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A Public Consultation on DFID's Health Strategy 2006

A Synthesis of Views

July 2006

**This report was compiled by Martine Donoghue & Ellie Bard, DFID Health Resource Centre.
(DFID Health Resource Centre, 5 – 23 Old street, London EC1V 9HL)**

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EXECUTIVE SUMMARY

As part of the development process for its next strategic health plan, DFID has undertaken a series of public consultations to elicit views on how it can most effectively use its resources and comparative advantage to improve the health of the world's poorest populations.

This report synthesises written submissions collected in July 2006 via a public consultation process. A paper along with a ten item questionnaire was posted on DFID's website and formed the basis of the consultation. The questionnaire invited comments on a wide range of topics that included: how to best assist countries scale up to universal access to essential health services; how to effectively facilitate and build human resources for health; and how to tackle 'off track' millennium development goals to get them 'on track.' Views on these topics and a range of other issues concerning health development in fragile states and broader matters of international health architecture were covered.

The consultation yielded a total of 59 submissions from a wide range of stakeholders (NGOs, Academics, Research Foundations, Private Sector, Government, members of the public etc.). NGOs were the largest group of responders.

A wide range of views were expressed in response to each of the ten questions asked. For the purposes of this Executive Summary the thematic areas identified by respondents are described, i.e. due to the breadth of points made within each question it is difficult to meaningfully synthesise the content further.

Gaps and further areas for DFID to target support were identified by respondents, however many participants also took the opportunity to say that what was required was 'more of the same.' It was argued that the benefits and impacts from DFID's implementation of its *Better Health for Poor People* strategy have yet to be reaped - more time is required to fully realise what has been started.

Summary of Questionnaire Findings

The following comments and recommendations were made by respondents:

1. What are the most effective ways to support countries' efforts to scale up to universal access to essential health services, especially for the poorest and most vulnerable?

Many respondents strongly argued that universal access can only be achieved by focussing upon **health systems development rather than adopting a vertical programme approach**. It was therefore recommended that DFID show international leadership in this area and that future grants to global public private partnerships should be carefully considered in the broader context of their need to contribute to the development of health systems generally. The following actions and thematic areas were identified as central to successfully scaling up to universal access for essential health services:

- Strong coordination of efforts at country and international levels;
- Assist national governments develop realistic, resource based national health plans and budgets;
- Stimulate political commitment;
- Sustainable financing;

- Strengthen human resource capacity and retention of health care professionals;
- Strengthen the capacity of distribution channels;
- Encourage poor countries to make more use of private sector providers for the delivery of public health goods and services;
- Continue to emphasise the importance of working sector wide in health to develop strong, long term partnerships.

2. What are the most effective ways to support countries' efforts to build and retain their health work-force?

- **Resources** for the international response to the health work force crisis preferably should be made available via individual country budgets and not by another 'stand alone' global initiative with its own sources and channels of funding.
- "**Blue skies thinking**" is required – most current strategies are concerned with restoring or building on the status quo. Whilst this may provide temporary respite, it was argued it is unlikely to lead to sustainable change. Therefore, imaginative planning which considers using available human capacity in very different ways in conjunction with alternative methods of service delivery is required.
- Build on the **human resource experience in Malawi** which is funded by DFID. A need to document and learn from the Malawi experience was voiced.
- At a **global level**, DFID should:

Work to ensure that human resources for health do not slip off the development agenda.

Help to generate more knowledge about human resources and appropriate solutions to the so-called 'crisis.' Whilst nurturing promising regional and global initiatives and influencing the behaviour of major donors.

Tackle fiscal policies that cap recruitment of health workers and constrain improvement of working conditions. This is an area where DFID can play an influential role through the IMF and World Bank.

- At the individual **country level** DFID was urged to:

Lobby for and facilitate the development of strategic health sector plans for human resources and assist countries and development partners reach a human resource partnership deal around such strategies.

Assist countries to establish and maintain appropriate information systems on human resources, including a database on migration to provide evidence for policy, planning and day-to-day decision-making, and to monitor the effect of any intervention programme implemented.

- At a **UK domestic level**, DFID should work with other UK government departments on further steps to manage migration. It was suggested that the ethical recruitment policies developed by the Department of Health may form the basis of an international code of conduct for other governments, as well as recruitment agencies.

3. What action needs to be taken to meet the off-track development targets: child, maternal and reproductive health?

In terms of child health key issues identified were:

- To consolidate **partnerships for one national child survival plan** at country level.
- Raise the profile of child survival through **advocacy and communication**.
- Enable, accelerate and sustain progress through **resource mobilisation** – ensuring that child survival interventions receive investments of similar scale to those allocated to HIV/AIDS, malaria and immunisations.
- Ensure that extra resources like the new International Finance Facility for immunisations (IFFm) are fully **integrated** into **national health systems** and build upon rather than destabilise routine programmes.
- **Support efforts to improve the use of medicines with children:** There is currently a lack of knowledge about how best to use medicines with children, and lack of paediatric versions of these medicines ("paediatric formulations"). This means large-scale treatment programmes for HIV/AIDS, malaria and TB are not optimising their resources

Key points made about **maternal and reproductive health** were:

- An MDG target on **universal access to reproductive health by 2015** and country health strategies/PRSPs incorporating sexual and reproductive health is paramount.
- Currently '**off track targets**' are **off target politically and financially**, so an increase in both is required.
- Improving maternal health is dependent upon the **development of health systems** which provide effective emergency obstetric care by well-trained and motivated staff. Women and baby friendly facilities are central to the promotion of facility based deliveries. Geographical equity issues also need to be paid attention to.
- The **lack of skilled attendants at births** is one of the main barriers to reducing maternal mortality in many developing countries.
- DFID was urged to take a lead in **advocating for increased funding for reproductive health** and implementing programmes specifically focused on the supply of contraceptives.

DFID was further encouraged to support a number of **cross cutting issues** impacting upon maternal and sexual/reproductive health, for example:

- Access to safe **water and sanitation**
- Primary and secondary **education - particularly for girls**
- Increase **immunisation/vaccination**

- Support the **inclusion of gender, social and community development** in health worker training and activities that enhance and promote decision making responsibility for women within communities.

4. In 2004 in Taking Action we set out how the UK would contribute to a more effective response to the prevention and treatment of HIV/AIDS. Should we be doing more?

- DFID should continue to help countries deal with their HIV/AIDS epidemic. Specifically, it should foster health systems strengthening; the involvement of the private sector; and the alignment of HIV and AIDS planning and responses within the health sector. It is also essential to better integrate sexual and reproductive health / TB/ maternal and neonatal child health with HIV and AIDS services.
- The issue of unsafe abortion and HIV+ pregnant women has received little attention. DFID should work with governments to address the issue of unsafe abortion.
- There is a need for an increased understanding of the political dimensions of HIV/AIDS and the health sector.
- It is important that DFID goes beyond supporting efforts to identify new technologies (e.g. condom products) and leads the dialogue to create a **political environment facilitating their introduction**.
- DFID should take the lead in revitalising **HIV prevention** efforts.
- **Palliative care** in HIV/AIDS policies and strategies are neglected.
- DFID could do far more to respond to the HIV epidemic by supporting countries address its related **TB/HIV** co-epidemic.
- More needs to be done on **prevention of mother to child transmission and paediatric treatment**. Additionally - national governments and international bodies (including DFID) must be held responsible for immediately increasing the numbers of children on antiretroviral treatment. This includes recognising children's rights to antiretroviral treatment as a fundamental human right, explicitly including children in national and international treatment targets, committing donor funds to meeting these targets; and ensuring children are included when monitoring progress.
- Better control and **integration of donor activities** is required.
- Support efforts that create a favourable **research and development** environment that encourages innovation, protection of intellectual property and long-term investment.
- Lead on discussions with industry and other stakeholders on matters to ensure a viable and sustainable supply chain – i.e. give better consideration to the **forecasting, manufacturing and distribution issues** associated with a scale up of HIV & AIDS services.

- DFID should help with the introduction of **health data systems** in sub-Saharan Africa and other low income countries. Such systems are largely non-existent and essential to recording patients, treatments and outcomes.

5. How should we respond to the health challenges in conflict and post-conflict environments and fragile states?

- There needs to be a **greater realism amongst donors** and other key actors about the prospects of achieving sustainability in fragile states. Donors must be prepared to accept longer timeframes than current funding rounds support, and a greater degree of risk regarding programme/investment outcomes.
- Facilitate and use an appropriate **mix of state and non-state centred aid modalities**.
- Better evidence is required about which model or combinations of **models for health care delivery** (basic packages, vertical approaches, islands of dependability, the role of hospitals) work better in environments of poor governance and limited resources.
- Focus support on the health system as a whole - particularly **primary care services**.
- **Human resources for health** were identified as critical – a range of points are made in the text of the report.
- DFID's policy shift to eliminate **user fees** for basic public health services was welcomed by respondents, and it was hoped that DFID would encourage other donors to not only adopt this same policy, but provide the substantial funding required to cover this health financing gap whilst supporting the necessary research to identify more equitable solutions.
- Support post abortion care, emergency obstetric care, HIV testing and other essential **sexual and reproductive health services** – especially for large numbers of women raped during wars. Sexual and reproductive health is often neglected in conflict areas and needs to play a greater role in all conflict and post-conflict programme work.
- More work needs to be done from the outset of any emergency and in fragile states to **link humanitarian assistance to longer term recovery**, development and system strengthening.
- The **emotional impact of armed conflict and human rights violations** needs to be better taken into account - these situations can result in high levels of depression and post-traumatic stress disorder.
- One essential area that often needs very 'hands on' assistance in such countries is the **supply chain**. By definition, in fragile states procurement and logistics are often poorly served and are particularly vulnerable to mismanagement or corruption.
- **Donor behaviour** needs to grapple with the challenge of drawing together a range of partners to 'harmonise to align' in the health sector. In terms of alignment between donors and partner governments, the emerging lesson is to focus on

government priorities. Where it is not possible or desirable to support the authorities' priorities, it is potentially possible to carefully 'shadow' align with systems, such as administrative boundaries or the budget and planning cycle at local level. More work is required about how to operationalise this principle in practice.

6. How can the accountability of recipient governments to their people for the effective use of health resources be improved?

Key issues identified were:

- **A comprehensive system of checks and balances is fundamental.** Decentralised services enable communities to demand more transparency from their local institutions. Dynamic and demanding NGOs in partnership with research organisations and the media etc can collectively create accountable structures related to government.
- Raise better awareness amongst donors at country level about including **civil society and the private sector participation** in policy discussions, as well as service delivery, and to advocate with governments to open up space for such participation.
- **Capacity building at all levels of MoH**, better payment of staff to improve motivation coupled with publicly enforced sanctions for corruption.
- **Be prepared to take tough decisions** – where it is judged that a national government is unable or unwilling to utilise funding for healthcare effectively, donors should be prepared to withdraw development assistance and channel resources through an alternative civil society or a non-governmental recipient.
- **Rules on conflicts of interest must be enforced** and companies that engage in corruption debarred from future bidding. No-bribe pledges Integrity Pact should be adopted to level the playing field for all bidders.
- **Rigorous prosecution** will send the message that corruption in health care will not be tolerated.

7. How can the performance and coherence of the international health architecture be improved to deliver better health for poor people?

- DFID should help simplify the over-complexity of the aid architecture – e.g. to half the number of global health partnerships (GHPs) by 2010.
- DFID is encouraged to consider decreasing its funding to GHPs and increase it at country level through sector funding (pools, sector budget support) and general budget support for poverty reduction.
- DFID's efforts to promote **greater donor harmonisation** through processes like the Global Task Team and Three Ones' were supported by respondents. However, the real impact of this work at country level was questioned. There were some concerns about the US Government's establishment of systems parallel to country health system for the delivery of ARV programmes. The UK Government was urged to use its capacity to influence the greater integration of PEPFAR work into public health programmes, and to demand greater accountability of the US Government to the Paris Declaration on Aid Effectiveness.

- In some institutions such as the IMF and World Bank, both of which have immense influences on health in developing countries, there is a **lack of transparency regarding policy making and decision taking**. The UK Government should press for further reform to improve levels of transparency and therefore facilitate greater accountability.
 - The UK Government, in its role on the IMF's Finance Committee is urged to address the **problem of IMF ceilings** on health sector spending to ensure that developing country governments can absorb and use new flows of foreign aid for use in increasing investments in health.
 - **More rigorous evaluation of the performance of multilateral organizations** working in the health sector might be helpful. DFID's Multilateral Effectiveness Framework was a good example of a non-subjective evaluation of country-level results, organizational systems and quality of aid, and usefully identified problem areas across a range of agencies. Such scrutiny, at regular intervals, could be very effective in stimulating remedial action which in turn would work to improve the "international health architecture".
 - **Policy implementation must be supported by strong advocacy within DFID, at the highest levels, on the importance of policy coherence between donors**. There is considerable donor policy discordance at country level which is contradictory and confusing (e.g. user fees/bed nets in DRC).
 - **Best practice principles** for GHPs (Global Health Partnerships) and the targets and prescribed behaviours for donors of the Paris Agenda must continue to be applied in the future.
 - A degree of **rationalisation and sharing of donor representation** between DFID and other development partners may be appropriate. However, the complete elimination of direct DFID representation in countries, such as Ghana etc. caused some concern because it was perceived to remove a source of authoritative guidance and co-ordination, and makes it somewhat more difficult for UK based organisations to make their contribution to development.
- 8. Where should we focus efforts for maximum gain in addressing the broader determinants of health?**
- DFID's **pro-poor approach** was commended and supported in terms of the need for its continuation and strengthening.
 - DFID and other donors should promote a **'joined-up' approach to tackling issues such as health, sanitation, nutrition and water provision**.
 - Promote policies that encourage **economic growth**.
 - Respondents made points about a host of inter-connected factors and determinants for health – these covered the areas of **education, electricity and power supply, water and land tenure reform, as well as climate change**.
 - Support actions that foster **representative governments; a free press; strong legal structures; and sound financial institutions**. These are structures that

support and enable a responsible and healthy society, and in the broadest sense are also considered determinants of health.

- National policies to encourage the development of a **vibrant private sector** will help sustain economic growth, adding to health care, education and other social services. DFID's support for the development of **public/private partnerships** in areas such as clean water, better housing, sound education and appropriate medicines continues to be essential.
- Some respondents strongly urged DFID to be cautious about how it supports the **privatisation of water** which has had strong negative implications for water provision in many developing countries, and to explore the prospects for public sector regulation of private sector water provision.
- **WTO & Food Security:** As the WTO Doha Development Round draws to a close this year, the UK must take a lead in ensuring that final negotiations at the WTO result in a re-balancing of economic privileges and co-ordinate a collective response which will restore food security and status as a human right, rather than a commodity.
- **Tariffs and Access to Medicines:** DFID was encouraged to support moves to eliminate tariffs and encourage the EU to work towards this at the WTO.

9. Are there gaps in DFID's response to the current and future health challenges?

- The lack of commitment to **palliative and community based care**
- DFID's **profile with respect to medicines issues** was considered noticeably lower than it has been formerly, and its inputs to medicines debates within the context of international public health are missed and needed. It was felt important to redress this gap.
- **Disability** is an area where much more explicit and concerted action is required. Disabled people are excluded from many development interventions, including health interventions, for multiple reasons, and DFID needs to support ways of addressing stigma and prejudice, inaccessibility to health facilities, inadequate communication methodologies and discriminatory policies.
- **'Neglected' diseases'** (Leprosy, LF, Buruli Ulcer etc.) - DFID could take an important advocacy role to ensure that tackling these diseases not only stays on the radar screen of major health multilateral donors but actually that the current imbalance is corrected.
- An increase in DFID's technical capacity in **nutrition** both in London and in priority countries with high levels of malnutrition like Ethiopia and Bangladesh was identified as lacking and an important area to redress.

For some, the issues they flagged were not thematic 'gaps' but rather the scale of DFID's response in some areas. For example:

For one NGO respondent, the major highlighted gap was the volume of planned aid expenditure and the speed at which the 0.7% of GDP target will be met.

For others, the level of financial support accorded to sexual and reproductive health rights programme work (including commodities and research into microbicides) was a significant short fall.

10. What should be the priority areas for research in improving the health of poor people?

The thematic areas identified were:

- Vaccines & Product Development
- HIV & AIDS – Diagnostics & Treatment
- Other Diseases – Communicable & Non-Communicable
- Health Systems / Operational Research / Cross Cutting Issues

Broadly speaking, respondent feedback demonstrated that whilst more resources and research were required, DFID was focusing its resources and assistance in the right research priority areas. In addition to the identification of specific research topics, many respondents provided overarching comments on the status and operating environment of international research and development (R&D). Some of these comments contained suggestions for the wider direction and focus for DFID's future role and support for research. Points made were:

- **Southern research capacity needs to be strengthened, for instance:**

Increase both the number and skills of African researchers – the need for stronger support for southern research leadership.

Make available scholarships for African researchers within African research institutions.

Address the capacity in developing countries to conduct clinical research

- **Mainstream R&D into the Development Process**

It was acknowledged that DFID has made significant efforts to support research in developing countries, and the new strategy provides another opportunity to review its institutional arrangements, so as to better integrate the financing, policy and implementation arrangements for research into DFID's country-level operations:

- **Responding better to time & money constraints**

It was argued that: **health research suffers from insufficient funding** and from a huge discrepancy between the magnitude of disease burden and the allocation of research funding. Crucially, it has resulted in a well recognised gap in the generation of new products and an asymmetry in the ability of poorer countries to use existing and new technologies. In recent years there have been some attempts to correct this gap but so far it remains largely uncorrected.

ABBREVIATIONS

ARVs	Anti retrovirals
DFID	Department for International Development
DRC	Democratic Republic of Congo
EHRP	Emergency Human Resource Programme
GHPs	Global health partnerships
GPPPs	Global public private partnerships
HR	Human resource
IFFIm	International Finance Initiative for Immunisations
IRS	Indoor residual spraying
KSF	Knowledge and Skills Framework
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MTEF	Medium term Expenditure Framework
NGO	Non-government organisations
NHS	National health service
NMAs	National medical associations
PDPs	Product-development public-private partnerships
PEPFAR	President's Emergency Plan for AIDS Relief
RH	Reproductive health
SADC	Southern African Development Community
SRH	Sexual and reproductive health services
SWAp	Sector wide approach
TA	Technical assistance
UN	United Nations
WHO	World Health Organization

1. BACKGROUND & PUBLIC CONSULTATION PROCESS

DFID's health strategy¹ is currently being revised as a response to significant changes in the international development agenda since the Millennium Summit (2000), and the UK Government's firm commitment to translate the 2005 G8 commitments into action. To inform its new strategy development, a series of public consultations are being undertaken to elicit views about how DFID can most effectively use its resources and comparative advantage to improve the health of the world's poorest populations.

This report synthesises views collected via a public consultation exercise based on written submissions. More specifically, a public consultation paper was posted on DFID's webpage, along with a ten item questionnaire that invited comments on a wide range of topics that included: how to best assist countries scale up to universal access to essential health services; how to effectively facilitate and build human resources for the health; and how to tackle 'off track' millennium development goals to get them 'on track.' Views on these topics and a range of other issues concerning health development in fragile states and broader matters of international health architecture were covered.

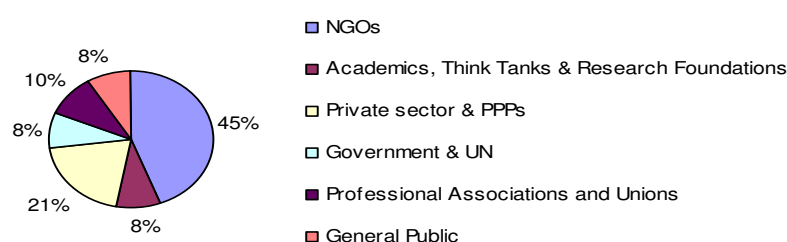
This report complements a further two day public consultation exercise conducted in May and June 2006, and which consisted of focus group discussions that involved key stakeholders in the UK health and development sector. The views expressed in those forums are reported elsewhere². Some of the organisations that participated in the May/June consultations also made written submissions which are included here.

2. NUMBER & TYPE OF RESPONDENTS

This public consultation conducted via email yielded a total of 59 submissions (Appendix 1). An additional two submissions were excluded because they were publications (e.g. a large Harvard publication on climate change) with no specific commentary. Of the 59 submissions, two agencies made two submissions each – all were included.

Figure 1 shows respondents by constituency type - with NGOs being the biggest group of responders.

Figure 1: Responders by type of constituency group



The majority of respondents chose to answer selected questions with only 20% answering all ten questions. On average, most constituency groups answered between six to seven questions from the ten item questionnaire. Questions 1 and 2 which focused on scaling up

¹ DFID's current health strategy entitled *Better Health for Poorer People* was published in 2000.

² Druce N, Bard E. DFID Health Resource Centre June 2006. Consultations on DFID Health Strategy, 25th May and 6th June 2006: Synthesis Report.

essential health services and health work force development and retention were the most frequently answered questions (Table 1).

Table 1: Number and type of questions answered by constituency group

Number/Type of Questions Answered by Constituency Group							
	NGOs n= 26, (%)	Academics, Think Tanks & Research Institutes, N=5, (%)	Private Sector & PPPs, n =12, (%)	Govnt & UN n=5, (%)	Professional Organisations & Unions, n=6, (%)	General Public n=5, (%)	Num of all submissions that answered question
Q1	22 (85)	1 (20)	8 (67)	3 (60)	5 (83)	4 (80)	43 (73)
Q2	19 (73)	3 (60)	8 (67)	5 (100)	6 (100)	2 (40)	43 (73)
Q3	10 (39)	2 (40)	6 (50)	4 (80)	4 (67)	4 (80)	30 (51)
Q4	18 (69)	1 (20)	8 (67)	3 (60)	4 (67)	2 (40)	36 (61)
Q5	13 (50)	1 (20)	5 (42)	4 (80)	4 (67)	2 (40)	29 (49)
Q6	13 (50)	1 (20)	5 (42)	4 (80)	3 (50)	2 (40)	28 (48)
Q7	9 (35)	2 (40)	8 (67)	3 (60)	3 (50)	3 (60)	28 (48)
Q8	12 (46)	3 (60)	6 (50)	3 (60)	5 (83)	4 (80)	33 (56)
Q9	13 (50)	2 (40)	4 (33)	3 (60)	3 (50)	4 (80)	29 (49)
Q10	15 (58)	2 (40)	10 (83)	3 (60)	2 (33)	3 (60)	35 (59)
Av num questions answered by group	6	4	6	7	7	6	6

3. SUMMARY OF VIEWS

A synthesis of key themes and views expressed in the written submissions are reported in this section according to the structure/content of the questionnaire. Care has been taken to capture the range of views expressed about each question. Within questions, views are not reported by any particular order of priority.

Q1: What are the most effective ways to support countries' efforts to scale up to universal access to essential health services, especially for the poorest and most vulnerable?

Respondents identified a plethora of ways and means to support countries' efforts to scale up to universal access to essential health services, these included:

- Many respondents strongly argued that universal access can only be achieved by focussing upon **health systems development rather than adopting a vertical programme approach** (i.e. the latter being a recent international trend). The work of DFID in health systems development was welcomed but considered insufficient, by some critics, to counteract the potential impact of global public private partnerships (GPPPs) to distort priorities at country level. It was also suggested that there appeared to be a disparity between the stated ambitions of DFID (i.e. to move towards more 'country-led' development, building health systems, flexible programmatic instruments such as sector-wide approaches and budgetary support) and the increased emphasis on the International Finance Initiative for Immunisations (IFFIm), Advance Market Commitments, and the proposed Air Travel Levy, all of which are concerned with the provision of commodities. It was therefore recommended that DFID show international leadership in this area and that future grants to GPPPs should be carefully considered in the broader context of their need to contribute to the development of health systems generally.
- The following actions and thematic areas were identified as central to successfully scaling up to universal access for essential health services:
 - Strong coordination of efforts at country and international levels;
 - Assist national governments develop realistic, resource based national health plans and budgets;
 - Stimulate political commitment;
 - Sustainable financing;
 - Strengthen human resource capacity and retention of health care professionals;
 - Strengthen the capacity of distribution channels;
 - Encourage poor countries to make more use of private sector providers for the delivery of public health goods and services;
 - Continue to emphasise the importance of working sector wide in health to develop strong, long term partnerships.
 - Fight corruption, stigma and discrimination.

Other points made were:

- **Proportionate responsibility:** Ensuring access to healthcare is a national government duty, but a global concern requiring all sectors of society and all nations to contribute according to their abilities.

- **Community empowerment:** Communities, empowered with information, are potentially the most powerful forces for accountability.
- A call was made for DFID to rapidly **scale-up its ten-year agreements** with recipient countries and to move away from shorter term commitment plans. Better efforts should also be made to ensure that conditionalities are far more transparent, and clearly communicated to recipients. Without such clarity of commitment it is impossible for governments to undertake health service planning or implement strategies to improve their systems. DFID should also specify how it will address administrative and bureaucratic constraints that delay and reduce disbursements.
- **Holistic development:** Availability of medicines and health services does not equal access to healthcare. While insufficient healthcare infrastructure represents the most obvious treatment bottle necks, environmental factors, such as sanitation, road and communication infrastructure, education and political stability, also impact access to care directly and significantly.
- **Coordination / pooling:** To encourage a clear coordinating process for all supporting donors is essential.
- **Upgrade supply chain activities:** DFID needs to capitalise on the gains it has already made, and use its strong position as a global leader in innovative health care provision, to encourage other donors to commit to increasing both partner government and non-government supply chain capacity, while working in a harmonised and collaborative way.
 - **Procurement:** Support efforts to develop partner country procurement capacity, which will lead to long term and sustainable benefits. Lack of in-country procurement capacity is now recognised to be a critical barrier to the effective management of health programmes and, by extension, improved health outcomes. Most countries wish, understandably, to manage procurement themselves but a number of problems often need to be addressed before this can occur successfully, many of which stem from the critical shortages of skilled and experienced human resource available to manage programmes.
 - **Logistics:** Good logistics is essential in scaling up but is often the less attractive area for donors. While vehicle donation may be more common, real involvement with the management and maintenance of for example, the vehicle fleet including ambulances, is less frequent
- **Use of alternative actors:** A way to reach people not yet covered by the expanding health system is to train a temporary level of health worker, of the community health worker type. The history of the community health worker, from being an integrated part of a particular political and economic context, to concerns about sustainability and lack of community support in new economic situations, should not put donors off supporting them in the short to medium term. Concerns about sustainability would not be there if they were seen as an interim measure, with a plan to phase them out as primary health care services gradually expand. Furthermore, NGOs may have the skills and resources to provide services in remote areas not yet covered by the health system. If NGOs use the same reporting forms, health information system indicators, training manuals, treatment regimes and case definitions as the national system this allows for constructive engagement with government structures and systems.

- **Private for-profit:** A clear distinction needs to be made between the not-for-profit private sector and the for-profit sector. Both will require regulation but in different ways and this may not initially be a priority for an overstretched Ministry of Health. It is important that donors help integrate this into medium term plans as the fragmentation, contracting costs, perverse incentives and increased need for regulation created by an expanding for-profit private sector can reduce the equity and effectiveness of the system as a whole.
- **Research & Development:** Scaled-up treatment now and in the future will depend upon the establishment of commercially viable medicines markets in developing countries. Where normal economic markets are insufficient to sustain research efforts, more use should be made of the public/private partnership approach - the multiyear nature of research and development programmes dictate that commitments to them should be long term in nature.
- **Decentralisation:** Decentralisation to provincial and district level will need to be carefully planned so that increased responsibility is matched by sufficient skills, confidence and resources. There will also be a need for initial capital investment in infrastructure, particularly communication infrastructure. Donors can play a meaningful role in facilitating this process.
- **Health Information Systems:** These will need to be supported to adapt to expansion. New services are likely to attract more cases as they become established in previously unserved areas. It is also likely that some indicators may initially appear to get worse before they get better. It is important that health information systems are developed and interpreted in context, so that blame is not automatically apportioned to changes in indicators without taking background factors into account. Extra support could be provided by donors for what is likely to be an intense initial phase.
- The **identification of best practices** from in-country and elsewhere is important.
- It was recommended that development partners work with **blocks, regions or sub-regions** regarding the provision of technical assistance to scaling up access, i.e. rather than with individual countries. The experience of, for example, the Southern African Development Community (SADC), has shown that progress on many medicines issues can be made more rapidly when undertaken collectively. Significant advances have been made by SADC member states on medicines safety and quality issues, including harmonization of medicines regulation guidelines. Promotion of regional cooperation on medicines issues can likewise be very effective. For example, in Africa, the exchange of information and technical expertise across countries has speeded up and enhanced national drug policy implementation. It is most effective when policies and strategies are mutually relevant and/or easy to adapt.
- DFID should continue to **support multilateral systems** which build capacity; support countries' own health efforts and address their disease priorities. In addition, DFID should engage with the EU to ensure it is more focused on countries' health priorities.

Q2: What are the most effective ways to support countries' efforts to build and retain their health work-force?

The following comments and recommendations were made by respondents in their submissions on this topic:

- Build sustainable **strategic and leadership capacity** to plan and manage human resources (HR) across the health sector.
- Facilitate significant and sustained **resource allocation**.
- DFID should emphasise that **additional financing for HR be made through the government budget** (and not by alternative funding mechanisms). The financial resources that will be required to support the HR partnership deal will be substantial and long term. It was stated that, it is important to learn from the recent past and avoid turning the international response to the HR crisis into another "global initiative" with its own sources and channels of funding. The experience with budget support initiatives for poverty reduction in many African countries suggests that countries already have financing channels that enable donors to place substantial resources through the government system, whilst ensuring accountability and transparency in the use of funds. In the view of some respondents, this should be the preferred financing channel, i.e. with HR becoming part of the broader Medium term Expenditure Framework (MTEF). It was suggested that countries familiar with sector wide and budget support initiatives should be prioritised by DFID to start or pilot responses to the HR crisis.
- **Global leadership** in human resources (HR) is currently weak, in spite of all the effort put into initiatives such as the Joint Learning Initiative (2002-4), the High Level Forum meetings and the World Health Report 2006. The global community is failing to capitalise on the momentum and support generated by these initiatives. Furthermore, the view was expressed that, the technical inputs to these initiatives has been extremely weak resulting in few imaginative and workable ideas for addressing the current HR problems. It was suggested, that in parallel to medium-term strategic plans, some serious '**blue sky**' thinking is required because most current strategies are concerned with restoring or building on the status quo. It was argued that whilst this may provide temporary respite, it is unlikely to lead to sustainable change. Imaginative planning which considers using available human capacity in very different ways in conjunction with alternative methods of service delivery is needed.
- Build on the **HR experience in Malawi** which is funded by DFID.
 - Document the 'Malawi experience' – warts and all – to derive lessons so that better use of large amounts of funding to HR can be made by other countries in similar situations.
 - Ensure that robust evaluation systems are in place, or that a series of independent studies are done. It was felt this is such an important innovation in donor support to HR monitoring and evaluation (M&E) cannot be left entirely to national systems which are widely known to be weak. It was suggested that a case for stepping slightly out of line with the sector wide approach (SWAp) M&E philosophy was valid.

- Use whatever influence DFID can through the SWAp, linkages with the Cabinet Office, and other means, to provide extra funding to ensure that complementary strategies for salary top-ups are developed and implemented (e.g. effective recruitment and retention schemes and simple but workable performance management systems).
- In whatever way possible, DFID should **lobby at country level** for the health sector to develop and use some form of strategic HR plan – however basic in the initial stages. This should then be reviewed and improved based upon M&E systems and operational research – again however basic in the initial stages. Many countries lack the HR capacity to carry out this work – at least within government. DFID may need to provide technical assistance (TA), most of which is likely to be external initially, but should support the growth of TA at national and regional levels to ensure that it will be available in the longer term. This could be done by giving preference to TA bids that include national or regional consultants and/or providing additional funding to involve ‘apprentice’ consultants as part of the TA.
- **DFID should help countries and development partners reach the HR partnership deal at country level.** The only alternative is for government and development partners to reach a deal around an HR strategy, led by government that has gained sufficient consensus from development partners. It has to be a *quid pro quo* arrangement, and it must involve the upper levels of government and the heads of mission. Only DFID and some of its like minded partners are in a position to break the ice and take the lead in shifting the paradigm of HR inaction, because they can contribute sector experience, understanding of health systems and a good reputation as development partner prepared to take calculated risks.
- At a global level, DFID should help to **generate more knowledge** about HR and appropriate solutions to the so-called ‘crisis.’ Whilst nurturing promising regional and global initiatives and influencing the behaviour of major donors.
- DFID currently funds world class **research** (e.g. through the DFID/ ESRC joint scheme, and to some extent ad hoc research support from country offices). HR policy makers also need more rapidly available and regionally relevant research. What is needed to complement the current research portfolio is support for more operational research across a number of countries within a region.
- Neither WHO nor the World Bank has been able to demonstrate leadership in addressing the HR crisis. Several **regional and global initiatives** such as the Global Health Workforce Alliance are being established, and a Regional Platform for Human Resources for Health in Africa and a Regional Observatory for Africa are being proposed. Although none are showing great promise at the moment, DFID should, in the absence of any other viable initiatives, join with other like-minded donors (e.g. Norad) to provide initial support, at least for a time-limited period. In turn for support, DFID should aim to influence some of the agenda of these initiatives; in particular, the need for the kind of ‘blue sky’ thinking about the future health workforce in the context of an increasingly global labour market that will be able to deliver services, especially to the poor.
- DFID should **capitalise on the UK’s respected position** in international development to ensure that HR does not slip off the development agenda once the impact of the JLI and the World Health Report 2006 has worn off. Where possible, it should influence the development agendas of the EU, World Bank and WHO and

if possible aim to reduce the potential negative systems effects – especially on HR – of major funding initiatives such as the Global Fund, PEPFAR and the Gates Foundation.

- Migration and the health work force is a complex area, where the rights of individuals to travel and seek employment and training, needs to be managed to retain health workers where they are most needed. The **ethical recruitment policies** developed by the Department of Health may form the basis of an international code of conduct for other governments, as well as recruitment agencies.
- It is important to think more imaginatively about how the UK can support the planned **movement of healthcare professionals and managers in training**. Examples could include joint medical schools or planned rotations to give health professionals opportunities abroad – i.e. without a permanent loss of skills to their country of origin. As our supply of clinicians increases we should be exploring planned external rotations where junior staff can move to posts overseas without losing their opportunity to progress in the UK system. Similarly most management trainees on the NHS graduate scheme currently choose to visit the USA or Australia on their overseas placements. We could link these schemes much more dynamically with the needs of developing countries.
- Effective capacity building needs **long term planning and investment** and the development of human resources, networks and infrastructure. The Wellcome Trust and DFID have entered into a partnership to support health research capacity strengthening in Malawi and Kenya over the next five years, with each organisation contributing £10 million. If successful, DFID could take this model forwards into other African countries.
- Another priority for the DFID Health Strategy could be to “**train the trainers**” in Africa, to encourage people to remain in their home country to become trained in health research and/or health policy, or to return to their country after training. Incentives might include **improved salary and conditions** for health researchers, in the same way that DFID is tackling capacity strengthening for clinical workers in some African countries.
- There is cautious optimism that the **EHRP (Emergency Human Resource Programme)** will provide a working model which can be successfully rolled out to other developing countries. However, there is a risk that lack of funding could serve to fatally undermine innovative and well-structured initiatives like the EHRP. DFID therefore needs to consider how it can ensure the **sustainability of such programmes** in the long-term. This presents a considerable challenge, particularly with respect to influencing donor behaviour and securing the commitment of future governments to taking forward the progress made during a programme's original lifespan (six years in the case of EHRP).
- Effective national HR options and strategies depend upon international action to tackle **fiscal policies** that cap recruitment of health workers and constrain improvement of working conditions. This is an area where DFID can play an influential role through the IMF and World Bank. These agencies have a critical role in stressing the priority of recruitment, both in public forums and in dialogue with Ministries of Finance, and must become more transparent in their advice. Capacity building of Ministries of Health is also essential, to ensure that the need

for investment in the health sector is appropriately recognised in national financial planning.

- Alongside support for source-country health systems, DFID should **work with other UK government departments** on further steps to manage migration. Key opportunities include:
 - Strengthening and implementing international guidelines on ethical recruitment.
 - Developing bilateral agreements with source-country governments. The Memorandum of Understanding with South Africa is often cited as a good model. DFID should work with the Department of Health and NHS to examine its impact and identify lessons, with a view to spreading the model to other countries, if it is or can be effective.
 - Increasing the possibility for skills circulation by working with UK health trusts to develop flexible conditions of service that allow migrant workers to spend time in their countries of origin without damage to their UK career.
 - Working with the NHS Links scheme and other exchange programmes to promote co-ordination with national PRSPs and health sector plans, and maximise their impact.
- Source countries should establish and maintain **appropriate information systems on human resources**, including a database on migration in order to provide evidence for policy, planning and day-to-day decision-making, and to monitor the effect of any intervention programme implemented, and consider the use of resources accrued from debt relief and development-assistance programmes to augment salaries and incentives for health workers.
- Source countries could agree **mechanisms of compensation** for the loss of skilled health workers to developed countries and of recouping their investment in training, so that the issue can be taken up at the level of Heads of State and Government and their OECD and G8 counterparts. Steps should be taken to foster international cooperation with benefits for all parties, such as bilateral national agreements and international rotational exchange programmes.
- Experience and resource analysis is likely to point towards **poly-competent health professionals** to lead and provide health services at district level. DFID should be prepared to make a **long term commitment to governments** willing to develop this model and to provide the required resources at district level. This commitment needs to be made for a long period to allow the experiment to demonstrate its full potential.
- Trade unions and professional bodies are in a position to **facilitate exchange/twinning programmes for health professionals**, so that they are given opportunities to acquire knowledge, expertise and training. Some other measures which should be considered include the Knowledge and Skills Framework (KSF) which is a crucial dimension of Agenda for Change. The KSF model could benefit developing countries health systems in two ways: offering a training package; and the *skills escalator* model could be used to provide more nurses.

Q3: What action needs to be taken to meet the off-track development targets: child, maternal and reproductive health?

Points made about 'off track' *child health* development targets were:

- Consolidate **partnerships for one national child survival plan**.
- Raise the profile of child survival through **advocacy and communication**.
- Enable, accelerate and sustain progress through **resource mobilisation**.
- Ensure that child survival interventions receive **investments that are of similar scale** to those allocated to HIV/AIDS, malaria and immunizations. Pneumonia, diarrhoea and neonatal conditions cause many more deaths each year than HIV/AIDS, yet these diseases receive only a small fraction of health expenditure, possibly because they don't have the lobbies that HIV/AIDS does.
- The number of infants that die before their first month of life is an area long neglected. Encourage increased attention to **postnatal and neonatal health** programmes in national health policies.
- It is essential that **child health initiatives** like the new International Finance Facility for immunisations (IFFm) be **fully integrated into national health systems** to ensure extra resources build up rather than destabilise routine programmes.
- The UK must continue to advocate for international child health actors to recognise the importance of **health system integrity**. The new Partnership for Child Maternal and Neonatal health may help if it works with national actors, donors and civil society to create empowering environments for enhanced political commitment to child maternal and neonatal health.
- Vaccines included in national plans should be selected through a **burden of disease analysis** (with children prioritised). Immunisations like measles need to be increasingly prioritised through routine programmes rather than form part of targeted campaigns. Training on the management of immunisation systems needs to be embedded in core health worker curriculum with maintenance of cold chain, logistics and waste management all given equal attention.
- Two of the most effective preventive measures are **safer delivery practices and the avoidance of breast-feeding where the mother is HIV positive**. These could be helped through **education** which covers healthcare and nutritional practices, pre and post delivery, and infant health.
- **Use of medicines with children:** A lack of knowledge about how best to use medicines with children, and lack of paediatric versions of these medicines ("paediatric formulations"), means that large-scale treatment programmes for HIV/AIDS, malaria and TB are not optimising their resources. Improving this situation will necessitate action on multiple fronts, including: revising and updating the 14th WHO Model List of Essential Medicines to incorporate paediatric medicines that meet the criteria for classification as an essential medicine; development of a Model Paediatric Formulary to improve prescribing at point of care; development (as an interim measure) of a "dosing tool" for key medicines for

major diseases based on adult formulations; updating treatment guidelines to incorporate evidence and the latest information on dosing requirements for children; promotion of rational use of paediatric medicines through development of paediatric good prescribing guidelines and training programmes; speeding up of licensing of paediatric formulations; development of pharmaceutical quality control specifications for paediatric medicines; collaboration with the pharmaceutical industry to develop priority paediatric formulations; and improved procurement and supply management of paediatric formulations for treating priority diseases.

- Encourage governments to make some '**grants**' available to new mothers to be utilised in child health. Women could be encouraged to 'ring-fence' the grant and protect it for the wellbeing of the child.

Points made about *maternal and reproductive health* were:

- An MDG target on **universal access to reproductive health by 2015** and country health strategies/PRSPs incorporating sexual and reproductive health is paramount.
- It was suggested that **maternal mortality be used as an indicator of progress** towards scaling up health services and that this option be explored with the United Nations Millennium Project. There was strong concern that many national governments have not made maternal health a priority on their agenda; using it as a "tracer" for healthcare provision would be a direct way of raising its profile.
- Currently '**off track targets**' are **off target politically and financially**, so an increased emphasis on both is required.
- Good reproductive health and child health can be achieved **without secondary care facilities**. Indeed it is crucial to take a public health approach – where a population-based assessment of health needs is combined with the delivery of effective interventions that take into account broader determinants of health such as empowerment and poverty.
- Maternal health, on the other hand, is highly dependent on **good health services at a secondary care level**. Improving maternal health is therefore dependent on the development of health systems which provide effective emergency obstetric care. Infrastructural capacity-building should occur in tandem with the development of well-trained and motivated staff. Geographical equity issues also need to be paid attention to.
- Whilst not the sole factor, the **lack of skilled attendants at births** is one of the main barriers to reducing maternal mortality in many developing countries, and there is an overwhelming need for accessible, comprehensive health systems to cope with obstetric emergencies.
- National medical associations (NMAs), or other national bodies representing health professionals, are a civil society group which could do much more to champion maternal health, and we would urge closer relations with **NMAs to build their capacity** in this role.
- **Universal access to family planning** services and abortion services are feasible through low-skilled health workers. Efforts to improve **universal access to modern contraception**, especially effective long-term methods need to be scaled-up. This will assist in reducing the need for abortion whilst at the same time increased access to

safe abortion is also required. Female education and employment are good contraceptives and protectors of women's health, and livelihoods and micro finance programmes can significantly improve nutrition, so a multi-sectoral approach to this area should be encouraged.

- DFID is urged to take a lead in **advocating for increased funding for reproductive health** and implementing programmes specifically focused on the supply of contraceptives. With the current trend towards increased use of direct budgetary support as an aid modality, the decision making process as to where funding is directed lies increasingly with partner governments and, despite the increasing commitment by countries to improve reproductive health services, there are pressures from other parts of the health sector. We therefore strongly believe that DFID should build upon its international reputation in maternal and reproductive health, by providing increased support and advocacy at both the international and country levels.
- Reproductive health services are often hampered by **lack of reliable and good quality supplies of essential medicines and commodities**. Compounding this problem is the fact that the responsibility for funding, procuring and delivering reproductive health (RH) items is increasingly being pushed back to national governments, who are not always fully prepared for this task. Sustained efforts are now needed to ensure that the *Interagency List of Essential Medicines for Reproductive Health* is actively applied by ministries of health, international organisations and important global funders (such as UNFPA, the World Bank and the Global Fund to Fight AIDS, Tuberculosis and GFATM) in procuring RH commodities. Additionally, development and application of internationally agreed standards to assess national procurement and delivery capacity as a prerequisite for the use of funds for reproductive health commodities must be encouraged.
- Ensure **ante-natal and maternity facilities** in clinics are clean and welcoming - at present many women are reluctant to attend such facilities as they are dirty and staff (who are underpaid and under-resourced) often show little commitment to their job or respect for patients. **Women and baby friendly facilities** are central to the promotion of facility based deliveries. Upgrading maternities, health centres and hospitals to at least basic Emergency Obstetric Care status would be a major contributing step.
- **Pregnant women and under 1s should be treated as a single 'package'**, with increased awareness of the part that reducing perinatal and neo-natal mortality would play in reducing overall infant and child mortality; with around 4 million neo-natal deaths annually, particularly in the perinatal period and first week of life improvements are certainly needed in the antenatal period, during labour and delivery and the immediate post-natal period.
- Effective strategies to promote and implement programmes for the **prevention of mother to child transmission of HIV** are essential and eminently achievable given the right degree of political will and resourcing.
- For other problems of the developing world, such as malaria, TB and gut helminths, there needs to be more work on treating these diseases in pregnancy and/or women of child-bearing potential. This will require the development of an infrastructure on **pharmacovigilance** in the countries most affected to gather data (e.g. through pregnancy registers) to support the safety and efficacy of medicines in these women.

- There are significant challenges facing pharmaceutical companies working on **medicines for use in pregnancy** and DFID could encourage debate among all interested stakeholders to find ways of reducing industry's concerns and enabling more work to be done sooner. For example, one of the major hurdles in developing an effective microbicide for HIV is the lack of toxicity data to support the use of these drugs/agents in pregnancy.
- **Mobilise communities** to ensure users/potential users are involved in service planning and monitoring at all levels - to ensure that issues such as accessibility and acceptability are addressed. This must include female representation but also involve men where they are husbands/partners.
- **Support enabling legislation** to ensure that care provision is enhanced rather than hampered by professional boundaries and inappropriate laws (e.g. that appropriately trained and supervised health workers can give necessary medications and treatments without delay, for postpartum haemorrhage, infection etc.).

A number of **cross cutting issues** impacting upon maternal and sexual/reproductive health were identified by respondents, for example:

- There is a temptation to adopt targeted programmes with shorter time frames to address child, maternal and reproductive health because they are such important priorities, but in the end care has to be taken that these programmes do not attract resources away from the **development of the system as a whole**.
 - Access to safe water and sanitation
 - Primary and secondary education for girls
 - Increase immunisation/vaccination rates
 - The UK should encourage the **inclusion of gender, social and community development** in health worker training while supporting civil society to build social capital as a way of reducing power inequities, and enhancing decision making responsibility for women within communities.
 - Promote **women's empowerment** so that women have the freedom to make choices about their own health and that of their children.
 - Greater focus on **community health education and health promotion**, using culturally appropriate approaches which can easily be understood (i.e. in local languages and through drama, song, the media etc. rather than just printed materials).

Q4: In 2004 in Taking Action we set out how the UK would contribute to a more effective response to the prevention and treatment of HIV/AIDS. Should we be doing more?

Respondents answering this question (i.e. 61% of all respondents) identified some additional areas for DFID's support and action. Against this back drop, respondents also made positive statements about *sustaining* DFID's *current action* in a range of policy areas—some plaudits were:

“The strategy set out in Taking Action is clear and comprehensive....We would like to highlight and commend the actions carried out in Ethiopia by DFID to ensure the continued provision of vital condom social marketing services. In 2004, DFID, combined with two other European donors, recognised the risks posed by a funding gap in a highly effective condom social marketing programme which was an important component of the national HIV prevention strategy. The unprecedented collaboration between donors (setting common reporting formats, requiring a single proposal, and effectively offering a combined funding mechanism) and the commitment to maintaining the provision of vital HIV/AIDS prevention services in the face of funding shortages was a model of donor support that may offer lessons to other countries.”

“The UK Government should continue to play a leadership role in working closely with the Governments of the most affected countries – in particular in sub-Saharan Africa – helping them enhance their domestic response to this pandemic. DFID should also continue to play a coordinated and brokering role in supporting the work of charities and donors within these effected countries.....and it is imperative that DFID continues to work with individual governments in the developing world to ensure that the political will is there to promote co-ordinated health improvement plans and associated infrastructure, and with the Global Fund for the provision of treatments.”

“Effective action against HIV/AIDS cannot be driven by treatment and prevention targets alone. It requires significant shifts in the relationship between countries and within societies. DFID needs to continue to support those areas of HIV/AIDS scale up where other donors and recipient countries are failing to act ensuring ethics and principles of equity, quality and adequate coverage are addressed. Political support for issues around sexual health and HIV/AIDS is critical.”

Respondents identified the following areas as those where DFID could be doing more to contribute to the effective prevention and treatment of HIV/AIDS:

- There should be a greater focus on **prevention and linkages with sexual and reproductive health (SRH) and rights**.
 - DFID should work with governments to address the issue of **unsafe abortion**. The issue of unsafe abortion and HIV+ pregnant women has received little attention.
 - **Support supplies security, particularly condoms** but also other SRH supplies. This should include building the capacity of southern governments to assess in a timely fashion the need for condom supplies and ensure effective distribution logistics.

- It is important that DFID goes beyond supporting efforts to identify new technologies and leads the dialogue to create a **political environment facilitating their introduction**.
- **Awareness of sexual and reproductive health (including specific teaching on HIV and AIDS) should be mainstreamed** so that it is not seen as solely the responsibility of the Department of Health in each country, e.g. Departments of Education should ensure sexual and reproductive health is a compulsory part of the curriculum in every school, there should also be programmes to reduce stigma and promote social inclusion.
- DFID should take the lead in **revitalising HIV prevention efforts**, as resources increasingly seem to be allocated to treatment at the expense of prevention. There appears to be an increasing shift away from the provision of condoms, for a variety of reasons, and whilst there is increasing access to treatment, there appears to be insufficient acknowledgement internationally that HIV/AIDS is preventable. By allocating sufficient resources and commitment to prevention, DFID could make a significant difference in the fight against new infections, which is the only way of decreasing HIV prevalence and curbing the spread of this pandemic, and which in turn could impact upon other co-infections such as TB and malaria.
- **Palliative care in HIV/AIDS policies and strategies are neglected**. In many DFID strategies and reports on HIV/AIDS, palliative care is not explicitly mentioned and therefore it is not being delivered or supported in practice. This needs to change. Palliative care needs to be scaled up through integration with already established community based care programmes, inclusion in national AIDS strategies, training for health care workers and carers and ensuring accessibility of essential palliative care drugs, especially opioids, through the removal of barriers such as laws and regulations

DFID is strongly requested to include clear frameworks and timelines for future action with targets relating to the whole spectrum of prevention, treatment and care including palliative care.

- **DFID could do far more to respond to the HIV epidemic by supporting countries to address related TB/HIV co-epidemics**. TB is the leading killer of people with AIDS, responsible for up to one-third of AIDS deaths globally according to the World Health Organization (WHO). Despite the obvious, demonstrated links between TB and HIV and the rising co-epidemic in sub-Saharan Africa, no reference to TB/HIV co-infection was made in *Taking Action*. Given the challenges and delays in rolling out anti retrovirals (ARVs)—such as those demonstrated by WHO's 3x5 initiative—universal access to TB treatment would save lives and buy precious time in which to access ARVs. DFID should strategically increase and monitor specific TB and TB/HIV bilateral expenditures. In conjunction with this, DFID could play a key role by encouraging multilateral funding sources, such as the World Bank and the Global Fund, to recognise the challenge of the co-epidemic and proactively encourage increased investments accordingly. By providing significant long term predictable funding to mechanisms such as the Global Fund to Fight AIDS, TB and Malaria and promoting the scaling-up of the WHO 'two diseases, one patient' strategy real progress could be made in the fight against HIV/AIDS.

- DFID is to be commended for the leadership it has shown in promoting issues related to children affected by HIV and AIDS. However, more needs to be done on **prevention of Mother to Child Transmission (PMTCT) and Paediatric treatment. Treatment for all by 2010** – additionally:
 - **Child specific treatment targets:** National governments and international bodies must be held responsible for immediately increasing the numbers of children on antiretroviral treatment. This includes recognising children's rights to antiretroviral treatment as a fundamental human right, explicitly including children in national and international treatment targets, committing donor funds to meeting these targets; and ensuring children are included when monitoring progress.
 - **Child-focused research and development:** Governments, donors and pharmaceutical companies must, respectively, support and produce antiretroviral treatment appropriate for young children. Most urgently, there is a pressing need to develop simple and affordable diagnostic tests for young children to ensure early identification of infection, increase child-focused research and development, and produce affordable, fixed-dose combination antiretroviral drugs for young children.
- DFID should provide **increased financial and practical support to governments** in Africa to strengthen healthcare systems, scale up effective and affordable drug distribution systems, and improve laboratory services.
- DFID should **fund technical and financial support for civil society** to play an expert role in scaling up proven models at country level, through direct funding and through budget support.
- **Better control and integration of donor activities is required:**
 - Pressure to set up parallel/new systems to deal with HIV issues should be resisted. This is currently a major threat to non-HIV initiatives because it draws resources (people, hardware, money and focus) away from other key conditions (e.g. malaria) leaving fragile health systems even more fragmented and dysfunctional.
 - DFID should assist bilateral and multilateral donors to work within the framework of National AIDS (or health) Plans to avoid duplication and disjointed approaches
- The UK's leadership role in the area of HIV/AIDS research and development is recognised world-wide, and it is important that the Government's commitment continues. One of the prerequisites for a continuous investment by the industry into research, discovery and development of new medicines is the existence of a **favourable environment that encourages innovation, protection of intellectual property and long-term investment and which recognises that medicines are only one aspect of sustainable healthcare**. Additionally, DFID has a crucial role in continuing to work with other governments to ensure that there is political will and action in developing world as well.

- Better consideration must be given to the **forecasting, manufacturing and distribution issues** associated with a scale up of HIV & AIDS services and DFID could lead in discussions with industry and other stakeholders on this matter to ensure a viable and sustainable supply chain.
- Greater attention should be paid to **"horizontal" management of medicines issues**. DFID could do more to: (1) focus attention on issues that are relevant to *all* medicines, including efficient supply management, efficacy and safety, rational use and comparative cost-effectiveness and (2) demonstrate that activities to increase supply of medicines for priority diseases can be oriented so as to increase supply of *all* essential medicines. In so doing, DFID could enable the momentum and energy generated around medicines for fighting HIV/AIDS to have further and wider impact.
- DFID should help with the introduction of **health data systems** in sub-Saharan Africa and other low income countries. Such systems are largely non-existent, but without them (even at a basic or low level) health workforces cannot do their work properly in terms of recording patients, treatments and outcomes.
- More focus is needed on **evaluating the effectiveness of interventions** using indicators that matter - such as functionality and productivity of households and individuals affected by HIV/AIDS.
- More investment is required to keep people living with HIV & AIDS through **improved nutrition and the use of alternative but proven immune boosters** (e.g. Neem extract) that are locally available, sustainable and non toxic.
- **Building stronger health systems and building the capacity of health care professionals and community based organisations to effectively reach the groups most vulnerable** to the epidemic are key to the response
- DFID should continue to promote the **mainstreaming of gender concerns** within all HIV programming.
- **Think and act laterally.** As a consequence of HIV & AIDS older people are often faced with increased responsibilities, including economic generating activities and social welfare, within communities. Addressing the **disabilities** (including blindness) of this section of the population is important to an effective HIV/AIDS strategy.

Q5: How should we respond to the health challenges in conflict and post-conflict environments and fragile states?

50% of NGOs submitting written comments on DFID's next Health Strategy were keen to comment on how to respond to health challenges in conflict and post-conflict environments and fragile states. Respondents took care to write detailed remarks and recommendations. Recommendations from NGOs and other constituency groups were wide ranging and included the following:

- **Address inequity** and tackle the barriers to access faced by marginalised communities
- **Flexibility and contextual understanding** are central to responding to health challenges in difficult country environments.
- As far as possible, provide **long-term financial and/or technical commitment**.
- There needs to be a **greater realism amongst donors** and other key actors about the prospects of achieving sustainability in fragile states. Donors must be prepared to accept longer timeframes than current funding rounds support as well as a greater degree of risk regarding programme/investment outcomes. Donors' expectations must be realistic – in countries facing chronic under investment in health systems health outcomes will not improve in the short term.
- Facilitate and use an appropriate **mix of state and non-state centred aid modalities**
 - In the view of one respondent, NGO work should be funded cautiously. It was argued that the most effective functions NGOs can perform are to provide resources and work in partnership with local people and as far as possible, to provide essential health care services in the short and medium term, while developing the capacity of personnel to build on this to develop long-term provision. If well organised and adequately resourced, a state-funded system is more likely to provide appropriate universal access to health care, whatever the preferred delivery mechanism. It must however be developed with local personnel, so that ultimately they 'own' it and ensure it functions. They are less likely to do this if it is imposed.
- Support the establishment of **accountability mechanisms** for communities and health workers; support civil society actors to build the capacity of poor and marginalised communities to recognise their rights and hold governments to account; strengthen the capacity of governments to fulfil their responsibilities and actively engage with their clients
- Develop appropriate **user-fee exemption schemes**. DFID's policy shift to eliminate user fees for basic public health services was welcomed by respondents and it was hoped that it would encourage other donors to not only adopt this same policy, but provide the substantial funding required to cover the health financing gap whilst supporting the necessary research to identify more equitable solutions.
- **Health financing** issues need to be better thought through. More consideration of how to meet the health financing gap and how to use resources more efficiently is needed. Evidence should be collated on how governments can generate and sustain financing for their countries' health facilities. Donor mechanisms, such as Trust Funds, CAPS,

TRMs, etc. should be submitted to in-depth evaluation. The cost of basic packages should be better assessed, as should mechanisms to finance them.

- More work needs to be done from the outset of any emergency and in fragile states to **link humanitarian assistance to longer term recovery, development and system strengthening**.
- Support Post Abortion care, Emergency Obstetric Care, HIV testing and other essential **sexual and reproductive health (SRH) services** – especially for large numbers of women raped during wars. SRH is often neglected in conflict areas. It must play a central role in all conflict and post-conflict programme work.
- Demand for **greater coordination among relief agencies** in crisis situations, including UN agencies (as part of UN reform process).
- It was recommended by some that the UK needs to expand the number of fragile states it gives long-term support to. Donors need to establish a process, which ensures that all fragile states have a lead donor eliminating ‘**donor orphans**’.
- Ensure funding is available for **cross-border initiatives**.
- Focus support on the health system as a whole with a particular emphasis on **primary level services**.
- Better evidence is needed on which model or combinations of **models for health care delivery** (basic packages, vertical approaches, islands of dependability, the role of hospitals) works better in environments of poor governance and limited resources. Basic packages are promising, but more robust evidence is required on their usefulness in fragile states, both from the supply and demand side. Implementation strategies on how to roll out the basic package and how to relate it to other health components, such as hospitals and ‘non-essential’ health interventions, need to be further explored.
- A range of points were made about **human resources** for health:
 - Increased investment in health sector human resources is required, including innovative approaches for the training, retention and motivation of health workers. DFID’s support to such programmes in Zambia and Pakistan were particularly highlighted and praised.
 - More work is needed on the best mix of health providers, including how national plans can be used for service delivery, and what is the trade-off with building MoH capacity (including strengthening public health, which needs to be done through state channels). More work is also needed to define the pre-requisites that will have to be in place before a national non-state entity or international agency can take on a contracting role.
 - Evidence is required on how to (re)-build the health workforce in fragile states. Programs such as project-based capacity building and training without accreditation should be evaluated, as well as the unregulated use of incentives by various agencies.

- It was suggested that NHS staff could be encouraged to contribute towards reconstruction programmes as part of their personal development plans - with country-specific preparation and security training being imperative.
- A good nursing service is an essential component of any effective health care system, not least because nurses have important organisational as well as direct patient care/education roles and skills. Therefore in such circumstances, DFID should support projects which draw together, support and educate existing and/or potential nurse leaders (as it did in a small way indirectly in Kosovo) and national nursing associations (NNAs). These people can then contribute to deciding on, planning and implementing health services most appropriate for their country situations in the short and long term, in conjunction with other local and international health care personnel.
- Support the development of appropriate **information systems** and use of nationwide surveys, particularly to monitor the health of marginalised groups. Where possible, non-governmental providers should be encouraged to use government data collection systems (or underlying methodologies and indicators) to ensure consistency.
- The **emotional impact of armed conflict and human rights violations** also needs to be taken into account as these consequences can result in high impact disorders such as depression and post-traumatic stress disorder. Mental health issues should be addressed in the community context through culturally appropriate interventions, engaging several sectors (health, education, rural development/income generation).
- One essential area that often needs very 'hands on' assistance in such countries is the supply chain. By definition, in fragile states **procurement and logistics** are often poorly served and are particularly vulnerable to mismanagement or corruption.
- Donor behaviour needs to grapple with the challenge of drawing together a range of partner to '**harmonise to align**' in the health sector. In terms of alignment between donors and partner governments, the emerging lesson is to focus on government priorities. Where it is not possible or desirable to support the authorities' priorities, it is potentially possible to carefully 'shadow' align with systems, such as administrative boundaries or the budget and planning cycle at local level. More work is needed on how to operationalise this principle in practice.
- **Public health is neglected** in reconstruction programmes which see solutions in medical led rather than health-led solutions; e.g. rebuilding inappropriate hospitals rather than focusing on primary health care. In the first instance, health advisors should be part of the DFID emergency response team to these countries.
- **Lessons learned** from Department of Health/DFID/Foreign and Commonwealth Office engagement in **Iraq** should be incorporated into the new health strategy.

Last but not least, it was observed that the underlying causes of emergencies and fragile states need to be addressed at the diplomatic level and via human rights advocates.

Q6: How can the accountability of recipient governments to their people for the effective use of health resources be improved?

The following suggestions were made about how the accountability of recipient governments to their people for health resources may be improved:

- It is the **responsibility of each government** to ensure that resources are being appropriately used. The UK Government, and other development partners, can encourage countries to do so by promoting the infrastructure necessary to foster such a climate, for example, the existence of a democratic electoral system and a free and open press.
- **A comprehensive system of checks and balances is fundamental.** Decentralised services enable communities to demand more transparency from their local institutions. Dynamic and demanding NGOs in partnership with research organisations and the media can also collectively create accountable structures on government.
- **Country ownership needs to be broadened** and firmly based on a consensus between all stakeholders in society and not just between state agents. For instance,
 - Support **capacity building of civil society** in developing countries so they can engage effectively in discussions with government about allocation of the health budget and develop skills for budget monitoring and policy analysis, in order to better hold governments to account.
 - Raise better awareness amongst donors at country level about including **civil society and the private sector** participation in policy discussions, as well as service delivery, and to advocate with governments to open up space for such participation.
 - DFID was encouraged to recognise the role and contribution of trade unions in working with governments (e.g. to actively support the strengthening of free and democratic trade unions, and give credibility to the trade union movement by ensuring that DFID country offices use the *How to work with Trade Unions* paper and develop working relationships with trade unions, alongside other civil society organisations, and encourage recipient governments to include trade unions in their consultation and decision-making processes).
- **Capacity building at all levels of MoH**, better payment of staff to improve motivation coupled with publicly enforced sanctions for corruption.
- **Be prepared to take tough decisions** – where it is judged that a national government is unable or unwilling to utilise funding for healthcare effectively, donors should be prepared to withdraw development assistance and channel resources through an alternative civil society or a non-governmental recipient. In addition to helping ensure that funds allocated for health are used appropriately, this will demonstrate to national governments that donors are prepared to withdraw funding if basic principles of accountability and transparency are not upheld
- **Locally owned research and knowledge** generation is more likely to be published in popular media in country and therefore will increase populations' awareness and political pressure surrounding health issues and good governance issues generally.

- **Better communication strategies** with the public on what they are entitled to, what their governments have committed to and what health resources are deployed where, for example through an Ombudsman.
- **Strengthen coordination between donors and partners** to ensure accountability.
- Procurement processes should be **competitive, open and transparent**, and comply with Transparency International's Minimum Standards.
- **Rules on conflicts of interest must be enforced** and companies that engage in corruption debarred from future bidding. No-bribe pledges Integrity Pact should be adopted to level the playing field for all bidders.
- **Rigorous prosecution** will send the message that corruption in health care will not be tolerated. To facilitate this, there must be robust **whistleblower protection** for both government employees and private sector health, pharmaceutical and biotech employees.

Q7: How can the performance and coherence of the international health architecture be improved to deliver better health for poor people?

- **DFID should work to ameliorate the negative impact of a fragmented international health architecture.** For instance, The World Health Organisation (WHO) has been increasingly sidelined by the growing involvement of the World Bank in health policy, and has suffered from poor management. Funding levels and morale at WHO are low. DFID needs to focus on strengthening WHO, and following the tragic death of Dr Lee, it is important that the opportunity for management reform is taken. DFID must lobby to ensure that Dr Lee's successor is chosen through a more transparent and democratic process.
- **DFID should help simplify the over-complexity of the aid architecture – e.g. to half the number of global health partnerships (GHPs) by 2010.** While the aid architecture has changed in recent years it has not become simplified. Ministries of health and finance may have fewer projects to deal with but these have given way to global health partnerships (GHPs) and to other forms of earmarked funding that continue to place unacceptably high transaction costs on ministries. Some of these sources are so huge (PEPFAR) that they can easily destabilise whole sectors. DFID is encouraged to consider decreasing its funding to GHPs and increase it at country level through sector funding (pools, sector budget support) and general budget support for poverty reduction. DFID should also ensure that the GHPs to which it financially contributes (including the GFATM) operate through existing country coordination mechanisms (such as SWAps) and harmonise their financial instruments with those of government, and not the other way around.
- Improving health outcomes requires effective **multisectoral approaches**. Today's health architecture consists mainly of development aid mechanisms and fails to address structural gaps and broader questions, such as how global public goods for health are identified and promoted. Efforts to tackle disease should include system-wide efforts to ensure effective procurement, delivery, management, regulation and rational use of essential medicines. The Global Task Team recommendations address the issue of improved coordination for international development assistance. Current levels of unhealthy competition between development agencies should be reduced. For progress in relation to long-term financing and harmonisation and alignment, there must be a shared understanding of health and development between key agencies within the UN system and in the wider international community.
- **DFID should help harmonise Technical Assistance (TA).** Placing TA within government control and ensuring that it supports an agreed programme of work remains a distant prospect in most developing country health systems, including many where SWAps have been in operation for quite some time. DFID has been supporting efforts to harmonise TA provision in many countries, and there are some positive experiences (pooled TA, resource centres, etcetera) that ought to be better analysed and their lessons disseminated.
- DFID's efforts to promote **greater donor harmonisation** through processes like the Global Task Team and Three Ones' were supported by respondents. However, the real impact of this work at country level was questioned. There were some concerns about the US Government's establishment of systems parallel to country health system for the delivery of ARV programmes. The UK Government was urged to use its capacity to influence the greater integration of PEPFAR work into public health

programmes, and to demand greater accountability of the US Government to the Paris Declaration on Aid Effectiveness.

- **UN organisations need to be reformed** for increased efficiency, reduced duplication, quicker and more efficient processes, reduced red tape, and improved coordination between them and other partners. UN organisations (especially WHO) need to re-focus on poverty since this is often the cause and effect of ill health.
- In some institutions such as the IMF and World Bank, both of which have immense influences on health in developing countries, there is a **lack of transparency regarding policy making and decision taking**. The UK Government should press for further reform to improve levels of transparency and therefore facilitate greater accountability.
- **More rigorous evaluation of the performance of multilateral organizations** working in the health sector might be helpful. DFID's Multilateral Effectiveness Framework was a good example of a non-subjective evaluation of country-level results, organizational systems and quality of aid, and usefully identified problem areas across a range of agencies. Such scrutiny, at regular intervals, could be very effective in stimulating remedial action which in turn would work to improve the "international health architecture".
- **Best practice principles** for GHPs (Global Health Partnerships) and the targets and prescribed behaviours for donors of the Paris Agenda must continue to be applied in the future.
- The **number of international actors working through national governments needs to be reduced/better coordinated**. A recognition of the demands placed on limited capacity and HR in respective MoHs should be backed up by the implementation of strategies to both increase HR capacity to handle this work, and reduce competing demands placed on MoH by donor agencies. Better coordination of NGO, private sector, government and donor activities is required to ensure that each of these works in a complimentary way and maximises coverage/access.
- The UK Government, in its role on the IMF's Finance Committee is urged to address the **problem of IMF ceilings** on health sector spending to ensure that developing country governments can absorb and use new flows of foreign aid for use in increasing investments in health.
- **Policy implementation must be supported by strong advocacy within DFID, at the highest levels, on the importance of policy coherence between donors**. There is considerable donor policy discordance at country level which is contradictory and confusing (e.g. user fees/bed nets in DRC).
- A degree of **rationalisation and sharing of donor representation** between DFID and other development partners may be appropriate. However, the complete elimination of direct DFID representation in countries, such as Ghana, where UK NGOs and other UK institutions (e.g. NHS) have important historic links could be counter-productive because it removes a source of authoritative guidance and co-ordination, and makes it somewhat more difficult for UK based organisations to make their contribution to development.
- A stronger machinery for representing **female gender issues within the UN** is required.

Q8: Where should we focus efforts for maximum gain in addressing the broader determinants of health?

The following comments were made about how to better address the broader determinants of health:

- **DFID's pro-poor approach should be continued and strengthened.** By addressing the underlying causes of poverty, and thus ill-health, DFID can maximise the impact of its interventions. The UK government should continue to work with, and lead, the international community in addressing the links between ill health and poor sanitation and nutrition, for example. Given that many of the underlying causes of ill-health do not necessarily fall under the remit of government ministries of health, DFID and other donors should promote a 'joined-up' approach to tackling issues such as health, sanitation, nutrition and water provision. The UK government should seek to use its position to leverage support for under-resourced health priorities, focusing particularly on the EC and G8 countries.
- **Promote policies that encourage economic growth - wealth is strongly and causatively associated with good health.** Global improvements in life expectancy over the last century are due to more countries being able to afford better sanitation, living conditions and nutrition, as well as the ability to afford medical technologies such as vaccines and antibiotics. This also means facilitating conditions for better property rights, freedom of contract and the rule of law.
- **Education:** DFID has a role to play on the ground in many developing countries to maximise the benefits of new "fresh starts" for education. Following its successes in Kenya, Nigeria, Bangladesh and India, DFID should respond to the challenge of improving access to education with a sustained Sector Wide approach in one or two developing countries. This would recognise the profound influence of education on health outcomes and promote mutually-beneficial cross-sectoral working. It could include initiatives such as school-based nutrition programmes, education on sexual health, and adolescent-oriented programmes which would enable young people to make more informed choices about their health.
- **Climate change** – this will adversely threaten social, economic and environmental determinants of health in the next decade and beyond if not controlled. DFID needs to join up with other UK Government departments to secure technological research, development and investment for **hydro-electric, solar, and wind energy resource development in developing countries**, so as to maintain and improve health and well-being not just for the world's poor, but for global populations.
- **Women's empowerment (social and economic) and welfare** – poverty is a determinant of health and poverty itself is subject to many determinants such as, education, governance and advocacy. Without synergistic action any isolated approach will quickly reach an impasse; the commitment to integrated, locally owned and sustainable development is the only effective way forward.
- **Electricity / water and land tenure reform** – i.e. a sizeable proportion of the disease burden in poor countries is related to poor sanitation and the inhalation of smoke from cooking indoors using biomass fuels.

- **Representative government; a free press; strong legal structures which also enforce human rights; and sound financial institutions** are structures that support and enable a responsible and healthy society, and in the broadest sense are also considered determinants of health.
- National policies to encourage the development of a **vibrant private sector** will help sustain economic growth, adding to health care, education and other social services. DFID's support for the development of **public/private partnerships** in areas such as clean water, better housing, sound education and appropriate medicines is essential.

On the other hand, other respondents strongly urged DFID to be cautious about how it supports the privatisation of water which has had strong negative implications for water provision in many developing countries, and to explore the prospects for public sector regulation of private sector water provision. DFID was encouraged to consider working with civil society to push for the inclusion of water and sanitation in future Poverty Reduction Strategy Papers. This would enable DFID to use future Country Assistance Plans to support poor countries in reclaiming control of their water supply.

- **Involvement of civil societies** whose aim are to advocate for policies that are supportive to health & help build social support systems that enable people to make health choices.
- **WTO & Food Security:** DFID could take a major step in improving the health of the world's poor by directly addressing the wide-ranging political, economic and social factors which undermine food security. Trade liberalisation, in particular, has had a devastating effect on Southern economies: destroying livelihoods, driving up rural unemployment, creating the conditions for poverty, malnutrition, disease and death. DFID is urged to tackle this problem at a fundamental principled level. As the World Trade Organisation (WTO) Doha Development Round draws to a close this year, the UK must take a lead in ensuring that final negotiations at the WTO result in a re-balancing of economic privileges and co-ordinate a collective response which will restore food's status as a human right, rather than a commodity.
- **Tariffs and Access:** Tariffs are a factor in reducing access to affordable medicines, as acknowledged in the High Level Working Group's report and the recent report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health. DFID is encouraged to support moves to eliminate tariffs and encouraging the EU to work towards this at the WTO.
- **Greater tobacco control**
- **Ensure that equity assessments are mainstreamed in the planning and evaluation of health programmes.** Collect data on socioeconomic status, gender and ethnic group, and analyse health outcomes for different groups. Try to counteract the prevailing trend that means that new health interventions reach the better-off first, by planning the initial deployment of new programmes in areas at greatest need.
- **Research into health delivery systems and implementation of research** is a key requirement to achieve the health related Millennium Development Goals (MDGs). A leading research institute stated that funding for development and the provision of emergency aid must be balanced with funding of appropriate health research evidence, which can lead to effective interventions and new products.

- **DFID & WHO Commission on the Social Determinants of Health:** Respondent views differed about the weight DFID should accord the findings of this commission. On the one hand it was argued that, the UK should continue to support the WHO Commission on the Social Determinants of Health to ensure this work is integrated into national poverty reduction strategies. It was suggested a basic step may be to lead on some work about what an essential package of basic services would cost, and how the present focus on MDG indicators could be enhanced with cross-sectoral indicators of impact. Exploring cash transfers as a mechanism for breaking the vicious cycle between poverty and ill health that was also highlighted as requiring increased attention.

Countering this, another submission argued that DFID should be sceptical of calls from UN commissions that argue that income inequality is the greatest determinant of health. The WHO's Commission on the Social Determinants of Health is likely to advocate the expansion of welfare payments and greater regulation of labour markets as a way of tackling ill health. However it was argued that, evidence shows that while health inequalities do increase when a country has rising per capita incomes, the health of all members improves, albeit at slightly different rates. Thus, it would be a mistake to respond to health inequalities with policies that forcibly redistribute wealth from rich to poor because this will stifle economic growth - undermining the very process that is most associated with improving health. This commission is due to report in 2008, and DFID should not endorse its recommendations before conducting a thorough, independent review of its findings.

Q9: Are there gaps in DFID's response to the current and future health challenges?

Identified **gaps** were:

- The **lack of commitment to palliative and community based care**. It was argued that palliative care is hugely under-resourced and neglected at all levels, and a call was made for DFID to demonstrate strategic policy leadership and support in the following areas: education and training in palliative care; support a WHO lead on palliative care; promote and support efforts to increase and improve the availability and use of drugs for pain control; and by lobbying and campaigning DFID may use its position to mainstream palliative care within global partnerships strategies and country health strategies via informed and aware DFID Health and population advisers.
- DFID's **profile with respect to medicines issues** – this is noticeably lower than it has been formerly, and DFID's inputs to medicines debates within the context of international public health are missed (and needed). It was felt important to redress this gap.
- It was argued DFID had a strong leadership role to play in **rationalising the health aid architecture**, supporting efforts to **promote the use of human rights instruments in health**, and **engaging with the private corporate sector** in ways that are consistent with good development practice.
- **Disability** is an area where much more explicit and concerted action is needed. Disabled people are excluded from many development interventions, including health interventions, for multiple reasons and DFID needs to support ways of addressing stigma and prejudice, inaccessibility to health facilities, inadequate communication methodologies and discriminatory policies.
- **Strategic investments in country health information systems** - DFID's health strategy should be more explicit about the role of monitoring, including management, accountability, and impact evaluation. Effective monitoring, especially of the MDGs, cannot be achieved without this.
- **Cost-effective forms of malaria vector control** - according to one NGO submission, DFID should start to actively support methods such as indoor residual spraying (IRS) with DDT. It was suggested DFID should follow the example of WHO, and other bilateral donors, and diversify funding for malaria prevention programmes to include IRS with DDT.
- **'Neglected' diseases** (Leprosy, LF, Buruli Ulcer etc.) - DFID could take an important advocacy role to ensure that tackling these diseases not only stays on the radar screen of major health multilateral donors but actually that the current imbalance is corrected.
- **ACT and point-of-use water treatment** are two health technologies that should be taken to scale as soon as possible, and substantial investment in those areas would also be warranted.
- **Increase investment to WHO** which provides critical technical assistance to African countries on TB/HIV management.

- **Increase DFID's technical capacity in nutrition both in London and in priority countries with high levels of malnutrition** like Ethiopia and Bangladesh.
- **Invest in better occupational safety and health and the development of workers' self-organisation in this field.** More emphasis needs to be placed on the need for appropriate legislation on occupational health and safety and on the effective enforcement of existing laws and regulations. .
- **Training of health workers** at different levels is crucial to building capacity – there is opportunity for DFID to take a more strategic and systematic approach to supporting long term links between NHS and UK teaching and training institutions and their counterparts in the developing world.
- **Facilitate high-speed internet connections** to African universities and health ministries where access to the internet is intermittent, too expensive or both.
- **Encourage other bi-lateral donors to contribute to PDPs** - long term sustainable funding for product-development public-private partnerships (PDPs) must be addressed, combined with the significant increase in funding that will be needed over the next few years. DFID has already made a significant contribution to the neglected disease PDPs and the UK could play a further role to encourage other bi-lateral donors to contribute to PDPs, in order to deliver on the 2005 G8 pledge to support this mechanism, as well as making further investments, in particular in the area of diagnostics and (non-HIV) vaccine research and development.

For some, the issues they flagged were not thematic 'gaps' but rather the scale of DFID's response in some areas. For example:

For one NGO respondent, the major highlighted gap was the volume of planned aid expenditure and the speed at which the 0.7% of GDP target will be met.

For others, the level of financial support accorded to sexual and reproductive health rights programme work (including commodities and research into microbicides) was a significant short fall.

Q10: What should be the priority areas for research in improving the health of poor people?

Appendix 3 lists a wide spectrum of areas identified by respondents as priority areas for research. In summary, identified thematic areas were:

- Vaccines & Product Development
- HIV & AIDS – Diagnostics & Treatment
- Other Diseases – Communicable & Non-Communicable
- Health Systems / Operational Research / Cross Cutting Issues

Broadly speaking, respondent feedback demonstrated that whilst more resources and research were required, DFID was focusing its resources and assistance in the right research priority areas. Leadership demonstrated by DFID in terms of its investment in the Global Alliance for TB Drug Development, microbicides etc. was welcomed. Yet gaps, such as neglected tropical diseases and non-communicable diseases, were also cited.

In addition to the identification of specific research topics, many respondents provided overarching comments on the status and operating environment of international research and development (R&D). Some of these comments contained suggestions for the wider direction and focus for DFID's future role and support for research. Points made were:

10a Southern research capacity needs to be strengthened

Some particularly stressed the need to continue building southern research capacity. In Africa particularly critical gaps were considered to hinder a firm local interest in, and pursuit of, research. Calls were made for DFID to:

- **Increase both the number and skills of African researchers** – the need for stronger capacity to gather, analyse and use health information were identified.
- Create better **support for southern research leadership**. It was felt DFID's current research consortia tend to be northern-driven. Real southern involvement should be emphasised in the tender and assessment process.
- Make available **scholarships for African researchers** within African research institutions.
- Work with the Medical Research Council, developing countries, and other stakeholders, including the industry, to identify ways to address the **capacity in developing countries to conduct clinical research**. There was concern that as the pipeline of the product development PPPs matures, the capacity of the few suitable clinical facilities, especially in Africa, will be dangerously over-stretched.
- To consider the **adaptation and use of the Cochrane Collaboration** as a model for professional collaboration and learning and transferring research into practice. Albeit associated with interventions mainly for developed health services, nevertheless it could be extended to countries with large poor populations.

10b Mainstream R&D into the Development Process

It was acknowledged that DFID has made significant efforts to support research in developing countries, and the new strategy provides another opportunity to review its institutional arrangements, so as to better integrate the financing, policy and implementation arrangements for research into DFID's country-level operations:

- DFID's **Country Assistance Plans**, which are produced in consultation with governments, business, civil society, and DFID officials, offer a valuable opportunity to

engage potential in-country research partners in a strategic consideration of health research priorities at a country level.

- A mainstreaming of research into country level plans would provide additional avenues for DFID to **engage developing country governments and scientists in establishing the most relevant and specific national scientific agendas** and plans. Such plans would identify the products that should be prioritised for research and could also include plans for the development of new clinical trial sites and facilities. Importantly they would detail the training and technical capacity gaps and requirements and identify immediate technical assistance needs.
- At the policy level, **developing country leaders are increasingly emphasising prevention while moving rapidly to treat those already infected**. An increasing number explicitly address research into new technologies as part of their national strategies for combating AIDS.

10c Responding Better to Time & Money Constraints

It was argued that:

- The question is not about whether the right responses are in place but rather that current efforts are not sufficient. Expanded, accelerated and intensified research programmes aimed at developing tools for conditions that are responsible for the burden of death and disease in the poorest countries are urgently needed. Health research suffers from **insufficient funding** and from a huge discrepancy between the magnitude of disease burden and the allocation of research funding. Crucially, it has resulted in a well recognised gap in the generation of new products and an asymmetry in the ability of poorer countries to use existing and new technologies. In recent years there have been some attempts to correct this gap but so far it remains largely uncorrected.
- There should be greater **acknowledgement of the costs and timescale in producing medicines**. On average, it costs £500million and takes about 12 years to discover, develop and introduce a new medicine. For medicines with no application except in the developing world, where prices are almost invariably at cost or very low, these are very considerable issues. The UK Government was urged, particularly by commentators from the private sector and PPP constituency, to consider the following funding incentives and regulations :
 - The effectiveness of **UK R&D tax incentives**: Broadly speaking these incentives were welcomed, but the value of the credits (some £550m in 2003/4 spread between 5000 companies) was considered relatively small when set against costs. Furthermore it was forwarded, that these R&D incentives favour small and medium enterprises. Yet it was argued that it is the larger companies which invariably bear the heavy financial burden of global clinical programmes.
 - **Advanced Market Commitments (AMCs)** were welcomed by respondents but with calls for the rapid conclusion of this proposal. It was argued that AMCs should not be considered for extension to medicines until the scheme for vaccines has been given a chance to prove itself.
 - Explore ways by which **medicines approved by the FDA and EMEA do not require further, additional time consuming** and bureaucratic regulatory approval processes at a local national level.
 - Innovative new proposals for **extended intellectual property rights** for companies producing medicines for diseases disproportionately affecting LDCs

and sub-Saharan Africa. DFID should promote the benefits of an effective IP environment, especially in emerging markets.

- DFID was encouraged by some to continue its **research on innovative financing mechanisms** and recommend that a working group look at different push and pull incentives, including the Industry R&D Facilitation Fund, which could provide adequate financing for research and development of drugs for diseases of poverty.

APPENDIX 1:**List of Organisations & Individuals Submitting Comments on DFID's Health Strategy (2006)****NGOs**

AMAR International Charitable Foundation
AMREF
Bioforce Training Institute
Britain-Nepal Medical Trust
British Red Cross
Concern
Health and Development Networks
Health Unlimited
Help the Hospices
International Agency for Prevention of Blindness (IAPB)
International AIDS Vaccine Initiative (IAVI)
International HIV/AIDS Alliance
International Policy Network
Marie Stopes International
Medact
Mercy Corps
Merlin
ORBIS
Population Services International (PSI)
RESULTS UK
Save the Children UK
Sightsavers
Tearfund
The Leprosy Mission (TLM)
Tropical Health and Education Trust (THET)
World Vision UK

Academics, Think Tanks & Research Foundations

International Health Group, Liverpool School of Tropical Medicine
Lymphatic Filariasis Support Centre, Liverpool School of Tropical Medicine
NHS Confederation
Universidade Federal de Pelotas, Brazil
Wellcome Trust

Private sector & Public-Private Partnerships

American Pharmaceuticals Group (APG)
Association of the British Pharmaceutical Industry (ABPI)
Astra Zeneca
Crown Agents
GlaxoSmithKline (GSK)
HLSP
International Partnership for Microbicides (IPM)
Liverpool Associates in Tropical Health

Private sector & Public-Private Partnerships (cont.)

Medicines for Malaria Venture (MMV)

PA Consulting

People in Health

TB Alliance

Government & UN

All Party Parliamentary Group on Population, Development and Reproductive Health

British Council (x 2 submissions)

WHO

WHO Essential Medicines

Professional Organisations & Trade Unions

British Medical Association (BMA)

Faculty of Public Health, Royal College of Physicians

Global Health Advocacy Project, Medsin

Royal College of Nursing

Trades Union Congress (TUC)

UNISON

Members of the General Public

5 submissions

APPENDIX 2:**Questionnaire for Public Consultation (written submissions)****How can we meet the challenge?**

We would like to hear your views on any or all of the following ten questions.

We would particularly like to hear how you believe DFID can best use its resources and comparative advantage to accelerate efforts to improve health.

Please limit your responses to a maximum of 5 sides of A4 paper.

1. What are the most effective ways to support countries' efforts to scale up to universal access to essential health services, especially for the poorest and most vulnerable?
2. What are the most effective ways to support countries' efforts to build and retain their health work-force?
3. What action needs to be taken to meet the off-track development targets: child, maternal and reproductive health?
4. In 2004 in Taking Action we set out how the UK would contribute to a more effective response to the prevention and treatment of HIV/AIDS. Should we be doing more?
5. How should we respond to the health challenges in conflict and post-conflict environments and fragile states?
6. How can the accountability of recipient governments to their people for the effective use of health resources be improved?
7. How can the performance and coherence of the international health architecture be improved to deliver better health for poor people?
8. Where should we focus efforts for maximum gain in addressing the broader determinants of health?
9. Are there gaps in DFID's response to the current and future health challenges?
10. What should be the priority areas for research in improving the health of poor people?

APPENDIX 3:**Areas identified for *research to improve the health of poor people* (Q 10)****VACCINES & PRODUCT DEVELOPMENT**

- **Clinical Trials:** Funding clinical trial sites in developing countries to facilitate bringing new drugs, diagnostics, vaccines and microbicides into practice is a major hurdle for progress in research to improve the health of poor people. The European & Developing Countries Clinical Trials Partnership (EDCTP) will hopefully play a major role in this area in future; an expansion of interactions between EDCTP and DFID (and DFID funding for EDCTP) could be of interest.
- **AIDS vaccines and microbicides** are amongst the most urgently needed global public health goods. This is appreciated by DFID and expanded and accelerated research programmes are still required to bring forward the most promising vaccine and microbicide candidates and move them quickly into clinical trials. This will require DFID to sustain and increase its investments in health related R&D and to complement this with leveraging greater participation, expertise and resources in developed and developing countries, as well as promoting effective partnerships between public and private sectors.
The UK can help to ensure that the Global HIV Vaccine Enterprise has the resources and political support needed to conduct AIDS vaccine R&D to the highest global standards.
- DFID could increase its investment to companies and Product Development Partnerships working on R&D for new TB diagnostics and a vaccine, i.e. in order to add to the leadership it demonstrates for its support to the R&D of new TB drugs.
- The forthcoming health strategy provides DFID with an opportunity to make a long-term commitment to mainstreaming the role of product development for the poor as part of its comprehensive approach to health improvement. DFID should:
 - **Increase resources for product development** based on transparent funding criteria and with clear metrics to assess performance (e.g. new HIV prevention technologies – such as microbicides - should remain a priority area of investment);
 - **Support the development of an enabling policy environment** that integrates health product innovation for developing countries into comprehensive health systems approaches – including increasing in-country R&D capacity and linking to efforts to improve access to medicines;
 - **Continue leadership in donor coordination on product development** and in planning for the introduction and use of future health technologies by developing countries.
- Malaria vaccine
- Leprosy vaccine

HIV & AIDS – DIAGNOSTICS & TREATMENT

- **Diagnostics for infants:** Research is urgently required on paediatric HIV treatment. The most commonly available and easy to use diagnostic test is inaccurate in children under 18 months of age. Infant diagnosis requires a complicated test measuring the presence of the HIV virus. Unfortunately, these tests require technical expertise as well as costly equipment, placing them out of reach of poor countries.
- **Paediatric HIV treatment:** Alarming few drugs in the current World Health Organization's ART guidelines are available in formulations that are affordable, feasible or acceptable for use in young children. The limitations of current formulations are substantial.

OTHER DISEASES – COMMUNICABLE & NON-COMMUNICABLE

- The benefits of reducing the burden of '**non-killer**' diseases such as vector born infections and non-communicable diseases could be given more emphasis in DFID's new health framework. These issues are of particular relevance in areas such as South East Asia, which are otherwise making good progress towards achieving the MDGs.

OTHER DISEASES – COMMUNICABLE & NON-COMMUNICABLE (cont.)

- Further research is needed to tackle viral diseases such as avian influenza, dengue and haemorrhagic fever.
- Diseases, such as African trypanosomiasis, and leishmaniasis, dengue fever. African sleeping sickness, river blindness, lymphatic filariasis etc remain neglected and DFID could consider fostering and financially supporting new PPPs to address these diseases.
- Effective control programmes for sickle cell anaemia.
- In relation to eye health in low and middle income countries. Specific research priorities could include effectiveness of health service delivery interventions ('organisation of care'), particularly in relation to cost (i.e. setting up a rural satellite hospital as opposed to conducting screening camps). Significantly more work needs to be done to review the impact of interventions, particularly in relation to quality of life.

HEALTH SYSTEMS/ OPERATIONAL RESEARCH / CROSS CUTTING ISSUES

- **Human resources for Health:** Anecdotal evidence suggests that good NHS Links appear to reduce migration through improving local conditions. However this needs to be properly researched and DFID may wish to consider funding research into how civil society support for developing countries can best reduce 'brain drain'.
- The past two decades have witnessed natural disasters and armed conflict on an unprecedented scale. The provision of emergency medical care in the wake of disasters is a major challenge and warrants research into **more** effective ways of saving lives in **natural disasters and prolonged armed conflict situations**.
- **Public private partnerships** have been shown to be successful in some settings, but more research is required into their cost effectiveness as well as their long term impact, including skills transfer, compared with other forms of health service delivery. Associated with these issues, is that of health financing: whilst services that are free at the point of delivery may improve access among the poor, cost recovery mechanisms are required to ensure sustainability (in the private sector).
- Research to explore **innovative and more effective delivery mechanisms** such as delivery of measles vaccines combined with vitamin A supplements and ITNs – are there ways that proven interventions can be combined in a more (cost) effective manner?
- **Education of girls and impact on their health** and that of the general population.
- It is necessary to conduct research into more economical and innovative ways of improving **nutrition, hygiene, sanitation, water purification and refuse collection and disposal**.
- In order to reap the benefits of R&D, we recommend that DFID supports countries to create management capacity, enabling legal and regulatory environments in order to absorb and distribute new drugs, diagnostics and vaccines.
- Medicines account for a significant percentage of health budgets — at both household and national levels. A key area for medicines research should therefore be that of **how to include medicines benefits when starting up health insurance schemes in developing countries**. There is a growing interest in using this approach to finance or supplement national budgets for health care services. DFID could play a leading role in disseminating experiences from developed and middle-income economies to developing countries.
- A range of operations research topics were identified and suggested for DFID support:
 - **What are the most effective ways of building health supply chain management capacity?**
 - More needs to be done on health systems and **how to reach the poorest populations?**
 - **Community based systems** and effective ways to scale up
 - The role of first line **community based care workers** in palliative care,
 - Increased work on **access to medicines and removing barriers**
 - The role of **palliative care in reducing stigma**
 - **Cost-effectiveness of community based interventions**

HEALTH SYSTEMS/ OPERATIONAL RESEARCH / CROSS CUTTING ISSUES (cont.)

- The **extent and nature of home based care services**. Therefore there is a need for research that: a) will help to improve quality of care in informal sector, including pharmacists and informal practitioners, and b) will help us understand why people choose one type of health care providers over another.
- Strategies for addressing equity issues more especially for poor women and children and rural populations.
- Ongoing **monitoring/research into 'what works'** e.g. the impact of health systems approaches and integration of maternal and neo-natal health indicators.
- **Access to medication/drugs**, including the issues of corruption, availability and distribution.