

# MDG Oriented Sector and Poverty Reduction Strategies

Lessons from Experience in Health

Mick Foster

October 2005





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## Health, Nutrition and Population (HNP) Discussion Paper

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## MDG ORIENTED SECTOR AND POVERTY REDUCTION STRATEGIES

### *Lessons from Experience in Health*

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**Abstract:** This review is a contribution to the debate on how to achieve and sustain the health-related Millennium Development Goals. It identifies ways in which government planning and budget processes and the management and delivery of external support can be more effective in supporting the goals, based on a review of how the health MDGs are being taken forward in a sample of low-income countries.

**Keywords:** Poverty, Health, Aid, Budgets, Planning

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## ABBREVIATIONS

ARI	Acute respiratory infection
CMR	Child mortality rate
CPIA	Country Policy and Institutions Assessment
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAART	Highly active antiretroviral therapy
IDA	International Development Association
IEO	Independent Evaluations Office, International Monetary Fund
IMF	International Monetary Fund
IMR	Infant mortality rate
ITN	Insecticide-treated bednet
JSA	Joint Staff Assessment (of a PRSP)
HIPC	Highly Indebted Poor Countries
HLF	High-Level Forum
IMR	Infant mortality rate
MBB	Marginal budgeting for bottlenecks
MCH	Maternal and child health
MDG	Millennium Development Goals
MOH	Ministry of Health
MMR	Maternal mortality rate
MTEF	Medium-Term Expenditure Framework
MP	Millennium Project
NDP	National Development Plan
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OED	Operations Evaluation Department, World Bank
PCR	Primary completion rate
PRGF	Poverty Reduction and Growth Facility
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
UPE	Universal primary education

Eight internationally agreed Millennium Development Goals (MDGs) to be achieved by 2015 were set forth in the Millennium Declaration adopted by the United Nations General Assembly in September 2000. Four of them are related to health:

- Reducing under-five mortality by two thirds
- Reducing maternal mortality by three quarters
- Reversing the spread of HIV/AIDS, malaria, TB and other communicable diseases
- Reducing the proportion of people who suffer from hunger by half

The goals were not new. They had been discussed and endorsed at many international forums throughout the 1990s. Yet progress on health bogged down in the 1990s because of the AIDS epidemic, the resurgence of diseases such as malaria and TB, and generally dysfunctional health services almost everywhere (UNDP n.d.). In Sub-Saharan Africa, these health-related factors were compounded by slow economic growth and falling per capita incomes, and by problems of war and insecurity in some major countries.

Since 2000, the MDGs have been integrated in the planning and work agendas of many countries and international organizations. As this paper will show, many countries refer specifically to the MDGs in framing their national development goals, and an increasing number of bilateral and multilateral agencies, including the World Bank, have woven them into all aspects of their daily work. The International Monetary Fund (IMF) incorporates the MDGs in its work through its Poverty Reduction and Growth Facility (PRGF).

This Discussion Paper summarizes work carried out for the 2004 High-Level Forum on Health, and reported in more depth in Foster (2004). The paper aims to draw lessons on how to accelerate progress toward the health-related MDGs, based on a literature review plus 14 country case studies of varying depth. The country cases were chosen to include all countries with completed PRSPs that were being supported by both the PRGF and a World Bank Poverty Reduction Support Credit (PRSC). Key objectives are to shed light on

- How national health goals compare to the MDGs
- The content and likely cost of strategies to achieve the targets
- Whether the costs can be financed, including discussion of macroeconomic constraints on increased public expenditure
- Whether increased public health expenditure can be effective, including discussion of reforms in the management of public expenditure and of foreign assistance

Main conclusions and recommendations are highlighted at the end of each section.

## MDGS AND NATIONAL TARGETS

All of our case-study countries referred to the MDGs in setting their own national goals and targets, and many of them set national targets that are consistent with the MDGs (appendix A). Although some countries have less ambitious targets than the MDGs, all 14 target an acceleration of progress relative to the historic trend. All have targets and indicators for child or infant mortality, maternal mortality, and improved access to safe drinking water<sup>1</sup>. Nine of the 14 countries set a lower maternal mortality rate (MMR) target,<sup>2</sup> and half of the sample countries set lower child mortality targets. All countries except Ethiopia (which starts from a very low base) have adopted more ambitious water targets, and those few with nutrition targets have also aimed beyond the MDG.

All address communicable diseases, although fewer PRSPs include disease-specific targets, and there is a wider choice of targets with indicators reflecting local data availability and not necessarily in line with the MDGs. All but Nicaragua and Tajikistan address HIV/AIDS. Nutrition is universally mentioned, but few countries have specific targets, and the indicators used, again, depend on local data availability and in some cases differ from the MDGs.

The MDGs do not capture all of the goals to which countries are committed and are not equally relevant everywhere (appendix B). Some countries assign higher priority to peace and stability or overall economic growth than to an exclusive focus on poverty. The specific health-related MDGs also need to be adapted to the circumstances of individual countries:

- Countries that have already met a goal may wish to set a more challenging target, as with HIV/AIDS in Uganda or access to clean water in Albania.
- The target reductions from a 1990 baseline may now be unachievable. If little progress was made, for example, in reducing child and maternal mortality in the 1990s, an even faster rate of reduction is now required to reach the 2015 targets.
- The MDG targets may be inappropriate as well as too challenging for middle-income countries like Albania where, for example, maternal mortality is already low. The MDG target of a three-quarters reduction would imply achieving levels similar to those of far wealthier countries and would involve assigning greater priority to the MDG than to other health goals (e.g., reducing chronic illness) that may be more important nationally.
- The MDGs exclude some health issues that are important in specific countries, for example, smoking in Vietnam, cervical cancer in Nicaragua. A health policy exclusively focused on the MDGs would have significant gaps.

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<sup>1</sup> Albania has near-universal access to safe water, and the target relates to household connections.

<sup>2</sup> Ethiopia lowered a previous more challenging target.

- The MDGs may require disaggregation to address inequality by setting more challenging subtargets for population groups and regions with particularly poor health outcomes, like Vietnam.

#### **SUMMARY**

**MDGs need to be adapted to national circumstances and priorities.**

### **SHOULD STRATEGIES BE “NEEDS BASED,” “RESOURCE CONSTRAINED”—OR BOTH?**

Though not formally linked to the MDGs, the PRSP has in practice become the main national planning instrument for articulating the strategy for achieving national goals related to the MDGs. The Millennium Project argues that national poverty reduction strategies should be “needs based,” setting out strategies consistent with reaching the MDGs and challenging the donor community to fill the financing gap left after reasonable national efforts at resource mobilization. Others stress that, to be useful, the PRSP should set out clear priorities based on a realistic assessment of available resources.

By developing multiple scenarios, some countries (Rwanda, Senegal, Niger) have shown how the PRSP can be used both to guide the allocation of the resources they expect to have and as a bid for additional support. A “high” scenario is used to attract additional finance by showing what could be achieved with it, while realistic or low-case scenarios set out how priorities should be assigned to expenditure plans if fewer resources are available (WHO 2004; IMF 2003).<sup>3</sup> The World Bank and the IMF have supported countries wishing to take this approach, but a strong case can be made for more actively encouraging it.

#### **SUMMARY**

**Reconcile “needs based” and “resource based” approaches by developing more than one scenario for PRSPs.**

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<sup>3</sup> The “high-case” scenarios have not been directly related to achieving the MDGs, but the principle is the same.

## **FRAMING HEALTH STRATEGIES TO ACHIEVE THE TARGETS**

Most PRSP health strategies are dominated by health services and attempt to deliver a similar package of essential interventions that is derived from an international consensus on “what works.” The focus is on promotive and preventive interventions and on primary health care delivery. The strategies give priority to the areas most closely linked to the MDGs, with reproductive and child health and the control of the major communicable diseases given high priority. PRSPs include the costs of expanding education, roads, water and sanitation, and their contribution to achieving health targets is often recognized but seldom quantified (Country Case Studies; WHO 2004).

State-funded health systems in many countries are grappling with similar problems: staff availability, pay, and motivation and the difficulty of managing a complex and geographically dispersed service with inadequate financial resources and institutional capacity relative to expectations of what can be delivered. Service coverage is low, especially in rural areas, and nearly all PRSPs envisage substantial provision for reducing geographical barriers to access, building new primary facilities, increasing operating budgets, and providing incentives for personnel to work in underserved areas. However, trends in actual health expenditure are mixed, with no strong evidence as yet of the increases in spending that would be required to implement these plans (Table 1).

**Table 1: Trends in Public Expenditures on Health**

Albania	Increased health spending as share of budget and GDP since 2001, narrowing gap with Western Europe with rapid growth performance.
Benin	Committed to increase health budget, but failure to disburse budgeted funds led to a reduced budget share more in line with absorptive capacity. The 2003 and 2004 budgets of roughly 2 percent of GDP represent 90 percent of the amounts envisaged in the Poverty Reduction Strategy Paper (PRSP), but actual disbursement in 2003 was only 1.5 percent of GDP—about two thirds of plan.
Burkina Faso	<i>PRSP</i> : Envisaged increasing the health budget share from 9.8 percent in 2000 to 11.5 percent in 2003, raising per head health spending from US\$7.7 to \$9.5. <sup>a</sup>  <i>Medium-Term Expenditure Framework</i> : Envisaged health sector share of 7.5 percent in 2004, increased to 8.5 percent in the budget due to Heavily Indebted Poor Country (HIPC) funds.  <i>Actual spending</i> . Just \$5.90 in 2003, 6.3 percent of budget, due to low HIPC spending. Instead of increasing as envisaged, health spending has fallen as share of budget, GDP, and in real per head terms.
Cambodia	Government health expenditure doubled from 0.57 percent of GDP in 1999 to 1.20 percent of GDP in 2003. Public health spending per capita increased by more than 40 percent between 2001 and 2003 but from a very low base (around \$3 per head). However, domestic public expenditures represent an estimated 9 percent of total health sector expenditures
Ethiopia	Spending has fluctuated as low as 5 percent of government spending since 1992/3, short of the 8.2 percent targeted in the PRSP for 2004/5. Spending of \$1.50 per head in 2000/1 was possibly the world's lowest. Regional subsidies are forecast to be flat, limiting scope for increase.
Ghana	Spending (government and donors) has increased by 30 percent in real terms since 2001. Government is exceeding the 11 percent target share of recurrent budget—but due largely to increases in salaries and investment. Nonsalary recurrent budget (and productivity indicators) have fallen.
Nicaragua	Spending per capita as a share of GDP increased from 2.2 percent (\$17) to 2.95 percent (\$22) from 2001 to 2003. Current GDP share is sufficient to meet National Development Plan cost estimates to achieve the goals.
Tajikistan	Health care spending fell from 1.17 percent of GDP to 1.01 percent, and from 6.3 percent to just 5.3 percent of government spending from 2001 to 2003.
Tanzania	Spending increased 75 percent in real terms in three years to fiscal 2004, but the budget share of 9.7 percent is below the Abuja 15 percent target. Spending including donors amounted to only \$7.26 per capita, and the budget share dropped in both 2003 and 2004. There was some increase in the share devoted to primary and preventive care.
Uganda	Health share of noninterest budget increased from 2.5 percent in 1987/88 to 9 percent in 1998/9 and 12.2 percent in 2002/3, with improved targeting. The share of Maternal and Child Health Programme (MCHP) has been raised to 15 percent target share for 2007/8. Current per head spending of between \$8 and \$9, will reach \$11 in 2015 with 15 percent share. Implementation rate has been more than 95 percent, but fell to 90 percent in fiscal 2003 due to recruitment problems.
Vietnam	Due to data limitations and gaps, the trend is unclear, but a substantial increase in funding of services for the poor seems to have occurred.

a. All dollars in this report are U.S. dollars.

Source: Country Case Studies.

Decentralization, in some form, is a nearly universal theme. Institutional approaches range from limited changes to increase the responsibility of lower level units under health ministry authority, to contractual arrangements with public and/or private entities to provide agreed levels of service, to full decentralization of responsibility to a democratically accountable lower tier of government. Efforts to help communities hold service providers accountable are also increasingly common, including community management of primary health facilities (Benin, Burkina Faso, Rwanda, Nepal). An increased community voice is often linked to community financing schemes. Pre-payment schemes increase utilization by those who are covered, but inability to pay usually excludes the poor from participation (Rwanda coverage ranges from 10 to 50 percent of population, Ghana similar). The desire to decentralize responsibility and hold those delivering services accountable for results has not always been accompanied by sufficient willingness of finance ministries, health ministries, or donors to decentralize control of the resources on which performance depends. Reasons of lack of capacity and problems of accountability are cited, but the effect is that good managers may be frustrated in their efforts to achieve improved results (Box 1).

**Box 1: Is there a need to delegate more authority to those responsible for achieving results?**

**Benin.** Policy in 1995 envisaged decentralization to health facilities and districts, public-private partnerships, and performance contracts. Overcentralized budget management has frustrated this policy and prevented planned increases in health expenditure but is now being addressed with PRSC support.

**Burkina Faso.** Complex multilevel planning but overcentralized and complex procedures contribute to low budget execution (below 80 percent including Heavily Indebted Poor Country (HIPC) funds ) and very late release of funds, especially at the periphery. Key MDG priorities are heavily dependent on HIPC funds and donor projects, but there are large shortfalls in this funding. The PRSC supports limited introduction of more decentralized access to funds at district level.

**Ethiopia.** Health sector support is inconsistent with block-grant funding of regions. Health Sector-wide Approach (SWAP) is mainly project financed, but donor projects achieve lower and more variable disbursement than government funds. Government is seeking more budget support.

**Ghana.** The Ministry of Health (MOH) has a performance contract with the Ghana Health Service (GHS), but the MOH has retained responsibilities for procurement, staffing, and training. There are 23 administrative steps for districts to access central government funds.

**Nepal.** Reviews in the late 1990s concluded that vertical projects were inefficient and unsustainable and urged decentralization and enhancement of the community role. Detailed budget programming and late donor confirmation of support results in late releases. But decentralization is proceeding. Sub-health posts are being handed to communities, so far with limited powers (no control over hiring staff). There are, however, plans to empower local bodies to vary compensation and to devolve drug and medical supply purchase to districts. Public-private partnerships are also being expanded.

**Tanzania.** District health plans require formal approval by a basket funding committee. This delayed fund release in fiscal 2003.

Source: Country Case Studies.

Households usually bear most of the costs of health care, but the consequence is low utilization of services by poor households. Most attempts to protect the poor's access to services by exempting them from payment have failed. Abolition of user fees can lead to big increases in utilization (Uganda), but poses risks to quality, and the increased demand may not be sustained unless there is an increase in facility-level operating budgets to replace the lost revenue. Several case study countries are piloting approaches to reducing or eliminating cost barriers to the poor.

PRSPs say little about how nonpriority expenditures can be contained to permit expanded services for the poor, with Nicaragua one of the few making explicit reference to increased reliance on the private sector to fund services for the better-off. In Ghana, the stated priorities (district services and nonsalary recurrent spending) have been squeezed by big increases in spending on salaries, on investment, and on central spending; in Burkina Faso, the primary health share of the total health budget has fallen, whereas policy is to increase it.

### SUMMARY

- Stronger interdepartmental coordination is needed to move from “health services strategy” to “health strategy.”
- Plans for expanding support to high-priority interventions (on which there is broad agreement) need to be balanced by plans for how funding can be withdrawn from lower-priority services.
- In most countries, achieving national targets requires institutional reforms to strengthen performance incentives, but with accountability for results matched to more reliable access to the necessary resources.

## ESTIMATING THE COSTS OF ACHIEVING THE TARGETS

Health is just one of the sectors competing for scarce funds to accelerate progress toward national goals and the global MDGs. Explicit assumptions linking public expenditure costs to expected health outcomes are necessary to make the case for increased resources, both with the Ministry of Finance and with the donors. They can also help set budget priorities in light of available resources, and provide a quantified framework for subsequent monitoring and evaluation, and for setting realistic targets for managing performance.

The shortfall in resources has been highlighted in global estimates, but most national poverty reduction strategies do not estimate the public expenditure cost of achieving their targets (Soucat et al. 2002). Most of the health strategies we looked at have been costed, but few of them articulate clearly (and provide evidence for) the assumed chain of causality linking the resources required to the activities to be undertaken, the outputs to be produced, and the expected impact on outcomes. Many countries still produce incremental health budgets not linked to objectives or even activities (e.g., Tajikistan). Others produce detailed activity-based budgets in which it is difficult to link the many objectives and activities to overall strategic priorities (Ghana, Tanzania). In most cases,

the goals are determined with reference to the MDGs and to the expectations of the donors, the plans reflect national constraints and priorities and available resources, but the links between the two are not specified. A more explicit treatment of the links from resources to outcomes would probably reveal that the health goals are in most cases inconsistent with health budgets. None of the countries is close to meeting the 15 percent health sector budget share agreed by African countries in Abuja, more than half of them are spending less than \$10 per head on health, yet in several countries the share is both low and not increasing (Ethiopia, Benin, Burkina Faso, Tajikistan, and Tanzania in the 2004/5 budget). By accepting targets that may be inconsistent with the proposed resources, health ministries risk undermining public confidence and the morale of health workers, while missing an opportunity to make a convincing case for an increased budget.

Different approaches to costing are in use for different purposes. Estimates of the cost-effectiveness of specific health interventions have provided a sound basis for deciding what should be included in essential services packages. For costing national strategies and relating them to outputs, however, it is necessary to consider the cost and impact of measures to address institutional and incentives problems and to prepare cost estimates that can be “mapped” to the way that budgets are actually allocated. One approach that is being piloted aims to do this by packaging interventions in terms of how they are delivered (facility-based, outreach, community-based) and focuses on bottlenecks constraining coverage and effectiveness (physical accessibility, human resources, logistics and supply, cost and other barriers to demand and utilization, gaps in technical and organizational quality, and steering and management costs) (Soucat et al. 2002). The approach can help make the case for increased funding by identifying the areas affording the most scope for significant impact on health outcomes at modest cost. In Mauritania, the 40 percent increase in the health budget in 2002 was reportedly influenced by analysis suggesting that a targeted increase could achieve within five years a 30 percent reduction in child mortality and a 40 percent reduction in maternal mortality (Soucat et al. 2002).<sup>4</sup> The approach can also reveal how marginal costs rise as the MDG targets are approached. In Ethiopia, a 42 percent reduction in under-5 mortality could be achieved for less than half the cost required to achieve the 66 percent reduction called for to achieve the MDG. Though useful as a conceptual approach, the realism of the analysis has yet to be confirmed in terms of actual outcomes.

#### SUMMARY

- Strategies should include explicit analysis of expected linkages between costs-outputs-outcomes.
- Cost estimates should address institutional constraints and be prepared in a form that can be mapped to budgets and support resource bids.
- Priorities should be identified to permit adjustments in the light of resource availability.

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<sup>4</sup> Knippenberg et al (2003) report that application of the marginal budgeting for bottlenecks approach for preparing health MTEFs in Mali and Mauritania resulted in doubling of health budgets.

## ARE MACROECONOMIC FRAMEWORKS TOO RESTRICTIVE?

There is some debate over the wisdom of increasing public expenditure as steeply as would be required to reach the MDGs, even if such increases could be financed from external grants.

Aid only transfers real resources when net imports increase. If the aid is spent on domestic goods and services instead of imports, then the non-aid sector of the economy must be persuaded to absorb the aid by exporting less and importing more. This increases the availability of domestic goods and services to meet the aid-financed demand for them. If the increased expenditure financed by aid does not result in increased net imports, it will simply squeeze out existing customers for the goods and services bought with the aid, an effect that could be equally well achieved without aid by using fiscal and monetary policy. The problem of “Dutch disease” arises because the increase in demand for net imports required to absorb the aid may require some appreciation of the real exchange rate, potentially damaging the competitiveness of the traded goods sectors that are thought to be of particular importance for economic growth<sup>5</sup>.

These problems of aid absorption are very relevant to the health sector, where local costs typically account for between 70 and 75 percent of total public sector health spending (Millennium Project (2003). As described in the previous paragraph, increased public expenditure on health therefore implies a re-orientation of domestic resources towards producing more public sector health services, and fewer private sector goods and services, particularly traded goods and services. This may be desirable if the additional public sector health outputs are more socially valuable than the private sector outputs they displace. That may well be the case with cost-effective health spending, especially when the positive impact of improved health on productivity is taken into account alongside the social benefits. However, if we assume that the public sector expenditures with the highest benefit: cost ratios are undertaken first, while the least profitable private sector activities are displaced first, the diminishing marginal benefits of additional public expenditure will eventually fall below the rising marginal costs of displacing private sector activity. Irrespective of Dutch disease, there will come a point beyond which increased public expenditure on local costs should not be undertaken, even if financed by grants. The argument is not about whether such limits are needed but concerns the judgment on where they should be set.

These issues are not discussed in most PRSPs (IEO 2004), perhaps because governments recognize that the macroeconomic framework has to be negotiated with the IMF, because the existence of an on-track IMF program remains a prerequisite for accessing significant external aid or HIPC debt relief.

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<sup>5</sup> IMF (2005), The Macroeconomics of Managing Increased Aid Inflows: Experiences of Low-Income Countries and Policy Implications. Policy Development and Review Department, August 8, 2005.

The IMF has often been accused of preventing countries from adopting ambitious spending plans, even when financed from aid. However, IMF policy is to support increased aid, stating that additional aid inflows should be accommodated by appropriate adjustments of the program's fiscal and financing targets, "if they can be effectively absorbed and utilized without endangering macro stability." (IMF 2004). Moreover, IMF programs have actually overestimated foreign aid, overestimated GDP growth, and consequently overestimated both domestic and foreign resources available to finance public expenditure (IMF and IDA 2003).<sup>6</sup>

Despite this evidence, it could still be argued that the IMF may unintentionally restrain future aid commitments by negotiating fiscal frameworks that assume only modest growth in aid. Countries may not push for additional aid flows, nor will donors offer such aid, if the macroeconomic projections on which the expenditure program is based do not show a clear need for it. Table 2, showing the assumptions for our sample countries, does suggest a conservative bias in the projections, all but one of which converge toward a level where public expenditure as a share of GDP is around 25 percent. No country is projected to spend more than 30 percent of GDP on public expenditure. Countries spending more than 25 percent of GDP assume a flat or declining share of public spending. Only two countries assume more than a 2 percent of GDP increase in the share of public expenditure within the projection period, both of them countries starting from a low base of public expenditure (less than 20 percent of GDP). With per capita economic growth typically forecast at between 3 and 4 percent a year, the projections imply an increase of about 50 percent in public expenditure per capita by 2015. This may sound like a lot, but it would leave all but three of our countries spending less than \$20 of public funds on health—still far short of estimates of the cost of delivering the essential health package to all. In a 3 to 7 year projection period, less than half of our sample countries project any increase in net external financing as a share of GDP. Even relatively well-performing and low-income countries are projecting aid increases for themselves that are well below the commitments made at Monterrey.

The fiscal frameworks in IMF programs are difficult to assess, because the Fund provides no clear justification for the assumptions on the level and financing of public expenditure (IEO 2003). The convergence of spending toward roughly 25 percent of GDP is not a result of any IMF policy, although it may reflect a tendency for IMF country staff to encourage countries to move toward a level of expenditure that Board and senior management have found acceptable in other cases. Whatever the explanation, the lack of variation is surprising. Countries differ in their needs: low-income countries with poor infrastructure and low education and health levels could make a strong case for a higher public expenditure share to create the conditions for faster economic growth and poverty reduction<sup>7</sup>. Countries differ in their ability to finance expenditure, both their ability to

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<sup>6</sup> This overestimation of the available resources is just as serious as underestimation, because unplanned shortfalls in resources may necessitate damaging short-term cuts in public spending, often focused on easy to cut nonsalary recurrent budgets. Overestimation thus results in disproportionate negative impacts on outputs by denying staff members the resources to do an effective job.

<sup>7</sup> See for example, Millennium Project (2004).

attract external aid and the scope for mobilizing domestic resources without damaging growth and stability. It would also be reasonable to expect that, other things being equal, public expenditure would be higher in countries like Uganda and Burkina Faso, where almost all aid flows are recorded in the IMF public expenditure tables, than in countries like Benin, where more than half of aid is not included (Tables 3–5). The lack of explicit rationale for the assumptions, together with the absence of the expected degree of difference in projected spending between countries, adds up to a strong case for a more open debate on the macro framework.

The PRSP preparation and annual review process may provide an appropriate forum for the wider debate on the level and means of financing public expenditure. Both Ministry of Finance and IMF views need to be reflected in the PRSP. Good practice in this regard includes:

- The government personnel who prepare the macroeconomic framework for the budget should be responsible for (or at least heavily involved in) developing the fiscal envelope for the PRSP.
- The IMF should also be involved at an early stage, through the resident representative.
- Open debate supported by high quality technical analysis. In Uganda and Tanzania, independent macroeconomic analysis that commanded the respect of IMF staff was helpful in persuading the Fund to accommodate higher expenditure.
- The PRSP needs to be adapted in the light of events. Several countries have coordinated the annual PRS review with adjustments to the targets, the macroeconomic framework, and the expenditure priorities and budget ceilings.

Another problem is that aid commitments are short-term and unreliable, whereas the additional public expenditure that is needed is mainly for recurring costs that will need to be sustained and to grow into the indefinite future. The problem is further reinforced if a temporary surge in aid causes Dutch disease, damaging the potential of the economy to finance higher spending through economic growth. Countries therefore face significant risks if they establish health systems that cannot be maintained if donor preferences change.<sup>8</sup> A number of approaches could be taken to managing this problem: the International Financing Facility as a way to ensure growing aid at least at global level; increased reliance on multilateral channels less subject to political pressures; longer-term commitments to specific expenditure programs, with guarantees that they will continue as long as the program-specific conditions are met; compensatory mechanisms to smooth fluctuations caused by shortfalls by individual donors; further debt relief as a form of irrevocable long-term commitment; increased use of aid for reserve build-up to help manage aid fluctuations. Each of these requires donor willingness to commit their money longer term in ways that are less at risk of interruption by events outside program objectives.

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<sup>8</sup>For poor countries such as Tanzania and Ethiopia, sustaining per capita expenditure increases financed by a doubling of aid flows would require the higher level of aid to be maintained for 20 years or more. See Foster (2003).

## SUMMARY

- Involve the MOF and IMF in preparing PRSP macro-fiscal frameworks to ensure consistency with the budget, but with explicit rationale and more open debate.
- Coordinate annual PRSP progress review with budget cycle including revision of macro-fiscal framework and budget ceilings and priorities.
- Reduce risks of aid dependence by longer-term commitments less prone to interruption, more reliable timing of disbursements.

**Table 2: IMF Macroeconomic Frameworks in Case-Study Countries**

Country	GDP growth per year (geometric average, percent)		Domestic revenue (percent GDP)		Net external finance <sup>a</sup> of public expenditure (percent GDP)		Public expenditure, (percent GDP)	
	Historical (years)	Projected (years)	Base (year)	Projected (year)	Base (year)	Projected (year)	Base (year)	Projected (year)
Albania	6.4 (1999–2003)	6.1 (2003/7)	22.0 (2003)	22.4 (2007)	1.7 (2003)	1.9 (2007)	26.5 (2003)	26.6 (2007)
Benin	5.6 (1999/2003)	6.6 (2003/6)	16.8 (2003)	17.0 (2006)	4.8 (2003)	3.5 (2006)	21.0 (2003)	22.0 (2006)
Burkina Faso	6.6 (1999–2003)	5.4 (2003/6)	12.4 (2003)	14.6 (2006)	8.7 (2003)	5.7 (2006)	21.6 (2003)	23.4 (2006)
Cambodia	5.8 (1999–2003)	4.7 (2003/9)	10.4 (2003)	14.0 (2009)	6.0 (2003)	23.4 (2005) 21.1 (2009)	17.4 (2003)	18.4 (2009)
Ethiopia	3.7 <sup>b</sup> (1999–2003)	6.8 (2003/6)	19.6 (2003)	20.4 (2006)	14.8 (2003)	8.6 (2006)	29.1 <sup>c</sup> (2001)	29.5 (2006)
Ghana	4.7 (1999–2003)	5.0 (2003/8)	20.8 (2003)	22.4 (2008)	8.0 (2003)	5.1 (2008)	29.0 (2003)	24.3 <sup>d</sup> (2008)
Nepal	2.2 (2000/3)	4.5 (2003/6)	12.3 (2003)	13.5 (2006)	2.9 (2003)	4.2 (2006)	16.3 (2003)	18.2 (2006)
Nicaragua	2.6 (1999–2003)	4.2 (2003/8)	21.9 <sup>e</sup> (2003)	22.1 (2008)	10.5 (2003)	8.7 <sup>f</sup> (2004)	30.3 (2003)	28.7 (2004) 26.8 <sup>g</sup> (2008)
Rwanda	5.6 (2000/3)	5.3 (2003/6)	13.5 (2003)	13.6 (2006)	10.5 (2003)	17.1 (2004) 13.9 (2006)	24.1 (2003)	28.3 (2004) 25.1 (2006)
Tajikistan	9.5 (1999–2003)	5.9 (2003/10)	16.8 (2003)	19.1 (2010)	2.8 <sup>h</sup> (2003)	1.2 (2010)	19.0 (2003)	22.1 (2010)
Tanzania	7.6 (1999–2003)	6.1 (2003/6)	11.4 (2003)	14.0 (2007)	7.7 (2003)	10.7 (2007)	18.6 (2003)	25.4 (2007)
Uganda	5.6 (2000/3)	5.8 (2003/8)	12.3 (2003)	13.4 (2005)	11.5 (2003)	8.5 (2005)	23.7 (2003)	22.9 (2005)
Vietnam	5.4 (1999–2002)	6.8 (2002/7)	22.5 (2002)	22.2 (2007)	1.4 (2002)	1.6 <sup>h</sup> (2004)	24.8 (2002)	25.1 (2007)

Note: Nepal, Rwanda and Vietnam numbers are based on 2003 PRGF program. The other countries are based on latest 2004 reported programs. a. Including grants.

b. GDP (at factor cost) growth rate at constant prices.

c. Includes special programs such as demobilization and reconstruction, which accounts for around 0.7 percent of GDP.

d. Interest payment as percent of GDP decreases from 6.2 percent in 2003 to 1.7 percent in 2008.

e. These numbers are reported as total current revenue as percent of GDP, capital revenue is recorded under the capital expenditure (net of capital revenue).

f. Due to missing data for some of the financing projections, projection target year is different (2004) for net external financing. IMF Executive Board Completes Fifth and Sixth Reviews under Nicaragua's PRGF Arrangement (Sept. 2004).

g. Interest payment as percent of GDP decreases from 5.1 percent in 2003 to 2 percent in 2008.

h. These are data for net foreign borrowing. Grants are excluded due to missing projections for the program years (2005–2010). The program target year is different due to missing data for some of the financial projections.

## COORDINATING HEALTH PLANS WITH THE MTEF & THE BUDGET

The public expenditures implied by the PRS need to be implemented via the national budget. Good-practice approaches include:

- The PRSP establishes clear priorities and criteria, reflected in the guidelines and ceilings given to line ministries for preparing budget and MTEF proposals.
- Budget allocations are the outcome of an iterative process in which proposals by line ministries are scrutinized by the center, and adjusted in the light of national priorities and resources.
- There is an annual process for reviewing sector-level physical and financial progress, and the domestic and foreign financing requirements for the coming period, involving government and development partners, and timed to inform budget preparation.
- The incentives for line ministries to review their performance, construct well-designed budgets that shift resources toward national goals, and present them in ways that make the strategic shifts transparent, are reinforced by central scrutiny of budget proposals, challenging ministries to justify their bids.
- The Ministry of Finance and Cabinet establish and maintain the credibility of the process by ensuring that carefully prepared budgets that reflect national goals, receive favorable treatment in the budget that is finally approved, and in the timely and full release of funds.
- The approved MTEF is the same as the annual budget for the first year, and the chart of accounts is structured in such a way that spending priorities of particular importance for achieving the MDGs can be identified.
- The Ministry of Finance provides credible medium-term assurances of sectoral budget levels or shares to encourage line ministries to reallocate resources from lower priority areas without fearing that their budgets will suffer. Credibility can be built via a medium-term track record in which it is shown by example that the MTEF guides resources. Agreements with external partners on the health share of spending can also help build MOH confidence.

Many of these good-practice features are present in Albania, Benin, Rwanda, Tanzania, and Uganda, although the identification of priority expenditure programs is in some cases limited to the aggregate level (e.g., sector or subsector shares such as primary health), and only Uganda has a strong central budget “challenge” function. In countries with decentralized budget responsibility such as Vietnam and Ethiopia, it may be impossible for government to establish centrally a medium-term framework to determine public expenditure shares. The goal of achieving similar shifts in priority is being addressed

through increased resources for targeted national programs such as the province-level poverty health funds in Vietnam.

Not all MTEFs have focused sufficiently on achieving a strategic shift in expenditures toward national priorities. The MTEFs in Cambodia and Ghana, and to some extent in Tanzania, are based on detailed bottom-up activity costing, resulting in bulky documents where it is difficult or impossible to see how the changes in the budget allocations relate to higher-level goals and targets.

Where budget preparation and public expenditure management are particularly weak, there may be no effective means to ensure that health strategies are implemented. The effort devoted to preparing a health strategy and a sector MTEF is largely wasted if the annual budget is not in practice implemented and the medium-term priorities are not respected. Several of the countries in our sample still lack any credible mechanism for linking policy priorities to expenditure allocations, with budgets still prepared on an incremental basis, via fragmented parallel processes, and with actual budget execution not reflecting the approved budgets. In Tajikistan, for example, the budget is prepared incrementally on a line item basis; actual expenditure bears little relation to approved budgets, making it impossible to relate health outputs to budgets either for planning or reporting purposes. Cambodia is an extreme example, with health centers receiving less than 10 percent of their budgets, but several other countries need to establish credibility.

Improvements in public expenditure management require action by central economic ministries, although implementation may also require reform and capacity building at sector and local government levels.

#### SUMMARY

- Minimum standards of public expenditure management need to be attained before any health strategy can be effective.
- In good-practice cases, PRSP identifies spending priorities in consultation with sectors, MTEF-budget process shifts resources toward them, and priorities are reviewed and adjusted each year in light of performance.

### ABSORPTIVE CAPACITY

Very large increases in funding over a very short period of time, as envisaged in some estimates of the cost of reaching the MDGs, might well lead to difficulties in making good use of the money. However, in most of our case-study countries funding is inadequate at present and is increasing at a speed that could be effectively used if appropriately prioritized and managed without excessive bureaucracy. For example, existing capacity is underused in many countries, because low operating budgets mean that medicines and other consumables are unavailable or have to be paid for, while personnel lack the travel budget to expand outreach. Increased aid for nonsalary

recurrent costs and for financing free basic health services would enable use of that existing capacity. Reducing user fees can increase the utilization of services, but only if quality does not decline, which requires the lost revenue from fees to be replaced by increased budget funding.

Increased funding would also help overcome capacity problems caused by staff vacancies and by low output from underpaid personnel who need to devote time to alternative occupations or private practice. These problems can be relieved with additional funding for recruitment and for salary increases, although the increase would need to be sustainable and should preferably be sequenced as part of an approach that links increased pay to improved performance. In time, contractual arrangements with non-government agents could be put in place to expand services and support capacity development

A balanced increase in funding that addresses the critical constraints in a logical sequence could be well used in most of the countries considered. However, very large disease-specific programs (such as proposed HIV/AIDS treatment programs in Guyana and Tanzania that envisage spending sums equal to half of the existing health budget) may both experience and cause capacity problems by drawing disproportionately on available staffing and other resources.

Concerns about absorptive capacity frequently reflect concerns about governance and accountability rather than technical limits on spending, and procedural requirements intended to address those concerns cause the disbursement problems. In some cases, governance and expenditure management constraints are so pervasive that major reforms need to precede or accompany increased funding (Tajikistan, Cambodia). In other cases, government procedures are overcentralized and bureaucratic and need to be reformed to permit available funding to be spent (Benin, Burkina Faso). Donor project or pooled funding procedures are often part of the problem (Box 1). Donor procedures not only cause low disbursement but also divert capacity away from service delivery toward servicing the donor demand for meetings, field trips, reports, accounts, audits, and so on. By absorbing the capacity of financial management personnel, they impede government action to address the weaknesses that make parallel procedures necessary.

#### SUMMARY

- On present trends, the binding constraint is lack of finance, not lack of capacity.
- Capacity problems can be managed if health strategies tackle bottlenecks in a logical sequence, and avoid large “earmarked” commitments that distort health sector priorities.
- Where government is committed to improving financial management, external partners should use government systems while supporting coordinated action to strengthen them as necessary.

## REFORMING DEVELOPMENT ASSISTANCE

Development agency procedures are major constraints on the execution of public expenditure plans. *Commitments* are too short term to be the basis for long-term strategies. *Disbursements* often fall long short of commitments and are unpredictable and subject to interruption for reasons outside the program itself. Most development assistance is still committed through parallel arrangements and is imperfectly coordinated with government strategy.

Box 2, based on Appendix C, presents some rough estimates of the significance of aid to the budget. Budget support is increasing as a share of donor support, but even in the most highly aid-dependent countries it represents little more than half of the support for public expenditure and less than one third of total aid flows. On average, less than 20 percent of donor disbursement is provided as budget support. This is a major problem in aid-dependent countries where more than half of health spending may be donor funded and where the number of donors involved continues to increase. The priorities for increased spending are dominated by recurrent costs, spent via geographically scattered cost centers and difficult to support via projects without incurring high transaction costs. If the case is accepted for an increase in health spending in order to progress toward the MDGs, it seems inescapable that the bulk of the increase will need to be provided as budget support.

### Box 2: Where does all the aid go?

On average, for every \$1 disbursed by donors to our 14 case study countries, we estimate:

Direct donor spending (technical assistance and direct payments) not recorded in balance of payments	\$0.30
Recorded in balance of payments, but not reported as part of government spending	\$0.20
Aid earmarked to specific projects	\$0.30
Provided as budget support	\$0.20

Some of the budget support is itself earmarked to specific sectors or budget lines.

Source: Appendix C.

Meanwhile, countries continue to face the problem of coordinating large numbers of donors providing their assistance via multiple routes. Good practice approaches from our sample countries include:

- Joint Government-donor reviews of sector performance that are coordinated with the MTEF and national budget process and will feed in to a national PRS progress report or into a national public expenditure review process. There are a number of country examples where arrangements along these lines are in place, notably Uganda and Tanzania, where external partners work closely with government in sector working groups, and where the sector dialogue is coordinated around the annual budget cycle.
- Indications of future donor funding should be made early enough in the year to be taken into account in setting ceilings for budget preparation, and should be confirmed as the budget is being finalized.
- Donor policy dialogue at different levels needs to be coordinated. The PRSC and general budget support groups are the appropriate vehicles for addressing issues that are cross-cutting or are the concern of the central economic ministries. Of direct relevance to health, this includes the overall macro-economic framework, budget allocation, public finance management, civil service reform, and decentralisation. Where there is an established sector dialogue, the health content of the PRSC should rely upon the sector reviews to set and assess the achievement of sector level actions, as is the case in Uganda, avoiding overloading the budget support policy matrix with sector level detail.

Several of the country case studies suggest that large commitments from the global funds are distorting priorities in a number of countries: committing an unsustainable share of the budget to HAART for AIDS sufferers, sucking staff and resources into vertical programs with costs that are neither replicable nor sustainable without longer-term commitments than the donors have yet provided (Tanzania, Guyana, Ethiopia). GFATM has in some countries set up separate coordination arrangements specific to the funds it is providing<sup>9</sup>. Several countries are uncomfortable with the approach of some of these new actors. In August 2004, the Ministry of Finance in Uganda was reported as having decided to cap new project aid commitments that are outside the national health strategy<sup>10</sup>. There is a strong case for all external partners in the health sector working entirely within existing health sector coordination arrangements, and providing their assistance in support of the PRSP strategy, focusing first on filling the financing gaps for implementing the PRSP.

#### SUMMARY

- Progress toward the MDGs requires a further shift toward budget support as the main aid modality in aid-dependent countries.
- All donors should participate in sector coordination and provide sufficient information for government to include their commitments and disbursements in the macroeconomic framework and reflected in public expenditure plans.
- Where government has a sound sector strategy, the first call on donor funds should be to ensure that it is fully funded.
- Donors should try to commit early enough to inform the budget preparation.
- Where a strong sector level policy dialogue is in place, the PRSC should rely on sector reviews to agree sector level actions and to assess their achievement.

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<sup>9</sup> Barbara Bruns, informal note of June 28, 2004 workshop on the role of the IMF in relation to HIV programs.

<sup>10</sup> New Vision, Uganda, August 20, 2004.

## APPENDIX A: GOALS, TARGETS, AND INDICATORS FOR MDGS 1 THROUGH 7

GOALS AND TARGETS	INDICATORS
<b>GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER</b>	
Halve, between 1990 and 2015, the proportion of people whose income is less than US\$1 a day	<ol style="list-style-type: none"> <li>1. Proportion of population below \$1 (PPP) per day</li> <li>2. Poverty gap ratio [incidence x depth of poverty]</li> <li>3. Share of poorest quintile in national consumption</li> </ol>
Halve, between 1990 and 2015, the proportion of people who suffer from hunger	<ol style="list-style-type: none"> <li>4. Prevalence of underweight children under-five years of age</li> <li>5. Proportion of population below minimum level of dietary energy consumption</li> </ol>
<b>GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION</b>	
Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	<ol style="list-style-type: none"> <li>6. Net enrolment ratio in primary education</li> <li>7. Proportion of pupils starting grade 1 who reach grade 5</li> <li>8. Literacy rate of 15 to 24 year-olds</li> </ol>
<b>GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN</b>	
Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	<ol style="list-style-type: none"> <li>9. Ratios of girls to boys in primary, secondary, and tertiary education</li> <li>10. Ratio of literate females to males of 15 to 24 years of age</li> <li>11. Share of women in wage employment in the nonagricultural sector</li> <li>12. Proportion of seats held by women in national parliament</li> </ol>
<b>GOAL 4: REDUCE CHILD MORTALITY</b>	
Reduce by two thirds, between 1990 and 2015, the under-five mortality rate	<ol style="list-style-type: none"> <li>13. Under-five mortality rate</li> <li>14. Infant mortality rate</li> <li>15. Proportion of 1 year-old children immunized against measles</li> </ol>
<b>GOAL 5: IMPROVE MATERNAL HEALTH</b>	
Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	<ol style="list-style-type: none"> <li>16. Maternal mortality ratio</li> <li>17. Proportion of births attended by skilled health personnel</li> </ol>
<b>GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES</b>	
Have halted by 2015 and begun to reverse the spread of HIV/AIDS	<ol style="list-style-type: none"> <li>18. HIV prevalence among 15 to 24 year- old pregnant women</li> <li>19. Condom use rate of the contraceptive prevalence rate</li> <li>20. Number of children orphaned by HIV/AIDS</li> </ol>
Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	<ol style="list-style-type: none"> <li>21. Prevalence and death rates associated with malaria</li> <li>22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures<sup>1</sup></li> <li>23. Prevalence and death rates associated with tuberculosis</li> <li>24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)</li> </ol>
<b>GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY</b>	
Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources	<ol style="list-style-type: none"> <li>25. Proportion of land area covered by forest</li> <li>26. Ratio of area protected to maintain biological diversity to surface area</li> <li>27. Energy use (kg oil equivalent) per \$1 GDP (PPP)</li> <li>28. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons)</li> <li>29. Proportion of population using solid fuels</li> </ol>
Halve, by 2015, the proportion of people without sustainable access to safe drinking water	<ol style="list-style-type: none"> <li>30. Proportion of population with sustainable access to an improved water source, urban and rural</li> </ol>
By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	<ol style="list-style-type: none"> <li>31. Proportion of urban population with access to improved sanitation</li> <li>32. Proportion of households with access to secure tenure (owned or rented)</li> </ol>

## APPENDIX B: MDGS AND NATIONAL GOALS IN CASE-STUDY COUNTRIES

This appendix comes largely from the World Bank data base, judgments on degree of ambition based on whether the implied rate of progress is consistent with that needed to reach the target. In many cases, progress was slow or negative for the first decade after 1990, which would require catch-up to reach the MDG; hence some of my judgments differ from those of the World Bank, noted in footnote.

<b>Infant Mortality</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania	21 (2001)	9	17 (2004) 10 (2015)	Marginally less ambitious <sup>a</sup>
Benin	93(2002)	37	65 (2005) 28 (2015)	More ambitious
Burkina Faso	105 (2000)	Two-thirds reduction on 1990, baseline unclear	70 (2005) 45 (2014)	More ambitious
Cambodia	95 (2000)	Two-thirds reduction on 1990, baseline unclear	90 (2005)	Less ambitious
Ethiopia	97 (2001)	Two-thirds reduction on 1990, baseline unclear	85 (2005)	Less ambitious
Ghana	56 (2000)	Two-thirds reduction on 1990, baseline unclear	50 (2005)	Less ambitious
Guyana	IMR 58 (1999) 83% Measles immunization	IMR 25; 100% measles immunization	IMR 42; 92% measles immunization (2005)	More ambitious
Nepal	64 (2001)	Two-thirds reduction on 1990, baseline unclear	45 (2006)	More ambitious
Nicaragua	IMR 40 (1998)	Two-thirds reduction on 1990, baseline unclear	IMR 32 (2005)	Less ambitious reduction to 2005, but 2015 target is accepted.
Rwanda	107	Two-thirds reduction on 1990, baseline unclear	35 (2015)	
Tajikistan	36.7 (2001)	Two-thirds reduction on 1990, baseline unclear	32 (2006)	Less ambitious
Tanzania	IMR 99 (2000)	33	50 (2010); 20 (2025)	Less ambitious <sup>b</sup>
Uganda	88 (2000)	31 (2015)	68 (2005)	Consistent with MDG
Vietnam		Two-thirds reduction on 1990, baseline unclear	IMR 30 (2005), <25 (2010)	

<b>Child Mortality</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania		14		
Benin	151 (2002)	61	117 (2006)	More ambitious
Burkina Faso		69		
Cambodia	125 (2001)	38	118 (2005)	Less ambitious
Ethiopia	167 (2001)	64	160 (2005)	Less ambitious
Ghana	110 (2000)	42	95 (2005)	Less ambitious
Guyana		30		
Nepal	91 (2001)	48	72 (2006)	More ambitious
Nicaragua	CMR 50 (1998)	22	CMR 37 (2005); targets for immunization and reducing incidence of diarrhea, ARI .	Less ambitious to 2005, but 2015 target is accepted
Rwanda	107 (2000)	59	35 (2015)	More ambitious
Tajikistan		42		
Tanzania	161 (1999/2000)	48	79 (2010)	Less ambitious
Uganda	160 (1995)	54	103 (2005)	Consistent with MDG
Vietnam	<b>38 (2001)</b>	17	<5MR 36 (2005), <32 (2010)	Less ambitious
<b>Maternal Mortality</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania	MMR 20 (2000)	10	15 (2004) 11 (2015)	Marginally less ambitious <sup>c</sup>
Benin	495(Govt) 850 (WB/UN)	248 (WB/UN)	475 (2006) 390 (2015)	Less ambitious
Burkina Faso	484 (2000)	Three-quarters reduction on 1990, baseline unclear	350 (2004) 200 (2014)	Rate of decline more ambitious
Cambodia	437 (1998)	Three-quarters reduction on 1990, baseline unclear	372 (2005)	Less ambitious
Ethiopia	600, revised to 500 in progress report (2001)	Three-quarters reduction on 1990, baseline unclear	425, revised to 450	Target revised from more to less ambitious
Ghana	200 (2000)	Three-quarters reduction on 1990, baseline unclear	160 (2005)	Less ambitious
Guyana	190 (1997)	69	130 (2005)	Less ambitious
Nepal	415 (2001)	Three-quarters reduction on 1990, baseline unclear	300 (2006)	More ambitious
Nicaragua	MMR 148 (1999)	Three-quarters reduction on 1990, baseline unclear	MMR 129 (2005)	Less ambitious to 2005, but 2015 target is accepted
Rwanda	810 (2000), qualified attendance 35%	Three-quarters reduction on 1990, baseline unclear	MMR 202(2015) Qualified attendance 60% (2010)	More ambitious rate of decline
Tajikistan	43 (2001)	Three-quarters reduction on 1990, baseline unclear	40 (2006)	Less ambitious rate of decline
Tanzania	529 (1996)	MMR 133; 90% attended births.	450 (2003), 265 (2010); 80% attended births (2010)	Less ambitious
Uganda	505 (2000)	131	354 (2005)	Consistent with MDG
Vietnam	160 (1995)	Three-quarters reduction on 1990, baseline unclear	80 (2005), 70(2010)	Less ambitious <sup>d</sup>

<b>HIV/AIDS</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania	Less than 100 known cases 2002	Halt and reverse by 2015	Prevent HIV/AIDS taking hold	MDG target not appropriate.
Benin	4.1% (pregnant women)	Halt and reverse by 2015	<6%	Not comparable
Guyana	237 reported cases, 74 women 15 to 45 yrs (1999)	Halt and reverse by 2015	161 reported cases (64 women 15 to 45 yrs) in 2015	More ambitious
Tanzania	7.8% 2001	<8%	Reduce prevalence and promote behavior change	More ambitious (MDG achieved)
Uganda	6.5% Rate peaked 1992/3.	Halt and reverse by 2015	5% (2005)	More ambitious
Vietnam			Indicators but no target	
<b>Other Infectious Diseases</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Benin		Reduce malaria death rate below 1990 7.6/100,000	6.2/100,000 by 2015	More ambitious
Tanzania			Malaria case fatality rate	
Vietnam			Indicators but no target	
<b>Water and Sanitation (% access to safe water unless otherwise indicated)</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania	97%	99%		
Benin	66% (2001)	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	74% (2005)	More ambitious
Cambodia	29% (1999)	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	40% (2005)	Consistent
Ethiopia	30% (2000)	62%	39% (2005)	Less ambitious (no improvement in 1990s)
Ghana		76%		
Guyana	92% (1999)	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	95% 2003, 100% urban by 2005	More ambitious rate of change
Nepal	72 (2001)	83%	85 (2006)	More ambitious
Nicaragua	Water 67%, sanitation 84%	85%	Water 75% (2005), sanitation 88% (2004)	More ambitious
Rwanda	Safe water 52%, sanitation 15%	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	Safe water 72%, sanitation 56% (2015)	
Tajikistan	51% (2001)	Halve, by 2015, the proportion of people without sustainable access to safe drinking water	58% (2006)	More ambitious rate of change
Tanzania	58% national 48% rural	79% <sup>e</sup>	85% rural (2010)	More ambitious
Uganda	55% (2002/3)	72%	100% (2015)	More ambitious
Vietnam	77% (2000)	77%	80% urban, 60% rural have safe water by 2005; 85% rural by 2010.	More ambitious (MDG target achieved)

<b>Education and Gender Equality</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania	NER 93% (2002); girl: boys 1.02	100%	100%	Same; gender equality already achieved.
Benin	NER 81% 84% complete; 0.65 girls/boy enrolled	100% complete primary by 2015; Girl/boy ratio 1.0 by 2005	99% net enrollment rate (NER) and 1.0 girl: boy ratio by 2015.	Marginally less ambitious
Burkina Faso	41% NER	100%	70% "in 10 years"; no gender target given.	Less ambitious
Cambodia	NER 84% (2001)	100%		
Guyana	NER 97% (1999)	100% NER and primary completion rate (PCR)	100% NER 2005	More ambitious
Nepal	NER 80 (2001)	100%	NER 90 (2006)	More ambitious
Nicaragua	NER 75% (1999)	100%	83% NER (2005), no gender target.	Consistent growth rate <sup>f</sup>
Rwanda	NER 72 (2000)	NER 100 (2015)		Same
Tajikistan		NER 100 (2015)	NER 90% (2015)	Less ambitious
Tanzania	NER 60% 1999/2000	100% NER	100% literacy 2010, NER 70% 2004; gender equality in enrolment 2005.	More ambitious growth rate
Uganda	NER 83-90% (poorest to richest), P7 year NER 10% (2002); girl: boy 0.98	100%, girl: boy 1.0	100% (2003), 1.0 girl: boy in primary	More ambitious date for universal primary education (UPE). No secondary gender target.
Vietnam	95% NER (2000)	100% NER	NER97% 2005,99% 2010; gender gaps closed 2005, ethnic gaps closed 2010;100% female literacy <40 by 2010	More ambitious rate of change.
<b>Income Poverty</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to MDG</i>
Albania	17% extreme poverty (\$1 per day) 1998	11%	9% (2015)	More ambitious
Benin	Baseline data lacking.	Halve % on<\$1 per day.	Halve % on<\$1 per day.	Same
Guyana	35% below national poverty line (1999)	26.1% (national, not \$ per day)	31.4% (2005)	More ambitious.
Rwanda	60%	30%	<30%	Same
Tanzania	36% below basic needs, 19% below food poverty line	19.3% basic, 10.8% food	17.8% basic, 9.3% food by 2010	More ambitious
Uganda	35%	28%	10% (2017)	More ambitious
Vietnam		40% reduction 2000–10 in percent of population living below international poverty line, 75% reduction in those below international food poverty line.		

<b>Hunger and Malnutrition</b>				
<i>Country</i>	<i>Current status</i>	<i>MDG Target 2015</i>	<i>PRSP/national target</i>	<i>Comparison of national target to HJ?////MDG</i>
Albania	8% malnutrition of <5s in 1999	4% (no 1990 baseline available)	None	
Benin	16% below minimum energy consumption, 23% <5s malnourished.	Halve % hungry and % malnourished		More ambitious reduction in underweight children.
Cambodia		Halve, between 1990 and 2015, the proportion of people who suffer from hunger		More ambitious reduction in stunted <5s
Ghana	25% (1999)	Halve, between 1990 and 2015, the proportion of people who suffer from hunger		More ambitious reduction in underweight <5s
Nicaragua	1998: 20% chronic malnutrition of under 5s.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	2004:16%	Faster reduction
Tanzania		Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Reduce prevalence of stunting from 43.4% to 20%. Reduce the prevalence of wasting from 7.2% to 2%.	
Vietnam	34% <5 malnutrition (2000)	Reduce <5 malnutrition to 25% 2005, 20% 2010.		Faster reduction than MDGs (WDI base year)

IMR Infant mortality rate; CMR Child mortality rate; ARI Acute respiratory infection; <5MR Under-five mortality rate; NER Net enrollment rate. PCR Primary completion rate; UPE Universal primary education; UN United Nations; WB World Bank; WDI World Development Indicators.

*Note:* Where cells are left blank, we lacked the baseline data to calculate what the MDG target would imply for the 2015 target.

a. Harrison, Klugman, and Swanson (HKS, 2004) classify the target as “more ambitious” based on the rate of reduction to 2004. Presumably, the 2015 target in the PRSP still does not achieve the MDG because of the need to make up ground lost when IMR increased after transition started.

b. HKS say more ambitious based on target rate of improvement from 1999, but this follows slow progress in 1990s.

c. See previous comment on IMR.

d. HKS say more ambitious based on rate of change to 2005, but the 2010 target suggests that this rate of decline is not expected to be maintained thereafter.

e. Sixty-nine percent from WDI data.

f. HKS say less ambitious based on target of percentage completing in six years (more demanding than the MDG).

*Sources:* National data and data base compiled by DECDG (Development Economics DataGroup), and used in Harrison, Klugman, and Swanson (2004).

## APPENDIX C: OFFICIAL DEVELOPMENT AID

**Table C1: What percentage of Official Development Aid is recorded in the balance of payments?**

Country	<i>Official transfers and net disbursements<sup>a</sup> as percentage of net ODA disbursements<sup>b</sup></i>				
	1998	1999	2000	2001	2002
Albania	53	43	57	77	68
Benin	68	77	53	76	65
Burkina Faso	104	95	84	88	68
Cambodia	n.a.	n.a.	74	87	92
Ethiopia	n.a.	n.a.	57	54	72
Ghana	n.a.	n.a.	n.a.	57	16
Nepal	n.a.	107	90	75	70
Nicaragua	49	62	75	46	80
Rwanda	n.a.	n.a.	n.a.	97	75
Tajikistan	n.a.	33	35	74	114
Tanzania	36	79	87	40	0
Uganda	89	79	63	98	112
Vietnam	51	52	51	53	48
Average	64	70	66	71	73

Sources: a. International Monetary Fund

b. Development Assistance Committee and World Development Indicators on donor-reported aid disbursements.

**Table C2: What percentage of official flows supports government expenditure?**

Country	<i>Net official flows in fiscal tables as percentage of net official flows in the balance of payments</i>						
	1998	1999	2000	2001	2002	2003	2004
Albania	<b>91</b>	<b>105</b>	<b>87</b>	<b>64</b>	<b>82</b>	<b>43</b>	<b>64</b>
Benin	66	67	59	67	54	55	46
Burkina Faso	62	88	89	94	96	98	100
Cambodia	0	0	63	53	61	57	54
Ethiopia	0	0	82	93	88	108	99
Ghana	0	0	0	155	86	83	80
Nepal	0	51	63	64	61	57	76
Nicaragua	82	104	79	75	88	87	84
Rwanda	0	0	0	<b>80</b>	<b>71</b>	<b>72</b>	<b>79</b>
Tajikistan	25	71	11	25	17	14	28
Tanzania	92	48	61	87		73	77
Uganda	78	88	89	75	96	98	95
Vietnam	67	70	68	59	78	42	50
Average	70	77	68	76	73	68	72

Sources: See table C1.

**Table C3: Budget Support as Percentage of Official Finance of Government Expenditure**

Country	<i>Budget support disbursements as percentage of gross official flows recorded in "Government Revenues and Expenditures"</i>						
	1998	1999	2000	2001	2002	2003	2004
Albania	30	13	22	4	16	15	8
Benin	23	30	2	34	5	12	n.a.
Burkina Faso	15	18	10	22	30	34	29
Cambodia	n.a.	n.a.	16	7	16	13	10
Ghana	n.a.	n.a.	n.a.	37	43	52	56
Rwanda	n.a.	n.a.	n.a.	45	65	51	63
Tanzania	38	31	31	44	58	56	57
Uganda	36	34	32	42	52	56	50
Average	29	25	19	29	36	36	39

Note: Some data relate to financial years. FY2002/3 is reported as 2003. Data for 2004 are mostly program projections.

Sources: Latest PRGF reports, Government Revenues and Expenditures tables.

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