sludge digestion and gasification; decentralized wastewater treatment systems in low-income areas, among others.

Remarkably the country did not suffer from a water borne disease epidemic in the massive resettlement post-April 2015 earthquake, but building back and sustaining the sanitation gains after the earthquake

¹³⁷ UNHABITAT and UNICEF.

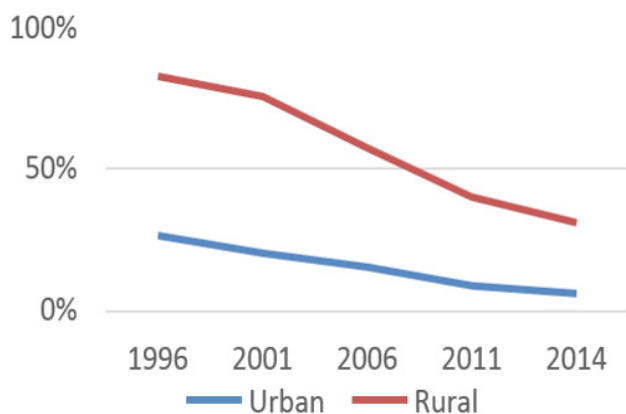
is the new challenge for Nepal. While the sanitation and hygiene master plan envisages the ODF campaign through no subsidy approach and a behavior change campaign, the mass destruction of household and institutional toilets has hindered the ODF status of various districts, Village Development Committees (VDCs) and municipalities. In the post disaster reconstruction phase, the WASH sector closely coordinates with the shelter sector to ensure household sanitation is an integral part of the housing reconstruction work and financial support is provided on the topping of the housing support as to ensure damaged toilets are reconstructed. The sanitation facilities in institutions specifically in health facilities and schools will also be the integral part of housing reconstruction of health facilities and school buildings.

The sound and complementary activities of the various development partners and the GON should continue and provide a solid foundation on which to achieve the acceleration of the sanitation target.

PROGRESS SINCE THE CEB REVIEW

In the MDG baseline year, access to improved sanitation in Nepal was 6 percent. The original MDG target for sanitation was to reduce the proportion of people without access from 94 percent by one half. Nepal reached 62 percent sanitation coverage in 2011 and the GoN set the more ambitious targets of raising access to 80 percent by 2015 and 100 percent by 2017, mostly by continuing its successful ODF campaign. In 2014, the access to improved sanitation was 60 percent which increased to 81 percent by July 2015.

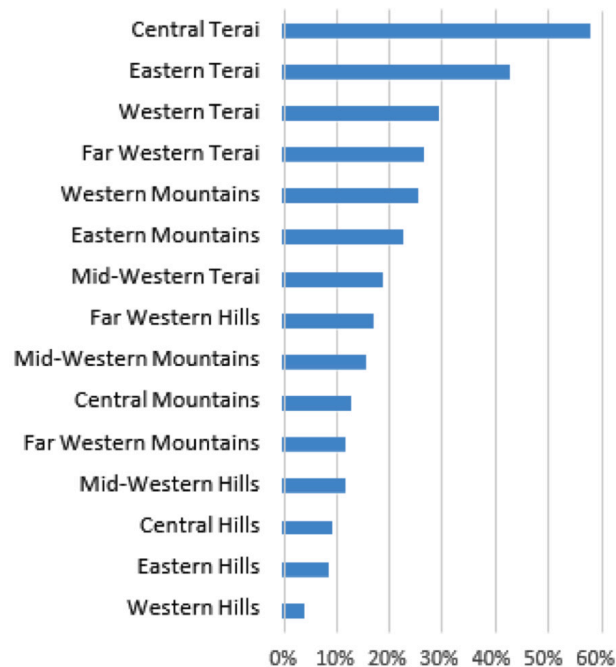
SANITATION COVERAGE IN NEPAL, URBAN AND RURAL



Source: Government of Nepal.

The number of declared VDCs doubled from 995 in 2013 to 2032 in 2015 and rural urban gap in sanitation coverage narrowed down. Also, the collaborative efforts of WASH stakeholders has been instrumental in narrowing the gap in access to improved sanitation coverage between the rich and the poor with 73 percent of the poorest wealth quintile having access to improved sanitation against 74 percent of the richest wealth quintile (NMICS 2014).

SANITATION COVERAGE IN NEPAL, 2011-2013



Source: Government of Nepal.

Although the sanitation coverage in the country was increasing rapidly from 2011-2013, there are still some areas, where the sanitation coverage was very low, less than half the national average. Indeed, the eight Terai districts from Parsa to Saptari in the Central and Eastern Region are lagging far behind the rest of the country as the sanitation coverage in these districts was only 27 percent. The Government of Nepal with support from various development partners has initiated targeted programs for these lagging districts. This included understanding the specific issues of these communities and preparing sanitation promotion activities suited to their precise conditions, conducting the Terai Conference on sanitation for wider advocacy awareness and participation, as well as the launch of innovative approaches like sanitation marketing.

The traditional notion of sanitation has undergone a significant transformation from a mere toilet building enterprise to the attainment of ODF and total sanitation situation. Sanitation, historically treated as an add on activity of drinking water supply project, has got a new identity in the domain of national development framework and is being recognized as a cross-cutting sector with multiple levels of benefits.

Due to continuous and collaborative efforts by the Government, development partners, civil society organizations and I/NGOs, the recently promulgated Constitution of Nepal 2015 has recognized access to safe water and sanitation as citizens' fundamental right. The periodic plans have focused on total sanitation. Issues of urban sanitation have become more prominent and implementation of the water supply and sanitation activities has been given more prominence after the establishment of a separate Ministry of Water Supply and Sanitation (MoWSS) in January 2016.

LESSONS LEARNED FROM COUNTRY EXPERIENCE

The main lesson learned during the process of achievement of MDG targets through MAF process is the Government of Nepal's recognition of the value of community engagement in dealing with sanitation issues. This has led to a move towards Community Led Total Sanitation (CLTS) movement where a community owned model through peer pressure and common understanding will lead to longer term sustainability. Nepal's Sanitation and Hygiene Master Plan puts emphasis on the role of women, need for follow-up programs, attention/ provision to poverty and natural disaster issues, and the need for local leadership. By adhering to the implementation of the Plan and strengthening the activities under it, development agencies can continue to help GoN to achieve and maintain open defecation free status.

A consolidated master plan, like NSHMP, which sets the sector guiding principles and puts the local governments at the center, has turned out to be the driving force leading the sector achievements. Under this decentralized model, the District Water, Sanitation and Hygiene Coordination Committees (D-WASH-CC) and Village/ Municipality WASH Coordination Committees (V-WASH-CC/ M-WASH-CC) are responsible for promoting and ensuring sanitation coverage in their constituencies. A High-Level Sanitation Advisory Board, chaired by the National Planning Commission (NPC), has been created to oversee MAF implementation and monitoring and also to facilitate coordination across the various line ministries. This mechanism was working so well that it was continued in the post disaster relief and reconstruction phase. The focus now is to build

permanent system encompassing these coordination mechanisms for long-term sustainability.

The slow pace of sanitation was due to diversified subsidy modalities, actions without proper planning at the VDC or district levels, and less focus to sanitation in schools and other institutions. The prevailing cultural dogmas have further challenged the sustainability of ODF. Community's easy acceptance of open defecation has lowered ODF process particularly in the Terai regions. The Terai focused sanitation interventions has shown that only by adopting a holistic approach and addressing specific local challenges, improvement in sanitation can be made. Also, ODF slippage at some places appears to be a prominent challenge due to lack of water supply facilities. Hence it is critical to take water supply and sanitation as integral components for sustainability of sanitation achievements.

With regards to sanitation promotion, allocation of budget for standalone sanitation program and water supply and sanitation projects are not enough. Resources for WASH in school, health institutions and public places are necessary but other sectoral programs such as education, health and public housing should also be prioritized. The recent total sanitation approaches such as School Led Total Sanitation (SLTS), Community Led Total Sanitation (CLTS), Local body Led Total Sanitation (LLTS) with no subsidy, and mobilization of local resources are the key factors of the success in the rapid sanitation coverage. The SLTS has been pivotal in promoting child, gender and disable friendly school sanitation facilities including menstrual hygiene of girls and spreading sanitation coverage in the school catchment.

In order to increase the profile of sanitation in the country, and strengthen inter-ministerial coordination, a high level MAF advisory committee was in place with the chairpersonship of the National Planning Commission. This committee will have to be continued to function with specific Terms of Reference for coordination towards achievement of SDG targets.

Multi sectoral collaboration and convergence particularly with Health, Nutrition, Education and Local Government was also a success. The integration of WASH as an integral component of the Multisector Nutrition Programme and the launching of "Golden 1000 Days Campaign", the Child Friendly and Environment Friendly Local Governance Programme of MoFALD, the Girl's Toilet Programme and WASH in Health efforts of the MoH has provided additional impetus to prioritise sanitation in the sectoral plans and programmes.



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