



Department  
for International  
Development



## Health position paper

### Delivering health results



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# Executive summary

This policy position paper sets out how DFID works to improve health outcomes in developing countries. It explains DFID's public health approach<sup>1</sup>, which combines investments that achieve targeted results with investments that strengthen broader health systems. This approach is rooted in the UK Government's commitment to improve the health and wellbeing of the world's poorest people.<sup>2</sup> Working in tandem with other partners and in support of a prioritised national plan, the UK approach delivers gains that countries can sustain and build on. Over the long term, investments in health and health systems have the most impact when they go hand in hand with other investments that build opportunity for poor people. These include education and nutrition investments but also investments in political stability, sound governance, broad social inclusion, systems to protect rights and property, and economic growth.

Globally, health is improving. Since 1990, with a significant contribution from UK development programmes, the number of children under five years of age dying from preventable causes has fallen from around 12 million each year to around 7 million. The number of girls and women dying during pregnancy and childbirth has fallen from 400,000 a year to under 275,000.<sup>3</sup>

Yet there is still much to be done. The poorest people in both low and middle income countries suffer the most from ill health, and women suffer more than men. The differences in death rates between men and women are larger in many low and middle income countries than in developed countries. In sub-Saharan Africa, relative mortality risks are getting worse for women rather than better.<sup>4</sup> Much of this suffering could be ended by using existing means to treat and prevent illness and to promote health, and by applying evidence of what works. DFID's approach aims to accelerate uptake.

Poor health is both a cause and a consequence of poverty, and widens inequities. The costs of seeking health care contribute to poverty as well as limiting the ability of poor people to get help. The poorest and most marginalised suffer most: they are not only more exposed to health risks but also less able to take preventive measures and less likely to have access to services. Poor health limits people's ability to get jobs, run businesses and take part in the cultural and political life of their communities.

The UK's Coalition government is committed to improving health as part of its international development work.<sup>5</sup> The UK is working with governments and other partners to maximise the health impact of its work. Between 2010 and 2015 UK aid is being used to:

- Help immunise more than 55 million children against preventable disease;
- Provide 140 million treatments that, with other partners, will help eradicate guinea worm and control five other neglected tropical diseases;
- Save the lives of at least 50,000 women in pregnancy and childbirth and 250,000 babies;
- Enable at least 10 million more women to use modern methods of family planning;
- Help halve malaria deaths in at least ten of the world's highest burden countries.
- Prevent 10 million children under 5 from going hungry and reach 20 million children with nutrition related interventions.

- Reach more than 60 million people, ensuring access to basic services such as pit latrines and communal water pumps as well as improved hygiene.

This paper describes the approach that underlies the commitments and activities already articulated in a series of documents: ‘Scaling up Nutrition: The UK’s position paper on under-nutrition<sup>6</sup>’, ‘Choices for women - planned pregnancies, safe births and healthy newborns’, DFID’s Framework for Results for improving reproductive, maternal and newborn health<sup>7</sup>; ‘Breaking the Cycle - Saving Lives and Protecting the Future’, DFID’s Framework for Results for malaria<sup>8</sup>; ‘Towards Zero Infections’, the UK position paper on HIV in the developing world<sup>9</sup>; ‘UK aid: changing lives, delivering results<sup>10</sup>’; and DFID’s ‘Strategic Vision for Girls and Women<sup>11</sup>’.

The approach puts people at the centre of what the UK does (captured in Figure 1 and discussed fully on pages 6-14). It aims to maximise health gains through targeted, cost-effective health interventions that are delivered through strengthened, more efficient and effective health systems (including both public and private providers) and that engage communities in the promotion and protection of their own health. It incorporates work on the broader determinants of health, for example: improved access to water and sanitation and improved hygiene behaviour; increased girls’ education; women’s leadership and political participation; strengthened political systems; and greater resilience to the impacts of climate change, natural disasters and conflict.

DFID plays an important role in helping countries to develop their national health systems in ways that address problems of access, equity and coverage and so to accelerate progress towards universal health coverage (UHC). UHC is defined by the World Health Organization (WHO) as all people having access to the health services they need without the risk of financial hardship associated with direct out-of-pocket payments.<sup>12</sup> Moving rapidly towards UHC in a way that is likely to be sustainable requires governments to build both political and public support in country.

A set of key principles guides DFID support: (i) evidence-based decision making: decisions are based on the best available evidence of effectiveness; (ii) value for money: the UK is committed to maximise the value achieved with tax payers’ money; (iii) delivering more effective aid: helping countries deliver high quality health services accessible to the poorest and most marginalised people, and delivering sustainable results; and (iv) putting girls and women at the heart of DFID’s work and not shying away from addressing sensitive issues such as unsafe abortion.

DFID ensures its work complements the work of others, helps to strengthen national programmes and is aligned behind nationally led poverty reduction commitments. The bilateral programme is focused on 28 priority countries, many of which are fragile or conflict affected.<sup>13</sup> By also investing through multilateral agencies and global funds, the UK contributes to progress in all developing countries.

# 1. Progress since 1990 and the challenges ahead

Enormous progress has been made in the last two decades in improving the health and preventing deaths of women and children living in poverty. Between 1990 and 2011, the mortality rate in children under 5 years fell from 84.1 to 52.8 deaths per 1,000 live births, and in the same period maternal deaths fell from over 400,000 per year to under 275,000.<sup>3</sup> Whereas in 1990 there were over 12m deaths amongst children under 5, by 2012 there were fewer than 7.3m. Two diseases – polio and guinea worm – are well on their way to being eradicated and the life-expectancy for most HIV positive people has been transformed in the last two decades. Underpinning these advances are new technology, genuine innovation and scientific advances delivered through more efficient implementation strategies to meet growing demand, often in a context of reducing conflict, economic growth and better governance.

Yet this progress has not been evenly spread either geographically or between the rich and the poor. Almost everywhere, health and life expectancy are worse among those in the lowest income and wealth quintiles than among those in the higher quintiles.<sup>14</sup> Over seven million women and children still die every year, many during pregnancy and birth, the great majority from easily treatable or preventable conditions. Pre-term births and related health conditions account for over a million children under 5 dying every year. Every year, 50 million women give birth without skilled care or support, and complications during pregnancy and childbirth claim the lives of over 750 girls and women every day. Unsafe abortion causes the deaths of 47,000 women and girls every year and leaves 8.5 million suffering from injury, illness or disability. Infectious diseases also continue to impose a huge burden. The malaria burden has fallen and yet it still causes at least 655,000 deaths a year; more than 33 million people are estimated to be living with HIV. Neglected tropical diseases (NTDs) including elephantiasis, trachoma and other parasitic diseases continue to cause severe pain, suffering and disability amongst millions of the world's most neglected people. In addition, the burden of non-communicable diseases such as hypertension and diabetes in poor countries is growing alarmingly fast. Few low income countries are expected to achieve MDGs 4 and 5 at current rates of progress.<sup>15</sup>

The recent Global Burden of Disease 2010 study<sup>16</sup> found that there had been significant changes over the last 20 years in the main causes of premature death and disability worldwide. These changes have been driven by four main global trends: ageing populations; increases in non-communicable diseases; shifts towards causes of ill health that cause disability rather than death; and changes in risk factors such as high blood pressure, use of tobacco and alcohol, lack of exercise and air pollution. The changes have been less dramatic in sub-Saharan Africa, where improvements in life expectancy have been modest compared to those in other parts of the developing world and where communicable diseases that mainly affect children and young adults are still the biggest causes of premature death and disability, though the burden of non-communicable diseases is rising fast.

There are many good reasons for the UK to invest resources, both human and financial, in improving the health of poor people. First and foremost, better health is an end in itself and a basic human right, to which many poor people do not have access. Yet it can be achieved at low cost if the right interventions are chosen and are implemented in ways that minimise costs. Better health also contributes in several ways to

higher productivity and hence economic growth. Healthier (especially better nourished) children have better cognitive development and learn more at school, making them more productive as adults. Healthier adults of working age lose fewer days to illness and are more productive when they are working. As life expectancy increases, people have a greater incentive to save for education and for old age, so investment in the wider economy can increase, boosting growth. Ill health is impoverishing for individuals, both because it reduces productivity and because of the costs of seeking health care. Prevention of ill health can reduce treatment costs for national health systems as well as for individuals, so freeing up public resources for alternative uses. Furthermore, the existence of global public goods provides justification for additional investment, for example in communicable disease control, research, and pricing agreements for access to medicines.

The knowledge and the tools exist to prevent or treat many of the conditions that affect poor people. New technologies and innovations are making faster progress possible (for example, more effective vaccines, longer lasting bed-nets and more stable and cost-effective medicines). However, the challenge is to get these tools to those who need them the most, i.e. the poorest, the most marginalised and those in fragile or post-conflict states.

There are three sorts of challenges preventing faster progress:

a) A series of **systems challenges** that can lead to poor quality health services, with a lack of proper drugs and medical supplies and no means to responsibly refer patients. These challenges are aggravated by an inequitable distribution of health infrastructure, services and trained health workers. There is often not the predictable domestic financing required to allow a planned reform of the health system over time, nor the system capacity to regulate non-state providers of goods and services.

b) A **lack of incentives and accountability mechanisms** within the health system to deliver quality health services to the poorest in a **transparent** manner. In many countries, the poorest and most marginalised people have little or no voice to demand better access to quality services from either the public or the private sector. For example, in the public sector many poor people pay illegal charges for health care and encounter facilities with no drugs and absent health workers. Poor people are often unable to challenge unresponsive and unaccountable service providers, and health systems tend to reflect historical trends in resource allocation, favouring the urban elites. Reallocation of resources to better reflect health needs across the whole population requires political commitment to change incentive structures and build accountable and transparent systems.

c) Insufficient investment in the **social, economic and environmental determinants** of health. This includes water, sanitation, hygiene and education, and means addressing social, political and rights issues that have an impact on health. These issues include child marriage, female genital cutting and violence against women and girls, alongside supporting women's economic empowerment and women's political participation and leadership. These broader investments, in addition to transforming lives and preventing poor health, enable communities to better manage new and growing risks such as those associated with climate change and non-communicable diseases.

**Addressing these challenges in an effective, coordinated way is essential to saving the lives and improving the health of the most vulnerable** in low-income countries and to promoting development and reducing poverty. Even in wealthier environments and countries, uneven access to services of varying quality undermines the achievement of national health targets. In the near future many developing countries will have an opportunity to invest wealth from natural resources in building human capital. This wealth needs to be carefully managed if it is to be used to reduce social inequities.



## 2. Delivering results: what the UK is doing

**In 2010, the UK Government commissioned root and branch reviews of its bilateral and multilateral programmes.**<sup>17</sup> DFID's bilateral health work has changed as a result of these reviews: it is more focused on fewer countries where it is most needed – particularly in countries that are off track to meet MDGs 4, 5 and 6 and those affected by conflict or fragility.

**The UK uses its multilateral engagement, as a country partner, board member and funder, to drive results for health where they will have the biggest impact.** The UK has increased its support to the better functioning multilateral instruments, including UNFPA, WHO, GAVI, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and others, and negotiates and monitors improved performance. Many of the expected results are set out in 'UK aid: Changing lives, delivering results'.<sup>10</sup>

### **Box 1: Family planning is essential for development**

An estimated 225 million women who wish to avoid pregnancy do not currently use an effective contraceptive method, and 75 million unintended pregnancies occur every year in developing countries. The moral imperative is clear: enabling choice for girls and women to determine whether, when and how many children they have. Moreover, increasing access to modern contraceptives and reducing unintended pregnancies dramatically improves health outcomes for women and children. Meeting the access gap could avert around a quarter of maternal deaths and a fifth of newborn deaths. Young women and girls can dramatically improve their life chances through delaying the age of first pregnancy. Enabling girls and women to plan their family size can also have a transformative effect on overall development.

#### **Building on current political momentum**

To accelerate progress in meeting MDGs 4 and 5, developing country governments and partners have begun to make ambitious commitments to increase contraceptive use and to invest in national programs to increase access to family planning, most notably under the auspices of the UN Secretary General's Global Strategy for Women and Children's Health "Every Woman, Every Child". But much more is needed, including

- greater political commitment from donors, country governments, private sector and civil society to enable women in developing countries to choose whether, when and how many children they have; and
- sufficient well-allocated resources to meet the unmet need for family planning for women in the poorest countries.

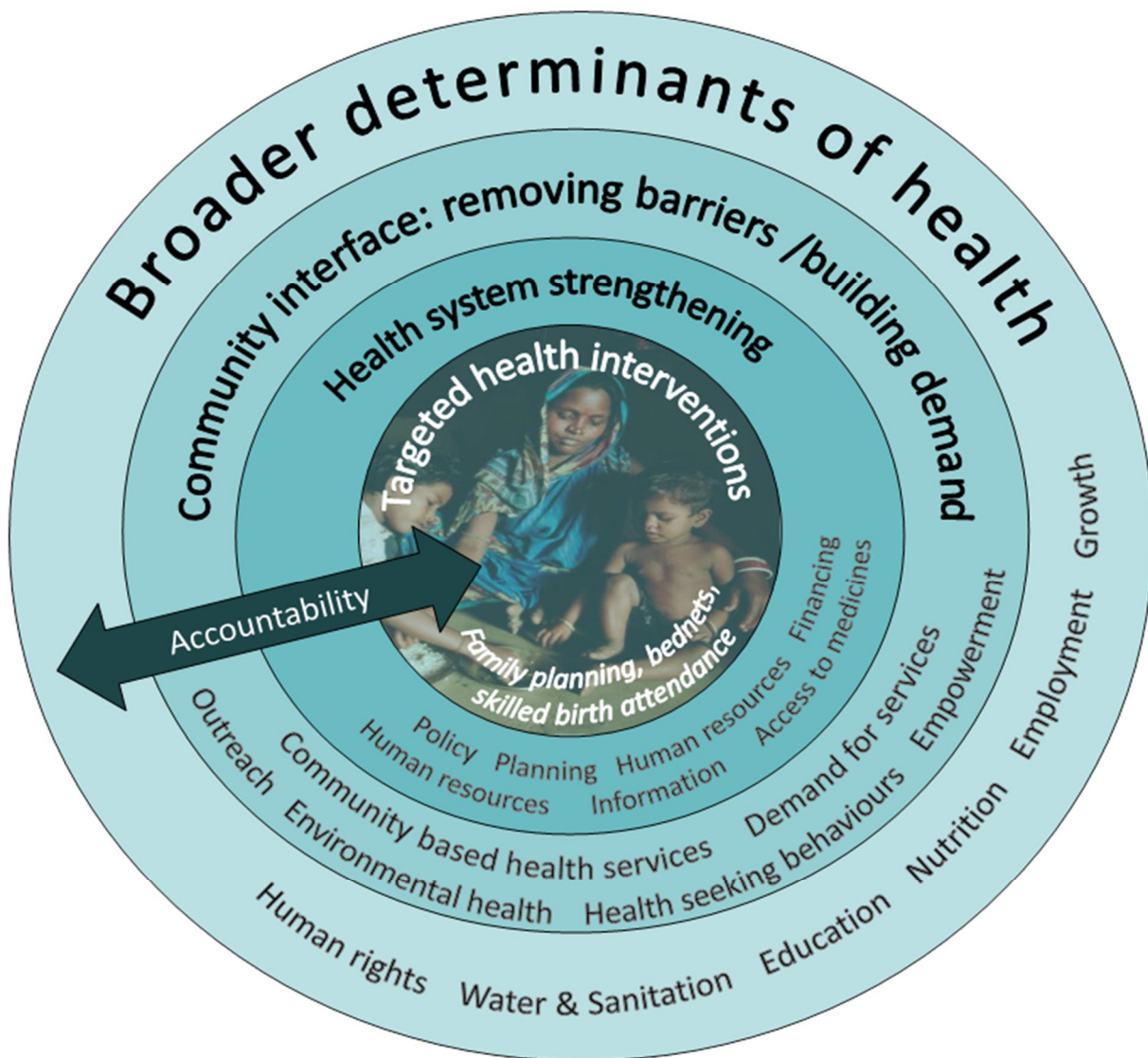
The UK is working in partnership with the Bill and Melinda Gates Foundation, UNFPA and others on a process to accelerate progress by extending voluntary family planning to 120 million additional women. Partners came together at the London Family Planning Summit in July 2012 to make over \$4 billion worth of commitments towards achieving this goal by 2020.

**The UK seeks to obtain the best possible results with its health aid budget to reduce poverty and improve the lives of the poorest people.** The MDGs, especially those most off track (1c, 4, 5 and 6),



continue to provide the context for DFID's health programming priorities. DFID's approach builds on its comparative advantage in health as articulated in the Health Portfolio Review 2009.<sup>18</sup> Particular strengths identified included: strong technical capacity at global and country level, deployed in support of clear priorities and backed by political commitment; flexible funding and a well-developed understanding of partnerships; country ownership; and recognising the importance of global architecture.

While the reasons behind preventable morbidity and mortality may be well known and the necessary interventions mostly well understood, a broad approach to addressing health challenges is necessary in order to make a significant impact on their causes and to ensure that actions taken are sustained into the future. The diagram below identifies the multiple levels at which DFID operates in order to deliver its health results. These levels are interdependent and the boundaries around them are porous.



**Figure 1: Sustainable Results in health require a comprehensive approach with all its multi-layered investments**

## *Targeted health interventions...*

The diagram, which has meeting the health needs of individual people at its core, identifies specific, evidence-based and targeted health interventions as the critical lever for saving lives, controlling disease and making people healthier and more productive. These are safe, appropriate services, delivered promptly and with adequate quality to prevent, diagnose and treat some of the main causes of mortality and morbidity amongst the poorest people whenever and wherever they are needed. Targeted health interventions offer immediate benefits and returns in terms of health improvement and demonstrating results.

These approaches are also important for ensuring that specialist expertise and resources are focussed on priority health problems such as skilled attendance at birth, newborn care, malaria/tuberculosis (TB)/HIV/family planning services, micronutrient supplementation, pneumonia and acute malnutrition in children and others.

## *... in a context of health systems strengthening*

To ensure that targeted services are effectively delivered and sustained over time, it is critically important that interventions are planned and delivered in ways that take into account the local context and help strengthen the national health system, putting countries in the driving seat. WHO has defined the key health system building blocks as: 1) a set of effective, safe services; 2) a capable health workforce; 3) information systems that help map disease and measure health impact; 4) availability of medical products, vaccines and technologies to prevent and treat disease; 5) the funding needed to provide health services; and 6) the leadership and governance systems to ensure that resources are used to maximum effect.<sup>19</sup>

This is why the second ring of the diagram in Figure 1 identifies the need for a **system-based response to ensure sustainable results**. This helps to sustain the rapid short term gains of targeted interventions by delivering them as part of a package of care supported by a country's national health system and delivered through the most appropriate part of the system. It is not helpful for health workers and drug supplies to be drawn away from other programmes in order to fuel a programme targeting one disease. A health facility, especially in a rural or resource constrained environment, should be equipped and able to respond to the multiple needs of its users to an acceptable level of quality: a woman may be pregnant but also HIV-positive; a child may have pneumonia but its mother may need nutrition counselling; a blind child also needs to be immunised and protected from malnutrition; a disabled woman will also need sexual and reproductive health services. In practice, at the clinic level, health workers have to tackle the multiple health needs of anyone who walks through the door and they need the training, support, medicines, and equipment to do that. Hence programmes that strengthen the six building blocks of the health system will be critical to achieving improved health outcomes and impact.

DFID's approach, therefore, supports targeted cost-effective interventions and seeks to ensure that these interventions support the longer term development of a health system fit to meet the needs of the population. In some circumstances this means supporting private sector providers (for-profit or non-profit, formal or informal) to deliver more good quality essential health commodities and services to poor people, and helping to strengthen the capacity of governments to regulate these providers and to finance use of the services by the poor. For example, the African Health Markets for Equity programme is supporting the provision of cost-effective essential health services by franchised private providers in Kenya, Ghana and Nigeria, as well as supporting governments to build their capacity for engaging with and regulating the private sector, and introducing demand-side financing mechanisms to ensure that poor people can benefit from the services.

**Box 2: Cost-effective Interventions to address need**

Cost-effective health interventions can be simple and inexpensive and many are proven to be effective in developing countries. The Disease Control Priorities Project (2006, updated version expected soon) identified the following “best buys”:

**The Ten Most Cost-Effective Ways to Improve Health:**

1. Vaccinate children against major childhood killers, including measles, polio, tetanus, whooping cough, and diphtheria.
2. Monitor children’s health to prevent or, if necessary, treat childhood pneumonia, diarrhoea, and malaria.
3. Tax tobacco products to increase consumers’ costs by at least one-third to curb smoking and reduce the prevalence of cardiovascular disease, cancer, and respiratory disease.
4. Attack the spread of HIV through a coordinated approach that includes: promoting 100% condom use among populations at high risk; treating other sexually transmitted infections; providing antiretroviral medications, especially for pregnant women; and offering voluntary HIV counselling and testing.
5. Give children and pregnant women essential nutrients, including vitamin A, iron, and iodine, to prevent maternal anaemia, infant deaths, and long-term health problems.
6. Provide insecticide-treated bed-nets in malaria-endemic areas to drastically reduce malaria.
7. Enforce traffic regulations and install speed bumps at dangerous intersections to reduce traffic-related injuries.
8. Treat TB patients with short-course chemotherapy to cure infected people and prevent new infections.
9. Teach mothers and train birth attendants to keep newborns warm and clean to reduce illness and death.
10. Promote the use of aspirin and other inexpensive drugs to treat and prevent heart attack and stroke

The reality is that many cost-effective interventions are not delivered in developing countries, particularly to the poorest and most disadvantaged. This only worsens health inequalities, not only in terms of access to services but also in terms of the resulting health outcomes. In Mozambique, for example, there is assistance during delivery for 89% of births in the highest income quintile; the corresponding figure for the lowest quintile is 25%. It also matters where you live: 81% of urban births are attended by skilled personnel, yet only 34% of rural births are. The under-5 mortality rate for the lowest income quintile is almost twice that of the highest quintile (196 compared to 108) and the rate is higher in rural areas than urban areas (192 compared to 143).

Targeting those most in need would direct resources to address the underlying burden of disease for which cost-effective interventions exist. In the absence of well-targeted interventions, it is likely that health outcomes will remain poor for certain groups (income, gender, geographical location, and ethnicity) and health inequalities could widen. Without addressing health inequalities, it will be much more difficult for countries to make progress towards the MDGs.

Research suggests targeted implementation of cost-effective interventions would have considerable impact on health outcomes. The Lancet series on child survival estimated that the lives of 6 million children could be saved each year if 23 proven cost-effective interventions were universally available in the 42 countries responsible for 90% of child deaths, and WHO estimates that 22m additional women would have access to essential services if countries followed advice on building more capacity and accountability into their health services.

This approach measures success in terms of **specific results and outcomes for poor people** (such as reduced burden of disease, improved child survival and better maternal health), and approaches the achievement of these outcomes through a combination of targeted and system based interventions. For example, increasing coverage of essential services requires skilled and motivated health workers to be in the right place at the right time.

### **Box 3: Building sustainable effective services: the example of HIV and TB service integration**

Integrating service delivery is an important way to improve efficiency, reach more affected people and build the capacity and resilience of services to meet the changing needs of the community. There are undoubtedly challenges to integrated delivery, especially where diseases are quite different from one another, where they affect different populations or where the technical support to prevention and control require different skills or materials. For example, non-communicable diseases, discussed on page 20, are very different from infectious diseases, partly because of their chronic nature and partly because of the particular challenges they pose for prevention, diagnosis and treatment. However, there is some evidence that service integration including the prevention, treatment and care of TB and HIV/AIDS, the management of childhood fever and the delivery of control of neglected tropical disease activities, is feasible and that it can lead to important benefits including improved health outcomes, efficiency, sustainability, and value for money gains\*.

The HIV epidemic has contributed to a resurgence of TB, particularly in some of the poorest settings in sub-Saharan Africa. By 2009, for example, it was estimated that TB accounted for 1 of every 4 deaths among HIV-positive people. People living with HIV (PLHIV) have an estimated 20 to 30 times greater risk of developing active TB than people without HIV infection so there are important disease management reasons behind a growing movement to integrate HIV and TB services. UNAIDS and the Stop TB Partnership have a joint goal of reducing TB deaths among PLHIV by half by 2015 compared to 2004 levels\*\*.

The UK actively supports this goal, and it is clear that without collaborative and integrated delivery of HIV and TB control programmes it cannot be achieved. This includes increasing the delivery of the “3 Is” for HIV and TB: Isoniazid preventive treatment, Infection control for TB, and Intensified case finding for TB as well as initiating earlier antiretroviral treatment for eligible people. But it also includes support to scaling up the integrated delivery of these interventions at the clinic and community level. The UK is investing in strengthening collaborative TB-HIV control programmes through its multilateral support and a number of bilateral country programmes. For example, DFID is working with the Government of South Africa to expand the quality and access of public sector services including TB-HIV control, and increasing the speed with which new antiretroviral therapy and TB drugs get registered as they become available elsewhere.

\* The Global Network for Neglected Tropical Diseases; Sabin Vaccine Institute. A White Paper prepared for DFID on: Opportunities for Linking NTD Control to the Control of Malaria, HIV/AIDS, and Tuberculosis, with an Emphasis on Sub-Saharan Africa. 2010

\*\* World Health Organisation. WHO policy on collaborative TB/HIV activities: Guidelines for national programmes and other stakeholders. 2009

Around 25% of the UK's investment in health supports human resources for health,<sup>18,20</sup> and through the DFID Framework for Results for improving reproductive, maternal and newborn health, the UK government has committed to support at least two million women to deliver their babies safely with skilled midwives, nurses and doctors. Measures to strengthen the health workforce are most effective when decisions are

made at country level, framed by a good national plan, and responding to local needs and contexts, including whether public or private institutions are best placed to provide training. The UK adheres to the WHO Global Code of Practice on international recruitment of healthcare professionals to avoid weakening vulnerable health systems.

There is strong evidence<sup>21,22</sup> that health financing reforms and interventions are key to expanding access to priority health services and thus important factors for reducing mortality and morbidity - especially of women and children. There is increasing recognition globally of the negative impact that poorly designed and poorly operating health financing systems are having on the health and economic welfare of poor people. This is discussed further on page 14 and in Box 7. DFID plays an important role in helping countries develop their national health financing systems in ways that address these problems, supporting poorer countries to move more rapidly towards universal health coverage.

#### **Box 4: Strengthening Access to Medicines**

Access to essential medicines is embodied in the right to health, yet weak health systems result in this entitlement being denied. Medicines expenditure can result in catastrophic household expenditures for poor and near-poor families: 60% - 90% (WHO) of expenditure on medicines in developing countries is out-of-pocket, often spent in private pharmacies with unqualified providers.

Access to good quality, appropriate and affordable medicines is one of the six building blocks of an effective health system and requires a functioning pharmaceutical sector. Moreover, the pharmaceutical sector itself mirrors many of the needs of the wider health system, requiring financing, specialist human resources, health management information systems, strong governance and defined service provision (e.g. essential medicines lists and standard treatment guidelines).

Medicines expenditure is often the second largest health expenditure (after human resources) in developing countries, accounting for 30% - 60% (WHO) of spending. The 2010 World Health Report notes that three of the nine top causes of inefficiency in health expenditure relate to medicines, and that removal of this inefficiency could save 3-5% of total health expenditure in low-income countries. Improving the efficiency, rational use and health impact of medicines could accelerate countries' progress towards universal health coverage in addition to saving lives and preventing and limiting debilitating illness. Improving efficiency requires better public sector management of medicines and also more effective engagement with private sector pharmaceutical companies on issues of pricing, quality and distribution.

DFID works to improve access to medicines in a number of ways. One of these is through improving the value for money of basic lifesaving medicines. For example, DFID supported the **Clinton Health Access Initiative** with £9m of funding over 3 years (along with others) to engage in shaping commodity markets for HIV, TB and malaria. Working with private sector suppliers to reduce the costs of manufacturing and with countries to improve demand forecasting and drug introduction, CHAI has helped reduce prices and increase manufacturing reliability. It is estimated that this has resulted in \$600m of costs averted over the next 5 years for key HIV medicines. The UK's contribution to this work will avert costs equivalent to purchasing ARVs for an extra 500,000 people.



## *Building and maintaining a strong community interface*

The third ring of the diagram in Figure 1 identifies those investments that are perhaps most important – and certainly the most challenging. These relate to the community interface that enables and empowers individuals, families and communities to use services in an appropriate and timely way. Simply making good quality services available does not ensure that the right services are used by the right people at the right time to improve health. Demand for services (consumption and utilisation) also plays an important role in determining efficiency and impact.

Insufficient consumption of services may be caused by barriers to access directly related to health services, such as cost, lack of transport, previous experience of discrimination or disapproval when seeking services, and poor confidence in the quality and value for money of services.<sup>23</sup> For example, in poor countries, the heavy reliance on direct out-of-pocket payments creates financial barriers that prevent millions of people each year from seeking and continuing needed care.<sup>24</sup> Direct payments also result in financial hardship, even impoverishment for millions who use health services.<sup>25</sup> The removal of financial barriers is therefore integral to the larger goal of reducing poverty. For publicly-provided services, this could mean subsidising the removal of up-front fees at public health facilities (as has happened for example in Sierra Leone). For privately delivered services, it could mean removing charges for poor people through subsidising vouchers or insurance schemes, so that everyone, regardless of income or wealth, can gain access to, and even choose between, competing service providers. In both cases funding for such subsidies for the poor would need to come from the public purse. As the World Health Report 2010 makes clear, there is strong evidence that the most efficient and equitable way of raising funds to achieve universal health coverage is through compulsory prepayment, whether in the form of general taxation and/or compulsory contributions to a health insurance scheme. Yet in every country there are some people who are too poor to make a significant contribution and whose costs need to be covered by governments.<sup>26</sup>

Wider non-financial barriers also limit access to and utilisation of healthcare, especially social and cultural factors such as low and unequal status of women and girls, early and forced marriage, lack of or inappropriate information, lack of family, partner, community, social and political support for specific forms of healthcare, and harmful traditional practices. Understanding health-related behaviours and wider social practices and norms is a critical step towards empowering people to use health services and make healthy choices. The Safe Spaces intervention in Zambia, for example, is aiming to improve the sexual and reproductive health of adolescent girls by enabling them to acquire social, economic and health assets that will give them greater control over their own choices. Health service providers also need to be more responsive to people's needs, encouraging them to use effective and appropriate services. Citizens have an opportunity to play a role in shaping their own health, by demanding good quality services and helping to manage and account for them. Tools such as participatory budgeting, monitoring of public expenditure and community based monitoring of services can help enable citizens to hold their government and service providers accountable.

## *Understanding the broader determinants of health*

The outside ring of Figure 1 illustrates the wider system, government, and society in which health outcomes are achieved. **There are a number of other (non-health) factors underpinning the success of efforts to reduce mortality and morbidity.** The value placed on health and health services in relation

to other national priorities determines to a large extent the level of political will and consistent financial support from Ministries of Finance. Educated women are much more likely to space their children and women's empowerment and independence are vitally important to their ability to access services and to use household resources to improve their family's health and nutrition.<sup>27</sup> Working with men and boys is critical, both to build their support for women's and girls' health in a given context and to influence men's behaviours and therefore health outcomes.

Also included in this ring are water and sanitation and nutrition. Investments in water and sanitation can have significant health dividends for the poorest<sup>28</sup> and most recent estimates suggest that malnutrition is the underlying cause of more than 30% of under-5 mortality.<sup>29</sup> WHO estimates that 1.4 million preventable child deaths per year result from diarrhoeal disease, 88 per cent of which are attributable to inadequate access to water and sanitation and poor hygiene practice (inadequate WaSH).<sup>30</sup> Another 860,000 child deaths per year are due to malnutrition, around 50 per cent of which is attributable to inadequate WaSH.<sup>31</sup> DFID already supports one major integrated health, nutrition and WaSH programme in Bihar, India, and continues to work to achieve efficiency and effectiveness through integrated programming in areas where there are clear links between health and WaSH, in particular diarrhoeal disease, nutrition and NTDs. New research into the relationship between WaSH, nutrition, and enteric disease may help further improve understanding of the causes of stunting.

#### **Box 5: Nutrition**

Under-nutrition is associated with a third of child deaths, yet preventing it requires action across a range of sectors. UK support is focussed on **those most in need** and where there is strong evidence of **impact**: the first 1000 days from conception to a child's second birthday, after which the physical and cognitive damage of poor nutrition is mostly irreversible.

The UK actively supports the Scaling Up Nutrition (SUN) movement, which works with partner governments to accelerate progress in reducing under-nutrition. SUN takes a twin-track approach: first, it aims to scale up **nutrition-specific interventions** to address the immediate causes of malnutrition. Thirteen proven nutrition interventions, if delivered at scale, could together reduce chronic under-nutrition by one third. These include preventing and treating vitamin and mineral deficiency and support to exclusive breastfeeding. The health sector provides the main delivery channel for the nutrition-specific interventions but work with private sector companies is also required to develop new products and expand fortification of processed foods.

Secondly, SUN addresses the long-term underlying causes through **nutrition-sensitive interventions** by readjusting and redesigning programmes across a range of sectors including **agriculture, environmental health, water and sanitation, social exclusion and cash transfer programmes**, to ensure that they deliver nutrition results. This requires a cross-government effort linked through a common set of agreed results.

Since many health systems challenges lie outside the health ministry's control, such as public service employment practices, wage bill caps, or import controls that can include health commodities like nets and drugs, **success in tackling many difficult reforms often requires strong willed, joined up government**. Health services, as part of a health system, are thus delivered in most countries in the context of fundamentally important governance capability and practice. This includes decentralised service provision, accountable local authorities, domestic revenue collection and public financial



management, procurement and contract management, corruption control, regulatory controls, payroll audit and other civil service reform issues all underpinned by state legitimacy.<sup>32</sup> DFID uses institutional appraisal and political economy analysis to inform programme design and to build strengthened accountability between citizens and national and local authorities for services provided.

**The social, economic and environmental determinants of poor health fall within the responsibility of many government departments other than health.**<sup>33</sup> Health services do not, on their own, deliver optimal health outcomes equitably across society but the health system should be strong enough to identify causes of poor health, enable coordination across government departments to address these, build outreach, communication and education programmes that operate beyond fixed services and negotiate with Ministries of Finance for adequate resources.<sup>34</sup>

# 3. Delivering results: principles that guide DFID's work

As set out in chapter 1, delivery of the UK's support to health results is guided by four closely interrelated principles: basing decisions on evidence; maximising value for money; delivering more effective aid; and putting girls and women at the heart of the work. DFID also focuses on meeting the needs of the poorest and hence is increasingly working in fragile and conflict-affected states.

## *Evidence-based decision-making*

DFID is committed to ensuring that its investments in health are based on evidence of what works. Evidence is central to the way that DFID identifies new opportunities and seeks to learn from ongoing programming. Each new DFID investment requires a business case to be approved that includes an assessment of the strength of existing evidence and the identification of gaps for new research and evaluation.<sup>35</sup>

Through the Research and Evidence Division, DFID commissions new research and works through an Evidence into Action team to turn good research into practice. In addition, DFID is working with others to **identify and fill gaps** in the evidence base in a number of ways:

- a) Investing in systematic reviews of existing evidence to identify gaps
- b) Ensuring its top priorities are based on comprehensive evidence reviews (for example, those undertaken to support the Frameworks for Results on malaria and on reproductive, maternal and newborn health and the Position Paper on Scaling Up Nutrition;
- c) Supporting new evidence building through a series of long term research programmes (including research on the quality of care and health systems and service delivery)<sup>36</sup>;
- d) Supporting work on the development and introduction of new technologies and products to impact on diseases of poverty.

## *Value for money*

**DFID aims to maximise the impact of its support to improve poor people's lives and deliver health outcomes in an equitable, effective and efficient way.** This means using evidence on what works, where and why, to deliver cost-effective interventions that achieve health outcomes for those most in need, and delivering them in the right way. Value for money is achieved in practice by: ensuring partners understand what DFID means by improving results and value for money; rigorously monitoring progress; managing implementation well; and taking corrective action where necessary. It is important to recognise that some people and some geographical areas will always be more expensive to reach than others, and that higher costs do not always imply poor value for money. It may be more expensive to deliver services in rural areas than in urban or peri-urban areas, for example, but this does not necessarily imply that it is less efficient.

**The UK also works through its bilateral programmes to improve the value for money of its health systems support.** This includes the development and use of better metrics to assess the success of programmes. It is clear that isolating the impact of health systems investments on health outcomes is a

complex problem because many other factors (social, political and economic) also influence outcomes. There is, however, growing evidence that health systems interventions can lead to improved access to and coverage of services, which in turn contributes to better health outcomes. Countries with stronger health systems have been shown to have lower infant, child and maternal mortality rates.<sup>37</sup> Through investing in research and practice, DFID aims to develop better ways of demonstrating the association between systems strengthening and health outcomes and to improve understanding about what works and where.

### ***Delivering more effective aid***

**Aid for health has risen dramatically in recent years and this has been accompanied by progress towards the health MDGs.** But at current rates of progress the MDGs for child and maternal mortality will not be reached by 2015. More effective aid can help deliver improved outcomes. The principles of aid coordination, harmonisation and alignment set out in the Paris, Accra, and most recently Busan High Level Forums are designed to guide the collective response to supporting partner countries to improve health. DFID's work with others through the International Health Partnership to support countries' own plans puts these principles into practice to strengthen health services and health outcomes. Progress in the health sector has been encouraging, with evidence of accelerated progress on health outcomes where implementation of aid effectiveness principles has been strong.<sup>38</sup>

### ***Putting girls and women at the heart of DFID's work***

**DFID puts girls and women at the forefront of all it does**, as set out in the Strategic Vision for Girls and Women (2011). This is reflected particularly in 'Choices for Women', the UK's Framework for Results for improving reproductive, maternal and newborn health, but applies to all DFID's work on improving health outcomes.

The Strategic Vision for Girls and Women as a whole addresses critical determinants of health, alongside its particular focus on delaying first pregnancy. Getting girls into and through secondary school, building women's economic empowerment, engaging women in governance and accountability, protecting legal and inheritance rights, and ending violence against girls and women, including female genital cutting, are all critical to improving health outcomes. DFID's work with women and girls also aims to engage men and boys and where possible indicators of results are disaggregated by sex and by age.

### ***Targeting efforts to need***

DFID's efforts to improve global health focus on reaching the poorest people and supporting the poorest countries. DFID has health programmes in a number of countries mainly in Africa and Asia, but also supports many more through its contributions to multilateral agencies, global funds and international financing institutions.

DFID's 28 focus countries account for a third of the world's population and experience a disproportionate burden of disease, disability, and premature death.<sup>10</sup> Over 48% of the global burden of disease and more than 68% of the global burden of all communicable diseases are found in DFID focus countries (see table 1).<sup>39</sup>

### ***Working in fragile and conflict affected states***

A decentralised approach to working at country level, together with the strong focus on systems that genuinely deliver results for the poorest people, allows DFID to take a flexible and responsive approach to supporting health outcomes in difficult environments. Where services exist and are under threat for

extraneous reasons, DFID's approach is to safeguard national health systems while saving lives. Where there is little capacity or infrastructure, DFID seeks to find the right balance between working effectively to build services for the present and for the future. Conflict-affected and fragile situations require flexibility and innovative thinking. Programmes are based on a deep understanding of the context and the political implications of interventions in order to ensure that they are effective and that they do not further weaken existing national health systems. However, faced with insecurity, weak state capacity, difficult political environments and acute humanitarian crises, conventional approaches to aid delivery will often be inadequate. The UK's approach to service delivery in fragile and conflict affected areas is informed by the DAC Principles for Good International Engagement in Fragile States and Situations.<sup>40</sup>

**Table 1: Percentage of global burden of disease found in DFID focus countries**

*Total disability-adjusted life years (DALYs) in 28 DFID focus countries as a share of total global DALYs by condition or disease cluster<sup>41</sup>*

Health condition	% of global DALYs in DFID focus countries
HIV/AIDS	77%
Childhood-cluster diseases Pertussis, Polio, Diphtheria, Measles, Tetanus	82%
Diarrhoeal diseases	68%
Tropical cluster diseases Includes Chagas, Schistosomiasis, Leishmaniasis, Lymphatic Filariasis, Onchocerciasis	77%
Maternal conditions	64%
Perinatal conditions Prematurity/low birth weight, asphyxia, trauma, neonatal infections and other conditions	65%
Nutritional deficiencies Protein-energy malnutrition, Iodine and Vitamin A deficiency, Iron-deficiency anaemia	60%

### ***Health in a Humanitarian Crisis***

DFID works to strengthen collaboration between humanitarian and development health partners, to ensure that short-term humanitarian interventions support longer-term development goals, and that these longer term development interventions build resilience to conflict and disasters.<sup>42</sup> Building resilience includes strengthening health systems and strengthening the community interface, enabling them to be the first to respond when disaster strikes. Understanding of how best to save lives in an emergency is always improving and DFID is investing in research and innovation to improve it further. It is evaluating evidence on the cost-effectiveness of resilience-building activities to inform future activities. DFID works with others to strengthen early warning systems and facilitate early action using science, research and country knowledge.

The UK government continues to reinforce its capacity to respond to health emergencies and humanitarian crises in countries overseas, improving accountability, impact and professionalism. Health teams should work closely with, and strengthen national and district systems and local communities to leave behind expanded and more resilient health systems after an emergency.

# 4. Delivering results in future: better ways of working

## *Expanding partnerships*

**Non-state providers** (for-profit and not-for-profit, formal and informal) deliver a large share of health services across the developing world and are an important partner in the health system of most countries. Privately delivered services are often poorly regulated by the government, can be expensive, of variable quality and may not be accessible to the very poorest and most vulnerable if they are not publicly financed. Yet private providers can be much more sensitive to demand and sometimes offer better value for money than public providers. There are therefore great potential benefits from improving their incentives to deliver better quality services more equitably. Developing governments' capacity to contract, regulate, supervise and monitor private provision of services so that non-state providers become an integral part of scaling up cost-effective coverage of quality health services for the poorest is a very challenging but an increasingly pressing need if all people are to be reached with services at reasonable cost (see Box 6). The aim is to bring about sustainable market change that meets the needs of the poor.<sup>43</sup>

DFID has a strong network of global partnerships and continues to work with others, building new relationships where possible and putting effort into **public-private partnerships**, especially for the delivery of complex and longer term objectives. For example, when polio is finally eradicated, it will be the result of a broad coalition of governments, private foundations, pharmaceutical companies, multilateral agencies and charitable organisations.<sup>44</sup> And the approach being taken to control neglected tropical diseases relies on a vast partnership of private pharmaceutical companies, implementing partners and country governments working with donors, foundations and others to reach the people most affected. There is also considerable potential for future partnerships with food producers to improve nutrition

At a domestic level, public-private partnerships (PPPs) between governments and the non-state sector are complex but potentially effective, as their extensive use in India illustrates. Two types of PPP operate there: with NGOs/not-for-profit agencies and with the commercial private sector and larger corporate groups. While both types have shown high levels of utilisation and benefits, recent assessments highlight the need for active performance monitoring, sound contract management, basic cost and quality monitoring. To get the most out of these partnerships and to ensure the poorest benefit, there is need to build capacity within the public health system to design and manage these partnerships.

The UK considers its partnerships with the **multilateral agencies** responsible for health outcomes to be a fundamental part of achieving results. DFID undertook a review of its multilateral aid in 2011 with the aim of ensuring that the UK gets maximum value for money for UK aid through its contributions to multilateral organisations. DFID provides funding to these organisations both to provide development and humanitarian aid and to undertake a broad range of activities, such as providing global leadership on HIV and AIDS, malaria and TB, responding to natural disasters, providing large scale infrastructure and supporting children and women.

### **.Box 6: Harnessing non-state actors for better health for the poor (HANSHEP)**

HANSHEP is a group of development agencies and countries that seek to improve the performance of the non-state sector in delivering better healthcare to the poor by working together, learning from each other, and sharing this learning with others. Current members are the African Development Bank, the Bill and Melinda Gates Foundation, BMZ (the German Federal Ministry for Economic Cooperation and Development, represented by GIZ and KfW), DFID, the Government of Nigeria, the Government of Rwanda, the International Finance Corporation (IFC), the Public Health Foundation of India, the Rockefeller Foundation, USAID and the World Bank.

HANSHEP funds research into innovative, more effective models of non-state delivery and public-private collaboration; and provides resources to support the piloting and scaling of successful models. In this way, it seeks to better harness non-state actors (NSAs) to provide more accessible, higher quality, more affordable and better value healthcare for the poor.

Current projects include the Center for Health Market Innovations (<http://healthmarketinnovations.org>), which identifies, shares information about, and nurtures innovative delivery and financing programs that work to organize health markets. The Mining Health Initiative explores the potential to mobilise and support the mining industry in low income countries to extend and/or facilitate the delivery of quality and affordable healthcare for poor people. HANSHEP is also supporting IFC to deliver a pilot Health PPP Advisory Facility to help governments develop and implement public-private partnerships for better health for the poor.

The Multilateral Aid Review (MAR) confirmed that the multilateral system is a critical complement to what the UK government can do alone. This is particularly true in the health sector, where agencies such as WHO, UNICEF, UNFPA, UNAIDS, GFATM, GAVI and the World Bank all provide a significant contribution to global health outcomes. WHO, in particular, has a unique role to play as the technical agency responsible for setting standards, normative guidance, and establishing best practice. Multilateral organisations are able to work in many more countries than the UK can reach on its own and at a completely different scale. DFID continues to work closely with the best performing agencies, which are focused on results, are accountable and well run and deliver critical improvements to poor people's lives and health.

China and other **emerging powers**, including Brazil and India, have a large and growing role in global health. They bring new perspectives, new solutions and economic, technological and innovative strength. Several have made significant progress towards the health MDGs and towards achieving universal health coverage in their own countries. Recognising this, DFID is developing a new type of partnership with these countries. The Global Development Partnerships Programme (GDPP) is a new form of collaboration, where DFID works with emerging powers to maximise the collective positive development impact and focus on global public goods and collaboration on specific challenges in low income countries.

The GDPP aims to achieve **quicker developmental outcomes** and **harness innovation**. For example, helping low income countries to learn and benefit from China's progress in health, while leveraging value for money by supporting the capacity of China and India to develop and manufacture good quality, low-cost drugs, vaccines and health technologies. All of this helps DFID and others get more value for their money, while achieving greater impact and broadening the global health partnership. But it also recognises the growing complexity in the global development system. A majority – as many as three quarters – of the world's poor live in middle-income countries. Supporting these countries with technical assistance, shared

knowledge, investment in research, and pooled efforts to create global public goods can have lasting impact on the health of poor people in these countries and others.

The UK also seeks to leverage greater engagement **across the UK-based health community** in delivering results, unlocking the best the UK can offer for development work. The *Health is Global*<sup>45</sup> strategy sets out the UK's commitments across other government departments including the Department of Health, the Ministry of Defence, and the Foreign and Commonwealth Office. And the **Health Partnerships Scheme**<sup>46</sup> facilitates partnerships between UK-based health organisations and their counterparts in developing countries, enabling skills transfer, exchange of ideas and building support for broader UK development outcomes.

DFID's approach to supporting health outcomes in the poorest countries aims to help **future-proof health systems** to ensure that they are resilient and better equipped to address new and emerging challenges. These include emerging diseases and health problems (such as non-communicable diseases, mental illness and a greater focus on trauma), a changing environment (demographic change, urbanisation, climate change and food availability) and additional systems pressures (drug resistance, migration and disaster risk reduction).

**Non-communicable diseases (NCDs)** are increasing in all countries and **currently account for 63% of all global deaths or 36 million deaths each year.**<sup>47</sup> Although amongst the poorest people in the poorest countries, the greatest health impact is still caused by communicable maternal, peri-natal and nutritional conditions, in all of the world's regions except Africa, NCDs are or soon will be the major cause of mortality.<sup>48</sup> The four NCDs that cause the greatest mortality are cardiovascular disease, cancers, chronic respiratory disease and diabetes and they share common preventable risk factors such as tobacco, alcohol consumption and poor diet. Other NCDs are also important contributors to illness and disability, including mental illness and injuries. A recent study by Harvard School of Public Health and the World Economic Forum<sup>49</sup> indicated that over the next 20 years, NCDs will cost more than US\$30 trillion (which, for perspective, is about half of global GDP in 2010). Many countries will face a double burden in the coming decades as they experience climbing morbidity, disability and death from NCDs while they still face preventable mortality from communicable diseases, under-nutrition and maternal causes. DFID's current focus, as set out above, aims to **support health systems strengthening**, health worker capacity and access to essential medicines in order to help countries respond to all their health priorities. Increasing coverage, equity, access and quality within the health system strengthens service provision and community outreach to identify, prioritise and address all evolving health problems including NCDs.

DFID is engaged in activities that help tackle the NCD prevention agenda. These include research, vaccination programmes such as hepatitis B vaccination that prevents liver cancer, and support to the prevention of indoor air pollution. DFID has recently launched PRIME (*PRogramme for Improving Mental Health CarE*), a new research programme led by the University of Cape Town. The programme brings together a consortium of researchers from South Africa, UK, Uganda, Ethiopia, India and WHO to work on the feasibility, acceptability and impact of mental health care packages for priority mental disorders. DFID also supports a number of initiatives to reduce indoor air pollution, estimated by the Institute for Health Metrics and Evaluation to be one of the top five contributors to the burden of disease worldwide.<sup>16</sup> WHO has estimated that almost two million deaths every year are attributable to indoor air pollution from solid fuel use.<sup>50</sup>

The immediate and longer term future will bring additional pressures and challenges but also new opportunities. As urbanisation gathers pace, service delivery is hard pressed to keep up with demand. At



the same time, securing the underlying determinants of health, such as access to safe water, adequate nutrition and a good quality education continues to be a struggle for many people. Threats to household resilience will be most severe in relation to food, energy and water security and these will in turn have an impact on health outcomes. Threats to health service capacity in the form of drug resistance, migration of health workers and a growing number of rapid onset disasters could undermine the considerable progress that has been made. If addressed quickly enough, the negative impact of some of these changes can be mitigated. Urbanisation, for example, offers an opportunity to establish more cost-effective models of service delivery. DFID works with its focus countries and global partners to better anticipate these threats and to avert, mitigate or offset their impacts on health outcomes. For example, DFID is working with partners to track and curtail artemisinin resistance in south-east Asia in order to protect the use of first-line malaria treatment in high burden countries across the world.

### **Box 7: Financing Universal Health Coverage**

Global investment in health is higher than it has ever been. The report 'Financing Global Health 2010' shows that development assistance for health increased from \$5.59 billion in 1990 to \$21.79 billion by 2007 (in 2007 dollars). At the country level, domestic investments in health increased from \$128.18 billion in 1995 to \$241.33 billion in 2006. Yet the High Level Task Force on Health Innovative International Financing for Health Systems estimated that low income countries currently spend only US\$25 per capita on health, of which \$19 comes from domestic sources, and of that, \$10 comes from out-of-pocket payments. Out-of-pocket payments made at the moment when services are used act as a major barrier to access by the poorest, especially for women and children, and so will slow countries' progress towards UHC. DFID has long supported the development of equitable financing arrangements that lift the economic burden off the poorest, providing technical assistance to several countries that have successfully removed out-of-pocket payments for women and children including in Nepal, Sierra Leone, Uganda and Liberia. Other options for supporting access by the poorest include vouchers, cash transfers and contracting arrangements.

The World Health Report 2010 focused on health financing for universal coverage and the demand from countries for assistance in extending coverage has been increasing steadily. DFID is supporting the WHO Department of Health Systems Financing to provide technical support to these and other countries to undertake complex national reforms. China, Colombia, Ethiopia, Indonesia and other countries are all working actively towards restructuring their health systems to achieve UHC financed out of general taxation and other non-contributory mechanisms.

Health financing in India: A High Level Expert Group (HLEG) on UHC was constituted by the Planning Commission of India in 2010 with the mandate to develop options to deliver accessible and affordable health care to all Indians. DFID provided technical assistance to the HLEG, which has recommended an increase in public financing for health to 2.5% of India's GDP during the course of the 2012 to 2017 12th Plan period. Hundreds of millions of people will be affected. The growth of India's economy permits this increase in public financing of health, which will fund a package of primary, secondary, and tertiary care, free to all Indian citizens at the point of care.

DFID also looks to harness the opportunities made possible by technological innovation. Social media have the potential to facilitate accountability by enabling citizens to express opinions and challenge governments. The rapid increase in access to mobile phones creates exciting opportunities to use technologies to highlight service delivery weaknesses. Many developing countries are already leading the way on this. Examples include SMS for Life, helping to address drug stock-outs, and mobile phone technology to identify counterfeit

drugs. The use of handheld geographic information systems based on satellite technology has enabled polio vaccinators to identify every single household in previously missed areas of India, Nigeria and Pakistan, bringing the world one step closer to eradicating a human disease for only the second time.

## End Notes

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<sup>1</sup> Public health is a term used to mean “The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society” including through public and private providers, academia, science and commercial services (Faculty of Public Health, UK).

<sup>2</sup> This paper is aimed at a broad range of professional colleagues working in public health, nutrition, governance and other areas of development across a range of organisations and countries. As a policy position paper, it stops short of being a full health strategy and so does not contain new policy or a full reflection of the whole of the UK government’s health investments in developing countries.

<sup>3</sup> Lozano, R. *et al*, Progress towards Millennium Development Goals 4 and 5 on maternal and child mortality: an updated systematic analysis, *The Lancet*, Volume 378, Issue 9797, Pages 1139 - 1165, 24 September 2011.

<sup>4</sup> World Development Report, Gender Equality and Development, World Bank, Washington DC, 2012

<sup>5</sup> The Coalition Agreement states “We will support actions to achieve the Millennium Development Goals. In particular, we will prioritise aid spending on programmes to ensure that everyone has access to clean water, sanitation, healthcare and education; to reduce maternal and infant mortality; and to restrict the spread of major diseases like HIV/AIDS, TB and malaria.” *The Coalition: our programme for government* <http://www.cabinetoffice.gov.uk/news/coalition-documents>

<sup>6</sup> <http://www.dfid.gov.uk/What-we-do/Research-and-evidence/case-studies/research-case-studies/2011/Scaling-Up-Nutrition-Unlocking-puzzles-to-transform-thinking-and-action/>

<sup>7</sup> <http://www.dfid.gov.uk/documents/prd/rmnh-framework-for-results.pdf>

<sup>8</sup> <http://www.dfid.gov.uk/Documents/publications1/prd/malaria-framework-for-results.pdf>

<sup>9</sup> <http://www.dfid.gov.uk/News/Latest-news/2011/30-years-of-HIV-Towards-zero-infections/>

<sup>10</sup> <http://www.dfid.gov.uk/News/Latest-news/2011/The-future-of-UK-aid/>

<sup>11</sup> <https://www.dfid.gov.uk/Documents/publications1/strategic-vision-girls-women.pdf>

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<sup>12</sup> *World Health Report: Health Systems Financing: The Path to Universal Coverage*. World Health Organization, Geneva. 2010

<sup>13</sup> DFID's focus countries for bilateral support are Afghanistan, Bangladesh, Burma, Democratic Republic of Congo, Ethiopia, Ghana, India, Kenya, Kyrgyzstan, Liberia, Malawi, Mozambique, Nepal, Nigeria, Occupied Palestinian Territories, Pakistan, Rwanda, Sierra Leone, Somalia, South Africa, Sudan, South Sudan, Tajikistan, Tanzania, Uganda, Yemen, Zambia, Zimbabwe

<sup>14</sup> Gwatkin, D, Wagstaff A, & Yazbeck, A, *Reaching the Poor with Health, Nutrition and Population Services: What works, what doesn't and why*, The World Bank, Washington DC, 2005

<sup>15</sup> Just 9 out of 137 developing countries worldwide are set to achieve both Millennium Development Goals (MDGs) 4 and 5 to improve the health of women and children. The remaining 128 developing nations will fall short. Based on current trends, 31 developing countries worldwide will achieve MDG 4 (to reduce the under-5 mortality rate by two-thirds between 1990 and 2015) and 13 countries will reach MDG 5 (to reduce the maternal mortality ratio by three-quarters during the same period). Lozano, R. *et al, op cit*.

<sup>16</sup> Institute for Health Metrics and Evaluation. *The Global Burden of Disease: Generating Evidence, Guiding Policy*. Seattle, WA: IHME, 2013

<sup>17</sup> Available at <http://www.dfid.gov.uk/Documents/publications1/mar/BAR-MAR-summary-document-web.pdf>

<sup>18</sup> <http://www.dfid.gov.uk/Documents/publications1/health-portfolio-review-rpt-2009.pdf>

<sup>19</sup> *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. WHO, Geneva 2007

<sup>20</sup> Campbell, J., Jones, I., Whymys, D.; *More money for health - more health for the money: a human resources for health perspective*. *Human Resources for Health* 2011, 9:18 doi:10.1186/1478-4491-9-18.

<sup>21</sup> High-Level Taskforce on International Innovative Financing for Health Systems: 2009. Working Group 1 Technical Report: Constraints to Scaling Up and Costs. [http://www.internationalhealthpartnership.net/en/taskforce/taskforce\\_reports](http://www.internationalhealthpartnership.net/en/taskforce/taskforce_reports)

<sup>22</sup> Mangham, L.J.; Hanson, K.; *Scaling up in international health: what are the key issues?* Health Policy Plan, 2010

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<sup>23</sup> Financing global health 2010 ([www.healthmetricsandevaluation.org](http://www.healthmetricsandevaluation.org))

[http://www.healthmetricsandevaluation.org/publications/policy-report/financing\\_global\\_health\\_2010\\_IHME](http://www.healthmetricsandevaluation.org/publications/policy-report/financing_global_health_2010_IHME)

<sup>24</sup> McIntyre D, Thiede M, Dahlgren G, Whitehead M. 2006, What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts? *Social Science and Medicine* 62: 858–65

<sup>25</sup> Moreno-Serra, R., and Smith, Peter, "The Effects of Health Coverage on Population Outcomes: A Country-level Panel Data Analysis, Results for Development Institute, Imperial College London, December 2011.

<sup>26</sup> World Health Report 2010 Chapter 5: An Agenda for Action

<sup>27</sup> Shantayanan Devarajan and Ritva Reinikka, Making Services Work for the Poor: The poor need more control over essential services IMF, Finance & Development September 2003

<sup>28</sup> *Ibid.* The World Health Organisation estimates that almost one tenth of the global burden of disease could be prevented by improving water supply, sanitation, hygiene and water resources management.

<sup>29</sup> Robert E Black, Lindsay H Allen, Zulfiqar A Bhutta, Laura E Caulfield, Mercedes de Onis, Majid Ezzati, Colin Mathers, Juan Rivera, Maternal and child undernutrition: global and regional exposures and health consequences. *The Lancet*, [Volume 371, Issue 9608](#), Pages 243 - 260, 19 January 2008

<sup>30</sup> Prüss-Üstün A, Bos R, Gore F, Bartram J. Safer water, better health: costs, benefits and sustainability of interventions to protect and promote health. World Health Organization, Geneva, 2008.

<sup>31</sup> *Ibid*

<sup>32</sup> Health, Wealth and Welfare, Bloom, D., Canning, D., and Jamison, D., Finance and Development, IMF March 2004.

<sup>33</sup> Wilkinson, R and Marmot, M editors **Social determinants** of health: the solid facts. 2nd edition, WHO 2003. and Commission on Social Determinants of Health, WHO 2008

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<sup>34</sup> World Health Organization, Commission on Macroeconomics and Health, 2001, *Macroeconomics and Health: Investing in Health for Economic Development* (Geneva: WHO)

<sup>35</sup> DFID How To Note on assessing the strength of evidence <https://www.gov.uk/government/publications/how-to-note-assessing-the-strength-of-evidence>

<sup>36</sup> Current research covers work on infectious diseases of poverty including: malaria, neglected tropical diseases, TB, HIV, pneumonia and diarrhoea, reproductive, maternal and newborn health, health systems strengthening and non-communicable diseases.

<sup>37</sup> Katherine A Muldoon, Lindsay P Galway, Maya Nakajima, Steve Kanters, Robert S Hogg, Eran Bendavid and Edward J Mills, Health system determinants of infant, child and maternal mortality: a cross-sectional study of UN member countries. *Globalization and Health* 2011, 7:42 Available at <http://www.globalizationandhealth.com/content/7/1/42>

<sup>38</sup> 'Progress and challenges in Aid Effectiveness: What can we learn from the Health Sector?' OECD Working Party on Aid Effectiveness Task Team on Health as a Tracer Sector, June 2011

<sup>39</sup> The overall burden of disease is assessed using the disability-adjusted life year (DALY), a measure that combines years of life lost due to premature mortality and years of life lived in states of less than full health.

<sup>40</sup> The DAC principles include do no harm; prioritise prevention, focus on state-building, promote non-discrimination, and use practical coordination mechanisms among others. They can be found here: [www.oecd.org/dataoecd/61/45/38368714.pdf](http://www.oecd.org/dataoecd/61/45/38368714.pdf)

<sup>41</sup> WHO Global Burden of Disease database. No data was available for Occupied Palestinian Territories or South Sudan.

<sup>42</sup> The UK's Approach to Disaster Relief and Humanitarian Support: '*Saving lives, preventing suffering and building resilience*', September 2011

<sup>43</sup> In some countries, DFID is starting to apply the Making Markets Work for the Poor (<http://www.markets4poor.org/>) approach to understand health markets to analyse markets in specific health products and services and to inform strategies and programmes that improve access for the poor.

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<sup>44</sup> The Global Polio Eradication Initiative is a public-private partnership. Its goal is to eradicate polio worldwide. Further information is available at <http://www.polioeradication.org/>

<sup>45</sup> The Health is Global strategy is hosted by the Department of Health and can be found at: [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_088702](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702)

<sup>46</sup> See the website: [www.thet.org/hps](http://www.thet.org/hps) for more information and details about who is eligible and how to apply.

<sup>47</sup> Global status report on non-communicable diseases 2010, WHO. This report can be found at: [http://www.who.int/nmh/publications/ncd\\_report2010/en/](http://www.who.int/nmh/publications/ncd_report2010/en/)

<sup>48</sup> This discounts the effects of age on mortality

<sup>49</sup> Bloom, D.E., Cafiero, E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi, M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A.Z., & Weinstein, C. (2011). The Global Economic Burden of Noncommunicable Diseases. Geneva: World Economic Forum. See <http://www.weforum.org/EconomicsOfNCD>

<sup>50</sup> UNDP, WHO (2009) The Energy Access Situation in Developing Countries; a Review Focusing on the Least Developed Countries and Sub-Saharan Africa



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