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RESULTS FOR DEVELOPMENT INSTITUTE

POST-2015 HEALTH MDGS

JULY 2012

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1. Introduction

This report has been prepared by the Results for Development Institute (R4D) with the purpose of reviewing and contributing to the evidence base concerning progress on the health Millennium Development Goals (MDGs) to 2015 and beyond. For this purpose, the evidence base comprises experience with the MDGs to date, current debates and policy developments, the aim of a post-2015 global agreement similar to the MDGs, how a global agreement might add value to national efforts, and the type of agreement that might be made, including targets and indicators. This paper on the health MDGs is complemented by similar work on the education MDGs. The authors and Results for Development Institute are grateful to the Overseas Development Institute (ODI) for subcontracting this research.

2. Methodology

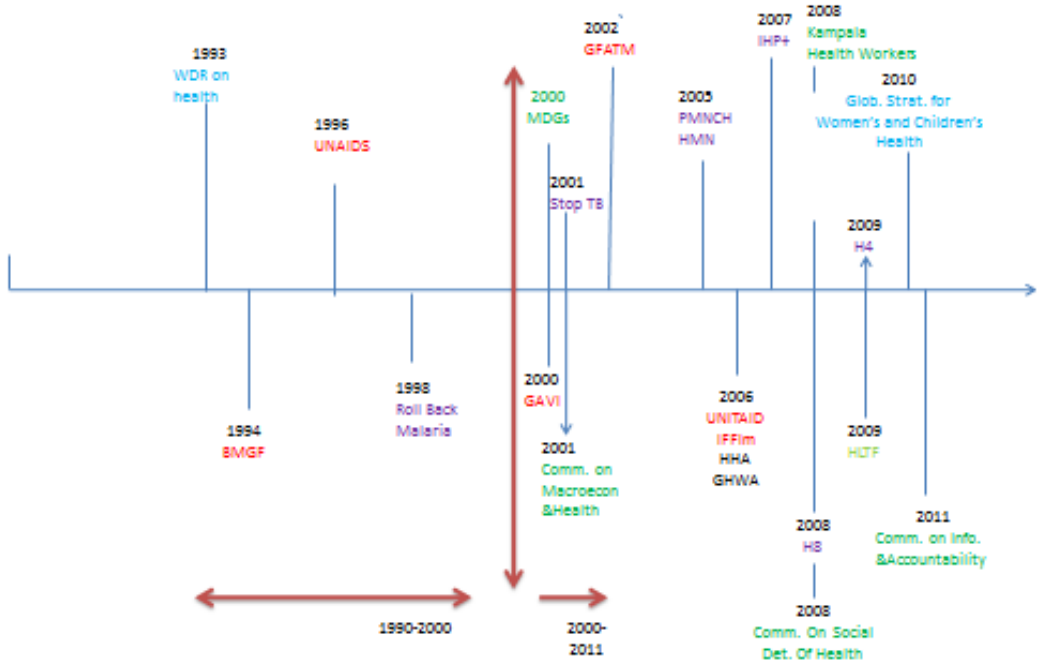
Our study undertook a combination of literature reviews, interviews with key stakeholders in the health field, and a roundtable discussion. Interviews were semi-structured and were conducted between March 1 – May 31, 2012 with key stakeholders from bilateral donors(1), non-governmental organizations (1), academic institutions (1), middle-income country decision-makers (2), United Nations agencies (2), think tanks (2), global financial institutions (5), and foundations (7). Study participants provided their personal opinions rather than the opinions of their institutions. Annex B details participants from the interviews and the roundtable discussion, and a summary of the views and key questions raised by respondents is provided in Annex C.

3. What has been the impact of the health MDGs? Evidence from the literature

Lack of evidence for causal link, but heightened activity. It is not possible to attribute accurately and specifically the causal contribution of the health MDGs (Annex A) to recent improvements in global health outcomes, because of the absence of the counterfactual, as well as measurement issues in the decades prior to the introduction of the MDGs. However, as shown graphically in Figure 1, the period since the formulation of the MDGs in 2000 has seen, by comparison with the previous decade, an explosion in new global health funding institutions and partnerships. Examples include the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund against AIDS, TB and Malaria (GFATM), UNITAID, the Partnership for Maternal Newborn and Child Health (PMNCH), the Harmonizing Health for Africa initiative (HHA) and the Global Health Workforce Alliance (GHWA), to name but a few. The decade also saw many significant global commissions and conferences whose objective was to highlight particular

issues affecting global public health, such as the Macroeconomic Commission on Health (2001), the High Level Task Force on Innovative Finance for Health (2009) the Commission on Social Determinants of Health (2008) and the UN Secretary General's Global Strategy on Women and Children's Health (2010).

FIGURE 1 GLOBAL HEALTH MILESTONES 1990-2011



Source: Authors

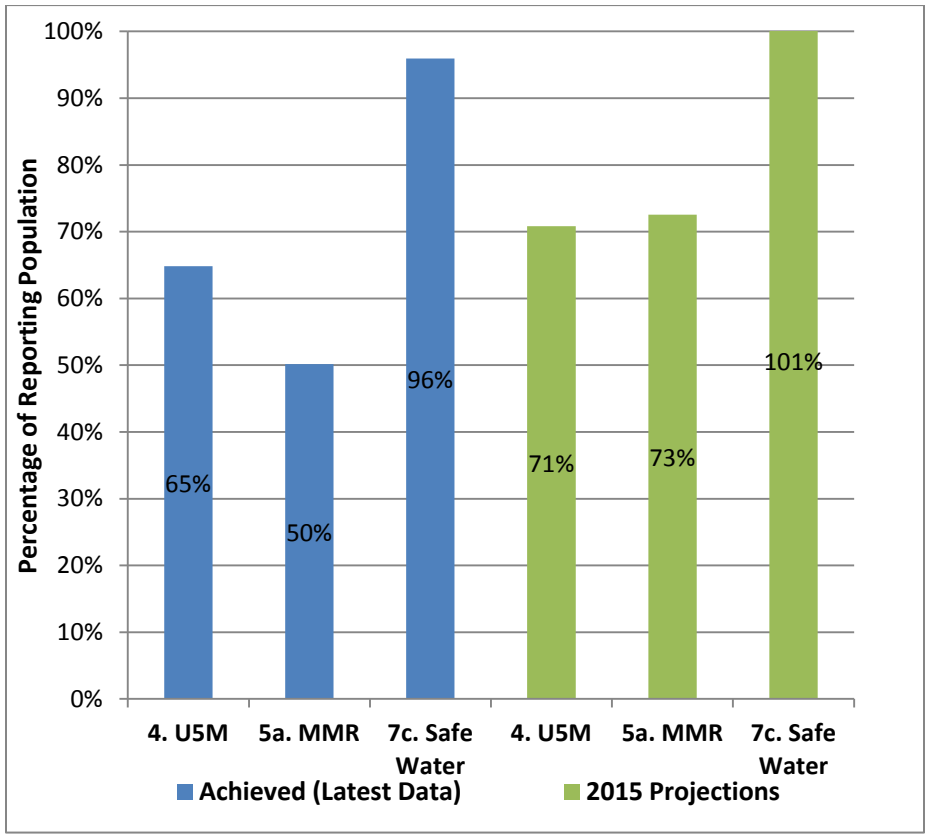
Shift in focus. The period since the start of the MDGs has seen a gradual shift from a focus on a single disease or health topic, to a more systemic approach, which recognizes that successful health outcomes depend on a variety of health (and non-health) inputs which have to be integrated at the national, district and local levels. Thus, reducing the under-five mortality rate (U5MR) requires a systemic focus on maternal and infant nutrition, preventing mother to child transmission of HIV, protecting infants against malaria, improving water quality and so on.

Accelerated progress. Although achievement of the health MDGs will almost surely be uneven, and despite the lack of specific causal evidence, the available evidence suggests that the health MDGs have been effective in accelerating progress on target indicators, in stimulating global political support in the creation of significant global institutions dedicated to helping countries achieve the MDGs and in stimulating research and debate on systemic approaches to improving health outcomes. As discussed in section 3.3, the previous decade also coincided with increased donor financial resources for health (although the MDGs were less successful in stimulating increased domestic resources).

3.1. Health Outcomes

Figure 2 presents both actual and projected achievement of the health goals in percent of targeted population terms that are quantitative and have sufficient data for this analysis. By 2015 (the end date targeted for achievement of the MDGs), it is likely that the safe drinking water goal will be achieved (at 96 percent already, projected to reach 101 percent), while these data show that improvements to U5MR (65 percent of the total world population have achieved the MDG, projected to reach 71 percent) and maternal mortality--MMR (50 percent now, projected to reach 73 percent) may fall well short of their goals.

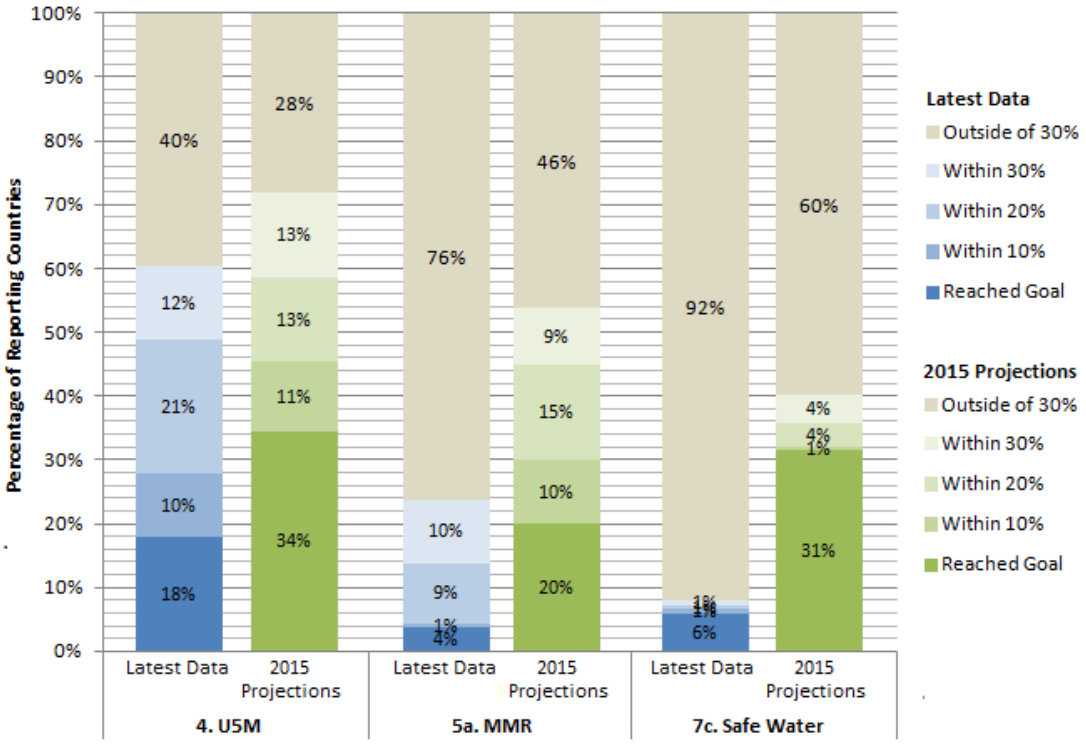
Figure 2 Achievement of Health MDGs (as a percent of the Total World Population, Latest Available Data)



Sources: United Nations Statistics Division 2012, UNdata 2012
Notes: U5M latest available data is for 2010, MMR and Safe Water are for 2008
Standardized data in the UN MDG database for MDG5b before 2000 sporadic and has improved only modestly since 2000
All projections linear, based on trend of past 3 data points.
Relevant indicators - Children under five mortality rate per 1,000 live births (U5M), Maternal mortality ratio per 100,000 live births (MMR), Proportion of the population using improved drinking water sources (Safe Water).
For countries that did not have population data for the year corresponding to the latest available MDG indicator data, population data for the closest preceding year was used, e.g. for the latest available U5M data (2010), we use Pakistan's population data for 2009 since 2010 was not available.

"Pass-fail" may not adequately describe progress. Yet at the country level, even though many will likely not fully achieve the MDGs, many of the "failed" countries may be very close by 2015. For U5M and MMR, around 35% of the countries that are expected to "fail" to make the target are projected to be within 30% of achieving their goals by 2015 (Figure 3), leaving 46 and 74 countries, respectively, outside the 30% range. The safe water goal has seen great gains in high-population countries so it is likely to be met in population terms (Figure 3), though there has been only erratic achievement in smaller countries, so that 60 percent of countries are projected to "fail" on this goal, a higher percentage of failures than for U5M and MMR (United Nations Statistics Division 2012).

FIGURE 3 COUNTRIES ACHIEVING MDGS, ACTUAL AND PROJECTED (AS A PERCENT OF THE TOTAL WORLD POPULATION, LATEST AVAILABLE DATA)

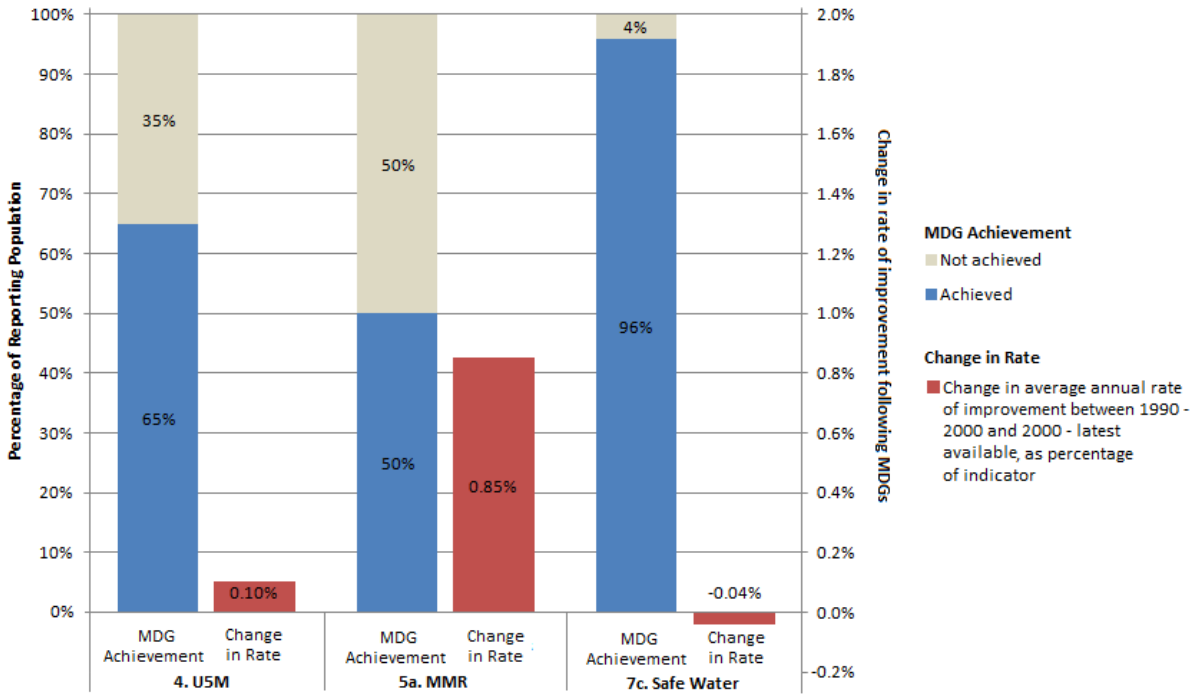


Sources: United Nations Statistics Division 2012, UNdata 2012
Notes: U5M latest available data is for 2010, MMR and Safe Water are for 2008.
All projections linear, based on trend of past 3 data points.
Countries that have maintained 100% access to safe drinking water since 1990 not included in 7c analysis.
For high population countries that did not have population data for the year corresponding to the latest available MDG indicator data, population data for the closest preceding year was used, e.g. for the latest available U5M data (2010), we use Pakistan's population data for 2009 since 2010 was not available.

Progress before and after 2000. Comparing the change in rate between the decades before and after the development of the MDGs, it becomes apparent, somewhat paradoxically, that in

aggregate, the health MDG indicators that have seen (even small) accelerations in progress correspond to the MDGs that are unlikely to be achieved (Figure 4). Additionally, some countries that have not yet achieved the MDGs have seen improvements at an unprecedented pace. This significant achievement is not acknowledged within the current framework and suggests a) that the original targets may have been over-ambitious for LICs, or fragile states, and/or b) that there needs to be a more differentiated metric other than "pass/fail" in terms of achievement.

FIGURE 4 RATE OF IMPROVEMENTS IN HEALTH MDG INDICATORS, 1990-2010

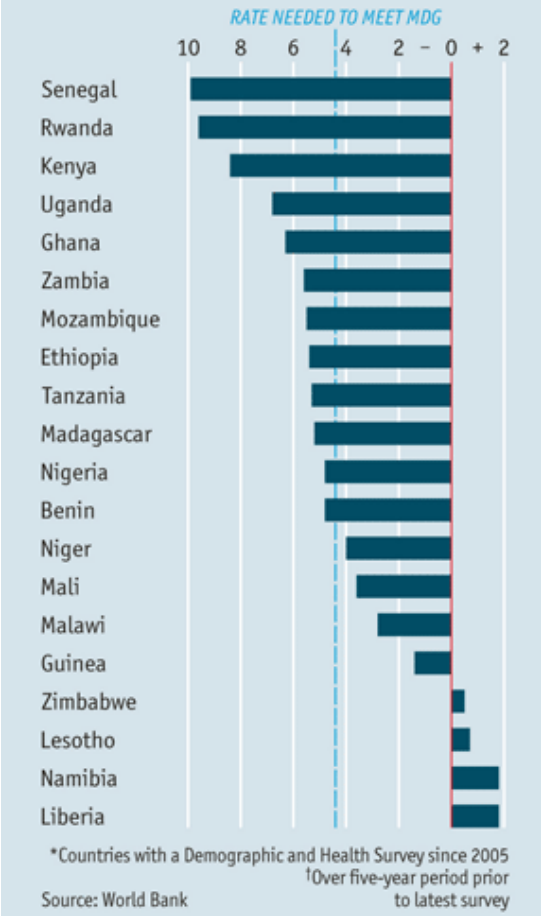


Sources: United Nations Statistics Division 2012, UNdata 2012
Notes: U5M latest available data is 2010, MMR and Safe Water are 2008
For high population countries that did not have population data for the year corresponding to the latest available MDG indicator data, population data for the closest preceding year was used, e.g. for the latest available U5M data (2010), we use Pakistan's population data for 2009 since 2010 was not available.

Recent progress is significant. A recent Economist article, *The Best Story in Development, Africa is experiencing some of the biggest falls in child mortality ever seen,* also describes a much more optimistic vision of progress than could be assumed by simply reviewing current "pass-fail" data. The article quotes the World Bank Policy Research Working Paper 6057 that 16 of 20 African countries which have conducted detailed surveys of living conditions since 2005 reported falls in their U5MR. Twelve had falls of over 4.4% p.a., the rate of decline needed to meet the MDG4 goal. Three countries saw falls of more than 8% p.a., almost twice the MDG rate and enough to

halve mortality in a decade. The article notes that the decline in mortality is speeding up and is now falling at about twice the rate of the 1990s and early 2000s, faster than China's decline in the 1980s. The declines have happened across the continent and across large and small countries, with different cultures and religions, with different rates of economic growth. Senegal, the highest performer, had relatively modest growth over the past decade. There appears to be no single magic bullet, but the case of Kenya, which has had remarkable success in cutting its infant mortality rates, points to healthy economic growth and a dramatic increase, from 8% to 60%, between 2003 and 2008, in the use of insecticide treated bed nets, which are estimated to have contributed 50% of the decline.

FIGURE 5 UNDER-FIVE MORTALITY PER 1,000 LIVE BIRTHS (% ANNUAL CHANGE)



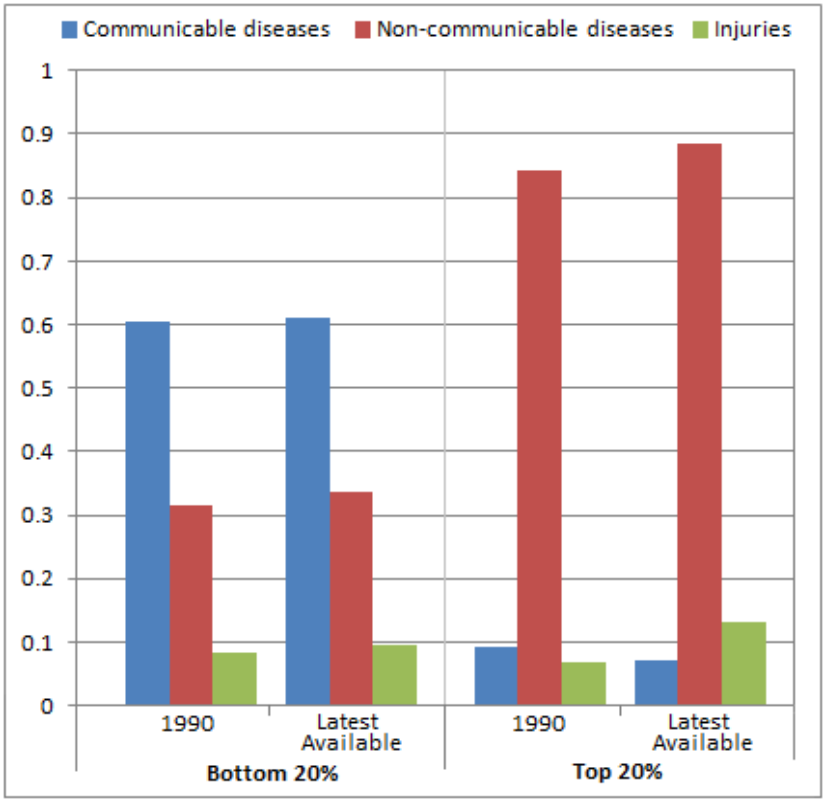
Source: *The Economist*, May 19 2012

3.2 EQUITY

Are the poorest neglected? A criticism of the current MDGs is that they do not take into account inequities in the provision of health services and achievement of health outcomes amongst different segments of the population. A 2010 UNICEF report found that health MDG indicators are typically worst among the poorest, in rural areas, among children of less educated mothers, and for boys (under-5 mortality) (UNICEF 2010).

Unpublished findings (Gwatkin, 2012) show that, despite general improvements within disease categories, the distribution of deaths by cause for the total population of LICs has remained relatively consistent since 1990 (see Figure 5), with the burden of communicable diseases falling heavily on the poorest. In the future, it is likely that the burden of communicable diseases will fall – see the discussion above on U5MR – but it is likely that the burden will remain highest for the poorest segments of the population, who are most exposed. It is quite possible that a country could achieve the MDGs while the lowest quintiles by income level achieve little progress.

FIGURE 6 CAUSES OF DEATH BY GLOBAL INCOME QUINTILE AS A PERCENTAGE OF TOTAL DEATHS, 1990 AND 2004

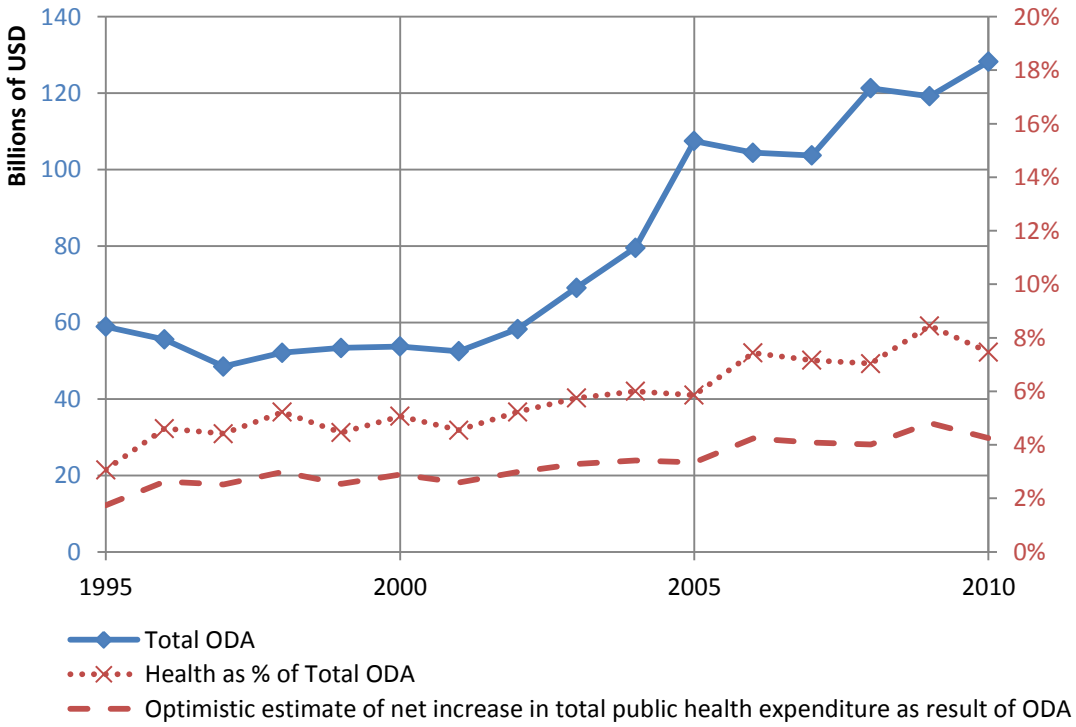


Sources: Gwatkin, Guillot, and Hueveline 1999; Gwatkin 2012.

3.3 Financial Resources

Increased resource flows. Overseas Development Assistance (ODA) for all sectors combined increased dramatically immediately following the introduction of the MDGs, and the health sector's share of these resources has more than doubled (Figure 6). This suggests strongly that the MDGs and their emphasis on health have been successful in motivating contributions of financial resources from donors. However, there is also evidence (IHME, 2011) that this has allowed many recipient countries to substitute away domestic health resources to other purposes. According to IHME data, for every $1 of development assistance for health (DAH) channeled through government, governments on average took $0.43 to $1.14 away from the health sector (Lu et al. 2010). This suggests therefore that there has been a relatively smaller increase in total resources flowing directly to health since the advent of the MDGs, than suggested by the official ODA data. Using the lower of the IHME figures ($0.43) of substitution, the total net value (after accounting for substitution) of the ODA for health in 2010 would be about $34 billion versus about $45 billion of gross ODA. This is not necessarily problematic if resources were diverted to infrastructure investments which themselves can provide health benefits, such as water supply and sanitation, food security, rural roads, electrification etc.

Figure 7 ODA to Health, 1995 to 2010



Sources: OECD 2011, United Nations Statistics Division 2012, Lu et al. 2010

Uneven resource distribution. Analysis suggests that the MDGs helped direct donor funds to countries in need. A UN study (Hailu and Tsukada 2012) found that aid has shifted since 2000 to focus more on countries that need to make the most progress on the MDGs. Yet the shift has been much more pronounced within multilateral, compared to bilateral aid, perhaps because geopolitical interests and policy conditions have more influence in bilateral interests (Hailu and Tsukada 2012). A 2010 World Bank analysis supports the view that country need continues to be only a minor factor in health aid flows, particularly for reproductive health. Despite overall improvements, "only a third of ODA for RH has targeted countries with high MMR and high TFR," (World Bank 2010, 16).

The World Bank also reports that the increases have not been evenly distributed across health MDGs: "While total ODA for health rose fivefold [from 1995 to 2007]… commitments for reproductive health increased only about 61 percent," (World Bank 2010, 16). The largest share of aid to health targets HIV/AIDS, with these programs gaining 41% of all health aid in 2009 (OECD 2011). These data provide an important argument in favor of a systems approach to any new "MDGs". However there is an important caveat – the fundamental tension between the desire of donors and countries alike to achieve easily monitored and visible results, which may be perceived to be achieved by focusing on a single disease and the need for system wide approaches whose impact may be more difficult to measure and communicate. New "single issue" initiatives continue to proliferate.

4. Conclusions – Guiding Principles for the Post-2015 Agenda

The current health MDGs will need continued focus beyond 2015. We conclude that the current MDGs are likely to have to be included in some form in the post-2015 goals. It would send an unfortunate signal if an MDG were dropped post-2015, if progress fell far short of the 2015 target (e.g., for maternal mortality reduction or HIV/AIDS).

Goal design. We also conclude that the goals should be simple enough to be politically intelligible and acceptable, and meaningful to politicians and laypeople. They should also be rigorous enough to be challenging and sophisticated and flexible enough to take into account differences in particular situations, and they should be stated and measured in a way that indicates progress, rather than a simple pass or fail. It would seem valuable to include a mechanism to review, and adjust, goals and targets mid-way to account for unforeseeable circumstances and ensure that goals remain relevant and appropriate. Adding an explicit equity dimension to the post-2015 health goals would seem to be essential and could contribute to the principle of making them more applicable to all countries, rather than the LICs alone. This is so since there are health equity gaps in all countries from the poorest to the richest, and countries trying to attain more equitable achievement of indicators might need to make

changes in their social arrangements to do so. In addition, the post-2015 approach should include some kind of explicit accountability mechanism. Finally, the health goals should be able to be explained at least within a conceptual framework for health development, if not within a general framing of the post-2015 goals. All of this requires considerable thought and appropriate responses which meet the political and technical needs of the multiple actors in global health.

Accountability. A mechanism that might be set up along with the new goals could both hold countries and their decision-makers and donors to account, and also facilitate getting back on track if a country falls off the path to attainment. This might involve defined groups that would conduct periodic formal reviews of progress toward targets, accompanied by providing advice about how to measure and improve performance. The groups might include representatives of neighboring countries, or countries at a similar level of income—so that peers would be reviewing one another and providing advice and counsel based on a familiarity with similar circumstances.

One model for an independent group is the UN Secretary General's Commission on Information and Accountability for Women's and Children's Health (WHO 2011). The Commission on Information and Accountability has established a global Independent Expert Review Group (iERG) of seven experts from the North and South with a mandate to both monitor resource flows compared to commitments from donor countries, but also to monitor results achieved. In addition, the iERG's terms of reference include identifying obstacles to implementing the Commission's recommendations and good practices in policy, delivery, accountability, and value for money. The iERG will issue its first report in September, 2012 and its mandate will expire in 2015(WHO 2012). The global iERG model might be adapted at a regional level with a mix of global and regional representation tilted towards the regional, to help monitor progress on post-2015 indicators with a strong mandate concerning identification and recommendation of areas where individual countries could improve.

Building on the mechanism developed by the UNDP through which countries report their progress on the MDGs, there could be additional mechanisms to measure and recognize the achievement of countries. Showcasing successful countries and providing recognition (press, media, country visits by UN representatives) at specified intervals could serve to encourage accountability and motivate progress through a positive competition to attain the recognition. It could also be useful to measure – and display - the rate of progress (or lack of) of countries towards post-2015 targets.

Ensure participation of LIC and MIC constituencies. Any new consultative process should ensure greater participation from LIC and MIC constituencies in the formulation of the post-

2015 health goals and care should be taken to ensure that the post-2015 goals are not seen as a creation of donor and global development institutions. The regular meetings of ministers of health in the WHO regions might be one existing mechanism that could be employed to solicit input on the post-2015 health agenda. The sessions on post-2015 should be open to key stakeholders, including civil society. The Regional Development Banks could also play an important convening role for their constituent countries. Constituencies within high-income countries (HICs) should also be involved in the goal setting so that the goals, to the extent feasible, have global ownership. The UNDP has recently initiated a 50-country national consultation process that will be a mechanism to build country ownership of the type desired. The list of countries where consultations are planned, however, reinforces the idea that the MDGs applied solely to LICS and MICs, since all of the countries on the list of 50 are in these categories (UNDP, 2012).

Increased country ownership, and a focus on outcomes. The relative share of ODA in the health expenditures of many middle income and low income countries is likely to continue to diminish in the post-MDG years. The debate surrounding new goals must therefore be centered on what countries can achieve with their own resources, rather than by aid flows. A focus on outcomes, rather than inputs, can reduce tensions from competing interests and allow countries to develop more creative and innovative solutions to achieve progress, while also encouraging value for money.

5. Options for Consideration

Three proposals. We are not able to propose a single, specific indicator which balances all of the considerations that we identify as desirable for post-2015 above. However, we provide three proposals which answer at least the majority of the questions posed and which would provide indicators which are broader than the current set that are focused on particular diseases or conditions. A summary of the authors' views on the post-2015 MDG framework can be found in Annex D.

1. **Global goals and local targets.** The first option addresses the issue of having one global goal, giving each country or region a way to customize its approach to achieving it. One way to address the competing interests might be to set global health goals (e.g., increase the rate of reduction of excess mortality[1]), but then ask each country (or region) to set its own specific targets on how to get there (e.g., for one country, the specific goals might be to reduce HIV transmission and increase its treatment and increase access to safe water, for another it might be to reduce tobacco abuse and

[1] Note that this would need to be carefully formulated to meet the political intelligibility test.

obesity, while for another it might be to reduce road accidents and hypertension). The goal of reducing excess mortality would provide a universally-applicable framework and also have an equity dimension, since the biggest gains in excess mortality reduction would be possible for those suffering the greatest amount of excess mortality—in most situations the most disadvantaged. In contrast, establishing country-specific targets could be problematic for two reasons. First, it would be difficult to establish politically intelligible global indicators based on the aggregate of separate country goals. Second, countries might be tempted to set themselves easily attained targets.

2. **Stunting as an indicator of vulnerability.** The second option is to have one goal that focuses on the most vulnerable (is poverty targeted) and that might be addressed in different ways in different countries—and also one that requires a multi-sectoral approach. One possible overall indicator for health development (and well beyond!) is the stunting rate. Stunting (height for age) is the result of many factors, some direct, such as poor nutrition, but many indirect, such as poor health, mother's education (lack of which contributes to poor nutrition, low income, and poor health), access to water and sanitation (which contributes to poor health), short birth spacing and high parity, and overall poverty. In addition, stunting is concentrated among the poorest. Thus, to reduce stunting, a multi-sectoral response (health, education, nutrition, water supply and sanitation, availability of contraception, status of women, and general poverty alleviation) targeted at the poorest is needed. This would seem to be just what any post-2015 targets might wish to achieve. Moreover, it would seem to be quite relevant to MICs, since it now is observed that the majority of the global poor live in MICs.
3. **A health systems indicator.** The third option takes a health systems approach rather than focusing on a health outcome indicator. A possible indicator that would meet this criteria would be the degree of attainment of universal health coverage. This could be measured using the indicator of the share of total spending on health that comes directly from the pockets of health services users at the time of use (for short, out-of-pocket (OOP) spending). Typically, OOP expenditures are much higher in LICs and MICs than in rich countries and are highly inequitable (World Bank Data, 2012). WHO guidelines advise that OOP expenditures over 15% of total health expenditures lead to impoverishment (WHO 2011). The more that people are covered by some kind of financial risk sharing mechanism, the lower is the share of total spending out-of-pocket. The more that families are covered by a risk sharing mechanism, the more they have access to all health services, not just a select few services that address specific problems. An equity dimension could be added to this indicator by focusing it on the share of total health spending that is out-of-pocket for the lowest (or lowest two) income quintiles. A concern is that this might misrepresent the situation if the low income quintiles did not have access to care and hence spent little out of pocket.

However, the results of household surveys conducted around the world show that the poor nearly always spend a surprising amount (and share of income) on health care, even in the remotest and least-well-served areas, often on traditional healers and informal “pill vendors”.

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ANNEX A. LIST OF HEALTH MILLENNIUM DEVELOPMENT GOALS

GOAL 4	**REDUCE CHILD MORTALITY**
TARGET 4.A	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
GOAL 5	**IMPROVE MATERNAL HEALTH**
TARGET 5.A	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
TARGET 5.B	Achieve by 2015 universal access to reproductive health
GOAL 6	**COMBAT HIV/AIDS, MALARIA, AND OTHER DISEASES**
TARGET 6.A	Have halted by 2015 and begun to reverse the spread of HIV/AIDS
TARGET 6.B	Achieve by 2010 universal access to treatment for HIV/AIDS for all those who need it
TARGET 6.C	Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
GOAL 7	**ENSURE ENVIRONMENTAL SUSTAINABILITY**
TARGET 7.C	Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation

ANNEX B. LIST OF RESPONDENTS

Participant List for Interviews, held between March 1 – May 31, 2012

Stakeholder Category		Organization	Title	Name
1	**Bilateral Donors**	Norad	Deputy Director General	Paul Fife
1	**Academic Institutions**	Harvard School of Public Health	Dean	Julio Frenk
1	**Think Tank**	Overseas Development Institute	Head of the Growth and Equity Programme	Claire Melamed
2	**NGOs - Northern**	Save the Children	Associate Vice-President of the Department of Health and Nutrition	David Oot
		Results for Development Institute	President	David de Ferranti
2	**Countries - MICs**	India	Former Secretary, Ministry of Health and Family Welfare	Kanuru Sujatha Rao
		Moldova	Minister of Health	Andrei Usatii
2	**United Nations**	United Nations	Principal Officer in the Strategic Planning Unit, Office of the Secretary General; Senior Officer and Economic Advisor, Office of the Secretary General	Ms. Eva Busza; Mr. Joe Colombano
5	**Global Financial Institutions**	World Bank	Director, Health Nutrition and Population Dept.	Christian Baeza
		African Development Bank	Director, Human Development Dept	Agnes Soucat
		World Health Organization	Senior Technical Officer, Partnership for Maternal, Newborn & Child Health	Shyama Kuruvilla
		World Health Organization	Assistant Director-General for Innovation, Information, Evidence and Research	Marie-Paule Kieny
		World Health Organization	Assistant Director-General for Reproductive Health and Family Welfare	Flavia Bustreo
7	**Foundations**	Bill and Melinda Gates Foundation	Senior Program Officer	Guy Stallworthy
		Bill and Melinda Gates Foundation	Senior Program Officer overseeing post-MDG activities; Senior Program Officer with the Policy & Advocacy team	Oliver Babson, Carol Welch
		Hewlett Foundation	Program Officer, Global Development and Population Program	Helena Choi
		Rockefeller Foundation	Managing Director; Associate Director, International Development; Associate	Jeanette Vega, Sundaa Bridgett Jones, Robert Marten

Participant List in Roundtable Discussion, held on June 7, 2012

Name	Affiliation
Amanda Folsom	Results for Development Institute
Anda Adams	Brookings Institution
Andrew Preston	U.K. Department for International Development
Armin Fidler	World Bank
Birger Fredriksen	Results for Development Institute
Claire Melamed	Overseas Development Institute
David de Ferranti	Results for Development Institute
Gina Lagomarsino	Results for Development Institute
Halsey Rogers	World Bank
Jose Dallo	United Nations Development Programme
Julian Schweitzer	Results for Development Institute
Katie Donohoe	U.S. Agency for International Development
Liesbet Steer	Overseas Development Institute
Maeve McKean	U.S. Department of Health and Human Services
Marilyn Heymann	Results for Development Institute
Marty Makinen	Results for Development Institute
Michelle Engmann	Results for Development Institute
Nick Burnett	Results for Development Institute
Nora O'Connell	Save the Children
Rebecca Fishman	United Nations Foundation
Todd Post	Bread for the World

ANNEX C. SUMMARY OF RESPONSES FROM RESPONDENTS

Below we summarize responses from interviewees and from the roundtable discussion. Following the summary of responses received we have included a list of key questions to be resolved on the way to the post-2015 global health agenda.

Agreement on efficacy. MDGs have been effective in mobilizing political support among donors, international agencies, and LIC governments. International NGOs have used the MDGs to focus their work and the work of the LIC governments that they support. The MDGs helped to accelerate health progress, but this is a proposition that is hard to substantiate objectively, especially given issues of attribution. It was the consensus of most (but not all) respondents that the MDGs were much more of a focus for LICs that are donor-dependent than they have been for middle-income countries (MICs). Many respondents noted the unprecedented external resource flows for health to LICs since the MDGs and within those flows, they particularly noted the quantity of resources flowing to HIV/AIDS. Some, but not all, respondents felt that the focus on specific health indicators had left other parts of the health system, or other health issues, relatively neglected.

Support for another round. The great majority of respondents strongly supported another round of global goals for health development post-2015. There is a consensus that the work on the current health MDGs is not finished, so that they should not be dropped in the post-2015 round, especially concerning MDGs 4 and 5. The goals would serve to provide additional focus on health development and also to mobilize resources around the goals. However, the goals might be broadened from the current set in order to achieve more than the strengthening of a limited set of health interventions (as the current MDGs tended to do—even though less was achieved in terms of maternal mortality reduction than in terms of HIV/AIDS control and treatment). There is a consensus among respondents that the health MDGs should not expand dramatically and at the same time there was some trepidation that the number of health MDGs might be cut back post-2015.

Simple, visible and communicable goals. There was widespread support for finding formulations for post-2015 MDGs that would be simply stated, easily communicated to the lay audience and therefore politically acceptable. Two particularly interesting comments made by respondents suggested: (1) putting all of the new goals into a conceptual framework, so that their relevance to overall health development would be clear and (2) developing the new health goals as a part of an overall conceptual framework for all of the post-2015 goals, so that their relevance to the overall agenda would be clear. For

Enhanced role for LICs and MICs. There is a broad consensus among the respondents that the post-2015 MDGs should be formulated with LICs and MICs playing a much bigger role and that

the post-2015 MDGs should apply to all countries, not solely LICs, for both resource commitments and results. This idea is that all countries should aim to achieve the post-2015 targets; for example attaining a target growth in the share of people living with HIV under ART. Overall, more respondents came down on the side of a global set of goals versus a more-decentralized approach, where regions, or countries, might set their own goals. However, among those preferring global goals, there was sentiment toward national or regional tailoring of indicators under the global goals. Some of the respondents expressed dissatisfaction with the current MDG approach of having a single "pass or fail" type of target for all countries (e.g., reduce the under 5 mortality rate by two-thirds) and would prefer indicators where an achievement could be represented as a gradient (e.g., accelerated rate of decline of under 5 mortality by X percent).

Accountability. The MDGs created an important framework for accountability for all countries. However, accountability mechanisms could be strengthened in the next round. Countries and decision-makers respond strongly to comparisons between and across countries. There are various formulations for mechanisms to compare across countries that can serve as direct, or indirect, mechanisms to encourage accountability.

Disease focus. NCDs are receiving a lot of attention in post-2015 discussions. The majority of respondents thought that non-communicable diseases (NCDs) should be included post-2015, although there was not unanimity, since it was observed that the poor in LICs are still in the main more affected by infectious diseases. Another observation was that NCDs are relevant to higher income populations within LICs and that governments could therefore improve NCD indicators by serving mainly the rich.

A focus on equity. There was wide support for making equity a more explicit part of the health MDGs post-2015, including one suggestion that the post-2015 MDGs should focus on the poorest quintile of each country's population.

The key questions raised by the respondents concerning the post-2015 health development agenda are:

- How to obtain input from all countries at all levels of income and from representative constituencies in them on the content of the new goals?
- How to come up with politically intelligible, measurable, yet tailored and challenging goals and related indicators?
- Whether to try to construct an overall MDG or health development framework into which the post-2015 goals would fit and demonstrate consistency and coherence?

- Where can a global framework add value to what's already happening in development? Will it be policy change, advocacy, or resource transfer?
- How can a post-2015 goal framework encourage aid efficiency?
- What will be the unit of analysis of the goals? Is the purpose of the goals to help countries, or people?
- How to accommodate the existing goals, but yet make new goals broader such that they encompass and encourage overall health development, not only specific programs?
- Should goals be universal or country-specific? Should goals be tiered by region/income status? Common goals, country-level targets?
- Goal structure: Is it possible to incorporate these items into a politically intelligible agenda?
    - Rights perspective. How best to address equity?
    - Health systems approach, to discourage previous emphasis on vertical programming
    - Quality: How to include quality indicators?
- How to construct indicators that would allow the acceleration of progress to be measured and appreciated, rather than taking a pass/fail approach?

ANNEX D. KEY QUESTIONS TO RESOLVE TO GET TO THE POST-2015 HEALTH DEVELOPMENT AGENDA

TABLE 1. COMPARISON OF BROAD APPROACHES TO POST-2015 AGENDA

	Approach	Advantages	Disadvantages
Universality	Global goals	• Global solidarity • Political intelligibility • Avoids possibility of inaction by countries in setting own goals • Avoids possibility of countries setting easily achievable goals that do not accelerate progress ⇨ Greater potential to influence donor policies and programs	• Lacks country ownership and relevance
	Tiered structure	Middle ground	
	Menu approach	• Greater country ownership and relevance ⇨ Greater potential to influence country policies and programs	• Lacks global solidarity • Less politically intelligible • Possibility of inaction by countries in setting own goals • Possibility of countries setting easily achievable goals that do not accelerate progress
Threshold	Pass/fail	• Politically intelligible • Maintains incentive to achieve	• Offers no support to achieve beyond basic threshold
	Goal ranges	• Account for data errors and allow for flexibility	• Offer less incentive to achieve beyond bottom of range • Less politically intelligible

Source: Authors

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