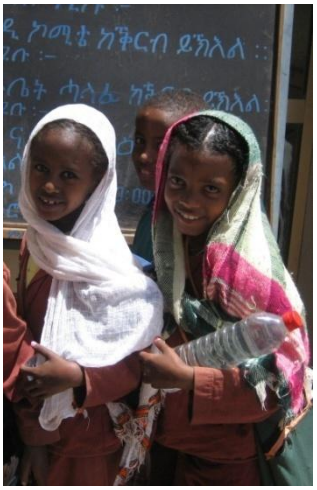

# Annual Independent Review of the UK Government's Global Health Strategy

Working with Brazil, Russia, India, China & South Africa

June 2010

Mott MacDonald

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# Contents

# List of Acronyms

| | |
|---|---|
| APPGs | All Party Parliamentary Groups |
| BIS | UK Department for Business Innovation and Skills |
| BRICS | Brazil, Russia, India, China, South Africa |
| CAP | Country Assistance Plan |
| CEPR | Centre for Emergency Preparedness and Response |
| COP15 | The United Nations Climate Change Conference 2009 |
| DECC | Department of Energy and Climate Change |
| Defra | Department for Environment, Food and Rural Affairs |
| DFID | Department for International Development |
| DH | Department of Health, UK |
| EU | European Union |
| FCO | Foreign and Commonwealth Office |
| G20 | The Group of Twenty Finance Ministers and Central Bank Governors |
| GHS | Global Health Strategy |
| GOScience | The Government Office for Science |
| HMG | Her Majesty's Government |
| HMT | Her Majesty's Treasury |
| HPA | Health Protection Agency |
| IPO | Intellectual Property Office |
| MDGs | Millennium Development Goals |
| MHRA | Medicines and Healthcare products Regulatory Agency |
| MoD | Ministry of Defence |
| MoH | Ministry of Health |
| MOU | Memorandum of Understanding |
| NHS | National Health Service |
| NICD | National Institute for Communicable Diseases |
| NPSA | National Patient Safety Agency |
| PHI | Partners in Health Innovation |
| PPP | Public Private Partnership |
| RCUK | Research Councils United Kingdom |
| RSA | Republic of South Africa |
| SARPAM | Southern Africa Regional Programme on Access to Medicines |
| TB | Tuberculosis |
| NICE | National Institute for Health and Clinical Excellence |
| UKTI | United Kingdom Trade and Enterprise |
| UN | United Nations |
| US | United States of America |

# Executive Summary

The UK Global Health Strategy (GHS), "Health is Global" was launched in September 2008. This first annual independent review assesses the coherence and consistency of the UK government working in the BRICS countries (Brazil, Russia, India, China and South Africa) against that strategy. Terms of reference can be found at appendix A.

The process used for this review included a review of the grey literature and relevant websites, followed by a two stage interview process (see Section 2). Interviewees were in the UK, Geneva and in each of the BRICS countries. The main departments involved in the review were: Department of Health (DH), the Foreign and Commonwealth Office (FCO) and the Department for International Development (DFID). Other government departments and non-governmental public bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Health Protection Agency (HPA) were also interviewed as they play a significant role in the delivery of some areas of the GHS. Section 3 presents the findings from these interviews at central and country level.

**Overall conclusion:** There are some good examples of coherence in UK government working on the GHS in the BRICS countries, which is impressive given the short time frame. There is a fairly good level of awareness of the GHS among UK based staff working with and in the BRICS countries with most of those who are aware of the strategy reporting positively regarding the potential for the GHS to bring a more coherent approach to health work. There are examples of successful joint working across government departments; a degree of shared language on global health; some high level commitment to global health thinking and a number of examples of a coordinated approach. However, there are several areas where UK government departments can better coordinate and plan the approach to the GHS in the BRICS countries. Much of the current activity appears to be ad hoc and opportunistic. Activities are unevenly clustered in certain areas of the GHS, and other areas have not been addressed (see appendix B). There is an overall impression that better cross government coherence on global health is needed.

The main **challenges** to coherent and consistent work on health span a range of organisational areas within UK government. Firstly, most central and BRICS country UK government **strategies** are not taking into account the GHS, and so do not present a coherent framework for work across government on health. There are no clear **priorities for action** agreed between the main government departments. Secondly, this review found that strong and high level **leadership** of the GHS was not fully established either in the UK or in the BRICS countries. This is both a cause and effect of some of the other challenges. **Communications and coordination** appear to be ad hoc, informal and not institutionalised, particularly at country level. The **spirit of the GHS** (as articulated in the GHS principles) is not well embedded in the main government departments that have the highest level of funding and responsibility for working overseas (DFID and FCO). Finally the review has shown that the strategy is too ambitious for a coherent implementation in the BRICS within the resources currently available. DH and FCO staff are not able to cover the huge agenda within the current **organisational structure and resources**. There is, however, potential and desire for building on the existing good working practice.

**Recommendations:**

1. Implementation of the **GHS action in the BRICS countries needs to be better planned in terms of priorities and country level strategies**

- DH should lead a process with other departments to prioritise which BRICS countries to focus work in a way that will have the highest impact for the GHS. This could sit within a wider prioritisation exercise.
- Realistic and deliverable plans for implementing the GHS should be developed at country level for priority countries, with common ownership by all the departments in the country, and either FCO or DFID acting as the lead department.

2. **More effective leadership and active champions** are needed to provide impetus, oversight, and monitoring to activities within BRICS countries.

- DH should develop its role as the functional lead and natural custodian of the GHS in the UK. This will require a more active role for ministers and support from director level management.
- The Cabinet Office and FCO should support DH in convening and coordinating ministerial meetings to deliver more consistent leadership across government.
- The FCO or DFID should provide leadership for in the priority countries. Where there is a DH member of staff within the Embassy or DFID, there still needs to be higher level leadership of the dialogue process and monitoring of the work.

3. **Coordination and communication between government departments working in the BRICS countries needs to become more institutionalised**. The ambitious and complex nature of the strategy means that simple messages are required for better mainstreaming across government.

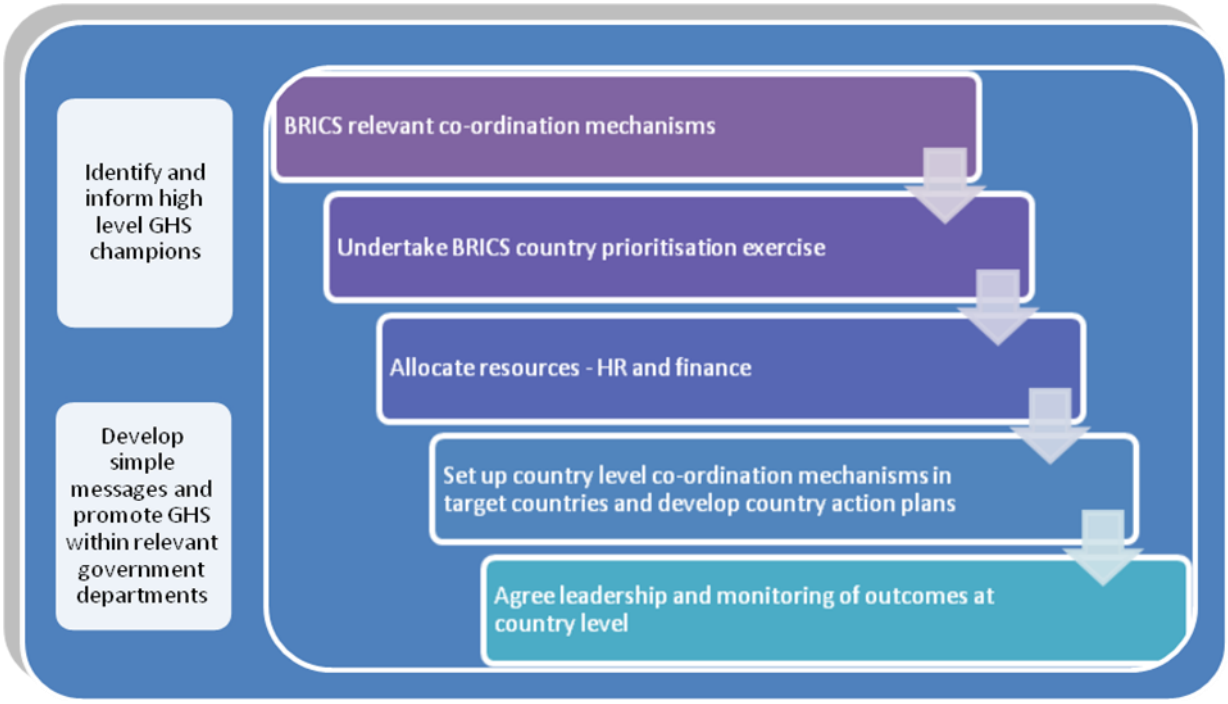
- The Global Health Officials' Steering Group needs to meet regularly and become more institutionalised within government.
- Coordination mechanisms need to be developed in the priority countries and these should include all relevant government departments and non government actors.
- Simple messages should be developed from the GHS for communication throughout government, especially for the priority countries and for staff working with those countries.
- DH ought to investigate Parliamentary awareness of GHS including select committees and All Party Parliamentary Groups (APPGs) to see how Parliament might support a more coherent approach.

4. **Resources for BRICS focussed activities should be better organised** and allocated across departments to ensure the GHS is supported by staff that are accountable and by sufficient funds.

- DH London based staff should be enabled to monitor and coordinate GHS work in priority countries (BRICS or other middle income countries), to ensure a coherent and consistent approach.
- A cross government fund for global health should be created, that can be used for activities in the priority countries and for international level work;

- In the priority countries a post in the FCO or DFID (DH funded or shared) should be made available for coordinating the GHS work. Staff working on the GHS internationally should have the appropriate skills and experience

**Figure 1.0: Graphical representation of recommendations and possible sequencing of tasks.**



# 1. Introduction

This report is a review of the UK Global Health Strategy, "Health is Global". The review looks at the coherence and consistency of UK government working in the BRICS countries (Brazil, Russia, India, China and South Africa) in line with the GHS. At the time of the GHS launch in September 2008, the UK Government's initiative reflected rapidly growing concerns across national governments, international bodies and others, about the links between health policy, globalisation and early signs of financial downturn, new disease pandemics, and an increasing understanding of climate change impact and mitigation. There was a need for both domestic and international policy to consider global health and the impact of other policies on health much more robustly and strategically, and to strive for more consistency and coherence. Many government departments and agencies work on issues that either directly or indirectly affects global health and this strategy seeks to provide a framework for departments to work more strategically together to make the most of opportunities to improve health.

The GHS presents ten principles which underpin the strategy[1]. The strategy builds on successes to date and identifies five future areas for action:

- Better global health security;
- Stronger, fairer and safer systems to deliver health;
- More effective international health organisations;
- Stronger, freer and fairer trade for better health;
- Strengthening the way we develop and use evidence to improve policy and practice.

Within each area for action the strategy sets out a number of 'we wills' and outlines 27 "indicators" or "targets" describing the difference, by area, expected in five years time.

**Brazil, Russia, India, China and South Africa – BRICS[2]**

This group of countries has developed over the past five years as a critical and powerful sub-group of middle income countries with some key common interests, including a significant presence and influence in the G20 and COP 15. As individual countries they are powerful global economic actors, with major foreign policy agendas that include growing roles in international development. Brazil, Russia, India, China and South Africa are addressing the need for economic, financial and institutional reform through mechanisms such as the G20, managing global pressure on resources, promoting lower carbon growth and sustainable development, achieving the Millennium Development Goals (MDGs), and reducing conflict. Their relationships with the US and the EU will be critical in shaping the world in the next decade.

Collectively these five countries account for 43% of the world's population and are home to 710 million poor people, (60% more poor people than in sub-Saharan Africa). They also face significant public health problems, particularly in addressing the double burden of the health transition. Typically they are spending between 3% (India) and 11% (Russia) of their government expenditure on health, which is between 4 and 15 percentage points lower than the USA and Northern European countries[3]. Learning from experience across Government with the BRICS countries will contribute to the overall delivery of the GHS by 2013.

[1] Department of Health (2008). Health is Global: A UK government strategy 2008-2013.

[2] Though this review is focused on the BRICS countries there is recognition that this term is out of date and is not well liked by the countries themselves. A number of other emerging economies are important partners for global health, for example Mexico and Indonesia. However we will use the term BRICS sparingly and will refer to the need to scope work in a wider range of countries for global health.

[3] World Health Organisation (2009). World Health Statistics.

# 2. Approach

Health is Global set out a commitment to review the progress of key areas of the Global Health Strategy annually, with a full review scheduled to take place in 2013. This first review evaluates the coherence and consistency across government in the 'BRICS' countries, Brazil, Russia, India, China and South Africa.

The GHS is innovative; it sets out an ambitious approach to tackling global health issues through strategic and effective working across UK government departments, agencies and non-governmental organisations. Implementation of the strategy is in its infancy, and it is important to clarify that the commitments set out are not easily achieved over a short period of time. It is notoriously challenging to co-ordinate delivery of coherent messages across government as departments often do not have complementary objectives.

This process used for this review included:

- A review of the grey literature and relevant websites (including a self assessment of progress to date against the 'we wills' that had been provided by the Global Health Team at DH);
- A two stage interview process with nearly fifty phone or face to face semi-structured interviews. Interviewees were in the UK, Geneva and in each of the BRICS countries. A full list of interviewees can be found at appendix C.

The first stage interviews focussed on a small group of key individuals who are heavily involved in the implementation of the GHS. The aim had been to identify a number of initiatives that could be mapped onto a selection of “we wills” and then to follow up with further interviews to analyse the initiatives in more detail. However the initiatives identified were not easily mapped onto the “we wills”. They have therefore been mapped onto the GHS broad areas (the five main areas for action) by country (see appendix B). This gives an idea of the range of work that is taking place in the five countries. A small number of initiatives were explored in more depth and used to illustrate good practice and challenges. Second stage interviews concentrated on gathering information about cross government working and identifying how activities were implemented. The following areas of organisational management were explored after testing on DH staff and a small number of interviewees:

- Strategies and policies;
- Leadership;
- Communications and coordination;
- Organisational culture;
- Systems and resources (finance and human resources);
- Overseas management structures.

In addition the interviews explored the depth of awareness and understanding of the GHS and its power as a strategic impulse behind the activities at country level (i.e. was it providing the necessary framework to ensure consistent and coherent working?).

The main departments involved in the review were: DH, DFID, BIS, IPO, and FCO. Other government departments were interviewed including Cabinet Office. Non-government agencies such as NICE and HPA were also interviewed as they play a significant role in the delivery of some areas of the GHS. Even though they are not government, they receive most of their funding from DH and so are viewed as part of government by stakeholders in other countries. For this reason they are included fully in the review.

# 3. Findings

The findings show an overall strategic framework of the government departments' work in the country, examples of work within the global health strategy and analysis of the coherence and consistency of the work overall in that country. Findings in Russia and Brazil were sparse, which in itself shows that efforts have been more focused on China, India and South Africa. A table summarising the health initiatives and activities by country and by GHS area can be seen in appendix B.

## 3.1 Global Health Strategy in India

**UK HMG Government Departments and their Country Strategies**

The focus of the work of FCO in India is guided by the Prime Ministers' Initiative. Signed in September 2004 this set out a new strategic partnership between the UK and India. Areas covered include economic and trade issues, science and technology and sustainable development. The scope and importance of UK/India relations are reflected in the network of five High Commissions across India[4] which house a range of UK government departments and units including the FCO, DFID, UKTI, Defra, BIS and the Climate Change and Energy Unit. All of these have some input to health.

DFID's India Country Plan runs from 2008 – 2013 and plans for a spend of approximately £825 million in the first three years. It is then anticipated that the overall aid allocation will decline as India becomes a Middle Income Country and the focus of DFID's assistance shifts more towards technical cooperation. Health is a key activity with about 45% of DFID's spend going to this area. This is mainly through government at central level and in DFID's five focal states[5], focussing on maternal and child health, HIV/AIDS and tuberculosis. There are also large sector support programmes in the focal states as well as an access to medicines project. DFID spent approximately £125 million on health in 2008/09.

The UK Science and Innovation Network is jointly funded by FCO and BIS. Its remit is to encourage, promote and facilitate R&D collaborations between academia, research establishments and corporate in the UK and their Indian counterparts using platforms such as seminars, workshops, sponsored visits and researcher exchanges. The network also works very closely with the Research Council UK (RCUK) - UK's largest research funding body which has an office in the British High Commission in New Delhi. The Climate Change and Energy Unit based at the DFID office in New Delhi brings together staff and resources from the FCO, DFID, DECC and Defra. The Unit ensures that all UK development work in India, including health, takes account of climate change.

Unlike other UK government departments listed above DH does not have a presence in the network of High Commissions. However DH has seconded a public health consultant, to head up the Indian Institute of Public Health in Hyderabad. This is intended to support India in its strategy to build public health capacity and leadership and is part of the DH response to the GHS.

[4] A High Commission in New Delhi and Deputy High commissions in Mumbai (Maharashtra), Chennai (Tamal Nadu), Kolkata (West Bengal), Bangalore (Karnataka).

[5] Madhya Pradesh, Orissa, Bihar, Andhra Pradesh and West Bengal

Between the departments listed above there is no current joint strategy for health but there an initiative underway to form a Dialogue on Health between India and the UK (see below).

**Awareness and use of the Global Health Strategy**

Awareness of the GHS varied widely. It was described by some within HMG as a useful framework within which to think about the current and potential contributions of HMG departments, or at least to describe them more coherently. For example the DFID health adviser used the GHS structure to brief the DFID Head of Office in preparation for the UN India Round Table meeting in early March 2010. He perceived this as leading to more coherent recommendations coming out of the meeting. Where there was awareness and use of the GHS it was admitted however that other plans and strategies had a greater bearing on departmental and individuals' work.

The GHS has clearly influenced the work being done on the proposed UK-India dialogue on health (see below) but it is not clear that it has had a large amount of influence on the latest thinking of the UK-India Roundtable. There are issues of overlap of these two initiatives which are discussed below.

**Examples of joint UK government department activities**

The proposed **Dialogue on Health** between India and the UK will cover many of the areas covered by the various HMG departments and networks mentioned above. This is being led by DH with engagement and support from DFID. The Dialogue is closely connected to the GHS, recognising the increasing importance of India in global health, and the opportunities from closer working between the UK and India in responding to a range of global health challenges. Potential opportunities for collaboration are identified under the five areas of action in the GHS and a way forward is outlined including proposals for regular meetings and communication, and the suggestion that there should be an action plan. In recognition of the many other UK departments working in India the emphasis is on DH supporting the delivery of their work but it stops short of proposing that the dialogue should provide some coordination between them. It also does not appear to have any connection with the conclusions of the latest UK-India Roundtable (see below). The latest draft of the proposal dates from December 2008 and DH is awaiting comments from the India Ministry of Health and Family Welfare. A change of government in India in 2009 and scheduling problems for arranging a ministerial visit to the UK have delayed progress.

The **UK-India Round Table** is a FCO initiative, originally set up in 2000 by the then Foreign Secretary Robin Cook and his Indian counterpart. Both FCO and DFID are ex officio members. The primary purpose is to discuss issues that may affect the bilateral relationship and to reflect on ways in which it can be strengthened. The Round Table consists of about 30 senior people, drawn equally from India and the UK and from a variety of sectors such as academia and business; the group meets annually, in alternate countries. It typically makes a wide variety of recommendations which sometimes include health, which are assigned for action and follow up by FCO, DFID, UKTI and DH. The last Roundtable in February 2010 discussed health, agreeing on the value of having a 'strong and robust relationship' between the health systems of the two countries which could build partnerships for exploring and developing different models and approaches for affordable healthcare; carrying out joint research; and improving service delivery and reduce costs. The Roundtable recommended that a detailed proposal and implementation plan be developed, and a sub-group should convene a group of Indian and UK experts from the private and public sectors who would also be potential participants in partnerships. There are

some potential areas of overlap with the GHS and the Dialogue on Health but these do not seem to have been considered.

DFID India has been funding a project led by the Clinton Foundation HIV/AIDS Initiative which works with the private sector to improve **access to medicines** for HIV/AIDS, malaria and other diseases in developing countries. Part of this involves addressing barriers to market entry, faced by India generic drug manufacturers who have significant potential to provide affordable medicines. Unlike in the UK where there has been good joint working in this area, there has been some tension between UKTI and DFID at the project's inception as UKTI had been concerned that the assistance given to Indian companies was potentially at the expense of UK business. DFID assured them that it was not, and UKTI have had little involvement in the project since.

**Example: Increasing Access to Essential Medicines in the Developing World**

A UK government policy on Access to Medicines was jointly developed in 2004 by DFID, DH, DTI (now BIS), FCO, Treasury, Inland Revenue and IPO. A good practice framework for pharmaceutical companies followed in 2005. The work was reviewed in 2008 and was found to have had a good impact on company behaviour in respect of access to medicines. Though this example took place before the GHS, the work on access to medicines continues and is an example of good practice in cross government working.

There is an on-going steering group for this piece of work, lead by DFID and comprising of DH, IPO and industry representatives. Also there is a joint BIS/DFID International Trade Unit. This set up has resulted in good joint understanding of commercial and developmental objectives of BIS/IPO, DFID and DH.

The departments have spent a lot of time agreeing common "lines" and developing joint briefing and shared objectives. This makes it easier to approach negotiations and work with countries with a coherent and consistent UK position, and helps to resolve any differences in position.

**Analysis of coherence and consistency of UK work in India**

Strengths: Staff in HMG in India make efforts to ensure consistency and coherence between their programmes. There is easy and quite energetic communication between the different departments such that each seems to have a good level of awareness of what the other is doing and they are able to identify opportunities for working together. This communication tends to be in the form of regular two or three way teleconferences, rather than formal communication channels. It is driven by a culture of willingness to work together. Across the different parts of HMG that were interviewed there is a recognition of the contribution that each can make to others in terms of information or contacts.

The DH secondee is widely recognised as a useful resource (especially by UKTI and DFID). She and her institution have been engaged in a variety of activities and offered advice and contacts to several departments. She has helped to facilitate the work of the HPA, the NHS National Patient Safety Association (NPSA) and NICE in India and is also credited with promoting a better understanding of the NHS within DFID so that they in turn can respond to India's interests in the UK health system. Other examples of joint working between The DH secondee and DFID include an assessment of preparedness to address the health impact of climate change, and a subsequent workshop.

The resolutions of the UK-India roundtable offer opportunities for greater engagement by some departments especially DH, and the proposed Dialogue on Health could potentially bring greater coordination in line with GHS objectives.

Challenges:
*Communications:* Although there is regular informal communication, there is no overarching formal network or coordination group on health. The informal teleconferences have the potential to lack coherence with various small groups communicating with each other rather than through one channel. It also seems to be very driven by some enthusiastic personalities and therefore may be prone to lapsing when those individuals move on to other posts.

*Planning and leadership:* There is no single point of leadership on health issues in HMG in India. The UK–India Roundtable is clearly regarded as an important influence on how the health agenda develops, but at the same time the Dialogue on Health sets out some priorities in line with the GHS, but not related to the Roundtable outputs. Although it could be said that the Roundtable is more oriented to 'bluesky' thinking there are questions of how the two relate to each other.

Although the secondment by DH to the Institute of Public Health in Hyderabad appears to be reaping benefits in terms of contacts, knowledge and initiatives, whilst also building capacity in public health, it is not clear what the long term strategy is for this post (including beyond the secondment of the current post holder) nor whether HMG is taking the best strategic advantage of an initiative which seems to have been essentially opportunistic and presents slightly anomalous reporting lines. Moreover, although a contribution to supporting India in its public health capacity building is no doubt useful, it is only a part of the GHS.

*Culture:* Despite the efforts to maintain good communications there are still areas where departments do not agree born out of their different approaches to the same issue. At the moment the tendency is to back off after difficult encounters and let possible inconsistencies sit rather than working through a coherent approach that meets both parties' objectives.

*Coordination:* Although staff within HMG perceive there to be consistency between what they are doing and trying to achieve this was not the perception of all the interviewees we spoke to outside of HMG. More consistent messages may need to be agreed and delivered, especially on follow through of GHS issues.

*Finance and systems:* The systems of the various departments are currently running independently of each other and there may be potential for greater synergy within joint initiatives. Each of the UK departments work to very different targets; both in terms of what they are trying to achieve and how this is measured. DFID's performance for example is in part measured by India's achievement of the MDGs, whereas UKTI is judged by the number of company contacts made and inward investment won for UK. Common work generally does not have its own measurement and could act as a deterrent for action unless both parties stand to gain. One solution to this may be to try to build common ownership and measurement of the achievement of the objectives of the UK dialogue on health which is closely aligned to the GHS and also to make sure that conclusions from the Roundtable are reflected in the Dialogue. There would however be questions about who would lead and monitor this process overall.

## 3.2 Global Health Strategy in China

**UK HMG Government Departments and their Country Strategies**

The FCO has an Embassy in Beijing and four Consulates General in Shanghai, Guangzhou, Chongquing and Hong Kong. The Embassy in Beijing hosts staff from UKTI, DECC and Defra that have some link with global health. The FCO political, economic and science and innovation

sections in the Embassy are most relevant to health work. There is also activity by non-departmental public bodies such as NICE and HPA.

The FCO's plan for work in China[6] was developed with coordination across Whitehall and therefore should reflect other departmental objectives. It briefly refers to global health issues in reference to WHO and to health sector reform in China, mentions the UKTI Partners in Health Innovation program and talks about free (but not fair) trade. However it does not offer a complete framework for health work in China.

DFID has a program with significant health interventions in China. The DFID Country Assistance Plan in China[7] runs from 2006 to 2011 and plans for approximately £30million spend per year, with £14m spent on health in 08/09 and £11m in 09/10. Beyond 2011 DFID funding in China is uncertain. The country assistance plan (CAP) plans for health activity in HIV and AIDS, TB and water and sanitation. The health aspect of the DFID program focuses on piloting pioneering projects that can be taken on and scaled up by the Chinese Government. It also works with the Chinese government on their development agenda in Africa and on their work with the multilaterals and the UN system.

DH funds a post responsible for DH-MoH bilateral work which is currently located in the DFID office after having moved from the UKTI team in the British Embassy. DH has an MOU with the Chinese Health Ministry, last signed in 2007 and due for renewal in 2010. The MOU commits to ministerial annual bilateral and a series of exchanges of personnel and information, research links and technical assistance for the mutual benefit of both countries. The MOU focuses on: public health emergency responses, infectious and non-infectious diseases, hospital management and service quality and community health systems. The MOU can be used as a tool to deliver the GHS in China if designed and agreed with GHS relevant content and activities embedded in.

**Awareness and use of the Global Health Strategy**

Most interviewees were aware of the Global Health Strategy, though did not use it fully to guide their work. They tended to use their own department's objectives and strategies as guiding documents. The main joint UK activities present in China, such as the Partners in Health Innovation, were in process before the publication of the GHS. However recent joint activity has been in part motivated by a DH visit and a growing awareness of the relevance of global health. Wider interest in health by the FCO is also a result of the huge health sector reform program initiated by the Chinese government in 2008.

**Examples of joint UK government department activities**

During the **influenza pandemic** alert the FCO worked well with research organisations and there was good exchange of viruses between research centres in China and the UK, and with the rest of the world. Chinese government officials have expressed their gratitude for this connection and have now set up their own WHO lab. However there was recognition that communications from the Embassy to the Ministry of Health (MoH) were not very productive. The Embassy officials were referred to the MoH website and the Chinese MoH was not keen to share any information

[6] Foreign and Commonwealth Office (2009). UK and China: A Framework for Engagement

[7] Department for International Development (2006). China: Country Assistance Plan.

on national contingency plans. An interviewee stated that the FCO may have got further if they had been closer to DFID, recognising that DFID had good contacts in MoH.

The **Partners in Health Innovation** (PHI) project ran from 2008 to 2010 with a total budget of £140,000 including staff and administration. It was initiated by DH and was lead by the Science and Innovation section of the Embassy. It was jointly implemented by UKTI and DH members of staff based in Beijing and was seen as an overarching program to implement activities under the MOU. Activities were co-funded with private sector health care and pharmaceutical companies wishing to gain contacts in and knowledge of the Chinese health sector. The project generated £1.1milion in match funding from partners. The main partners were AZ, GSK and Bupa from the UK, and Beijing and Shanghai Municipal Health Bureau in China. Activities have included training, exchanges and joint research in four priority areas (primary care, hospital management and health service assessment, infectious diseases and non-infectious diseases, and public health emergency).

PHI has its own website embedded in the FCO website, with no plans to transfer to DFID's website. DFID had very little involvement in this project, which was not consistent with their approach to health work in China. Perhaps as a consequence, the Chinese government saw PHI as a commercially driven and not consistent with the UK development work. Whilst they are willing to work with private sector, they are keen to be in the driving seat and not to be driven by commercial objectives. PHI is a good example of UKTI, DH and the FCO working together, with joint programming, funding and human resources. However the absence of DFID in the design may have been detrimental to long term work with the Chinese MoH. Interviewees felt that better consultation with the MoH is needed in order to focus appropriately. This program has now come to an end though some of the activities will continue. The DH member of staff was relocated to DFID in March 2010 in order to build on the close relationship DFID has with the Chinese MoH.

The **China Science and Innovation Board** was developed in 2009 and meets quarterly. Though the board have not yet discussed health, this coordination mechanism has the potential to be a useful vehicle for closer working on health research and could be used as a model for wider reaching coordination. The Board is composed of the heads of Science and Innovation within the FCO, UKTI, Research Councils UK Office, DFID, Climate Change and Energy and the British Council. The Board advises the Embassy's management and UK science and innovation stakeholders in maximising the impact of the UK's science and innovation work in China by: advising on strategy, agreeing joint plans and monitoring, ensuring clear relationship management and pubic communication in China and for relevant UK visitors, advising on proposals and funding opportunities, agreeing and raising with relevant UK bodies actions to improve delivery of UK objectives.

**Analysis of coherence and consistency of UK work in China**

Strengths: UK work on health in China is becoming increasingly consistent. There are more examples of joint working over the last two years and departments are starting to use a shared language. Whilst DFID is responsible for the majority of the funds going into health activity, there is increasing activity within other departments, particularly UKTI and the Science and Innovation section of the Embassy. There is evidence of an increase in shared points of view – for example as political and economic sections of the FCO are talking more about the significance of health for political stability and economic growth. There is at least one formal mechanism for coordination (Science and Innovation Board) and evidence of senior staff taking an overview of UK health work. One senior level interviewee asserted that all staff should think of themselves as working for HMG on health, not just for their department. This senior commitment is essential for

coherent and consistency. DH has a member of staff in the country and she is connected with all the relevant parts of the Embassy and DFID. There appears to be fluid information exchange and communication has been carried out in a more co-ordinated manner in the last six months.

Challenges:

*Communications:* UK government departments have generally worked fairly independently in China. Though there is regular email and phone communications, there is no overarching formal network or coordination group on health. Most communications are ad hoc and sometimes appear to be one sided requests for information rather than mutually beneficial communications between departments.

*Planning and leadership:* There do not appear to be many examples in China of joint or shared objectives on health in general or an understanding of the spirit of the GHS and this leads to a higher risk of incoherence. There is no country level planning or strategy to act as a framework for all global health activities. The DFID and FCO country plans and the MOU do not seem to be well linked and don't present a coherent and consistent picture. Though the DH member of staff would naturally lead on global health, there may also be a need for more senior level leadership and oversight to communicate a coherent message to government and to ensure good joint planning and implementation on health.

*Culture:* It appears that DFID has increased connections with the FCO and other departments over the last two years, however interviewees stated that the separate offices made it difficult to work closely together. Several interviewees described a culture difference between DFID and FCO offices and these often stemmed from the perceived objectives of the other department.

*Coordination:* The large number of UK organisations and activity in China increases the risk of incoherent work on health. Whilst HPA and NICE are independent of government, they are seen as UK government by the Chinese government, which means their activities need to also be coordinated in a UK approach to global health at the country level.

*Finance and systems:* Sharing of systems, such as monitoring of projects or financial management, has not been explored fully yet. It is possible that synergies can be found and experience within the UK organisations can be used more fully.

The perception of NICE as UK government has meant that the Chinese are unwilling to fund work by NICE as it would be seen as transferring funds to the UK government. This is not an issue limited to China, but also extends across other countries NICE work in. As NICE has no internal funds for work overseas some of the work in China has been stalled. DFID have provided £150,000 from 2009 – 2011 for NICE work in China, but this does not cover all the areas that have been requested by the Chinese government. The World Bank is the key client of NICE International and has an important role in supporting the NHS to share its expertise. Questions about the availability of funding for global health need to be addressed. Consistency between messages and action will deteriorate in China unless funding is secured.

## 3.3 Global Health Strategy in the Republic of South Africa

**UK HMG Government Departments and their Country Strategies**

A UK-South Africa framework for engagement by FCO and other HMG departments is currently being drafted. This is a cross Whitehall document modelled on the framework developed for China and will include a number of different areas including health.

DFID engages with South Africa within the context of its Regional Plan on Southern Africa. This pilots a regional approach to poverty reduction which is intended to add value to its specific work in South Africa; the SARPAM Access to Medicines Project is one such example. DFID's country specific work in health is delivered through its technical assistance programme which in 2008/09 totalled over £20 million, half of the overall DFID RSA aid budget. Funds are used to support South Africa's policy and programmes on Health and AIDS and more recently the secondment of a DFID senior health adviser to the RSA Department of Health.

DH activities in RSA are guided by a MoU which has been in place with the RSA DH since 2003. The initial MoU grew out of earlier efforts by both parties to address concerns about migration of healthcare workers from RSA to the UK, and was developed to promote a continued exchange of healthcare concepts and expertise. The second MoU signed for 2008 – 2013 is designed to foster closer working relationships on health matters by strengthening bilateral relations, enhancing clinical and technical skills and exploring best practice in health care delivery.

**Awareness and use of the Global Health Strategy**

Awareness and use of the Global Health strategy is limited. In the context of RSA; DH, DFID and FCO have some low level awareness of the GHS but it does not have a high impact on either the content of or their approach to their work. Although the GHS is seen by some as offering potential in terms of defining roles, in practice the DFID Regional Plan and the MoU have a much stronger bearing on what the respective HMG departments do and how they do it.

In terms of the coherence and consistency of activities with the GHS, although many of them loosely 'fit' into the 5 areas of action of the GHS, the DFID plan and the MoU vary in priorities and scope. The DFID Regional Plan places DFID's work in RSA within a regional context, and the scope of the MoU is much more modest than that of the GHS: it deliberately focuses on a limited number of things that can be achieved by both parties and on issues that are determined by the RSA DH.

**Examples of joint UK government department activities**

A **visit by Nigel Crisp**[8] to the RSA was carried out in March 2010 in response to a request from the Deputy Minister of Health. The purpose was for Lord Crisp to provide initial strategic advice and further motivate the current work underway in RSA in the field of quality and related issues, and to establish the basis and make proposals for further interaction with HMG in these areas and in relation to the MOU. The FCO facilitated discussions between Lord Crisp, DFID and the RSA MoH. DFID, through the secondee in the MoH was also closely involved in the organisation and facilitation of the visit. Three areas for further interaction between the two countries were identified including learning from the UK experience of modernising its service and establishing new approaches to quality, the possible 'loan' of experienced staff to RSA, and a two way

[8] Independent cross bench member of the House of Lords and NHS Chief Executive and Permanent Secretary of the UK DH 2000 to 2006.

management exchange programme. This visit showed good joint working on health between DFID, DH and the FCO.

Under the MoU there has been a **strategic research collaboration** that is being developed between the HPA and the RSA National Institute for Communicable Diseases (NICD). The long term objective is to develop a bid to an external funder for strategic research initiatives between the two institutions. An initial teleconference and visit in early 2009 identified potential areas for collaboration which were further developed at a workshop in October 2009. This produced detailed workplans and funding streams, bilateral training opportunities were identified and it was agreed that ongoing collaboration should be established as a part of the HPA future work under a MoU. An HPA-NICD MoU was signed in February 2010 and there is an upcoming HPA international public health secondment to NICD for 24 months. Both of these activities will help to achieve the aims of the GHS and to strengthen long-term ties with the region.

**Analysis of coherence and consistency of UK work in South Africa**

Strengths: In some respects South Africa offers an example of growing collaboration between DFID, DH and FCO. DFID and DH offer technical expertise and leadership in their respective areas, the DFID adviser in RSA MoH provides growing insight into national priorities and appropriate approaches, and the FCO facilitates relationships between the HMG and RSA and lends political weight to the relationship whilst recognising that there is also political capital to be gained. The High Commissioner is very much behind the common initiatives in health and this has helped to raise their profile. This comes from a common recognition by all three parties of the desire of RSA to reform its health system and to learn from the UK, the ambition of HMG to be influential in this, and the potential of the UK NHS to be one of the vehicles of this influence.

Challenges

*Communications:* Communications between the three parties are effective. Prior to this they seem to have been limited between DFID and DH. This is perhaps partly the result of the DFID office's focus being regional rather than country specific and the long term relationship which DH had with RSA independent of DFID's work. The DFID post in RSA DH is linked to a specific project and an interest that DFID has in supporting the new Minister. It is therefore not clear what will happen beyond the life of the project.

*Planning and leadership:* There is no single point of leadership on health issues, each department following its own agenda and working together where these overlap. However the High Commissioner offers high level support and oversight on common, politically high profile issues. From the point of view of the DH the MoU is its main vehicle for engagement under an arrangement that works well because it is flexible and responsive to what RSA DH wants and what DH can practically provide. And yet it is notable that DH, which has a large stake in the implementation of the GHS and a good relationship with RSA, does not link the objectives of the GHS with the MoU. Indeed the GHS seems to be largely irrelevant to the MoU.

*Culture:* There are cultural and capacity differences between DFID and DH in RSA, especially given the lack of DH presence in RSA.

*Coordination:* It is acknowledged that there are areas where DFID and DH overlap in terms of technical areas which have led to conflict in the past; this has been attributed to insufficient coordination between these overlapping agendas. However coordination has recently improved

with the FCO making particular efforts to ensure that HMG presents a united and coordinated front. A recently appointed FCO political officer in the British High Commission and the new DFID adviser in MoH and have been helpful in this respect.

*Finance and systems:* There is no formal joint working in terms of joint budgets or programmes but there is an increasing sense of common purpose and clarity of contribution, and regular communication between the departments. This is helped by regular visits by DH to RSA to facilitate the implementation of the MoU.

## 3.4 Global Health Strategy in Brazil

**UK HMG Government Departments and their Country Strategies**

The FCO have an Embassy in Brasilia and two Consulates General in Rio de Janeiro and Sao Paulo. The Embassy in Brasilia hosts staff from UKTI, DECC and Defra that have some link with global health. The Consulate's are trade focussed and are responsible for identifying local opportunities to develop trade between the UK and Brazil.

Diplomatic relations between Brazil and the UK have been positive in recent years, with inward and outward missions taking place regularly. Following a visit by President Lula to the UK in 2006 a MOU in Health Matters was signed with the Brazilian MoH. This focussed on the area of blood products and blood safety and provided commitment to the exchange of information on the development of health systems and associated technologies which may be of mutual benefit, interchange of health professionals, support for research and development activities to identify best practice and to study ways of collaborating in other health areas.

The DFID Brazil programme ended in 2004, however DFID still maintains a relationship with Brazil, working together in the run up to the G20 on multi-lateral reform supporting a Rio based Think Tank hosting seminars on Brazil as a global actor.

**Awareness and use of the Global Health Strategy**

FCO and DH staff both within the UK and Brazil are aware of the GHS; the principles and five areas for action are used at headline level to guide thinking and approach. Feedback indicated that the volume and breadth of the 'we wills' has resulted in them drifting out of people's focus. Concern was also voiced regarding the difficulty in measuring progress towards attaining the 'we wills' and staff across departments suggested that the introduction of personal objectives relating to these commitments and the GHS more generally would raise their profile and support staff in managing competing priorities. There has been confusion regarding the role of DH in international affairs and the GHS has helped to clarify the role and align DH more closely with other UK government departments. To date the GHS has had limited success in terms of providing a unified direction and delivering this direction within Brazil.

**Examples of joint UK government department activities**

Brazil is undertaking a period of health care reform designed to improve the quality of health and provide a spur for wider economic development. They are particularly interested in the UK primary care system, the way in which the NHS has benefitted from Public Private Partnerships (PPP). In 2009 the Brazilian Health Minister, Dr Temporao visited the UK to meet with the

Secretary of State and other senior health officials. During this visit Dr Temporao observed the way in which the NHS has benefitted from different types of PPP and in particular the way the initiative has helped to improve access to primary care and address inequalities. Full briefings on PPP were provided and the delegation visited an Integrated Health and Social Care Centre developed as a PPP project. Following on from this DH and UKTI have organised a seminar to be held in May 2010, coinciding with a major trade exhibition. This will facilitate further collaboration under the MOU, exchanging policy and to open up potential commercial opportunities for the United Kingdom.

**Analysis of coherence and consistency of UK work in Brazil**

Strengths: UK government departments have previously had competing objectives which has seen them actively working against one another in Brazil. This is improving with increasing examples of cross governmental working. In terms of the GHS, there is no formal connection with business processes within DH.

A good relationship exists between the UK and Brazil at ministerial level. This has been credited with elevating the profile of strong bilateral agreement, and providing a boost to the MOU at the stage when many begin to lose momentum. This strong relationship has been continued at senior governmental level, and a clear understanding of counterparts in both countries has enabled effective relationships to be built. A half-yearly FCO led meeting takes place at Whitehall which provides a network of people to involve in Brazil initiatives.

Challenges:

*Communications:* While communications between FCO staff in Brazil and DH staff in the UK to date have been effective, forthcoming budget cuts will mean that the frequency of regular missions will reduce. Staff in both the UK and Brazil recognise that they will need to be more creative in mechanisms for communications and establish regular video and teleconferences. Communications were strong across the UK based staff during development of the strategy, however it was felt that the communications process wasn't handled as effectively during the implementation phase with no structured communications across Whitehall and with staff in country.

*Planning and leadership:* Interviewees felt that the strategy lacked clear leadership, with lead responsibilities within DH not always clear. The GHS would benefit from stronger leadership and an increased strategic drive.

*Culture:* The GHS is very UK focussed, and misses an opportunity to engage staff in-country who have the skills and knowledge to progress the action areas. Specific parts of the strategy are difficult to translate in country and posts expressed an interest in being more involved with future developments. Staff across government and in country are sometimes unclear as to the relevance of DH involvement in international affairs. While the development of the GHS has helped this, as DH do not have an official mandate this is still somewhat problematic.

*Coordination:* As DFID no longer have an active programme in Brazil, DH staff are unclear when to involve DFID, and improved co-ordination of involvement has been identified as important. It is clear that UK government departments often have conflicting objectives, and while a lot of work has been done to build successful relationships, particularly between DH and MoH and DH and UKTI; posts have expressed difficulty in balancing these objectives. Stronger strategic partnerships between UKTI and DH have been recommended in order to take actions forward.

*Finance and systems:* While staff in Brazil are keen to take forward the actions within the GHS, budgets and sources of funding have been identified as a barrier to success. There is no allocated budget available to staff in Brazil to progress the GHS, which is a particular issue as staff often have competing commercial objectives.

## 3.5 Global Health Strategy in Russia

**UK HMG Government Departments and their Country Strategies**

The FCO Science and Innovation section is likely to be the most active part of UK government on health in Russia. The post in Moscow is new, and scoping is still taking place. There is a UK-Russia agreement on Science and Technology which was signed in 2007. It is due to be renewed in 2010 and there is scope for this to include health issues; subject to further discussion between FCO and DH. There is a large UKTI section in Russia, though health is not one of the priority sectors. DFID closed its bilateral development programmes in Russia in 2007 and there is just one program running still on Public Administrative Reform. There do not appear to be any UK government plans or strategies for Russia.

**Awareness and use of the Global Health Strategy**

Before the request for interviews there was no awareness of the GHS. However, having looked at the strategy, interviewees saw it as a useful document - as an already agreed cross government strategy covering a number of areas that touch on their work.

**Joint UK government department activities**

DFID are currently carrying out a piece of work ‘Russia as a donor’ with the World Bank. This does not specifically focus on health, but may have some impact on Russia’s development program in health. There does not appear to be any interaction with other government departments and this is project is managed from the UK. The FCO Science section assisted JSC Biopreparat in maintaining a dialogue with the UK HPA’s Centre for Emergency Preparedness and Response (CEPR) over the last 3 years. This is aimed at utilising Russian biotechnology knowledge and expertise in areas such as the creation of an anthrax vaccine. Both sides have agreed to form a joint working group for cooperation on bio-security, bio-safety, and development of innovative strategic vaccines, innovation treatment modes and therapies. FCO has funding from BIS for work on Science and Technology and could have up to £50,000 per year for Russia if a bid is successful.

**Analysis of coherence and consistency of UK work in Russia**

FCO staff in London are not aware of the NICE and HPA work in Russia, but HPA appears to be well connected to the Science section in the Embassy in Moscow. There is insufficient cross government working within Russia in the area of health currently. However there is potential for further work which could be pursued. The bilateral relationship between the UK and Russia has been difficult historically, however in the last 18 months this has began to normalise. The FCO want to find areas where UK and Russian can agree on partnerships and which fit into FCO priorities. However there is and will be a shortage of personnel to take on additional initiatives.

## 3.6 Central Findings Relevant to GHS Work in the BRICS Countries

UK government departments have varying objectives and approaches to working in BRICS countries.

**FCO** objectives appear to cut across political, developmental and commercial areas and are consistent with the aims of the GHS. The FCO hosts a number of different government department employees in posts within the BRICS countries, and also act as a platform for various areas of UK government work. The FCO does not have a health network, and health initiatives are based in various parts of an embassy ranging from the science and innovation section, political and economic section or the commercial section. Only the UK Embassy in China has hosted a DH member of staff, this post is situated within DFID. FCO GHS work in London is coordinated by a new (2007) post in the Global Economy Team. Through this post the FCO has coordinated well with DFID and DH on GHS issues. However there is no prioritisation of country work on health and little direct contact with the FCO posts regarding the content and substance of the GHS. There is also low awareness of global health issues at senior level in the FCO. A cross government network of officials involved in WHO governing body meetings has been active for some time. This forum has been used for discussing the GHS.

**Example: WHO Institutional Strategy paper**
The FCO/DFID Geneva mission is responsible for looking at health architecture, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and WHO. FCO and DFID staff in Geneva are aware of the GHS and use it regularly in their work to promote global health thinking and communicate with HMG policy on health. The office in Geneva communicates on a frequent basis with DFID and DH. China, India, South Africa and Brazil are very important partners for work on WHO and other UN organisations. The FCO office in Geneva feels they do not spend enough time linking up with these countries. When they have, for example at a recent climate change resolution, it has been very successful. There is potential to link Geneva based talks and negotiations to efforts on health at the country level. A recent outcome of the successful joint working by FCO, DFID and DH is the first joint WHO Institutional Strategy Paper.

**DFID** is responsible for the vast majority of HMG's funds spent overseas with a total health spend of £1.09bn (of which £685 million was bilateral aid in 08/09). The DFID health strategy[9], HMG HIV and AIDS strategy[10] and recent DFID nutrition strategy[11] all fit well into areas of the GHS, particularly the areas of 'better global health security' and 'stronger, fairer and safer systems to deliver health'. The DFID strategies do, however, go much further than the GHS. The DFID strategies do not refer to the GHS yet they direct much of the work that DFID undertakes overseas. Joint work to improve coherence means understanding the context and detail of other government strategies. For example HMG work on health in India, where prevalence of childhood stunting is 51%, must take into account the DFID nutrition strategy. DFID focuses its work on a select number of low-income countries, but still have programs in China, India and South Africa, where there is a large proportion of low income population and significant health issues. They were working in Brazil and Russia, but shut down their offices and programs in 2004 and 2007. Criteria for selecting priority countries include MDG status, UK long standing relationship and post conflict countries. DFID in the UK joins up to the rest of HMG on global health in a number of

[9] Department for International Development (2007). Working Together for Better Health.
[10] Department for International Development (2008). Achieving Universal Access.
[11] Department for International Development (2010). The Neglected Crisis of Under-nutrition.

ways. The most developed joint government working lead by DFID is in the area of Access to Medicines and the more recent initiative on Health and Conflict.

Since the GHS launch in September 2008 the **DH** has coordinated with various different departments. Coordination appears to be effective and has kept stakeholders informed of aspects of the GHS, but is not enough. An Officials Steering Group has been established, with representation from DH, FCO, HMT, Defra, MoD, GOScience, DFID and DECC. There has been no need up to now for the meeting of ministerial level group. In 2009/10 DH spent £119,800 on GHS related activities (including staff costs) in Brazil, India, China, and South Africa. In addition £521,000 was spent on HPA, NICE and Medicines and Healthcare products Regulatory Agency (MHRA) grants. DH International priority countries are currently determined by UKTI, however no formal prioritisation system exists for other aspects of the GHS and work is limited naturally by human resource constraints.

Intellectual Property is an issue that is recognised as having an international impact. The **IPO** has bilateral teams focusing on particular countries. Of the countries examined in this review, the IPO has close bilateral relationships with Brazil, China and India, providing technical assistance on general intellectual property work, but not specifically related to health. However they are scoping further work on health issues. The main criteria for choosing to work with a country are: importance to business, impact on international negotiations, influential players in negotiations, and who they can influence. They have a bilateral strategy and work with other government departments to ensure their priority countries are consistent with general priorities across HMG. The IPO has a budget for international work of approximately £100,000 per year. They do not have staff overseas, but rely on FCO, UKTI and DFID staff to provide information and to channel the work.

**Defra** has Sustainable Development Dialogues with the governments of India, China, Brazil, South Africa and Mexico. These were established in 2003 as a cross-Whitehall means of taking forward commitments made at the 2002 World Summit on Sustainable Development. They are government to government partnerships that consist of a high level policy dialogue and support for projects in agreed priority areas. Projects in each of these areas are funded through Defra's International Sustainable Development Fund, which is overseen by a Board which meets quarterly. in each of the Dialogue countries there are Defra funded posts based within the UK embassies or High Commissions. Health is not a priority within the Sustainable Development Dialogues.

**UKTI** have six priority countries for the healthcare sector: Brazil, China, India, Japan, Saudi Arabia (including United Arab Emirates) and the United States (South Africa is an opportunity market and Russia is not a priority at present). These are selected through discussions with members of their Strategy Board, which includes business people and trade associations in the healthcare sectors. These boards review priority markets regularly and overseas posts also feed in their views about the market in their host country. UKTI has two to three members of staff in each of their priority countries. The Strategy Board has DH representation; however DFID and are not represented. UKTI work very closely with DH International and are attempting to develop closer links to DFID. UKTI work in health care yet does appear to encompass objectives beyond the purely commercial. Objectives include the aim to learn from overseas markets and to improve the health of the people who live in that market as well as the health of people in the UK.

**HPA** is the national public health organisation for the United Kingdom, and widely acknowledged for its scientific expertise which is often sought by the public health institutes and Ministries of health in countries where DFID offers assistance. is an allied body that receives a significant amount of funding from DH. DH provided £1.9 million to HPA for global health work in 2008. The

international work of the HPA is guided by its own International Health Strategy running from 2006 – 2011. This strategy is generally consistent with the GHS, however the HPA recognises that there have been some adjustments in their

strategy in order to implement the Global Health Fund in line with the GHS. The HPA work directly with countries and currently have active initiatives in Brazil, Russia, India, China and South Africa either through the Global Health Fund or through their UK centres[12]. There is not a large degree of awareness of the role of the HPA within global health among other governmental departments.

**NICE** is also an allied body, and receives much of its funding from DH. NICE International was established in 2008, independently of the GHS. The GHS has been used as a lever for funding and has been a valuable document to drive the NICE International strategy. NICE are closely linked with other government departments, but have been working with DH, DFID and NHS Resource Centre. The FCO have assisted NICE in facilitating contacts, however further collaboration has been limited. As NICE International does not receive core funding, and activities are funded through project grants NICE is limited in terms of a strategic approach and cannot undertake long term planning in a number of countries.

**NHS Global** is currently under development, but is intended to provide a platform for direct technical assistance from the NHS to health systems in other countries. There are questions to be resolved between commercial considerations and coherence with DFID's health work on low income countries. However a framework for NHS involvement in international development has recently been published[13] and this describes good practice for successful NHS work overseas.

[12] National Institute for Biological Standards and Controls, Centre for Radiation, Chemical and Environmental Hazards, Centre for Infections, and the Centre for Emergency Preparedness and Response.

[13] Department of Health (2008). The Framework for NHS Involvement in International Development

# 4. Conclusions and Recommendations

## 4.1 Overall Conclusion

The Global Health Strategy is very ambitious, covers a wide range of areas and relies on interaction between government departments and with quasi-government organisations for its implementation. It is also fairly young (18 months) and so a high level of awareness across government departments would be optimistic.

There is a fairly good level of awareness of the GHS and most people who are aware are very positive about the potential for the GHS to bring a more coherent approach to health work. Some interviewees clearly saw how their department or organisation could contribute to the strategy in the BRICS countries. However, most activity is conducted by a small number of key individuals. Action in the reviewed countries appears to be ad hoc, opportunistic and lacks a strategic framework. Activities appear to be clustered in certain areas of the strategy for no apparent reason, and other areas have not been addressed (see appendix B). There is some evidence that UK work on health is not entirely consistent and coherent. This appears to be due to lack of strategic planning, leadership and lack of staff and resources.

However there are examples of good joint working across government departments; a degree of shared language on global health; some high level commitment to global health thinking and a few good examples of a coordinated approach. This work can be built on with better planning, clarity around leadership and allocation of staff and resources.

## 4.2 Priorities and strategies

Most of the UK government departments working overseas have prioritised their effort in a small number of focus countries. Focus countries tend to include different combinations of G20 countries and include some or all of the BRICS countries (except for DFID that focuses purely on low income countries). Though the GHS work appears to be more concentrated in a small number of countries, this is not as a result of a clear and coordinated planning process, but rather a more ‘back of the envelope’ prioritisation. A planned focus on a small number of countries would ensure a better use of existing resources and enable justification for improved resourcing.

Although some useful health related activities are taking place in the review countries, they are not part of a coherent strategic impulse specifically in line with the GHS. There are no BRICS country level plans for global health work. Some areas of the GHS are not being served well in the review countries. For example health security, trade and more effective international health organisations were underserved in most of the countries examined (see appendix B). In all of the countries except India, the trade activities seem to be exclusively focused on selling British products and services, rather than on the wider aspects of freer and fairer trade for better health. In the non-DFID countries there was no work on health systems.

Some government departments tend to be focussed on their own priorities and objectives and they do not see the bigger picture. This can lead to departments working in silos and a lack of a common approach. The links and inter-dependency between commercial, political, knowledge and developmental objectives are not always recognised.

The strategy details: “The difference we want to see in five years time...” and lists 27 outcomes that they wish to achieve. These are not used at all at country level for monitoring or even developing relevant country level indicators.

**Recommendations:**

1. **DH should lead a process with other departments to prioritise which BRICS and other middle income countries to focus work in a way that will have the highest impact for the GHS.** Cabinet Office, FCO and DFID should be involved in the process. This process should identify criteria for prioritisation, taking into account the different areas and planned outcomes of the GHS. It is likely that the countries will be middle income countries as the low income countries are already covered by DFID. It is quite possible that only 2 or 3 countries can be prioritised in the first 3 years due to resource constraints. However a step approach to inclusion of further countries and a regular review of priorities can be included in the exercise.
2. **Develop plans or strategies for Global Health work in BRICS priority countries.** This could be done within the process of a "Health Dialogue" much like the Sustainable Development Dialogues that Defra manages in its partner countries (see part 3.2.). Use the strategy areas and sub areas as a framework for analysing potential and essential areas of activity in a country. Make sure it is realistic and deliverable with available resources. Include a monitoring framework with measurable outcomes and indicators.

## 4.3 Leadership

This review has revealed a lack of high level leadership of the GHS at both UK an in the BRICS countries. This has meant that good overview and oversight is not happening across government. In the UK there is some question about whether the DH has the authority to lead on global health and to ensure that other government departments line up on the issues. Given the dominance of DFID in the international health arena and the amount of money they spend DH appears to be dwarfed by DFID's superior resources internationally. The FCO and Cabinet Office both coordinate international issues across Whitehall, but rely on functional departments to take the lead.

There is also a need for some strong coordination and leadership in the review countries. Because the GHS cuts across functional areas it is not obvious who is taking an overview and who should be responsible for strategic planning. Leadership requires a holistic approach, and not bias towards any particular departmental objectives.

**Recommendations:**

3. **DH should develop its role as functional lead and natural custodian of** the GHS in the UK for work in the BRICS. This will need a more active role for ministers and directors.
4. **The FCO and Cabinet Office should support DH in convening and coordinating** at ministerial level on a regular basis to deliver more consistent leadership across government. Early action on country prioritisation and planning is recommended. (Ministers need concrete objectives for any such meeting)
5. **The FCO or DFID should provide leadership in the priority countries.** Where there is a DH member of staff within the Embassy or DFID, there still needs to be some higher level leadership of the dialogue process and monitoring of the work.

## 4.4 Communications and Coordination

Except for some regular groups, communications between government departments on global health appears to be fairly informal. The formal channels have not become institutionalised and regular enough, except for some well functioning sub areas of the strategy. This may mean that links break down when key personnel move on. At the country level there was mostly informal coordination and communication, with very little evidence of a lasting mechanism for linking up UK government and non-government organisations. The best examples of coherence at country

level are backed up by London coordination mechanisms and joint working (e.g ITU) that have sometimes been in place for years.

For the ideas behind the GHS to become embedded fully into any of the relevant UK government departments there needs to be a better process of promotion and awareness-raising. It is unrealistic to think that this will change attitudes and culture rapidly, but a concentrated and targeted promotion and awareness raising campaign can be effective. The strategy is very large and complex. The large number of messages in it and the way they are written makes it difficult for people to digest quickly. There was low awareness of the detail of the strategy. For higher level commitment it may be necessary to also raise awareness within Parliament.

**Recommendations:**

6. The **global health officials steering group** needs to meet more regularly and become more institutionalised within government. This group should oversee other coordination mechanisms and ensure these exist for key health security areas.
7. **The lead in each priority country should set up a coordination mechanism,** that can link all UK work on global health and that can also act as an informal network between and within government and non-government organisations. Coordination at country level needs to be better to take advantage of synergies and sharing information.
8. **DH should develop some simple messages** from the global health strategy for communication throughout government - especially for the priority countries and for staff working with those countries.
9. DH ought to **investigate parliamentary awareness** of the GHS including select committees[14] and APPGs[15] to see how parliament might support a more coherent approach.
10. In medium term consider using the **health impact analysis methodology in the priority countries** for health impact analysis of policy choices in those countries. This would help to raise awareness and build capacity to think about health issues in a multi-sectoral situation.

## 4.5 Systems and resources

Staff: The planning and monitoring of work overseas are enormous tasks. DFID and FCO are well set up and resourced with staff, in country and regional teams both in the UK and overseas. DH, on the other hand, has never been designed to be an organisation that works primarily overseas. And yet the Global Health strategy work has to be functional in a certain number of key countries.

At present the DH set up is not well resourced and it is neither designed for any large amount of overseas work, nor work that needs to be coordinated in country. A tighter country focus may ensure that UK based resources can be organised to provide a fuller service to those countries – without appointing additional staff.

[14] There is a Commons Select committee on Health and one on International Development.

[15] There is an APPG for each of the countries and APPGs for health issues and particular diseases, health (national issues), overseas development and Parliamentarians for global action

The only country with a dedicated person working on global health is China, and this post has recently opened up to be more comprehensive, focussing on delivery of the partners in Health Innovation Programme. It is apparent that in the countries with a DFID presence it makes sense for DFID to take the lead on coordinating the global health activity in that country. However their focus on health is very much on the developmental aspects and they are likely to withdraw further from middle income countries in the near future. To embed the GHS effectively there needs to be improved coordination of all the health related work going on through the Embassy and OGDs, and to take a more comprehensive approach to global health. This will require DH and DFID to agree how this will work and whether a DH funded post is necessary.

Finance: Financial constraints have been a consistent theme in this review. As always international work, especially in countries with high levels of poverty and complex health issues, is a bottomless pit of financial need. Even in a middle income country engaging with governmen on health issues, may need some budget to allocate to strategic, well targeted activities. This money needs to be multi-annual so that medium term planning is possible and long term relationships, in the focus country, can be fostered. DH provided £1.9 million to the HPA Global Health Fund for work on global health in 2008. Due to delays including the Swine Flu pandemic there was some delay in allocating this funding and consequential lag in the start of some projects. While UK partners including NICE were invited to apply for funding from the HPA Global Health fund in August 2008, NICE has reported several missed opportunities due to lack of resources. It should be noted that the selection process for this funding allocation was highly competitive.

Systems: There are no incentives for HMG staff to work together consistently and coherently on global health at country level. Staff appraisal systems are designed around an individual department's objectives. Because the global health objectives have not been defined well at country level, there are no higher level global health objectives that can be translated into personal job plans. This in turn means that monitoring of action is not happening.

**Recommendations:**

11. DH **London based staff should be enabled to monitor and coordinate GHS work in priority countries (BRICS or other MICs),** to ensure a coherent and consistent approach.
12. A **cross government fund for global health in priority MICs** should be considered, that can be used for activity in the priority countries and for the international level work. This fund should be resourced from existing funds and should not require any request for new financing. This fund should be available for NICE and HPA country work as well as other implementing organisations. Decisions about allocations to activities should be decided at the country level, not at international level.
13. In the priority **countries a post in the FCO or DFID** (DH funded or shared) should be made available for coordinating the GHS work. Staff working on the GHS internationally should have the right skills and experience.

# Appendices

# Appendix A: Terms of Reference

ANNUAL REVIEW OF THE UK GOVERNMENT'S GLOBAL HEALTH STRATEGY

**"Coherence and consistency across government in global health, since September 2008. How well are we working with the 'BRICS' countries: Brazil, Russia, India, China and South Africa?"**

## 1. BACKGROUND

The UK Global Health Strategy, Health is Global, was launched in September 2008. It sets out the importance of coherence and consistency between international and domestic policies that affect global health.

The policy areas cover five main strands: security; health systems; multilateral reform; trade and evidence. Ten principles underpin the strategy.

This means creative, joined-up partnership both between UK government departments, and between the UK Government and a range of partners, including other governments.

A series of 'We Wills' describes our commitments in implementing the strategy. One is "we will commission an annual independent review of our progress (it will not look at all aspects of the strategy each year, but will select one or two key areas) and a full review in 2013."

The UK Government has long-standing relationships with BRICS countries that cuts across government departments. For example, a number of memorandae of understanding (MOUs) exist on trade and health systems. A number of reports from government departments, especially the Foreign Office (FCO), have also outlined relationships across several sectors. Recent developments since October 2008 mean they have increasing geopolitical importance.

BRICS countries face a variety of domestic challenges. Not only are they subject to global infectious diseases such as the H1N1 pandemic, but also increasing rates of cardiovascular and other non-communicable diseases, the tobacco epidemic, and the rising toll of deaths and injuries from road traffic hazards.

We also recognise that they are key global players in health. This is reflected in a number of other government documents. Recent ministerial visits, both outward and inward, also reflect their importance. For example, in September 2009 the Brazilian Health Minister did a keynote speech at Chatham House on global health and foreign policy.

Also during 2009, the Department for International Development (DFID) launched its White paper: 'Building our Common Future'. This highlights how we need to work more effectively across government to achieve broader ends with BRICS. Climate change and trade have integrated UK teams that demonstrate that such an approach can work. For example, since January 2009 a cross-government team has led UK work on climate change in India. This has meant factoring climate change adaptation into political negotiations and increasing work with the Indian authorities on Copenhagen.

The DFID White Paper also aims to increase our engagement by establishing a network of development professionals working with UK government teams in key emerging economies to address global development issues more effectively. This will be tailored to each country and may include strengthening links with research networks, private sector and civil society.

The FCO also launched a Framework for Engagement in China in 2009. This describes how the UK is working closely with China on sustainable development in Africa and on dissemination lessons to other developing countries of China's experience in reducing poverty over the last 30 years. Other key areas for increased engagement include climate, security and the international system.

The Global Health Strategy review this year will look at our work with BRICS countries.

2. SCOPE OF WORK

2.1 Purpose: to review progress since September 2008, on coherence and clarity of cross-government working with BRICS countries in global health

2.2 Scope: the consultants will work with government departments and other key stakeholders to

(a) Review current UK Government policy, strategy, objectives and ways of working with BRICS on global health issues

(b) Describe how effectively we are working across government, our non-government partners and with BRICS countries to achieve our global health goals. The focus should be on clarity of purpose and coherence and consistency of approach.

(c) Brief recommendations for how we can work better across government with respect to BRICS countries to achieve global health goals

3. PROGRAMME OUTCOMES

3.1 A draft paper and action plan and necessary iterations required to produce a final draft.

3.2 Final draft paper and action plan available by 30 April 2010.

4. THE REQUIREMENT

4.1 The consultants will use the principles and the five areas for action within the Global Health Strategy as the framework for their work.

4.2 The Contractor will liaise with the International Division at the Department of Health (DH) to identify all relevant stakeholders to be consulted during this review project. A range of activities may be undertaken to complete the work:

(a) This may include telephone, face-to-face interviews or questionnaires with key officials leading global health activities in BRICS across central government, including the devolved administrations and the arms length bodies. This will also include UK Government officials posted in these countries

(b) It may also include discussion with key representatives of the ministries of health of the BRICS countries

(c) An interim draft report must be included, preceding an expert/official level consultation.

(d) It must include a final report, agreed with the Global Health Strategy Steering Group, completed by the end of April 2010.

5. PROCESSES AND RESPONSIBILITIES

5.1 DH will:

(a) Appoint a project manager with a small support team of key officials from across government to co-ordinate the AUTHORITY's role in the review, including stakeholder engagement and communications.

(b) Establish project governance arrangements

5.2 The Contractor shall:

(a) Appoint a Contract Manager to oversee the work and liaise with / report to the DH's Project Manager

(b) Ensure adequate representation on governance arrangements as needed. Presentation at the Global Health Strategy Partners Forum on 24 March is suggested.

(c) Perform quality assurance on all aspects of the programme.

(d) Provide the Authority with timely evaluation and quality assurance information relating to the programme.

6. RACE RELATIONS

6.1 The Contractor shall in performing the Contract comply with the Authority's obligations under Section 71(1) of the Race Relations Act 1976 (as amended) as if the Contractor were a body to which the provisions of section 71(1) applies.

6.2 The Contractor shall monitor the representation of different racial groups among its employees having regard to the Authority's procedures for monitoring representation among its own employees.

7. CONTRACT MANAGEMENT AND MONITORING

7.1 This contract will be actively managed by the Department of health. :

7.2 The Contractor shall

(a) Monitor the quality of the service provision to ensure customer satisfaction in accordance with the key performance indicators outlined in the Contract, unless otherwise Approved by the Project Manager

(b) Provide a brief verbal or written report on progress to the Project Manager on a regular basis, at least weekly.

(c) Attend meetings on site to review progress and discuss the service, as required by the Project Manager.

8. SKILLS TRANSFER

8.1 Although no direct skills transfer is requested, the final recommendations and/or action plan should inform better ways of working.

9. PROJECT TIMETABLE

(a) A draft report with interim findings will be available by 23 March 2010.

(b) Presentation of the interim findings to the Global Health Strategy Partner's Forum on 24 March 2010.

(c) A final report will be available by 30 April 2010

10. EXPENSES

10.1 All Contractor expenses will be paid in accordance with Department of Health guidelines. Overnight stays will need to be authorised before the event, by the Project Manager.

# Appendix B: Table of Activities

| GHS Area for action | Brazil | Russia | India | China | South Africa |
|---|---|---|---|---|---|
| **General Health related Policy and Strategies** | | | *Prime Ministers' Initiative (2004) *UK-India Dialogue on Health (draft proposal) *DFID India Country Plan 2008 - 2015 | *DH MOU with China *DWP MOU with Chinese MoHRSS) *DFID Country Assistance Plan 2006 - 2011 *FCO The UK and China A Framework for Engagement | *UK-RSA framework for engagement (draft) *DH MOU with South Africa 2003 and 2008 *DFID Southern Africa Regional Plan 2006 - 2010 |
| **Better Global Health Security** | HPA GHF project on virology surveillance between UK and South America<br><br>HPA Training fellowships on influenza and exchange of personnel on pandemic planning | | DFID funded workshop on health and climate change in collaboration with the Indian Institute of Public Health in Hyderabad<br><br>An assessment of the state of preparedness to address the Health Impacts of climate change in India by DFID, GTZ and Indian Institute of Public Health in Hyderabad.<br><br>HPA - Indian Institute of Public Health in Hyderabad project to provide health security training in public health emergency preparedness | HPA seminars on emergency and pandemic flu preparedness. | Collaboration between RSA DH and UKDH experts on flu, facilitated by the FCO and funding by DFID to RSA to raise awareness of H1N1<br><br>DFID provision of 42m condoms before 2010 world cup<br><br>HPA cooperation on emergency preparedness for the 2010 World Cup to be held in RSA |

| | | | | | |
|---|---|---|---|---|---|
| **Stronger, fairer and safer systems to deliver health** | NICE scoping work - no funding available<br><br>NHS Blood and transfusion services technical assistance funded by the Brazilian government. | NICE work on health reform in Western Siberia | SIN and UKTI seminars to facilitate future cooperation between UK Medicines and Healthcare practice Regulatory Agency, NICE and GoI on medicines regulation.<br><br>Support to the Indian patient safety strategy (IIPH-H organised a workshop with Chief Exec of UK National Patient Safety Agency, and fellowships to UK)<br><br>DH & UK Food Standards Agency support to training in food safety | NICE work with MoH on Rural health care reform program - funded by DFID London<br><br>Sept 2010 Chinese MoH conference on Health Reform. DH to support speakers.<br><br>DFID work with China on financial support to health sector in Africa<br><br>DFID support to health sector reform in China £14m 08/09 and £11m 09/10 | Support by the UK Nursing and Midwifery Council to the new RSA Nursing and Midwifery Council<br><br>Collaboration between the RSA DH, UKDH and the Democratic Nursing Association of South Africa to support the International Council of Nurses Congress held in RSA in June 2008<br><br>DFID Rapid Response Health Fund on HIV/AIDS, including placement of adviser in RSA Dept. Health<br><br>Visit by Nigel Crisp to promote quality in service delivery |
| **More effective international health organisations** | | | | FCO bid to SPF for healthcare reimbursement project<br><br>DFID work with China on their interaction with WHO and GFATM. | Collaboration between RSA DH and NICE on quality and standards<br><br>RSA DH and NICE collaboration on quality and standards. |
| **Stronger, freer and fairer trade for better health** | | | DFID project on 'Working with the private sector to improve access to medicines for HIV/AIDS, malaria and other diseases', addressing barriers to Indian generic drugs manufacturing (from 2008)<br><br>Planned new trade policy unit (FCO, DFID, UKTI) | UKTI/DH Partners in Health Innovation Programme. Projects co-financed with UK private sector to deliver training, exchanges and joint research in four priority areas | DFID Southern Africa Regional Programme on Access to Medicines and Diagnostics |
| **Strengthening the way we develop and use evidence to improve policy and practice** | Research Councils MOU<br><br>HPA project with FIOCRUZ on vaccine development | HPA provided expertise and training to set up TB clinic<br><br>HPA project on the health risks of radiation exposure with CRCE | DFID funding for health research workshops (Research Councils UK and DFID)<br><br>MRC,UK and Indian Council of Medical | China Science and Innovation Board (DFID, FCO Science and innovation, UKTI, Research Councils UK office, Climate Change and Energy, British Council | HPA and RSA National Institute for Communicable Diseases strategic research collaboration for surveillance, epidemiology, training and laboratory re-development. |

| | | | | | |
|---|---|---|---|---|---|
| | | HPA consultancy advice and TA with Russian laboratories | Research workshop and planned collaboration on chronic disease<br><br>IIPH-H - development of training in public health management and PH skills.<br><br>HPA specialist reference and training support to a study on congenital rubella - supported by WHO | HPA work on Zoonotic diseases - joint research between universities and Mill Hill, lab to lab collaboration on Swine Flu)<br><br>DFID/FCO joint funding on innovation and development<br><br>Sep 2009 NICE contributed to the Symposium on Evidence Based Selection of Essential Medicines in Beijing organised by WHO. | |
| **Strengthening the way we develop and use evidence to improve policy and practice** | | | HPA collaboration with WHO - UK -India Colloquium on Vaccines Strategies with support from DFID<br><br>Joint workshop between the NICE and the Indian National Health Systems Resource Centre looking at UK experience of evidence based practice in health services provision. FCO/DFID. | MRC Global alliance for medical disease with Chinese institution | |

# Appendix C: List of Interviewees

| | |
|---|---|
| | **Cabinet Office** |
| Simon Strickland | Civil Contingencies Secretariat |
| Catherine Masterman | Cabinet Secretariat, European and Global Issues |
| | **Department for Environment, Food and Rural Affairs** |
| Hannah Schellander | Lead, UK-India and UK-South Africa Sustainable Development Dialogues |
| | **Department for International Development** |
| Simon Bland | United Kingdom Mission to the UN in Geneva |
| Carol Jenkins | DFID/BIS Trade Policy Unit |
| Jenny Amery | Head of Profession, Health |
| Saul Walker | Senior Access to Medicines Policy Advisor |
| Delna Ghandi | Senior Health Advisor |
| Anna Guthrie | |
| Liz Tayler | Regional Adviser, Africa |
| Qiao Huihong | |
| John Leigh | MDGs Team Leader and Human Development Adviser |
| Adrian Davis | North and East Asia |
| Billy Stewart | Senior Health and AIDS Advisor, India |
| | **Department of Health** |
| Robert Sloane | |
| Nick Banatvala | Head of DH International |
| Jay Bagaria | Public Health Advisor, Global Affairs Division |
| Helen Mc Kenna | |
| Anna Maslin | International Officer, |
| Yuyan Kong | Health Professions Leadership Team |
| Nicola Hamilton | International Programme Manager / Acting Head of DH International |
| | **Foreign and Commonwealth Office** |
| Mark Rush | Desk Officer, Global Health & International Development |
| Matthew Sholer | |
| Joanne Crabtree | India Desk Officer |
| Daniel Drake | China Bilateral/Internal Team Leader |
| Duncan Sparkes | |
| Chris Darby | Head of Science & Innovation |
| Julia Knight | Head of Russia Team |
| Deirdre Brown | |
| Ammaarah Kamish | |
| Sarah Riley | Head of South Africa Section |
| David Bacon | Science & Innovation Counsellor |
| Alan Searle | |
| | **UK Trade & Investment** |
| Ricardo Mendoca | Sector Manager - Life Sciences, Brazil |
| Jean Quinn | First Secretary / Life Science Team Leader |
| Robert Kipps | |
| Priya Varadarajan | Senior Trade and Investment Adviser, India |
| | **UK Intellectual Property Office** |
| Charlotte Heyes | Head of Trade Policy & Development |

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|---|---|
| | **Health Protection Agency** |
| Anthony Kessel | Director of Public Health Strategy |
| David Heymann | Chairman |
| | **Independent Consultants** |
| Stuart Smalley | Independent Consultant |
| | **Indian Institute of Public Health - Hyderabad** |
| Dr Marla Rao | Director |
| | **London School of Hygiene and Tropical Medicine** |
| Shah Ebrahim | Director, South Asia Network for Chronic Disease |
| | **Ministry of Health South Africa** |
| Bob Fryatt | Adviser |
| | **National Institute for Health and Clinical Excellence** |
| Kalipso Chalkidou | Director, NICE International |
| | **UK Collaborative on Development Sciences** |
| Kate O'Shea | Research and Policy Analyst |

# Appendix D: GHS Indicators

1. The FCO approach of integrating global health into foreign policy will have encouraged many more governments to do the same.
2. All government departments will have been working towards the MDGs – and we will be moving towards achieving the 2015 targets.
3. All low and middle income countries will have received support from WHO to assess their health vulnerability in relation to climate change, and many will have strategies to tackle it.
4. The UKs support for the delivery of healthcare to populations affected by conflict, both during and after conflict, will reflect the evidence of what works best, contributing to more effective healthcare delivery in these settings.
5. A greater proportion of the world's people will have safe water and sanitation.
6. Co-ordinated international efforts to increase agricultural productivity in developing countries, in an environmentally sustainable way, will have raised food security and improved nutrition for the most vulnerable.
7. There will be fewer new cases of AIDS, TB and malaria, and the UK and the rest of the world will be better prepared to face an influenza pandemic and other epidemics.
8. Over 100 countries will have banned all cluster munitions, reducing the humanitarian and health impact of conflict after it has finished.
9. Significant improvements in health systems from the resources going into combating AIDS, TB and malaria, and vaccine-preventable diseases.
10. A reduction in the global gap of 4.2 million healthcare workers. More countries will be self-sufficient, and where countries recruit from others, this will be done according to evidence-based codes of conduct.
11. A greater proportion of women with access to sexual and reproductive health services.
12. Globally, less corruption in the provision of medicines, with greater co-operation between industry, government partners and others to ensure the availability of safe, high-quality and affordable medicines.
13. Significantly more resources for tackling and preventing non-communicable diseases (such as heart disease, cancer and mental health) as well as violence and injury and road traffic accidents) in low and middle income countries.
14. Stronger strategies and actions in middle and low income countries to combat non-communicable diseases and violence and injury, with effective support from international agencies.
15. An increasing number of countries with effective patient safety programmes in place.
16. UN agencies working together more effectively and efficiently to tackle global health security threats and to eradicate poverty and diseases of poverty – for example, through having established one clear point of accountability in country.
17. International development agencies pooling a greater proportion of their money to finance directly the budgets of health sector plans in developing countries.
18. The EU reaching its collective aid target of 0.56% of gross national income by 2010, and being well on its way to reaching 0.7% by 2015.
19. Effective integration between the EU's European and global health research agendas, with better links to that of the WHO.
20. Fewer and better co-ordinated donor missions to developing countries taking place each year.
21. The NHS taking fair and ethical trade practices into consideration in its procurement of goods and services.
22. Significantly more patients accessing the treatments they needs, including for HIV.AIDS, malaria and TB.
23. A significant increase in the UK market share in the health sector in India, China and Brazil.

24. More international investment in life sciences coming into the UK.
25. The UK and other countries better able to predict and respond to emerging global health opportunities and threats,. For instance, we will have a deeper scientific understanding of the effects on health of changes in climate and water and food resources, and will use this to inform options for action.
26. Long-term investment partnerships addressing the most pressing needs for technologies to tackle the major global health issues. So, for example, more patients will have access to new, safe and effective drug treatments.
27. Enhanced, low cost access to research knowledge for researchers and policy makers in developing countries. Appropriate research products will be available to end users, for example, through electronic media.

# Appendix D: Structure of Interviews

1. Introduction & explanation of objectives
2. Can you please tell us about your role and involvement with BRICS countries?
    a. What has your involvement been with the GHS?
3. What has been your involvement in implementation of the GHS with BRICS countries? Can you give us a list of these initiatives and any relevant documents?
4. Which other UK govt departments and civil society groups are you working with on each of these initiatives?
5. We will be carrying out a second round of more detailed interviews with key stakeholders to discuss the commitments, their experience of working with other partners on these and to gain feedback on how cross governmental working could be improved. Apart from the people you have already mentioned do you have any suggestions of people we should approach for interview?
6. There are 10 principles of the GHS; are these principles something you are aware of? How do they have an influence/impact on the way you work?
7. We are specifically reviewing at the level of clarity and coherence of the GHS
    a. Can you provide any examples of clarity or coherence in implementation of the strategy?
    b. Can you identify any areas which require further improvement?
    c. Has the GHS has any impact on these ways of working in the last 18 months?
8. The GHS provides 41 'we will' commitments. We have selected 5 of these commitments to examine in detail in order to review the clarity and cohesion of cross-governmental working.
    a. Out of the initiatives that you have mentioned – are you aware of which "we will" they working towards?
    b. Do you think there are any other "we wills" which provide useful insight into cross-governmental working?
    c. How are you tracking your organisation's progress towards the commitments you are leading on?
    d. Do you have any comment/feedback on the 'we wills'?

NB: this structure may differ slightly depending on the organisation the interviewees are representing.

**Confidentiality**
Mott Macdonald will record all interviews and carry out a thematic analysis of the responses received. Quotes will not be attributed to individuals, however by nature of the purpose of this review, organisations may need to be identified. All people interviewed will receive a written transcript of the interviews immediately following the interview to ensure they are comfortable that the content will be reflected in the final report.

# Appendix E: Framework for Analysis

**The involvement of departments within the countries**

- Policy/strategy/action plans with the BRICS and for health overall. Do the departments have shared plans? If not are they at least consistent and not contradictory?
- Political interaction with BRICS countries – including UN work.
- Joint Activities/initiatives – how are they planned, implemented and monitored?
- Separate activities – are they aware of each other's activities in the countries? Do they coordinate activity?

**How they work together in country**

*Communications*

- Meetings – informal and formal
- Web/internet
- Publications
- Phone

*Culture*

- Sharing
- Non-competitive?
- Transparent/communicative
- Conflict resolution

*Leadership*

- Of policy.
- Leadership of GHS - To what extent is there leadership of the GHS? Where does it sit? How does the leadership operate?
- What would enable better leadership?
- Of 10 principles
- Initiatives
- Of the whole strategy

*Systems*

- MIS
- Finance – do the departments
- have joint budgets for activities? Or do they have separate budgets and contribute to things separately? How is this managed? Who accounts for the expenditure?
- Admin
- Other (e.g. forms, checklists etc)

*Staff*

- Skills and experience
- Responsibilities

**Principles**

How the 10 principles are applied:

- By individual departments and related organisations in how they work
- By departments as they work together

**GHS Quality and does it work?**

- How productive has it been to work together?
- Have they been able to work together on different areas of action with equal effectiveness?

**Impact of the GHS on how departments work together**

To what extent, and how, has the GHS in the countries:

- Acted as a catalyst to working together?
- Impacted on the technical content or scope of what is done?
- Influenced how priorities are set?
- Added value to individual departments and dept working together?
- Been used retrospectively rather than prospectively?
- Clarified roles and expectations?

**GHS and departmental objectives**

- How do the objectives (commercial, developmental or political, others?) of different departments differ and how has this affected their ability to work together and respond to the GHS?

**From the countries point of view**

- Are they aware of the strategy and if so what impact has it made on interactions with HMG?
- Triangulation of above e.g. is there joint working, how effective is it?

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# Appendix G: Country Specific Data

| | Population | Income per capita | Total GDP | GDP growth | Gini [16]coefficient | Expenditure on health as % of total exp[i]. | % on 1.25 per day[17] | Numbers of those living under $1.25 | MMR[18] | IMR[19] |
|---|---|---|---|---|---|---|---|---|---|---|
| **Brazil** | 191971506 | 10070 | 1612539 | 0.1 | 55 | 7.2 | 5.2 (21.5%) | 9598575 | 110 | 22.58 |
| **Russia** | 141800000 | 15630 | 1607816 | -7.9 | 37 | 10.8 | 2 (20%) | 2836000 | 28 | 10.56 |
| **India** | 1139964932 | 2960 | 1217419 | 6.1 | 37 | 3.4 | 41.6 | 474225412 | 450 | 30 |
| **China** | 1325639982 | 6020 | 4326187 | 8.7 | 42 | 9.9 | 15.9 (3%) | 210776757 | 45 | 20 |
| **South Africa** | 48687000 | 9780 | 276764 | -1.9 | 57 | 9.9 | 26 | 12658620 | 400 | 44 |
| **Total** | 2,848,063,420.00 | | 9040725 | | | | | 710,095,364 | | |

[16] Measure of inequality in terms of income – the higher the more unequal

[17] Bracketed rates in this column represent the % of people living below the country's own poverty line

[18] Maternal mortality rate per 100,000 live births

[19] Infant mortality rate per 1,000 live births