Working together for better health
Working together for better health
the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition

WHO Constitution

1 www.who.int/gb/bd/PDF/BDenglishConstitution.pdf
Preface

All of us want to be healthy. Whoever we are and wherever we live, we value our health and that of our loved ones above almost everything else. Good health and education are the foundations upon which we can realise our hopes, make the most of our lives, and fulfill our true potential.

Our own development in the UK over the last 200 years would not have taken place without access to health services, education and reliable water and sanitation.

Most of us in the UK can walk to our doctor’s surgery. We can get not just primary healthcare, but sophisticated medical help if things go badly wrong. But poverty bars many of the world’s people from what we take for granted. If you are denied a good education and access to clean water, or the chance to vaccinate your children and get medicine when you fall ill, then protecting your health becomes an almost insurmountable challenge.

Across the 20th century there was steady improvement in the health of the world’s population: people lived longer, had smaller families and lost fewer children from illness. But this progress has slowed right down, and the rise of HIV and AIDS puts even the gains of the last century at risk.

We have to change this if we want to deliver the Millennium Development Goals at the beginning of this new century. And delivering universal access to health, education, water and sanitation promises extraordinary results for global development.

Our strategy on health found in the following pages outlines the priorities that will guide how the UK works with developing countries to improve the health of their citizens. If we can invest in what works and bring together the efforts of governments, civil society and others, we can provide better – and fairer – access to the basic services that improve health. And if we do this then the health of the poorest people will be transformed.

Rt Hon Hilary Benn MP
Secretary of State for International Development
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## Abbreviations

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<tr>
<th>Abbreviation</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>AMCs</td>
<td>Advanced Market Commitments</td>
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<td>BMGF</td>
<td>Bill and Melinda Gates Foundation</td>
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<td>DALYs</td>
<td>Disability Adjusted Life Years</td>
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<td>EC</td>
<td>European Commission</td>
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<td>EU</td>
<td>European Union</td>
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<td>GAVI</td>
<td>The GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation)</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<td>GFATM</td>
<td>Global Fund to Fight Aids, Tuberculosis and Malaria</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IFC</td>
<td>International Finance Corporation</td>
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<td>IFFIm</td>
<td>International Finance Facility for Immunisation</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<td>PDPs</td>
<td>Product Development Partnerships</td>
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<td>PSA</td>
<td>Public Service Agreement</td>
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<td>SARS</td>
<td>Severe Acute Respiratory Syndrome</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children Fund</td>
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<td>UNITAID</td>
<td>International Drug Purchase Facility</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Chapter 1: Good health, fairer world: Why improving health is crucial in the fight against global poverty

Development is about eliminating poverty. And the good health of the people of the world is intimately bound up with the world’s prosperity. The healthier people are, the less likely they are to be poor – the more entrenched poverty is, the more likely people are to become ill and die.

Setting out our strategy

This paper sets out DFID’s strategy to support developing countries in improving the health of their people and reaching the Millennium Development Goals. The conclusions here are rooted in broad public consultation, analysis of the challenges facing developing countries and a review of the evidence for what works. Working together for better health updates Better Health for Poor People, launched in 2000, and sets out the principles and priorities that will guide UK efforts over the coming years. It also draws on recent documents, including the UK Government White Paper, Eliminating world poverty: making governance work for poor people (2006); Taking Action: The UK’s Strategy for tackling HIV and AIDS in the developing world (2004); and Health is Global: Proposals for a UK Government-wide Strategy (2007).

Health of the poor a priority

The health of the poorest people is a priority for DFID. And over the lifetime of this strategy, we will provide more resources to support countries in implementing their own plans, enabling them to build health systems which can deliver many different services. This will be underpinned by an international system that works together better with clear roles for all partners, a sensible division of labour and joint accountability in supporting country plans and priorities. We will link aid closely to results and will use UK assistance to support under-resourced countries where health indicators are worst.

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At the beginning of the 21st century poor people still cannot meet their needs and realise their full potential, because they suffer disproportionately from disease. Women and children are particularly vulnerable, and although poor people value good health above all else, too often they simply cannot get access to basic health services.

**Investing in health attacks poverty**

The evidence is unequivocal. Investing in people’s health drives back poverty. Conversely, failing to invest is not only disastrous for individual countries but has a global effect – as in the case of HIV and AIDS.

For most of the world’s poor people, protecting and maintaining their health is a daily and costly challenge – and the financial consequences of the death or illness of a family member can plunge poor families further into poverty. So improving health is essential if developing countries are to break out of the cycle of economic poverty.

Improving health means addressing the underlying causes of disease. This, in turn, means supporting people so they can meet their basic human needs: for clean air and safe water; adequate food; protection from environmental dangers; and opportunities to contribute to their communities and make informed choices. Achieving such social and economic development requires investment in: job creation; food security; women’s empowerment and gender equality; education; clean water and sanitation; accessible health services; and in reducing social exclusion. Inevitably many factors determine how much things change but top of the list has to be political will, and the decisions of governments in allocating resources.

Successfully improving health is most likely if it is embedded as a goal in a country’s overall plan to reduce poverty. DFID believes that huge improvements can be achieved by investing more in creating fair access to basic services for health, education, water and sanitation and social protection.

**Charting progress**

The Millennium Development Goals (MDGs) set a global target for what needs to be achieved to reduce poverty by 2015. Progress has been made but it has been too slow, despite the real gains achieved during the final quarter of the 20th century. And in the poorest countries, many gains have now been lost. If we cannot speed up our response, most developing countries, and almost all in Africa, will not even come close to realising the MDGs.

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3  *The Millennium Development Goals, Rising to the Challenges.* World Bank Report, 2006
That said, a greater international commitment to act against poverty and to increase resources for developing countries has been emerging and has brought a particular shift in relation to health, as reflected in chapter two.

Major challenges
Governments in developing countries understand the importance of investing in health to boost development. But as chapter three explains, they face major challenges in dealing with: high burdens of disease; weak health systems; poorly co-ordinated international support; and sometimes traditions or cultures which oppose key actions which will improve health.

UK Government priorities
The government’s priorities for improving the health of poorer people are outlined in chapter four. In order to strengthen delivery and ensure accountability within individual countries, these priorities require partnership with governments, civil society and others. While the responsibility for these priorities will largely fall to DFID, other government departments will also contribute.

The UK has committed to provide 0.7% of its GNI as aid by 2013. This is a welcome leap in the aid budget, and it demands imaginative approaches to delivering aid through bilateral and multilateral channels. We will allocate money based on the evidence of how effective these approaches are – for example, do they bring visible improvements in health and health services.

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1 Prime Minister’s Foreword to Eliminating world poverty: Making governance work for the poor. 2006
Chapter 2: 
Getting better: 
Where and why the health of poor people has improved

Throughout the 20th century and into the 21st century people’s health has improved. Life expectancy has increased, population growth has slowed and both adult and child mortality has fallen.

Economic development has doubtless improved people’s health. But dramatic improvements in Cuba, Sri Lanka and India’s Kerala state show that progress on health does not necessarily depend on high incomes or rapid economic growth.\(^5\)

Social improvements mean better health
Social changes, particularly the reduction of inequality and the greater economic empowerment of women, have also led to better health for women and their families. An educated woman, for instance, is 50% more likely to have her own children immunised\(^6\). And targeted incentive payments have encouraged school attendance and increased the number of people, particularly children, using health services. Poor people have used cash provided through targeted support and micro-credit schemes to improve their own and their families’ health.

Improvements in water supply, sanitation and hygiene have helped prevent diarrhoeal diseases, a major cause of child deaths. Girls who spend their days collecting water often miss out on schooling, so when water is available near the home it means they can go to school. Their attendance improves again when schools have water and appropriate toilet facilities.

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\(^6\) Girls’ Education: towards a better future for all. DFID, 2005
DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE

How better sanitation encouraged more girls to attend school in northern Nigeria

DFID’s £26 million Girls’ Education Project is implemented through UNICEF in areas of Northern Nigeria, where the gap between the numbers of boys and girls attending school is largest. At Konkiyel Primary School the project has provided a borehole to supply clean, safe water for drinking and hand washing, and two separate blocks of toilets for use by girls and boys. Twelve-year-old Aishatu Aliyu, a pupil in primary six at Konkiyel says: “Before the new block of toilets was built, we used to go to the bush. Apart from the risk of snake bites and other hazards, many girls were exposed to social embarrassments and even sexual abuse.”

With a safe and clean environment for washing and personal hygiene, the school is now more attractive, especially to girls. “Even during my monthly menstrual period, I can still attend school. With a toilet and water in school, I can take good care of myself without facing any embarrassment from the boys,” she says.

Aishatu is an active member of the school’s Environmental Health club set up after Head Teacher, Idris Ali, attended Hygiene and Sanitation training supported by the project. The club’s 45 members, most of whom are girls, ensure that toilets are kept clean and that children practice good use of the facilities. As a result of the project, girls’ enrolment has leapt from 161 in 2005 to 553. Boys too are attending in greater numbers, with enrolment more than doubling to 666.

The power of vaccines and essential medicines

New health technologies, and the systems to deliver them, have both reduced disease epidemics and population growth levels. Smallpox was the first disease to be eradicated in 1977. Polio, despite recent reversals, is likely to follow soon. Immunisation has dramatically reduced the incidence of a range of diseases. These include measles (60% fall in child measles deaths since 19997), diphtheria, whooping cough and tetanus. Advances in contraception, and the fact that more people are using it, have contributed to falls in global fertility rates – with women in 2006 having an average of 2.6 children compared to five in 19608.

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7 www.who.int/mediacentre/factsheets/fs286/en/
8 www.unfpa.org/swp2006/englishNotes/Indicators/e_indicator2.pdf
In recent years, access to drug treatment has transformed AIDS from a death sentence into a potentially manageable chronic illness. The availability of new technologies also holds the promise in the near future of further progress in reducing the impact of malaria and a number of other diseases which are preventable by vaccines. At the same time there are concerns. How, for instance, do we sustain funding for the take-up of new technologies, and how do we make sure it isn’t simply diverting resources from other vital programmes such as sexual and reproductive health and family planning?

**DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE**

**Making smallpox and polio history**

Thirty years ago, smallpox became the first disease to be eradicated by vaccination. This devastating disease killed almost a third of those infected. In the early 1950s an estimated 50 million cases occurred in the world each year, falling to 10 – 15 million by 1967, when WHO launched the campaign for the global eradication of smallpox. The last natural case occurred 10 years later in 1977. This major public health success was followed in 1988 by an effort to eradicate polio, a disease that caused widespread disability. Five million cases of paralysis due to polio have been prevented. Since 1988 DFID has contributed $570 million to the eradication effort that has reduced the number of cases from 350,000 to 2,000 and the number of countries where the disease is present from 125 to four.

The MDGs have successfully created a common global commitment and purpose to improve health. They are a yardstick to measure progress, and in 2006 the UN General Assembly incorporated additional targets and indicators for reproductive health, HIV and AIDS treatment, employment and the environment.

**More money available**

Today there is more money available for health through increased and improved aid, debt relief, and other initiatives promising large rises in development assistance up to 2015. These include the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the GAVI Alliance, UNITAID, the International Finance Facility for Immunisation (IFFIm), launched in 2006, and major investments in primary education through the Fast-track Initiative. Philanthropic foundations, particularly the Bill and Melinda Gates Foundation (BMGF), are also providing increasing support to improve global health.

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9 www.who.int/mediacentre/factsheets/smallpox/en/
10 www.who.int/mediacentre/factsheets/fs114/en/
What DFID invests in Global Funds and innovative financing approaches to aid

- DFID has committed £359 million over 7 years to 2008 to GFATM, with a doubling of our pledge for 2006-7 to £100 million per year subject to performance.

- DFID has committed £30 million over 2 years for the current phase of GAVI. For previous phases DFID has spent £35 million.

- UNITAID, the new drugs purchase facility, was established in September 2006. The UK was a founder member and pledged £15 million, as part of a 20 year commitment, increasing to £40 million a year by 2010, subject to performance.

- The IFFIm was launched in 2005, and will fund GAVI. It works by investing the majority of resources up front to increase the flow of aid – this makes sure that there is reliable, long-term funding for immunisation programmes and to develop health systems up to 2015. DFID has committed £1.4 billion.

- The UK announced support for Advanced Market Commitments (AMCs) in December 2004, developed it further at Gleneagles, and with Italy, helped launch the pilot for pneumococcal vaccine in Rome in February 2007. DFID has committed £485 million to the pilot AMC for pneumococcal disease.

- DFID has committed £150 million over 3 years (2006-2009) to fund the Fast-track Initiative in Education.

Aid and performance

We are now paying greater attention to ensuring that aid is used more effectively to support national poverty reduction strategies and to working collaboratively with other donors to support national efforts. There is an emphasis on linking aid to performance and the G8 (the group of leading, industrialised nations) is committed to increasing aid which delivers key services like vaccinations or training midwives to be with mothers when they give birth. We are delivering support as flexible, longer-term commitments, which means that countries can plan ahead. Developing countries have also accepted the need to increase their own budgets for health, and there is a growing determination to strengthen health systems so that a range of essential services is provided.
Major challenges

However, alongside these hopeful signs, new challenges threaten progress toward global health security. The uncontrolled spread of HIV and AIDS, and the possibility of an influenza pandemic pose major threats to humanity. Drug-resistance to tuberculosis, malaria and HIV and AIDS is increasing. The Severe Acute Respiratory Syndrome (SARS) epidemic in 2003, caused by a new infection, had massive economic effects. And changes in the climate caused by global warming also threaten to spread disease more widely. As the global population grows to between 7.8 billion and 10.8 billion by 2050\(^1\), the ecosystem will come under unprecedented stress. As most of this growth will be in developing countries, it will be a huge challenge to governments’ ability to deliver basic services. These new challenges affecting developing countries have to be faced, whilst also dealing with a growing burden of disease.

\(^{11}\) http://esa.un.org/unpp/
Chapter 3:
Making the diagnosis:
How we can improve the health of poor people

Millions of people still have no access to basic services, dying needlessly from diseases that can be prevented or treated at low cost. Poor health is holding back sustainable development and leaving many communities trapped in poverty. Notwithstanding increasing commitment and funding within many countries, weaknesses at policy and institutional level are frustrating efforts to improve services and address the underlying causes of ill health. Progress has been worst in countries in sub-Saharan Africa – especially among the poorest populations and among women.

DFID sees three major challenges:
• Slow progress in achieving the MDGs and addressing the major causes of disease.
• Failure to invest in strengthening systems which can deliver essential health services.
• Poor co-ordination of international support, leading to inefficiencies in delivering aid.

CHALLENGE 1:
Slow progress in achieving the MDGs and addressing the major causes of disease

The MDGs cannot be achieved unless we accelerate our efforts. Progress has been made in Asia, but Africa is way off track in reaching any goal. In sub-saharan Africa malnutrition is on the rise. Although rates are gradually falling, South Asia still has the highest rates and the largest numbers of malnourished children. Contrary to popular perceptions, the levels of under nutrition in densely populated South Asian countries (India, Bangladesh, Afghanistan and Pakistan) are much higher (38 to 51%) than those in sub Saharan Africa (26%)\(^\text{12}\).

Other regions have also seen progress, but gaps between the health of the wealthiest and poorest populations are widening. Without boosting investment and ensuring it is used effectively, most countries will not reach the health-related goals. Continuing increases in population, putting services under still greater demand, will further undermine efforts. The MDGs are inter-dependent:

• Progress on malaria (MDG 6) will improve maternal health (MDG 5) and child health (MDG 4).
• Progress on HIV and AIDS (MDG 6) and gender equality (MDG 3) will speed progress on all goals.

\(^{12}\) Repositioning Nutrition as Central to Development. World Bank Report, 2006
• Reducing hunger and malnutrition (MDG1) will keep more children alive (MDG 4).

Progress towards the MDGs has been far too slow in many low and middle-income countries, and the MDGs relating to health are the most significantly off-track.

| Table 1 |
|-----------------|-----------------|
| **Goals and targets** | **Sub-Saharan Africa** | **Southern Asia** |
| **GOAL 1 | Eradicate extreme poverty and hunger** | | |
| Reduce extreme poverty by half | | |
| Reduce hunger by half | | |
| **GOAL 2 | Achieve universal primary education** | | |
| Universal primary schooling | | |
| **GOAL 3 | Promote gender equality and empower women** | | |
| Equal enrolment for girls in primary school | | |
| Women’s share of paid employment | | |
| Women’s equal representation in national parliaments | | |
| **GOAL 4 | Reduce child mortality** | | |
| Reduce mortality of under-five-year-olds by two thirds | | |
| Measles immunisation | | |
| **GOAL 5 | Improve maternal health** | | |
| Reduce maternal mortality by three quarters* | | |
| * Millennium Indicators – The available data for maternal mortality and malaria do not allow trends to be analysed. Progress has been assessed by the responsible agencies on the basis of proxy indicators.**
| To achieve universal access to reproductive health by 2015 | | |
| **GOAL 6 | Combat HIV and AIDS, malaria and other diseases** | | |
| Halt and reverse spread of HIV and AIDS | | |
| Halt and reverse spread of malaria* | | |
| Halt and reverse spread of tuberculosis | | |
| To come as close as possible to universal access to treatment for HIV/AIDS by 2010 for all those who need it# | | |
| **GOAL 7 | Ensure environmental sustainability** | | |
| Reverse loss of forests | | |
| Halve proportion without improved drinking water | | |
| Halve proportion without sanitation | | |
| Improve the lives of slum dwellers | | |
| **GOAL 8 | Develop a global partnership for development** | | |
| Youth Unemployment | | |
| Internet Users | | |

* Confirming new commitments made by Member States at the 2005 World Summit the UN Secretary General’s 2006 annual report recommended the establishment of four new MDG targets, including two health targets under MDG 5 and MDG 6. The new targets and indicators will be referenced in the annual MDG progress report.

New health targets – data not yet compiled
MDG 1: Eradicating extreme poverty and hunger

Malnutrition undermines health investment

Malnutrition undermines investments in health, education and economic development. Over half of all child deaths occur in children who are underweight. It impairs learning and childhood development, reduces work productivity and leads to disability. Some of the critical issues influencing nutritional status are:

- deficiencies of micronutrients;
- infectious disease;
- inappropriate infant and child feeding practices; and
- discrimination against women and girls.

At the other end of the spectrum, obesity is a major factor in the rapid rise of non-communicable diseases, including cardiovascular disease and diabetes.

If we are to improve nutrition we need co-ordinated action to:

- secure food for people;
- respond to humanitarian emergencies;
- increase people’s income;
- empower women and improve the status of girls;
- create better access to clean water and sanitation; and
- promote dietary and lifestyle changes.

DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE

Tackling the underlying causes of ill health in Thailand

Thailand has show that moderate to severe malnutrition can be reduced by 75% in a decade. In 1981 about 51% of pre-school children suffered from malnutrition. The following year a series of reforms were introduced which changed priorities in favour of:

- preventative health measures;
- primary health care with an emphasis on nutrition, clean water and sanitation, essential drugs and immunisation; and
- community involvement in administration, financing and decision taking through village committees and village health communicators and volunteers.

The results were spectacular. By 1989:

- malnutrition had fallen to 21%;
- the infant mortality rate had declined from 41 per 1000 in 1981 to 28 per 1000;
- access of households to clean water had risen from 32% in 1982 to 78%; and
- 98% of all villages were taking part in the primary health care programme.


www.who.int/whr/2005/en/
MDG 4: Improving child health

Early deaths remain a problem

Fewer children are dying in the first five years of life (10.1 million in 2005 compared to 13 million in 1990) but little progress has been made in preventing deaths in the first month of life. The major investments in immunisation and in addressing specific diseases, have not been matched in efforts to prevent deaths in the first month of life, nor to provide safe water, sanitation and hygiene, nor to improve nutrition. But these are the very actions that offer the greatest gains.

- Three-quarters of the four million neonatal deaths each year could be prevented if women received the right care in pregnancy and childbirth.
- Growing numbers of vulnerable children are excluded from care and protection because their mothers are dying of AIDS.
- Half of all child deaths occur in six countries – India, Pakistan, China, Nigeria, Ethiopia and the Democratic Republic of Congo.
- Half are the result of five conditions – diarrhoea, pneumonia, malaria, HIV and AIDS, and measles, with malnutrition a factor in half of all deaths.
- At least 60 million girls who would otherwise be expected to be alive are ‘missing’ from various populations as a result of sex-selective abortions or neglect.

Most deaths can be averted

The truth of the matter is that most childhood deaths could be averted through action at community level, supported by a well-functioning health system.

MDG 5: Improving maternal health

Women die needlessly

More than half a million women still die unnecessarily each year due to complications during pregnancy and childbirth – 99% of them in developing countries. But for a few exceptions, maternal health has not improved since the launch of the Safe Motherhood Initiative in 1987. Most of these deaths would be prevented if every woman was attended during birth by a health worker with midwifery skills and backed up by timely access to emergency obstetric care when needed.

Different health threats

More than 200 million women either want to limit their family size or increase intervals between pregnancies. But most of them are either using no contraception, or are relying on often ineffective traditional methods. Each year 87 million women – including many adolescent girls – face an unplanned
pregnancy, of which 46 million seek an abortion. 19 million of these abortions occur in unsafe circumstances with a high chance of disability or death. HIV infection and TB are two of the most significant causes of death among pregnant women in countries where the epidemic is severe. HIV and AIDS-related services must be integrated into maternal health services.

Breaking down barriers

While the response of a health service to women’s needs is central, it needs to be complemented by greater attention to women’s rights – so that women can make their own choices and have access to services. We must address the social and

DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE

Reducing deaths from abortion in Nepal

A large proportion of maternal deaths in Nepal are due to unsafe abortion. Following widespread social pressure, in March 2002 the government legalised abortion. DFID has supported this effort, contributing to the evidence of the effects of unsafe abortion, preparing policies in the build up to legalisation, and supporting implementation of the law.

In the three years since the national programme was initiated, DFID has helped train 351 service providers and establish 163 simple, safe and woman friendly service sites in public hospitals and in private and NGO clinics. By December 2006, 70 of the 75 districts had at least one safe service site and 85,984 women had received abortion services.

Without this initiative, many of these women would have been driven to seek unsafe abortions, often with tragic consequences. Hospitals are reporting a reduction in the number of women presenting with complications due to infected abortion.

Jugmaya comes from the mountain area of Bhojpur district. She has a 10 year-old daughter, but all her time and energy is taken up by looking after her 16 year-old son who is completely paralysed on one side. When she became pregnant again, she and her husband felt that they would not be able to care for another child and decided to have an abortion at the Maternity Hospital in Kathmandu.

“As I had no experience of abortion before,” recalls Jugmaya. “I was very worried about coming. I was very relieved that the service was so good. I recovered quickly and was able to go home the same day. I will definitely recommend friends to use this service if they have an unwanted pregnancy.”

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20 Death and Denial: Unsafe Abortion and Poverty. IPPF, 2006
economic barriers to access and use of services such as the fees people are asked to pay, transportation costs, gender inequality and power relations in household decision-making.

Commitment waning

At the 1994 International Conference on Population and Development the international community made a bold commitment to sexual and reproductive health and rights. But this commitment is waning. Between 1995 and 2003 donor support for family planning supplies and services fell from $590 million a year to $460 million, the explanation being competing priorities in light of the HIV and AIDS pandemic\(^\text{21}\). Yet high birth rates remain one of the main development challenges. And among women of reproductive age, sexual and reproductive ill health accounts for one-third of the disease affecting them. Among the total population it is one-fifth.\(^\text{21}\)

It is critical that women gain access to contraceptives and to reproductive choices, such as safer abortion care. It is critical that we treat and prevent sexually transmitted infections, and place more emphasis on combined prevention interventions for HIV and AIDS. The more research we do, the more we will find effective, affordable and acceptable means of contraception and protection from sexually transmitted infections. Policies and programmes must specifically address young adolescent girls who are a particularly vulnerable group.

**MDG 6: Combat HIV and AIDS, malaria and other diseases**

Disease still rife

Despite massive increases in resources to tackle HIV and AIDS, TB and malaria, their impact is growing. We must use resources more effectively to support health systems, deliver integrated services and address the underlying reasons why people are vulnerable to such diseases.

- HIV and AIDS remains the greatest challenge, debilitating public services and private enterprise, and sabotaging progress. The 15 million children orphaned by HIV and AIDS\(^\text{22}\) carry huge implications for investments in education, health and economic development.

- With four million new infections each year, there are now almost 40 million people living with HIV and AIDS.\(^\text{23}\) Since the epidemic began 25 years ago, 25 million people have died of AIDS-related diseases.\(^\text{24}\)

\(^{21}\) *Adding it up – the benefits of investing in sexual and reproductive health care*. UNFPA/Guttmacher Institute, 2003

\(^{22}\) *A call to action: Children the missing face of AIDS*. UNICEF/UNAIDS 2005


\(^{24}\) *AIDS epidemic update*. UNAIDS 2006.
• Women, girls and vulnerable groups\textsuperscript{25} are being hit the hardest. In sub-Saharan Africa there are 14 adult women infected with HIV for every 10 adult men affected.\textsuperscript{26} Gender inequality and discrimination against vulnerable groups means they don’t have control over the sexual and reproductive aspects of their lives, nor access to the right health care. Halting the spread of the epidemic will only come with increased action on human rights and gender equality.

**DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE**

*Friends in Need: HIV/AIDS Services in Thailand*

Thailand continues to be challenged by the HIV/AIDS epidemic within high-risk groups like injecting drug users. This group is often discriminated against by public health care services.

As part of INNOVAIDS, a multi-country project to develop innovative HIV/AIDS prevention services, implemented by Population Services International (PSI), DFID provided financial support to the O-Zone drop-in centres. These centres are designed to reduce the rate of HIV among injecting drug users and provide alternatives to drug use. They provide peer support and educational tools to help drug users to take control of their lives and addictions.

Daeng’s HIV status was making him increasingly weak and he was having trouble sticking to his AIDS drug regimen. This allowed the virus to build up a resistance to the medication. After spending time at O-Zone, he decided to visit its medical clinic for a consultation and check-up. Despite opposition from an outside hospital, support through O-Zone and MSF allowed him to receive an effective drug treatment programme, and his health gradually began to improve. He credits his friends at the drop-in centre for helping him stay off drugs, and the programme for facilitating the improvement of his health. Daeng now has a job as a peer educator at O-Zone, and is helping drug users who are in the same position he once found himself in.

**Beyond sub-Saharan Africa**

While the greatest burden of HIV and AIDS remains in sub-Saharan Africa, people in Asia and Eastern Europe also face growing epidemics. Despite ambitious targets supported by social action and resources, the response has not matched the

\textsuperscript{25} Groups particularly vulnerable to HIV infection include men who have sex with men, injecting drug users, sex workers, prisoners and adolescent girls.

spread of new infections. It is a challenge in all societies to change deeply entrenched behaviours and cultural norms, particularly when these relate to sexuality, gender and power relations (that contribute to gender-based violence and discrimination).

While for some people HIV and AIDS is a manageable problem thanks to greater access to treatment, it has also created a monumental task in establishing sustainable, fair and affordable health systems that deliver care to all, including the most vulnerable. And as treatment is rolled out, it must be accompanied by investment in decent care for those who are dying.

**TB**

In 2005 there were 14.1 million cases of tuberculosis and 1.6 million deaths\(^{27}\). While many countries have made big progress, these gains are threatened by co-infection (instances where people are infected with both TB and HIV) and the emergence of drug-resistant TB strains.

**DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE**

**Improving TB Control Programmes in Pakistan**

Research in Pakistan funded by DFID examined why people stopped receiving TB treatment and why those who began treatment often didn’t follow their drug regimens. The research was designed in partnership with the Pakistan National TB Programme, so that the results were directly fed into national guidelines and training materials. This led to a pilot of TB services integrated within district health systems, provincial TB strategies, and guidelines for district planning and case management.

Successful treatment rates have now leapt from around 30% to 84%, making a significant contribution to the health of the estimated 250,000 new TB patients each year. The TB case management guidelines have been adapted and adopted by the national programmes in other countries such as Uganda and China.

See page 36 for details of major investment by the Government of Pakistan and other development partners in the health sector (supporting Pakistan’s Health Priorities).

**Malaria**

Half a billion people suffer from acute malaria each year, resulting in one million deaths\(^{28}\). These are mostly among children, and 90% are in sub-Saharan Africa. Widespread use of insecticide-treated nets and indoor residual spraying, coupled with more effective treatment regimes, promise rapid progress. But climate change will increase malaria risk considerably.

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27 www.who.int/mediacentre/factsheets/fs104/en/
28 www.who.int/mediacentre/factsheets/fs094/en/
Insecticide treated mosquito nets (ITNs) in Africa

- In Malawi delivery of ITNs is combined with other services. A nationwide programme, initially supported by DFID Malawi and now through the Health Sector Wide Approach, has been operating through antenatal services since 2002. ITNs are sold to pregnant women at a very low price. 42% of households own a mosquito net with net coverage for under-five children rising from 8% in 2000, to 20% in 2004.

- In Tanzania in 1994, a private textile company started to sell branded nets, and three competing brands entered the market soon afterwards. Over the next eight years, sales and coverage grew by about 20% per year, helped by a social marketing programme. Competition brought rapid improvements in quality and choice. By 2006, more than half of Tanzania's households owned at least one net, and net use is now steadily becoming a social norm. There has been a substantial decline in infant mortality rates, from approximately 100 per 1000 live births in 1995-99 to about 68 in 2000-04, and ITNs are one contributing factor. Tanzania is in the process of rolling out a national voucher scheme, to allow pregnant women to buy commercial ITNs at low prices. The voucher scheme is now being extended to under fives, and various catch up programmes are under consideration. DFID has provided over £12 million in support of social marketing of ITNs.
Partnerships to control the neglected tropical diseases (NTDs)

A number of partnerships with pharmaceutical companies have had spectacular success.

- River blindness (onchocerciasis) has been eliminated as a public health problem in 11 West African countries protecting 40 million people. Merck and Co. Inc., donate the drug ivermectin. Some 67 million people in 19 countries receive ivermectin through community directed treatment in Africa. DFID has provided £7.6 million to support the elimination of onchocerciasis from 1997 to 2007.

- Blinding trachoma is being treated with the drug azithromycin donated by Pfizer and provided through the International Trachoma Initiative alongside surgical treatment where necessary. It is also controlled by face washing and environmental change. Treatments have increased from 1 million to 16.6 million from 1999-2005 and surgeries from 5000 to 77,000 in 12 countries in Africa and Asia identified by the World Health Organisation as having especially high rates of trachoma infection.

- Guinea worm is close to eradication with cases falling from 1 million in 1988 to 25,000 in 2006. Asia has been certified as free of transmission and only 9 countries in Africa remain endemic.

- Lymphatic Filariasis has been eliminated in China from a population of 330 million. The donation of albendazole by GlaxoSmithKline and ivermectin by Merck & Co. Inc has enabled the launch of the Global Programme to eliminate filariasis which is active in 42 of 83 endemic countries. In 2005, 381 million received treatment. DFID has provided £4.3 million to support the elimination of Lymphatic Filariasis from 1998 to 2007.

- Schistosomiasis prevalence in Egypt has been reduced from 20% to between 2-5% using praziquantel. Similar success has been reported in China.

- Leprosy has been reduced as a public health problem and now is only a problem in 9 out of the 122 countries where it was present in 1985. The numbers of new cases has declined some 20% per year since 2001. Multi drug therapy is donated by Novartis.

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33 Dracunculiasis eradication. Weekly epidemiological record. 16(82):133-140. 2007
34 www.filariasis.org/resources/china_break_cycle.htm
38 www.who.int/mediacentre/factsheets/fs101/en/index.html
The shifting burden of disease

The health burdens of low and middle-income countries are particularly challenging because their populations are both growing and ageing. 1.6 billion adults are overweight\(^{39}\), which will mean they will have far more people with diabetes and cardiovascular disease, by far the largest global cause of death. Cancer is a growing challenge. Unchecked, tobacco use will cause 10 million annual deaths by 2020\(^{40}\), including 80% in developing countries\(^{41}\). Psychiatric conditions, particularly depression, mean people die early, and are particularly common in countries with a legacy of violent conflict. Six-hundred million people have a significant disability\(^{42}\), including 37 million who are blind\(^{43}\). Five million people die each year from injuries\(^{44}\), and 1.2 million people die through road traffic accidents\(^{45}\).

Illness and injury cause suffering even when they are not fatal. They affect the quality of life and life expectancy of many poor people. We take this into account by measuring the burden of disease in terms of Disability Adjusted Life Years (DALYs). Figure 1 shows how the main causes of this vary in different parts of the world.

**Figure 1: Burden of disease by disease categories by region**

![Diagram showing burden of disease by disease categories by region.](figure1.png)

Source: WHO Global Burden of Disease Data for 2002\(^{46}\)

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\(^{40}\) [www.who.int/tobacco/en/](http://www.who.int/tobacco/en/)

\(^{41}\) Curbing the epidemic: governments and the economics of tobacco control. World Bank, 1999

\(^{42}\) [www.who.int/nmh/a5817/en/](http://www.who.int/nmh/a5817/en/)

\(^{43}\) [www.who.int/mediacentre/factsheets/fs282/en/](http://www.who.int/mediacentre/factsheets/fs282/en/)

\(^{44}\) [www.who.int/features/qa/36/en/index.html](http://www.who.int/features/qa/36/en/index.html)


\(^{46}\) In Disability Adjusted Life Years (DALYs) per 100,000 population. The DALY is a measure of the burden of ill health taking into account reduced life expectancy and quality of life. The number of DALYs lost as a result of a disease is calculated by estimating the number of years lost due to premature death plus equivalent years of ill health.
By 2030, while the number of people with a communicable disease will fall, the number with non-communicable diseases will rise, along with the health needs of ageing populations. There has already been a shift towards chronic diseases requiring long-term and more expensive care in south Asia. Early action to prevent future disease, for example actions to reduce tobacco use and to improve diet, will bring major benefits.

**New epidemics**

Another threat is the emergence of new infectious diseases. Since the 1970s there have been more than 30 new disease outbreaks. In 2003, the 8,000 cases (774 deaths) of Severe Acute Respiratory Syndrome (SARS) in 26 countries caused economic losses of $30 billion. Avian flu has so far infected only 291 people (172 deaths) in 12 countries, but a future pandemic is thought to be inevitable – with fatalities estimated at up to 7.4 million. The UK Foresight Project outlined the risk of future infectious disease and highlighted the need to invest in new systems to detect, identify and monitor new threats. Driven by HIV and AIDS epidemics, tuberculosis is once again becoming a significant threat with the emergence of extensively drug-resistant strains. The UK plays an important role in monitoring diseases that spread across borders, implementing international health regulations and encouraging collective action against global health threats.

The challenge of rapidly rising populations can also undermine health gains and put a brake on economic growth. Many of the poorest countries will see a doubling or tripling of their populations over the next 50 years, excluding Southern Africa where HIV and AIDS is rife. This poses major challenges in reducing poverty, as countries find it difficult to meet the needs of growing populations, let alone in investing to improve the quality and coverage of basic services.

**MDG 7: Ensuring environmental sustainability**

**Environment and disease**

Preventable environmental causes are behind one quarter of global disease. This includes unsafe water (compounded by poor sanitation and hygiene); air pollution; and road traffic injuries. Each year more than 1.6 million people die as a result of indoor air pollution from cooking, heating and lighting using traditional fuels.

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47 Investing in Global Health, “Best Buys” and Priorities for Action in Developing Countries. Disease Control Priorities Project 2, April 2006
52 Population Growth and the attainment of the MDGs. APPG on Population, Development and Reproductive Health 2006 Hearings report.
53 www.who.int/heli/en/index.html
54 www.who.int/indoorair/health_impacts/burden_global/en/index.html
Climate change
Global warming and environmental change intensify threats to health, through higher temperatures, reduced rainfall, droughts and other extreme weather. There will be significant health implications as vector-borne and water-related diseases are influenced by temperature and rainfall.

Growing cities
Increased urban living brings particular health challenges, especially for the one third of the global population (and three quarters of sub-Saharan Africa’s urban population) who live in slums. High-density living, poor waste disposal, air pollution and violence all lead to increased vulnerability. The world’s slum population is forecast to increase from 998 million in 2006 to 1.4 billion by 2020.

CHALLENGE 2: Failure to invest in strengthening systems which can deliver essential health services

It is a major undertaking to plan, budget for and manage public services, and put in place health systems that respond to people’s needs. If a health system is to work, key building blocks need to be in place.

Key elements of an effective health system

- Government oversight and stewardship.
- A robust and ambitious health plan to ensure access to basic services.
- An adequate and reliable budget and effective financing systems.
- Protection from financial risk.
- An accessible, trained, motivated and productive workforce.
- Essential infrastructure, such as hospitals, roads and water systems.
- A reliable supply of essential medicines and health equipment.
- Ways to make use of the skills of both private and voluntary sectors, and to involve communities.
- Management capacity.
- Surveillance and information systems to adapt the health system to changing needs.
- ‘Surge capacity’ to respond promptly and effectively to disease outbreaks and other emergencies.

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55 State of the World’s Cities Report. UN Habitat, 2006/07
56 WHO defines a health system ‘to include all the activities whose primary purpose is to promote, restore or maintain health. This broad definition includes formal and traditional health services, self care, traditional public health activities such as health promotion and disease prevention and other health enhancing interventions like road and environmental safety improvement. Beyond the boundaries of the definition are activities whose primary purpose is something other than health – education for example even if these activities have a secondary health enhancing effect.'
Funding shortfalls
In many countries health funding falls far short of what is needed to provide access for everyone. Public health budgets are inadequate. Most are a long way off the $34 minimum\(^{57}\) which the WHO estimates must be spent on each person to deliver an essential package of care. While African ministers of health have committed to provide 15% of their governments’ budgets for health,\(^{58}\) few have met this target. Even if they did, resources would still fall far short of the per capita target. Most finance for health care in low-income countries comes from the pockets of poor people themselves, and much of this goes to unregulated, poor-quality services in the private sector. In the medium-term, donors will need to provide further financial assistance, because most low-income countries will not be able to raise enough to deliver basic health services for everyone.

Resource allocation
Resources are often allocated unfairly and inefficiently. Too often government budgets are not provided for the services that achieve the greatest health benefits, and that target diseases among the poor. Instead they disproportionately support hospital services for urban populations.

Planning constraints
The broader national situation can place constraints on health-sector plans. Investments in health will be more effective only if they work in tandem with efforts to strengthen government planning, management, financial and procurement systems, and improvements in monitoring progress. Broader governance reforms have a major impact on the health sector. For instance, strengthening public financial management systems has achieved a great deal over recent years. This experience needs to be applied to national procurement and supply systems, particularly for essential medicines. This will improve services and give donors confidence to use government systems – rather than to set up alternative systems that ultimately undermine government services.

Waste and fragmentation
Measures which are focused solely on specific diseases can offer outstanding results but sometimes this is at the expense of fragmentation of health services. While donor funds often target specific diseases through individual projects and promise quick returns, they can have unintended consequences on the wider health system and are not always sustainable. And if they are delivered through separate procurement, financing, accounting and reporting structures this can also prove wasteful for governments.

\(^{57}\) Recommended by the WHO Commission on Macroeconomics and Health.
\(^{58}\) Abuja Declaration 2001
**DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE**

**Disease-specific Dangers: Lessons from Nigeria**

A polio virus from Nigeria spread to 19 countries after the suspension of polio immunisation in Northern states in 2003/04. Both the Nigerian Government and international donors poured resources into the fight against polio, while the basic primary health care system, including routine immunisation, was allowed to collapse through mismanagement and diminishing resources.

After multiple rounds of National Immunisation Days for polio over several years, the population of northern Nigeria became highly suspicious of the exclusive emphasis on polio. Because, in the meantime, their children were dying in huge numbers of malaria, measles and other preventable diseases, with no access to medicines, vaccines or basic medical care. Nigeria’s child mortality rate has remained stagnant for four decades, and, in northern Nigeria, one child in four dies before its fifth birthday. This suspicion explained why there was a widespread boycott of the polio vaccine programme, amid rumours that the vaccine was deliberately contaminated with anti-fertility agents as a covert means of population control. As a result, the polio virus had a resurgence, reinfected at least a dozen previously polio-free countries and put global eradication in jeopardy.

In late 2005 the Nigerian Programme on Immunisation was restructured and a new strategy emphasized the importance of routine immunisation services in primary health care. The polio immunisation strategy in the north was changed from national immunisation days focusing on polio alone, to “immunisation-plus days” offering the full range of childhood immunisation, as well as other basic health protection products – in conjunction with a switch to a more targeted vaccine for polio. This led to a huge increase in routine immunisation rates in the north, both for polio and other standard vaccines.

Coverage of DPT3 vaccine doubled from 38% in December 2005 to 72% in December 2006. The number of cases of polio has reduced from 258 cases of polio (type 1) in the first quarter of 2006, to 15 cases in the first quarter of 2007. DFID has recently launched a £20 million routine immunisation programme in four northern states.

**Health worker shortages**

There are not enough trained and motivated health workers to deliver basic services, with the global shortage estimated to be four million by 2015. In 57 countries, mainly in Africa, this crisis is deepening, as long-term chronic under-investment is exacerbated by losses due to HIV and AIDS and outward migration of skilled staff. Many low-income countries have less than one health worker per 1,000 people – against a minimum recommendation of 2.5/1,000. And these are often concentrated in urban areas or the private sector.

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Using new health workers to extend health services in Ethiopia

Two years ago only two-thirds of Ethiopians had access to health services. Ethiopia’s new Health Extension Programme (HEP), supported by DFID, is designed to rapidly increase access. HEP targets households at kebele level (communities of about 5000 people). In each kebele, two female Health Extension Workers (HEWs) are employed by the respective districts following completion of a one-year training course. Each pair of HEWs is based in a Health Post, with technical support from a Health Centre and supervision from the district health office. Although the rollout of HEP is not complete, an independent evaluation found that its expansion has already improved access to preventive health care services in rural areas.

In 2004, a zonal administrator was asked if he would stay in a village overnight. His hosts were embarrassed when the administrator asked, “but what happens if I need a latrine?” The zonal administrator noted the obvious shame his question had caused. He was later invited a second time by the same village, but this time the whole village had built latrines as part of an intensive effort involving communities and guided by newly-deployed Health Extension Workers.

Drug supply breakdown

It is estimated that one in three people in developing countries does not have regular and affordable access to essential drugs. 137 million women who have expressed an interest to space or limit their family size are not using any form of contraception, and a further 64 million rely on less effective methods. National drug budgets are inadequate, procurement is often inefficient, corrupt or both. Countries do not maximise economies or flexibilities in international agreements, and logistics systems are often inefficient. Lack of confidence in the national drug supply system explains why donors establish parallel supply arrangements – which only increase the difficulty of managing drug supplies. Fake and substandard drugs are also a major problem, along with a lack of transparency in drug pricing and quality.

Fake drugs on the market

A reported 40% of artesunate drugs (an anti-malarial drug) bought in South East Asian Markets contained no active ingredient. In China up to 50% of drugs checked in one study were fakes.

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60 Increasing access to essential medicines in the developing world: UK government policy and plans. DFID, 2004
61 Adding it up – the benefits of investing in sexual and reproductive health care. UNFPA / Guttmacher Institute, 2003
62 Seiter A. Pharmaceuticals: counterfeits, substandard drugs and drug diversion. World Bank HNP Brief 2, 2005
Inadequate infrastructure
Too often physical infrastructure is inadequate. A functioning health system needs hospitals, clinics, stores and accommodation, as well as basic infrastructure such as safe water, sanitation, energy, waste disposal, road access and communications. Infrastructure often falls into disrepair because there is not enough money for ongoing maintenance.

Public versus private
In many countries health services are provided largely by the non-state sector. Very few low-income countries have the capacity to deliver the bulk of health services through the public sector. So it is crucial to make better use of non-state providers – not just private for-profit providers, but non-government and faith-based organisations. Typically, governments don’t have the capacity to regulate or work effectively with the private sector and so do not capitalise on opportunities to harness its contribution towards addressing public health priorities.
DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE

Transforming maternity services in Cambodia

The Khmer Rouge regime and decades of war in Cambodia destroyed practically all public institutions in Cambodia. Life expectancy is 54 years, while maternal mortality rates are very high with 472 mothers dying for every 100,000 births. The national health system was systematically restored, with international assistance, including DFID support, in the 1990s. The result, in tandem with general development, is that Cambodia has achieved a 30% drop in infant and child deaths in the last five years, and also made good improvements in the coverage of maternal health services. As part of its £15.4 million Health Sector Support Project, DFID provides £5.1 million to the Ministry of Health to deliver basic health care through an innovative contracting mechanism. The Ministry contracts international NGOs to manage the delivery of health services in poor districts by government health workers in government facilities. The NGOs are set targets for health care for women and children; the resulting increase in take up of services is impressive.

Mony, like his mother, was born in a dirt-poor village in rural Cambodia where little has changed for generations. Birth has always been the business of village midwives – often with tragic consequence. His first two sons were home-delivered, like Mony, his wife, and all their ancestors. But his new son was born in a nearby clinic, the result of outreach efforts by health staff that have transformed survival rates. His wife salutes the change in tradition. “Having babies at home means paying the midwife with lots of rice and other presents,” she notes. At the clinic, the total, including check-ups and injections was under £2. “Much cheaper,” she says with a smile. And safer and healthier.

Missing information

When reliable and well-timed health information is missing, planning and decision-making are difficult. This means governments are less able to identify priorities, allocate resources, monitor progress and evaluate results. It also limits accountability and how to identify systematic inequalities in health spending and achievements, particularly for marginalised and excluded groups. Only 2% of countries in the WHO Africa and south-east Asia regions have complete data for registered deaths.

Barriers to access

If the poor face barrier after barrier when they try to access services, the situation is worst for people with disabilities. Rural clinics are often located far from the population; roads may be in poor condition and transport unavailable or expensive; and access may be impossible during the rainy season. On top of this, health facility opening hours, waiting times and conditions, and staff attitudes can all make access difficult. The fees that people have to pay can price health care out of the reach of many, while women are further constrained by social and cultural norms, lack of domestic decision-making power and restrictions on movement.

DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE

Making Health Care Free in Zambia

Following debt relief, in 2006, the Government of Zambia removed user fees in all rural health facilities – 54 out of the country’s 72 districts, providing free health care to more than 7 million people. User fees had previously constituted only 5% of total health income, but given the costs of collecting the fees, analysis showed that there was almost no net revenue generation. Instead the fees were a barrier to access to health services – particularly for the poorest people in the country. Exemption policies were not working – for example, only 1% of exemptions were on the basis of poverty while 68% of the population is poor. Following removal of fees, use of health services rose rapidly – by over 100% in some clinics – with a 30% national average increase after three months of implementation.

DFID has provided the Government of Zambia with an additional £2.9 million in annual budget support for 5 years to help cope with the increased utilisation of services. However, Zambia suffers from a serious human resource crisis with one third of all rural facilities having no trained health workers. While it is generally recognised that removal of user fees is a good change in policy, until substantial progress is made in recruiting front line health workers, there are concerns over the quality of services being offered.

Peter had delayed his visit to the Nangongwe clinic in Kafue because he could not pay medical fees. It was only the excruciating pain that forced him to walk 15 kilometres from his Samatuli village. He was delighted when learned he would have to pay nothing.

“Not to pay anything when you visit a clinic is amazing and very good thing. It was like a dream to me. People have been dying because they don’t have money to pay at these clinics. Now these deaths will be minimised.”

Quote from a Zambian media report following the removal of user fees – April 2006
Matching incentives
Improving the supply of services has to be matched by incentives which stimulate demand – especially where activities (such as immunisations and appropriate child feeding) can prevent ill health. Voucher schemes and cash transfers have been effective and, used more widely, could promote services relating to significant diseases.

Fragile states
One sixth of the population of developing countries lives in ‘fragile states’\(^{64}\), where governments are unable or unwilling to provide services to most people. Such environments account for half of the deaths of children under-five in developing countries, a third of maternal deaths, and a third of those living with HIV and AIDS.\(^{65}\) And fragile states present a particular challenge for reaching the health MDGs. Not least this is because in countries affected by conflict, health infrastructure (such as clinics and hospitals) may have been destroyed, trained health workers may have fled, and immediate humanitarian needs may still need to be addressed. At the same time, re-establishing the state’s ability to manage the health system over the longer term remains a priority. Investing in basic services, that reach more of the population, can be a way to start working in less developed parts of countries and with fragile states.

CHALLENGE 3:
Poor co-ordination of international support leading to inefficiencies in delivering aid

The increased commitment to international development in recent years has led to a growing number of organisations getting involved – and also to difficulties for developing country governments in managing them. Today there are more than 40 bilateral agencies, 26 UN agencies, 20 global and regional financial institutions, and more than 90 global health initiatives. The scale of international private philanthropy is estimated to be between $10 billion and $25 billion a year\(^{66}\). At present, the means of co-ordinating this multiplicity of agencies and their support is unwieldy. As a result, governments are increasingly overwhelmed by the management and administration costs in dealing with myriad partners. Challenges like this led to the Paris Declaration on Aid Effectiveness in 2005, committing donors to making faster progress on working together more effectively.

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\(^{64}\) Although most developing countries are fragile in some ways, DFID defines fragile states as those countries where the government cannot or will not deliver core functions to the majority of its people, including the poor. The most important functions of the state for poverty reduction are territorial control, safety and security, the management of public resources, and the delivery of basic services. (DFID, 2005)

\(^{65}\) Why we need to work more effectively in fragile states. DFID, 2005

\(^{66}\) Klein, M and Harford, T. The Market for Aid. IFC, 2005
Disease-specific Dangers: Lessons from Rwanda

Rwanda has a relatively low rate of HIV/AIDS – about 3% – but high infant and child mortality rates. Yet in 2005 almost three quarters of donor assistance for health was for HIV/AIDS, and only 2% for health care services for childhood illnesses.

With 21 donors and 40 large NGOs active in the health sector, the challenges are significant. They include:

- High transaction costs, with administration consuming 27% of all health spending.
- Fragmentation, with the central government managing only 14% of donor expenditure.
- Misallocation of resources – for example only $1 million of donor funds was earmarked for integrated management of childhood diseases, compared to $18 million for malaria and $47 million for AIDS.
- Short-term, unpredictable funding – more than half of donor health projects in Rwanda are funded for less than 12 months.

The result is that health expenditure per head varies – from $1.86 to $11.84 between provinces. User fees persist and there is low coverage of key services – life-saving activities for maternal, neonatal and child health achieve less than 20% coverage. Improving the allocation and management of aid will have a significant impact on the health MDGs.

Too many donors?

In many countries there are too many donors involved, in others there aren’t enough. We need to evaluate arrangements designed to reduce duplication among bilateral donors, and adopt the best arrangements elsewhere.

There are powerful arguments in favour of multilateral approaches to health, yet aid is increasingly bilateral. Multilaterals represent a spectrum of organisations whose roles range from financing to technical assistance, setting norms and standards, and providing operational support. Each organisation has its own strengths which can be used to respond to specific challenges. However, multilaterals reach a larger number of countries than bilateral agencies and they open opportunities for gaining access to a larger proportion of total global aid. They are especially important in middle-income countries, can also reach fragile states and can deliver services in the absence of a functioning state. However poor overall co-ordination and their own inability to provide long-term commitments, significantly reduces their effectiveness in delivering aid. Donors further undermine the effectiveness of joint approaches through short-term financing tied to their own priorities.

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Clarifying roles
Within this diverse group of organisations, there is no agreed vision of who is best placed to do what, or what means of accountability there are. There is a particular need to clarify the roles of the WHO and the World Bank in assisting countries to develop national health systems and in deciding which plans are most suitable for large-scale aid support. And the roles of the global funds in strengthening health systems (especially GFATM and GAVI, and the World Bank) still need agreement.

UN re-organisation
The United Nations makes a significant contribution to health and HIV and AIDS at the international level. It brings different organisations together – through advocacy, by establishing norms and standards and providing policy guidance. However, in specific countries, duplication, overlap and competition between agencies lead to inefficiencies. In health, the UN is particularly fragmented, with four key agencies (the WHO, UNICEF, UNFPA and UNAIDS) together with numerous trust funds. The former UN Secretary General’s High Level Panel on System Wide Coherence recommended the UN should be reorganised, in the countries where it is active, to achieve better results and improve business practice. The ‘One UN’ model will consist of one UN country team, led by one accountable UN leader working within a unified plan (UNDAF) that responds to country needs, and financed by a predictable long-term consolidated budget. This model is being piloted and monitored in eight countries during 2007 and will be expanded if it succeeds.

European challenge
The 25 EU Member States made a commitment which will see annual EU aid double to over $80bn (£45 billion) in 2010 compared to 2004 levels. The challenge is to reach agreement in order to provide long-term, flexible and predictable funding that has a stronger relationship with improved results for poor people. A model of contracting is being considered that will link levels of financial support to a country’s performance across the MDGs.

Proliferation of initiatives
Global health initiatives and funds have increased since 1990 and are now an important part of the aid infrastructure. They are made up of more than 90 issue-based technical partnerships and funds each of which targets specific health issues, many of which are hosted by the WHO. The GAVI Alliance and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), provide substantial resources related to performance. Many of the gains in global health have resulted from targeted health initiatives like these, which are funded and implemented alongside the institutional health system.
However, while these can deliver impressive gains – for example in high immunisation coverage – they have often not been well integrated into country plans. Consequently budgets and the gains made initially have subsequently proved unsustainable. Sometimes these initiatives have undermined the ability of countries to set priorities within an overall health strategy and budget. As a result opportunities for delivering an integrated approach to health care have been missed. In some countries (as mentioned earlier) they have taken limited resources, particularly health workers, away from services that would be providing a more comprehensive range of health care.

Global initiatives and funds need to increase the effectiveness of their aid. They need to provide support in ways that strengthen systems so they can deliver health services and provide long-term, on-budget, pooled resources. Their business models must continue to evolve. They must be dovetailed with national planning processes and timelines. They should provide more predictable funding. And they must work collaboratively with UN agencies who can provide in-country technical support.

Philanthropic foundations have long supported development – the social sectors in particular. Today, the largest player in health is the Bill and Melinda Gates Foundation which has made grant commitments of $13.4 billion since its inception in 1994[^68]. It has focused efforts on research in new health technologies and ways to deliver them. It works with others, delivering support through the private sector, academia, global health initiatives and NGOs.

[^68]: [www.gatesfoundation.org/MediaCenter/FactSheet/](http://www.gatesfoundation.org/MediaCenter/FactSheet/)
Chapter 4:
Prescription for change:
What DFID will do to improve the health of poor people

Over the past ten years, DFID has played an important role in working to improve the health of poor people: by identifying priorities for action; providing substantial development assistance; building evidence for what works; and supporting action on neglected or controversial issues. Today we have a more flexible approach to providing aid – an approach that supports country efforts to build systems which will deliver effective health services.

Strengths
The particular strengths that DFID’s brings to its work in health come from:

• an explicit focus on reducing poverty and on fairness;
• a highly decentralised approach that directly supports countries by providing expertise and funding in response to their priorities and plans;
• skills and expertise with a strong interest in developing systems that deliver health services;
• the flexibility to create new approaches;
• a strong international influencing role; and
• the capacity to take advantage of the links between the health sector and ‘bigger-picture’ development processes such as ‘reducing poverty’.

DFID sees better health as imperative if we are to achieve the Millennium Development Goals. Our priorities include the improvement of sexual and reproductive health, working towards universal access to HIV and AIDS-related services and reducing health inequalities.

Commitments
DFID’s action on health is guided by our white paper – Eliminating world poverty – Making governance work for the poor. This sets out commitments on health strategy such as:

• spending at least 50% of DFID bilateral resources on improving basic services such as: education, health, water and sanitation, and social protection;
• supporting governments to develop long-term health plans;

69 Including HIV and AIDS
• helping countries solve staffing crises by supporting training and incentives for health workers, and expanding links between the UK’s National Health Service and developing countries, and exploring opportunities for health workers to return from the UK to their own countries;

• assisting governments in abolishing user charges for essential services;

• improving access to sexual and reproductive health services, and making gender equality and women’s rights a priority;

• supporting innovative financing approaches like the International Finance Facility for Immunisation, the Global Fund to Fight AIDS, Tuberculosis and Malaria and UNITAID; and

• doubling funding for research – particularly to help develop new generation drugs, diagnostics and vaccines against major communicable diseases.

Scope and strategy
The UK has committed to more than doubling its aid budget between 2008 and 2013, so our investment will increase significantly. At the same time, staff numbers within DFID will fall by 10% to achieve UK public service efficiency targets. This will require new ways of working with countries and demand a more strategic relationship with both the multilateral system and other development partners if we are to influence the effectiveness of aid.

In the face of globalisation and international trends, DFID is also enhancing its work across UK government departments to deliver more coherent responses for improving health and to maximise the UK contribution to development goals. The 2007 Crisp report70 recommends a number of ways the UK health service can better support developing countries.

DFID’s Public Service Agreement (PSA) identifies 25 countries as our key partners, commonly referred to as our “PSA countries”. There are 16 in Africa, 5 in Asia and 4 in EMAAD (Europe, Middle East, Americas, Central and East Asia Division). Annex 1 gives details of what DFID spends in health in these countries and other settings.

Priorities
DFID has four priorities to achieve better health for poor people:
• delivering more resources for health;
• expanding access to basic services;
• improving the effectiveness of international funding for health; and
• demonstrating results and building evidence of what works.

70 Crisp, N. Global Health Partnerships: The UK contribution to health in developing countries. 2007
Priority 1: More and better: Delivering more resources for health

To achieve the MDGs, there must be substantial increases in resources to finance basic services that will improve the health of poor people. This requires a flexible range of aid packages that will provide long-term and predictable aid in support of governments as they implement policies that will meet the needs of their people.

DFID: Delivering resources whatever the environment

- In our PSA countries that are dependent on aid and where governance is good (such as Malawi and Zambia) DFID sees delivering assistance through general and sector budget support as the best way to build government capacity.

- In our PSA countries that are fragile states (for instance DRC and Sudan) DFID uses new ways of financing to deliver predictable finance that can be protected from other weak governance problems. Financing should balance delivering services with the long-term building of institutions and states.

- Some PSA countries (like Pakistan and India) are not dependent on aid, yet have large numbers of poor people. Here, a critical issue is often establishing equality in providing health services, and the need to innovate ways of targeting the poor with health services. (See the box on Pakistan on page 36.)

- In middle income countries we work mainly through multilateral channels. For example, in the Caribbean, we have provided funding for a review of World Bank-funded programmes on HIV and AIDS, to help improve quality and speed up implementation.

- DFID is also active in the health sector in a number of non PSA countries. For example in Burundi we have helped the Government launch free health care for children and pregnant women by providing £1.5 million of essential drugs to meet the huge demand in services when the President scrapped patient fees.

- Other forms of funding still need to be used – appropriate to the needs of the country in question. These might be: project financing (especially to test new ways of financing); grants to civil society; and sponsoring technical assistance.

Effective use of resources

Existing resources can be used more effectively where, for one reason or another, a country is not yet able to efficiently spend or distribute their available budgets. We can help these countries to:

- make more appropriate choices between the multilateral and bilateral funding available, and amongst multilaterals;
better manage aid coming from the multilateral system (including from the UN family, international financial institutions and global funds);

be more innovative with aid funding, in order to pool donor contributions, and to incorporate a greater proportion of these into national health budgets; and

draw on the right technical assistance to improve the systems and institutions for managing their resources.

We can support countries to allocate a higher proportion of their spending on health – because many low-income nations allocate very little of their national budget on this area. So, along with financial aid, DFID and other partners have a role to play in promoting national health financing policies and practices that ensure – as the level of funding rises – that resources are used more fairly and effectively.

**DESPITE THE CHALLENGES, PROGRESS IS POSSIBLE**

**Supporting Pakistan's Health Priorities**

Through the National Health and Population Facility (NHF), DFID Pakistan provides budget support and technical assistance to seven national health and population welfare programmes. The NHF supplies £60 million in financial aid over four years (2003-07) and £8.5 million in technical assistance. Design of further health sector support beyond 2007, learning lessons from the NHF, is under way.

Since 2003 the NHF has been the catalyst for a 30% increase in Government expenditure on the health sector overall, and a doubling of funding to the seven national health programmes. The NHF, together with related DFID support to help develop Medium Term Budget Frameworks has helped improve programmatic and financial planning.

Annual Reviews have shown that NHF budget support has accelerated progress towards national programme results and targets. Particular successes are:

- the TB treatment programme, which has provided access to district funding for the TB drugs budget and increased TB cure rates;
- the Lady Health Worker programmes which now has almost 100,000 LHWs working primarily in rural areas, with an increased role in polio eradication, TB DOTS (Directly Observed Treatment Strategy) and family planning; and
- the EPI (Expanded programme of immunisation) programme which has seen the percentage of children fully immunised rise from 53% in 2001-2 to 77% in 2004-5.
Supporting fragile states

We need to provide more support to those fragile states that are furthest behind on the MDGs. The UK White Paper on Development commits DFID to investing more in these countries, while maintaining support to health sectors in a range of better performing states where there are still important health improvements to be made. Where governments are not delivering effective public services, and where DFID does not have a physical presence in a country, this may mean we need to work through UN agencies and civil society groups. However, DFID also has a commitment to strengthening government health systems in these countries.

DFID will

• Work with selected national governments to secure more resources for health, and to tackle whatever hinders the more effective use of available resources to meet the basic health needs of poor people.

• Increase bilateral funding for improving basic health services through aid packages that deliver more flexible, longer-term, and increasingly predictable financing for the health sector. This includes providing budget support to governments, under appropriate conditions.

• Continue to support multilateral approaches to national health initiatives, as long as this delivers effective aid through more predictable financing for health; strengthens national health systems; and improves the health status of poor people as a priority.

• Work with partners to invest more in improving basic health services in selected fragile states.

PRIORITY 2: Working together: Expanding access to basic services

Good governance contributes to improving the health of poor people because it helps to ensure that health investments deliver results. This means:

• supporting effective leadership;

• making progress in public-sector reforms;

• strengthening financial planning and management systems; and

• strengthening government supervision, control and regulation of all service providers. Ensuring that health policies are fair and consistently carried out.

Alongside this people must have their views heard and be able to hold governments and service providers to account –this is particularly challenging in fragile states.
Strengthening systems

We must help countries to build and strengthen their national health systems to deliver integrated, quality basic health services. This requires:

• having sound national policies in place and the institutions to make sure that priority programmes are implemented effectively;

• investing in human resources for health through comprehensive approaches to workforce planning; recruitment, deployment and retention; training; and maximising staff efficiency;

• strengthening national health information systems to improve data collection and management that will enable detailed monitoring and reporting of trends and results. This should improve decision making – including on how resources are allocated – and highlight gender inequalities or other concerns about fairness in access to health services;

• securing reliable supplies of safe and effective, affordable essential medicines and diagnostics;

• improving how health services are managed, including the effective regulation of non-state health service providers;

• ambitious longer-term national plans for the health sector should be developed and funded with support from development partners. This requires more predictable, longer-term aid commitments that can be factored into increasing national budgets for health.
Emergency Human Resources Programme in Malawi

DFID has provided £55 million over six years to fund the EHRP to support the training, recruitment and retention of health workers. The programme covers initiatives such as salary top ups, improvements in housing and training, the filling of short-term gaps with international volunteers, and incentives for retired health professionals to return to work.

It is a core component within the Ministry-led health sector plan and early indications are positive:

- 570 extra health professionals were recruited in the first six months.
- 60 volunteer medical specialists and nurse tutors have been recruited to fill critical gaps until more Malawians are trained, many from VSO.
- Training schools have increased intakes to double the number of nurses and treble the number of doctors in training.
- There is also evidence of fewer staff leaving service and progress on identifying remote areas for an incentive package.
- The GFATM will support EHRP with a focus on training health surveillance assistants.

Highlighting needs

We must focus resources on the major causes of disease and target the most needy. This includes addressing health needs that are often neglected, such as access to safe abortion, harm reduction strategies for HIV prevention (reducing risky lifestyle behaviours such as injecting drug use), and family planning services. The Disease Control Priorities Project 2006 (see box on next page) reinforces the importance of strong, integrated health systems, and provides a good basis for developing country governments as they make policy choices, set priorities and decide how to allocate their limited resources to achieve the greatest health benefits.
<table>
<thead>
<tr>
<th>Objective</th>
<th>Priority actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure healthier mothers and children</td>
<td>Ensure access to family planning, train skilled birth attendants, including in resuscitation of newborns, ensure good nutrition during pregnancy and childbirth. Immunise all children against major diseases and provide proper treatment of major childhood killers (e.g. Integrated Management of Childhood Illness). Teach family to promote hygiene and use oral rehydration therapy. Improve women’s status.</td>
</tr>
<tr>
<td>Stop the AIDS Pandemic</td>
<td>Treat other sexually transmitted infections that increase the risk of HIV, provide antiretroviral therapy especially for pregnant women, voluntary counselling and testing for HIV, promote 100% condom use, and education, especially among high risk populations. Harm reduction for injecting drug users. Combat stigma and discrimination.</td>
</tr>
<tr>
<td>Promote good nutrition</td>
<td>Ensure access to micronutrients through diet, fortified foods and supplements. Promote breast feeding. Regulate salt and saturated fats in food, public education campaigns.</td>
</tr>
<tr>
<td>Stem TB</td>
<td>Treat active TB cases, manage multi-drug resistant TB with new drugs, improve treatment of TB in HIV+. Develop a vaccine.</td>
</tr>
<tr>
<td>Control malaria</td>
<td>Expand preventive treatment for pregnant women, provide universal access to treated bed nets, spray insecticide indoors. Use cost effective drugs especially artemisinin combination therapy where needed.</td>
</tr>
<tr>
<td>Reduce burden of cardiovascular disease</td>
<td>Low cost cholesterol reducing drugs for those at risk, promote less salt, fat, calories, tackle tobacco – see below.</td>
</tr>
<tr>
<td>Combat tobacco use</td>
<td>Raise tobacco taxes to increase prices by at least 33%, ban advertising, restrict smoking in public places, nicotine replacement therapy.</td>
</tr>
<tr>
<td>Reduce injuries</td>
<td>Emergency medical response and trauma capacity, enforce traffic laws, make roads safer e.g. speed bumps, barriers. Taxes/laws to limit alcohol, drugs.</td>
</tr>
<tr>
<td>Ensure equal access to health care</td>
<td>Focus providers’ efforts on common causes of ill health, choose cost-effective interventions. Expand roles of non-doctors to deliver basic surgery and treat common conditions. Incentives to recruit and retain.</td>
</tr>
<tr>
<td>Forge strong health system</td>
<td>Support viable policies, funding commitments, incentives for R&amp;D, knowledge transfer, training in specialties with high disease burden.</td>
</tr>
</tbody>
</table>

Note: adapted from *Investing in Global Health, “Best Buys” and Priorities for Action in Developing Countries*. Disease Control Priorities Project 2, April 2006
Action on HIV and AIDS
Action on HIV and AIDS must ensure that HIV prevention, treatment and care, including decent end of life care, must be increased to get as close as we can to the goal of universal access to treatment by 2010 for those who need it. This must include greater emphasis on combined approaches to HIV prevention and on integrating HIV and AIDS with sexual and reproductive health, maternal health and TB services. It is essential that we address stigma and discrimination and ensure that women and young people, including orphans and vulnerable children, and marginalised groups (such as commercial sex workers, men who have sex with men, and intravenous drug users) have access to effective health services. We must continue to address gaps in effective palliative care for people living with AIDS. Children affected by AIDS must have access to basic services and social protection through broader support to vulnerable children.

Population
We need to re-prioritise sexual and reproductive health needs as essential to addressing population growth and ensuring that women have real choice, as well as for more effectively preventing the spread of HIV and AIDS, through services that are integrated at the point of delivery as far as possible.

Barriers to access
We must overcome barriers to accessing health services. This includes improving the supply of good quality health services and increasing demand. Removing barriers, such as the costs of health care, is part of the solution. But action is also needed to deal with social barriers – such as exclusion related to gender, ethnicity, caste or religion, community beliefs, and to encouraging healthier behaviour. Raising awareness of consumer rights and entitlements and supporting people to hold service providers to account can improve the quality of services and can achieve fairer distribution of services. DFID therefore has an ongoing role to work with civil society in improving health.

Gender equality
Evidence-based, effective public health approaches must be promoted while individual rights are protected. Culture, gender norms, political and religious beliefs must also be considered as they influence the design and delivery of policies and services. However, DFID has committed to challenge gender inequality (in the Gender Equality Action Plan), to champion sexual and reproductive health rights and to promote comprehensive and effective HIV prevention services.
Managing change

More action is required to deal with non-communicable diseases as countries become more developed. Population growth and rapid, unplanned, urban sprawl can perpetuate poverty and disease and may erode many of the health gains achieved through development.

Health in Middle Income Countries

If the MDG’s are to be met then improving the health of poor people in middle-income countries (MIC) should continue to be seen as a priority. Nearly a third of those living on less than $1 a day are in middle income countries, often in slums on the outskirts of large cities. While DFID will not be providing major funding for service delivery in MICs, governments must be encouraged to increase allocations to health budgets and prioritise resources towards the poorest and unhealthiest populations. DFID will help these countries identify how to reach groups that are not accessing basic services, in order to improve equity and outcomes. And DFID will also collaborate on improving the design of new programmes and support their implementation, through technical assistance, limited funding for pilot programmes and operational research, south:south knowledge exchange and testing of innovations.

Expanding basic services

Expanding access to basic services in education, water and sanitation, and social protection contributes to better health.

- The UK has already made substantial commitments to basic education. It has argued for including health issues and hygiene education into school curricula from the earliest age and for all schools to provide adequate water supply and sanitation facilities. The focus will remain on primary education, particularly for girls, but increased consideration will be given to working with governments to strengthen secondary education and ensure there are sufficient quality graduates to train for health service roles.

- Building capacity in local government will improve environmental health in the growing urban populations. Tackling unsafe water supply, inadequate sanitation and poor hygiene practices is vital in reducing deaths of young children. Health ministries have a role to play in promoting hygiene and sanitation through regulation, supporting local government and other ministries, and through health promotion.

• There are specific opportunities for DFID to contribute to better health through action in the infrastructure and environment sectors. Improved access to affordable, clean energy services is needed to reduce deaths from indoor air pollution. Reducing the rising toll of road traffic deaths and injuries requires a range of road safety measures. Improved infrastructure such as roads and transport helps overcome practical barriers to accessing health facilities.

• Developing countries need support to understand how climate change will affect economic growth and how they can reduce health risks that it brings. Research funding will identify the impact of climate change such as on patterns of disease like malaria. DFID is committed to working with others to make health and agricultural planning more resilient to short-term climate variability and to better understand the links between extreme weather and the impact of subsequent natural disasters on health.

• Work in the agriculture sector must consider implications for health such as the potential risk of increased malaria when irrigation is introduced. Agriculture, rural livelihoods and food security are also connected to nutrition. And DFID recognises the critical role of nutrition in child health and development, maternal health and prevention of non-communicable diseases, along with the importance of good nutrition for people living with HIV and AIDS. Many interventions that improve nutrition take place outside the health sector with action in areas as diverse as agriculture and disease prevention particularly important.

**DFID will**

• Work with country partners to improve governance and leadership within the health sector.

• Support selected countries to strengthen their national health systems to deliver basic services, including through investments in human resources for health; initiatives to scale up and integrate services; and to make best use of non-state providers to deliver affordable, good-quality care.

• Provide direct assistance for selected countries to deliver essential health services – including to poor and socially excluded or marginalised populations (with particular emphasis on women and children), and to support countries wanting to remove user charges to improve access to essential health care.

• Develop the next phase of *Taking Action*, the UK’s strategy to tackle HIV and AIDS in the developing world, and continue to support countries’ efforts to improve access to HIV and AIDS prevention, treatment and care, including good care at the end of people’s lives, and to pursue the goal of as near as possible universal access to antiretroviral treatment by 2010.
• Support country partners to give greater priority to sexual and reproductive health services with integrated HIV prevention and access to family planning and safe abortions.

• Work to promote transparency in the pricing and quality of essential medicines.

• Strengthen the capacity of partner countries to plan for and manage emerging health challenges that affect poor people, including epidemics of drug-resistant infectious diseases and non-communicable diseases.

• Ensure that investments in other sectors including water and sanitation, food security and nutrition, education, social protection, infrastructure and the environment lead to maximum health gains.

**PRIORITY 3: Making it happen:**
**Improving the effectiveness of international funding for health**

The multilateral system, including the UN agencies, development banks, global funds and health partnerships, has an important role in health. However, there is scope to improve the effectiveness and coherence of international aid by strengthening the performance and accountability of individual institutions and encouraging more effective co-operation between agencies.

**Coherent international response**
DFID is committed to promoting a more coherent international response to health, based upon sensible division of labour and joint accountability in supporting country plans and priorities.

**World Bank and WHO roles**
DFID sees the World Bank and the WHO with complementary roles in assisting countries to develop the systems that can deliver basic health services. The World Bank can ensure that health is prioritised in national development frameworks and budgets and move away from funding disease-specific initiatives towards broader financing for public services and longer-term budgetary support. The WHO, in addition to its crucial disease surveillance role, can provide high-quality guidance on acceptable standards. It can also supply technical assistance so that health ministries are able to boost basic health services, monitor health outcomes, and access resources from the global funds.
Global funds and overall coordination

Global health initiatives will continue to be an important part of the development landscape but the transaction costs they impose on governments must fall and they must collaborate better with national processes. They should also support strengthening of health systems that deliver health services more broadly – for example, ensuring better integration of common interests, such as reproductive health and HIV and AIDS services. The GFATM is well placed to do this, and to support comprehensive approaches to AIDS, TB and malaria and underlying health services. GAVI, with long term and predictable financing provided through IFFIm, can play a key role in helping countries put in place stronger systems for vaccine delivery as part of the overall effort to improve health services.

In the medium term, the large number of existing initiatives should be rationalised through mergers where possible. In the shorter term, the global funds, regional and international finance institutions and UN systems need to demonstrate much closer collaborative support of country health plans.

UN reform

DFID supports UN reform and the creation of ‘One UN teams’ to increase development effectiveness in individual countries. UN agencies should work in areas of their comparative advantage of normative, advocacy work, providing policy guidance and technical assistance. They will only be used as funding mechanisms, procurement or implementation agents in exceptional circumstances. DFID will favour funding joint programmes under unified UN country plans rather than stand-alone health initiatives of individual agencies. Global funding to UN agencies working in health is often fragmented and insufficient in implementing strategic plans. DFID will seek to provide the majority of its institutional support through core funding – not earmarked to fight specific diseases – to institutions which demonstrate results.

EU performance

As EU member states increase their contributions to ODA towards the target of 0.7 percent of their GNI, DFID believes the EU should provide a greater amount of predictable longer-term financing for health that is directly linked to progress on the MDGs.

DFID will

- Increasingly provide institutional support to the UN through core funding rather than through earmarked disease specific funds. At a country level, this is best done through joint UN country plans with pooled funding of a consolidated budget.
• Encourage the World Bank, the WHO and the major global funds (GFATM and GAVI) to define their collective roles in supporting countries to develop, finance and deliver improved health services, and to meet their commitments to work together more effectively.

• Encourage EC and EU member states to provide more aid for health that is specifically tied to progress on the MDGs and delivered through long-term predictable financing.

• Encourage global health initiatives to demonstrate improvements in making aid more effective, supporting country-led plans and reducing transaction costs.

• Explore new ways to strengthen the accountability of all major international health institutions to support sustainable expansion of basic health services at country level.

There is a growing emphasis within DFID on the results that investments in development bring. This means greater accountability for public expenditure, the realisation of international commitments, such as the Paris Declaration on Aid Effectiveness, and improved decisions about how resources are used to meet development objectives.

**Measuring results**

Results are increasingly measured in terms of improvements in the overall performance of countries’ health sectors, especially as DFID moves away from project-based funding towards sector-wide investments and budget support. DFID will aim to achieve this through countries’ own systems for assessing performance, and, where possible, will help strengthen these systems.

Demonstrating results will require not just better evidence, but better use of evidence, whether it is to show that a strategy is delivering or to show results within country programmes. The ‘Evidence for Action’ paper that accompanies this strategy sets out the role of evidence and describes how DFID plans to improve the way evidence is generated and used in achieving better results.
Increasing research
Evidence needs to be generated both by new research and by evaluating what has been done previously. The 2006 White Paper commits DFID to doubling its total research spending and a new research strategy is being developed for the period 2008/09 to 2012/13 that will determine research priorities. This must recognise that in many of the locations where DFID works there are constraints in technical capacity and the resources to undertake research relevant to health.

DFID has a strong track record in international health research and innovation and currently allocates 40 percent of its research budget in this area. Health policy and health services research is supported through multilateral and bilateral funding as well as specific research on the major causes of disease. Research to develop new ways of preventing and treating disease is particularly important with the threat of emerging drug resistance. The forthcoming DFID Science and Innovation Strategy sets out how DFID should continue investing in novel research and innovation designed to boost progress towards the MDGs.

DFID recognises the need to strengthen links between research and policy, including how policy makers are informed of research findings. There is also a need to convince policy makers in developing countries to use new products and technologies and to develop public-sector expertise in introducing drugs, vaccines and diagnostics.

DFID invests in bringing the products of research to market in developing countries and is funding a number of product development partnerships (PDPs) to achieve this. In the G8, the UK is also supporting an advanced market commitment model (AMC) for new vaccines. AMCs involve sponsors making legally binding financial commitments to support a market of a pre-agreed value. This market needs to be sufficiently large and credible to stimulate private investment in vaccine research and development as well as manufacturing the amounts needed.

DFID gives high priority to building research capabilities within developing countries and will continue to explore ways to support research institutions in these countries.

**DFID will**

- Work towards achieving specific results in health that are defined, monitored and reported at international and country levels in a way that reflects progress towards the MDGs.
- Measure results, where possible, at country level using information collected by national governments and other development partners. DFID will also support countries’ efforts to improve the tracking of progress in the health sector.
• Invest more in routine independent evaluations of policies and programmes to monitor progress; assess the quality of decision making and whether this has used information effectively; and to learn from experience.

• Consult widely to develop a new research strategy that will address:
  ■ How to build and use evidence for improving the health of poor people – particularly on developing systems that deliver health services and address priority diseases as well as emerging challenges such as non-communicable diseases, population growth, demographic change and climate change.
  ■ New ways to improve decision making for policy and practice by using information from research more effectively.
  ■ Development of innovative technologies and products such as new medicines, vaccines, diagnostics and contraceptives.
Health check: monitoring our strategy

DFID will monitor and report progress on implementing the commitments made in this strategy.

The process will seek to demonstrate results but avoid being too burdensome on DFID staff, partner countries and partner institutions.

- The Policy and Research Division will prepare a biennial review of progress, with input from regions. A short paper will be produced for ministers and the public to present some of the readily measured indicators and to provide details on achievements. This will also identify where there are problems and what DFID ministers and staff can do to address these. Each review will examine a specific theme in more depth.

- A formative review will be undertaken to allow the next health strategy to be developed. This will include looking at the impact of the health strategy in a few selected countries.

In monitoring the strategy DFID needs to distinguish between:

- actions that DFID carries out itself and for which it is directly accountable;
- actions that DFID hopes to encourage and see implemented by others in developing countries, influenced by DFID actions but led by countries themselves and influenced by other stakeholders, such as national governments, donors or civil society; and
- actions that take place internationally, in broader institutions or among other players. DFID may be supporting and influencing these but cannot be held directly accountable for their results.

As far as possible, DFID will use existing indicators and shared approaches – for example, to assess the performance of global partnerships and countries. Specific studies will be commissioned to look at issues not covered by existing or quantifiable indicators, and to better understand barriers to progress and what can be done about these.
Conclusion

There is no more effective way to reduce the devastating injustice of global poverty than by working to improve people’s health. We only have to look at the development of prosperous countries like our own, to see that creating broad and fair access to good health services is non-negotiable if we are to speed an end to poverty. But while the health challenges in our world can appear daunting, we also know from the history of the 20th century that huge and rapid improvements are possible in poor communities.

Against a background of growing popular support for making the world a fairer place for all countries, governments and other donors are now beginning to provide major funding to reach crucial and ambitious developmental goals such as global health.

DFID believes that this offers a critical point in prospects for transforming the health of the global population – and that this is an opportunity that we must not miss.

Strengthening the systems which deliver health services and integrating our sometimes disparate efforts will deliver significant change for good. If we can focus more on the major causes of disease – many of which can be dealt with by existing, proven means –and if we can provide more resources and deliver them effectively, good health will become a pathway to a fairer world.

Governments and donors must now link their ambitions on health with national plans for systems that deliver fair access to quality services – overcoming, for example, entrenched inequalities in areas like gender. And we must work to demonstrate the results of investment, showing why improving health offers outstanding returns and is essential to end extreme poverty.

Only through accelerating efforts to achieve the health and other MDGs can we clear the path to a fairer world which must come if poverty is to be ended.
Annex 1:
What DFID spends on health in poor countries

DFID spent £481.4 million in health via its bilateral programme in 05/06 (£387.6 in PSA countries and £93.8 elsewhere). DFID spent a further £173.6 million in health via its multilateral programme in 05/06. This is shown in the tables below.

DFID bilateral spend in health in PSA countries in 05/06

<table>
<thead>
<tr>
<th>Country</th>
<th>Main funding mechanism</th>
<th>Bilateral spend 05/06 (£ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Africa</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRC</td>
<td>Project, humanitarian</td>
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<td>Project</td>
<td>3.9</td>
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<td>Ghana</td>
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<td>Kenya</td>
<td>Project</td>
<td>34.5</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Project</td>
<td>0.2</td>
</tr>
<tr>
<td>Malawi</td>
<td>SBS</td>
<td>22.0</td>
</tr>
<tr>
<td>Mozambique</td>
<td>GBS, SBS</td>
<td>15.9</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Project, TC</td>
<td>27.5</td>
</tr>
<tr>
<td>Rwanda</td>
<td>GBS, project</td>
<td>7.1</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>To be determined</td>
<td>1.7</td>
</tr>
<tr>
<td>South Africa</td>
<td>Project, TC</td>
<td>6.2</td>
</tr>
<tr>
<td>Sudan</td>
<td>Humanitarian, project</td>
<td>16.0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>GBS, strategic grant agreements to CSOs</td>
<td>15.1</td>
</tr>
<tr>
<td>Uganda</td>
<td>GBS, humanitarian</td>
<td>13.2</td>
</tr>
<tr>
<td>Zambia</td>
<td>GBS, SBS</td>
<td>12.7</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Project, humanitarian</td>
<td>12.9</td>
</tr>
<tr>
<td><strong>Asia</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afghanistan</td>
<td>Trust fund</td>
<td>0.5</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Mix of instruments under SWAp (pooled funding, project funding, TC)</td>
<td>20.5</td>
</tr>
<tr>
<td>India</td>
<td>Sub sector budget support at national level and SBS in focal states</td>
<td>68.5</td>
</tr>
<tr>
<td>Nepal</td>
<td>SBS, TC</td>
<td>8.4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Mix of GBS, SBS, projects (including TC and humanitarian)</td>
<td>34.2</td>
</tr>
<tr>
<td><strong>EMAAAD (Europe, Middle East, Americas, Central And East Asia Division)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
<td>Project</td>
<td>6.5</td>
</tr>
<tr>
<td>China</td>
<td>Project</td>
<td>13.0</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Project</td>
<td>15.8</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Project</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>387.6</td>
</tr>
</tbody>
</table>

Abbreviations:
SBS  Sector budget support    SWAp Sector wide approach    TC  Technical cooperation
GBS  General budget support   CSO  Civil society organisation
Notes:

- Poverty reduction budget support (PRBS) is when a donor provides funds directly to a partner government’s central exchequer to support the government’s poverty reduction programme. PRBS can take the form of a general contribution to the overall budget referred to as General Budget Support (GBS) or it can be earmarked to a discrete sector often referred to as Sector Budget Support (SBS).

- Technical cooperation (TC) is the provision of advice and/or skills in the form of specialist personnel, training, scholarships and grants for research and associated costs.

- A sector wide approach (SWAp) is a Government led sector wide strategy through which major donors provide support.

### Remaining DFID bilateral spend in 05/06

<table>
<thead>
<tr>
<th>Country / Region / Organisation</th>
<th>Bilateral spend 05/06 (£ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non PSA Countries</strong></td>
<td></td>
</tr>
<tr>
<td>Various (range from £0.1 million to £4.6 million in 27 countries)</td>
<td>24.9</td>
</tr>
<tr>
<td><strong>Regional Initiatives</strong></td>
<td></td>
</tr>
<tr>
<td>Africa</td>
<td>13.8</td>
</tr>
<tr>
<td>Asia</td>
<td>4.4</td>
</tr>
<tr>
<td>Europe</td>
<td>0.6</td>
</tr>
<tr>
<td>Americas</td>
<td>1.4</td>
</tr>
<tr>
<td>GAVI</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>Various (range from £0.1 million to £4.6 million in 27 countries)</td>
<td>42.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>93.8</strong></td>
</tr>
</tbody>
</table>

### 2. Multilateral spend

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Bilateral spend 05/06 (£ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNAIDS</td>
<td>16.0</td>
</tr>
<tr>
<td>WHO</td>
<td>45.6</td>
</tr>
<tr>
<td>UN Population Fund</td>
<td>30.0</td>
</tr>
<tr>
<td>GFATM</td>
<td>10.2</td>
</tr>
<tr>
<td>Estimated DFID health expenditure delivered through the EC</td>
<td>71.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>173.6</strong></td>
</tr>
</tbody>
</table>

Notes:

- The estimated EC figure is based on DFID’s total funding to the EC in 2005/2006 and the proportion of EC ODA that went to the health sector in 2005.

- In addition to the multilaterals listed, DFID provided £655.7 million of funding to other multilateral institutions. This funding cannot be allocated to a specific sector.
Department for International Development

DFID, the Department for International Development: leading the British Government’s fight against world poverty.

One in five people in the world today, over 1 billion people, live in poverty on less than one dollar a day. In an increasingly interdependent world, many problems – like conflict, crime, pollution and diseases such as HIV and AIDS – are caused or made worse by poverty.

DFID supports long-term programmes to help tackle the underlying causes of poverty. DFID also responds to emergencies, both natural and man-made.

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- ensure that all children receive primary education
- promote gender equality and give women a stronger voice
- reduce child death rates
- improve the health of mothers
- combat HIV and AIDS, malaria and other diseases
- make sure the environment is protected
- build a global partnership for those working in development.

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DFID works directly in over 150 countries worldwide, with a budget of some £5.9 billion in 2006. Its headquarters are in London and East Kilbride, near Glasgow.

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Cover photo: Mother and child at clinic in Chiwamba, Malawi. DFID Malawi

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