



# HEALTH AND DEVELOPMENT

A Guidance Note to Danish Development Assistance to Health

**MINISTRY OF FOREIGN AFFAIRS OF DENMARK  
DANIDA**

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## **Introduction**

Danida's health sector support aims at alleviating poverty through evidence-based health sector development work and the concept of Primary Health Care. These principles remain valid today, but much has changed since the 1990s, when the present paradigm for health sector support was defined. International health policies, the further development of the Sector Wide Approach, global aid architecture – notably the rise of the global health partnerships – and new models for health care financing and private sector involvement have had a profound influence on health systems in poor countries. The advent of AIDS, the epidemiological transition, and rapid urbanisation call for a fresh look at what is important in health sector development. The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action set new standards for development assistance and change the way donors and their partner countries co-operate, and the Millennium Declaration with its three health related goals identifies important targets for 2015.

The objective of this guidance note is to help improve the quality of Danish health sector support and research for health. It is intended as a tool to improve Danida's dialogue with other donors, international institutions and the increasingly important policy dialogue between Danida and the partner countries. The note provides a framework within which partner countries, programme planners, researchers and implementers of Danish development assistance to health can elaborate sector programme support, health and research projects and multilateral development assistance. It provides general direction and defines major priorities for such assistance but it emphasizes that the dialogue with partner countries is the key instrument in tailoring assistance to national needs.

The note has three main chapters; the first describes the present global health situation, the second outlines likely trends in health and disease in the coming years, and the third provides an overview of how Danida intends to react to the challenges. An annex provides details on Danish support to research for health.

The target group for the note comprises Ministry of Foreign Affairs staff in general, Danida health advisers, embassy staff, partner country health planners, NGOs, researchers and consultants working with Danida-supported health programmes.

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## Abbreviations

|           |  |
|-----------|--|
| CSGH      | Copenhagen School of Global Health   |
| COHRED    | Council on Health Research for Development   |
| CSO       | Civil Society Organizations  |
| DAC       | Development Assistance Committee   |
| DALYs     | Disability-Adjusted-Life Years   |
| Danida    | Danish International Development Assistance  |
| DFC       | Danida Fellowship Centre   |
| DKK       | Danish Kroner. 1USD = approx. 6 DKK in March 2009  |
| GAVI      | Global Alliance on Vaccines and Immunization   |
| GBD       | Global Burden of Disease   |
| GFATM     | Global Fund against AIDS, TB and Malaria   |
| GHP       | Global Health Partnership  |
| DBL- LIFE | Centre for Health Research and Development   |
| DFC       | Danish Fellowship Center   |
| ENRECA    | Enhancement of Research Capacity in Developing Countries, former Danish research programme |
| ESSENCE   | Enhancing Support for Strengthening the Effectiveness of National Capacity Effort          |
| FFU       | Consultative Research Committee for Development Research                                   |
| GFHR      | Global Forum for Health Research   |
| HSPS      | Health Sector Programme Support  |
| ICPD      | International Conference on Population & Development                                       |
| IAVI      | International Aids Vaccine Initiative  |
| IPM       | International Partnership for Microbicides   |
| IPPF      | International Planned Parenthood Federation  |
| IWCH      | International Women and Children's Health  |
| KM        | Knowledge Management   |
| LEB       | Life expectancy at birth   |
| MDGs      | Millennium Development Goals   |
| MMV       | Medicines for Malaria Venture  |
| NHRS      | National Health Research System  |
| NGO       | Non Governmental Organisation  |
| OECD      | Organisation for Economic Cooperation and Development                                      |
| PHC       | Primary Health Care  |
| PPP       | Public-Private Partnership   |
| SARS      | Severe Acute Respiratory Syndrome  |
| SIDA      | Swedish International Development Cooperation Agency                                       |
| SRC       | Strategic Research Council   |
| SRHR      | Sexual Reproductive Health and Rights  |
| SWAp      | Sector-wide approach   |
| TAS       | Technical Advisory Services  |
| TDR       | UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Disease        |
| UNAIDS    | United Nations Joint Programme on HIV/AIDS   |
| UNDP      | United Nations Development Programme   |
| UNGASS    | UN General Assembly Special Session  |
| UNFPA     | United Nations Population Fund   |
| UNICEF    | United Nations Children's Fund   |
| UNIFEM    | United Nations Development Fund for Women  |
| WB        | World Bank   |
| WHO       | World Health Organization  |

## Glossary

**Accountability:** To ensure timely, clear and comprehensive information on development assistance, processes, and decisions (especially decisions on unsuccessful applications) to partner countries.

**Alignment:** To use country systems to the maximum extent possible. Where use of country systems is not feasible, to establish safeguards and measures in ways that strengthens rather than undermines country systems and procedures.

**Capacity building:** Capacity building is the process of assisting an individual or group to identify and address issues and gain insights, knowledge and experience needed to solve problems and implement change. Capacity building can be facilitated through the provision of technical support activities, including coaching, training, specific technical assistance and resource networking.

**DALY:** Disability Adjusted Life Years. DALYs express the total disease burden resulting from morbidity, mortality and disability. The DALY estimates years of life lost to premature death and years lived with a disability of specific severity and duration. One DALY thus corresponds to one lost year of healthy life.

**ENRECA:** A Danish bilateral programme for Enhancement of Research Capacity in Developing Countries (ENRECA) was created in 1988. Its objective was to strengthen research capacity building in developing countries. Since 2009 capacity building has been integrated in all Danida funded research programmes.

**Governance in research:** Research governance is a framework through which governments and institutions are accountable for the scientific quality, ethical acceptability and safety of the research they sponsor, permit or undertake<sup>1</sup>.

**Harmonization:** To implement, where feasible, simplified and common arrangements at country level for planning, funding, disbursement, monitoring, evaluating and reporting to government on donor-funded activities and resource flows.

**Knowledge Management:** Knowledge management is a set of principles, tools and practices that enable people to create knowledge, and to share, translate and apply what they know to create value and improve effectiveness<sup>2</sup>.

**Know-do gap:** The gap between what is known and what is done.

**Neglected diseases:** A group of tropical disorders, which are especially endemic in poor populations in developing regions of Africa, Asia and the Americas. Together they cause between 500.000 and 1 million deaths annually and include diseases such as Chagas disease, Schistosomiasis, Trachoma, Dengue fever, Leishmaniasis, Lymphatic filariasis and Onchocerciasis.

**Public health:** Collective action for sustained population-wide health improvement<sup>3</sup>.

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<sup>1</sup> Michael K Walsh et al (2005) The Research Enterprise: Improving the governance of health research, The Medical Journal of Australia, 182 (9): 468-471.

<sup>2</sup> Web source accessed 20 November 2008: <http://www.who.int/kms/en/>

**SBS:** OECD/DAC defines budget support as *non-earmarked donor funds being channelled to the partner government's national treasury, and thereafter managed in accordance with the partner's own budgetary procedures.*<sup>4</sup> This definition also covers sector budget support. Earmarked support therefore is not defined as (sector) budget support, even if the funds are managed based on the country's own procedures.

Budget support, however, is more than a mere transfer of funds. It is a package that consists of several elements - and it is the combination of these elements which is the key to achieving the results of budget support:

- The funds
- Policy dialogue - continuous - on critical development issues
- Conditions regarding policies, reforms and budget allocations
- Monitoring of performance and progress (including in poverty reduction)
- And, often, support for capacity development.

**10/90 Gap:** The recognition that only about 10% of the world's resources for health research are focused on diseases and health problems affecting 90% of the world's population<sup>5</sup>.

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<sup>3</sup> Robert Beaglehole et al. (2004) Public health in the new era: improving health through collective Action, *The Lancet*, Volume 363, Issue 9426, Pages 2084 - 2086, 19 June 2004.

<sup>4</sup> OECD/DAC: Harmonising Donor Practices for Effective Aid Delivery, Vol.2: Budget Support, Sector Wide Approaches and Capacity Development in Public Financial Management. DAC Guidelines and Reference Series, Paris 2006. As amended by the Working Party on Statistics in 2008.

<sup>5</sup> Web source accessed 20 November: improving health through collective Action, *The Lancet*, Volume 363, Issue 9426, Pages 2084 - 2086, 19 June 2004.

<sup>5</sup> OECD/DAC: Harmonising Donor Practices for Effective Aid Delivery, Vol.2: Budget Support, Sector Wide Approaches and Capacity Development in Public Financial Management. DAC Guidelines and Reference Series, Paris 2006. As amended by the Working Party on Statistics in 2008.

<sup>5</sup> Web source accessed 20 November:  
2008http://www.globalforumhealth.org/Site/003\_\_The%2010%2090%20gap/001\_\_Now.php

# Chapter 1. The Global Health Context

## 1.1 The Global Health Agreements

The right to health is a fundamental principle for development assistance. This principle is enshrined in the Human Rights charter<sup>6</sup> and although funding for health has increased in recent years, it is yet to have a profound influence on the health of people living in the least developed countries. Poor health is a cause of poverty in these countries and poverty is a cause of ill health - a vicious cycle.

Development assistance to health has a long history dating back to the middle of the 20<sup>th</sup> century. A milestone was reached in 1978 when all countries of the world met in Alma Ata to develop a strategy to tackle the problems in basic health care of the poorest countries. It was an opportunity to reaffirm the definition of health, which had been formulated in the charter of the World Health Organization (WHO) in 1946. During the Alma Ata conference the Primary Health Care (PHC) approach was endorsed in a declaration, which remains valid to this day (see Box 1).

Among the fundamental principles of the PHC approach are:

- *Equitable distribution*

Health services must be shared equally by all people irrespective of their ability to pay and all (rich or poor, urban or rural) must have access to health services.

- *Community participation*

There must be a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of health services.

- *Universal coverage*

### BOX 1

#### **WHO Constitution (1946):**

##### **Definition of health**

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

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

Source:

[http://www.who.int/governance/eb/who\\_constituti\\_on\\_en.pdf](http://www.who.int/governance/eb/who_constituti_on_en.pdf)

#### **Alma Ata (1978):**

##### **Primary Health Care Declaration**

“Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination”.

Source:

[http://www.who.int/hpr/NPH/docs/declaration\\_al\\_maata.pdf](http://www.who.int/hpr/NPH/docs/declaration_al_maata.pdf).

<sup>6</sup> United Nations (1948) *Universal Declaration of Human Rights*.  
<http://www.un.org/Overview/rights.html>

Universal coverage is the access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.

- *Intersectoral coordination*

Primary health care involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, water and sanitation, food, industry, education, housing, public works, and communication.

The Alma Ata Declaration emphasizes that health is a multisectoral issue and that improvements in health cannot be achieved through the efforts of the health sector alone. It is reliant on a comprehensive approach involving multiple actors.

The challenges that the PHC approach has encountered since the early years include constraints in mobilizing other sectors for health, prioritization of vertical programmes over integrated strategies and difficulties in organizing well-functioning referral systems.

At the turn of the millennium new emphasis was directed towards health improvements in low-income countries. The Millennium Development Goals (MDGs) were endorsed by the United Nations General Assembly in 2000 and out of the eight goals, three are directly related to health (Goals 4, 5, and 6, cf. Box 2). Health is also among the preconditions for the achievement of Goal 1: The eradication of extreme poverty and hunger.

The Millennium Declaration sets global targets for each MDG to be achieved by year 2015. Indicators to be monitored by all countries, so that progress can be assessed, have been defined.

The latest review of progress towards these targets, however, shows that there is a long way to go and that, in all probability, the targets will not be achieved globally due to limited progress in the poorest countries of the world, especially those in Africa<sup>7</sup>.

#### **BOX 2**

##### **The 8 Millennium Development Goals**

1. Eradicate Extreme Poverty and Hunger
2. Achieve Universal Primary Education
3. Promote Gender Equality and Empower Women
4. Reduce Child Mortality
5. Improve Maternal Health
6. Combat HIV/AIDS, Malaria and other Diseases
7. Ensure Environmental Sustainability
8. Develop a Global Partnership for Development

*Source: [www.un.org/millenniumgoals](http://www.un.org/millenniumgoals)*

## *1.2 The Global Health Situation*

The latest assessment of the Global Burden of Disease (GBD)<sup>8</sup> shows that major improvements have taken place over the past decades in areas such as child health, and

<sup>7</sup> United Nations (2008) *The Millennium Goals Development Report 2008*, United Nations.

<sup>8</sup> World Health Organisation (2004) *The global burden of disease: 2004 update*, Department of Health Statistics and Informatics in the Information, Evidence and Research Cluster of WHO.

that the world is experiencing an epidemiological shift also in third world countries where non-communicable diseases gradually will assume the larger burden of ill-health, while at the same time formidable obstacles remain in the area of communicable diseases. Little inroad has been made in the fight against HIV/AIDS in Africa. Some countries have experienced notable successes in fighting malaria, but malaria and TB, increasingly drug resistant, remain among the infectious diseases responsible for most deaths. Furthermore, long-standing global threats to health security remain and new ones have arisen such as SARS, avian influenza and health impact of climate change.

Total funding of health systems and health services in low-income countries has improved significantly in recent years following the recognition that improvements in health is a prerequisite for poverty alleviation as highlighted by landmark reports from World Bank in 1993<sup>9</sup> and the Commission on Macroeconomics and Health<sup>10</sup>. Development assistance to health has increased from USD 2.5 bn to USD 13 bn from 1990 to 2005<sup>11</sup>. The proportion of development assistance that is allocated to health has increased from 4.6% to 13% during the same period. This, however, masks great disparities between different health areas. For example, HIV/AIDS very often absorbs a disproportionately large share of the total; some countries receive more support for HIV/AIDS than for all other diseases combined. Global funding for HIV/AIDS has increased six fold since 2001 and the estimated total annual resources available for HIV in 2007 was 10 billion USD<sup>12</sup>.

### *1.3 The Global Health Policies and Architecture*

Global health policies and strategies are usually defined at large global conferences or at the WHO World Health Assembly where representatives of all governments of the world pass binding resolutions. The UN's Millennium Declaration setting out the Millennium Development Goals is one of the most significant agreements in this millennium.

Among other significant policies endorsed in this way is the UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001, where member states unanimously endorsed a series of time-bound targets in the Declaration of Commitment on HIV/AIDS<sup>13</sup>. In 2006 UN member states restated this commitment as well as the move towards universal access to HIV prevention, treatment, care and support by 2010. Likewise, the International Conference on Population and Development (ICPD and ICPD+10) resolutions are important policy setting landmarks. Among key priorities are: Sexual and reproductive health and rights (SRHR) in the context of health sector reform, sexually transmitted infections (STIs) including HIV/AIDS as an integral component of sexual and reproductive health programmes, and the reduction of maternal mortality.

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<sup>9</sup> World Bank (1993) *World development Report 1993: Investing in Health, Volume 1*, World Bank.

<sup>10</sup> Commission on Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*, WHO.

<sup>11</sup> World Health Organisation (2007) *Aid Effectiveness and Health. Making Health Systems Work, Working Paper No. 9*, 2 p, Department for Health Policy, Development and Services Health Systems and Services, WHO.

<sup>12</sup> UNAIDS (2008) *2008 Report on the global AIDS epidemic*, UNAIDS.

<sup>13</sup> United Nations (2001) *Declaration of Commitment on HIV/AIDS. "Global Crisis – Global Action"* <http://www.un.org/ga/aids/docs/aress262.pdf>

Among the very significant decisions adopted through the WHO system is the Convention against Tobacco<sup>14</sup> and the new International Health Regulation<sup>15</sup>.

The traditional partners in development assistance for health consist of a number of bilateral donors grouped under the Development Assistance Committee (DAC) of OECD, UN organizations (WHO, UNICEF, UNFPA and UNAIDS), the EU, development banks (World Bank, Asian Development Bank, African Development Bank) and a plethora of public-private partnerships (PPP), international non-governmental organizations and civil society organizations (CSOs) as well as a number of other stakeholders.

In recent years the international architecture for development assistance to health has changed dramatically with the increased recognition of the importance of health and funding for health. The number of government donors is rising as new east European nations and richer developing nations such as India, China, Brazil and South Africa are joining the group of donor countries.

There has been a huge proliferation of global health initiatives and today more than 200 technical partnerships and funds are in existence, each targeting specific health issues. The increase in the number of Global Health Partnerships (GHP) accentuates the old divide between those who focus on integrated health services (PHC) and those who call for disease-specific (vertical) health programs.

The major global health initiatives include the Global Alliance on Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, TB and Malaria (GFATM) and the President's Emergency Plan for AIDS Relief (PEPFAR). Philanthropic institutions and individuals, notably the Bill and Melinda Gates Foundation and the Clinton Foundation, are also making large contributions to health. All this has led to marked increases in the number of organizations getting involved and – as a consequence – to serious problems for developing country governments in harmonizing development assistance.

Developing countries with weak administrative systems are overwhelmed by the number of new actors, their different modalities, their off-budget support, their draining of the best staff, their topping-up practices of salaries to government officers, their individual reporting systems and their many technical missions. They are particularly vulnerable to poor overall coordination, short-term financing and assistance tied to the priorities of the individual donors.

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<sup>14</sup> World Health Organization (2003) *WHO Framework Convention on Tobacco Control*, WHO. [http://www.who.int/tobacco/framework/WHO\\_FCTC\\_english.pdf](http://www.who.int/tobacco/framework/WHO_FCTC_english.pdf)

<sup>15</sup> World Health Organization (2005) *Revision of the International Health Regulations*, <http://www.who.int/csr/ihr/WHA58-en.pdf>

Recognizing these challenges, donors committed themselves to working more effectively together in the Paris Declaration on Aid Effectiveness in 2005. The Declaration laid down six principles for this coordination including baselines for monitoring progress. Progress in this respect has, however, been uneven with some partners providing increasingly well aligned and harmonized assistance while others prefer to pursue their own priorities with little reference to the priorities, plans and processes of recipient countries.

### **BOX 3**

#### **Paris Declaration**

We reaffirm the commitments made at Rome to harmonise and align aid delivery. We are encouraged that many donors and partner countries are making aid effectiveness a high priority, and we reaffirm our commitment to accelerate progress in implementation, especially in the following areas:

- i. Strengthening partner countries' national development strategies and associated operational frameworks (e.g., planning, budget, and performance assessment frameworks).
- ii. Increasing alignment of aid with partner countries' priorities, systems and procedures and helping to strengthen their capacities.
- iii. Enhancing donors' and partner countries' respective accountability to their citizens and parliaments for their development policies, strategies and performance.
- iv. Eliminating duplication of efforts and rationalising donor activities to make them as cost-effective as possible.
- v. Reforming and simplifying donor policies and procedures to encourage collaborative behaviour and progressive alignment with partner countries' priorities, systems and procedures.
- vi. Defining measures and standards of performance and accountability of partner country systems in public financial management, procurement, fiduciary safeguards and environmental assessments, in line with broadly accepted good practices and their quick and widespread application.

*Source: <http://www.oecd.org/dataoecd/11/41/34428351.pdf>*

## Chapter 2. Health and Disease Trends in Developing countries

### 2.1 Determinants of Health

Good health is closely linked to a number of social, economic and environmental determinants and analyses of health have in recent years included such determinants.

The greatest share of health problems is attributable to the social conditions in which people are born, grow, live, work and age. Inequity in health is a consequence of social inequities and related to the differences in living conditions and lifestyles of families and individuals, such as smoking and alcohol abuse. People who are poor, vulnerable, and socially disadvantaged have less access to health resources. They get sicker and die younger than more privileged people. Today, health equity gaps are growing, despite progress in global wealth and technology.

WHO established the Commission on Social Determinants in Health in 2005. In the Commission report the important characteristics of ill-health have been identified and measures to tackle them have been outlined. The main recommendations are shown in Box 4.

The health sector cannot tackle these challenges alone. An intersectoral approach is needed to effectively address the many determinants of ill health. Investments are needed to improve areas like education, water and sanitation, nutrition, social services, gender inequality and environment. For instance, the illiteracy of women is directly related to child mortality.

Ministries of Health cannot change such conditions on their own, but they can assume leadership in promoting actions across government departments and the civil society at large. An area where intersectoral collaboration can yield quick gains is water and sanitation, where improvements could lead to marked reductions in diarrhoeal diseases and worm infestations. Education, transport and labour market policies are other key sectors under government control that can be shaped to promote good health.

#### **BOX 4**

#### **Overarching recommendations and key areas for action of the WHO Commission on Social Determinants in Health:**

1. Improve the conditions of daily life – the circumstances in which people are born, grow, etc. Key areas for action include: child development and education for boys and girls; healthy places (social and physical environment); fair employment and decent work; social protection across the life; universal health care.
2. Tackle the unequal distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally. Key areas for action include: health equity in all policies, systems and programmes; fair financing; market responsibility; gender equity; political empowerment; good global governance.
3. Measure the problem, evaluate the action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the SDH.

*Source: World Health Organization (2008): Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the commission on social determinants of health, WHO.*

The World Health Report 2002<sup>16</sup> identified the top ten risks globally in terms of the burden of disease they cause. These are underweight, unsafe sex, high blood pressure, tobacco consumption, alcohol consumption, unsafe water, poor sanitation and hygiene, iron deficiency, indoor smoke from solid fuels, and high cholesterol and obesity. Addressing these risk factors more vigorously could result in very significant health gains at a moderate cost. The report suggests that an extra decade of healthy life could be within the grasp of many of the world's poorest countries.

In addition, there are growing collective risks of disease outbreaks, epidemics, industrial accidents, natural disasters, and other health emergencies that can rapidly become threats to global public health security.

Risk factors for chronic diseases caused by poor diet, alcohol and tobacco abuse are modifiable and related to individual lifestyles. These health-compromising behaviours are disproportionately concentrated in socially disadvantaged groups, both in developed and developing countries. Effective strategies to address these challenges must tackle the underlying social conditions that make people more susceptible and disadvantaged. Gender inequality is also an important factor for ill health, especially of women and girls in developing countries.

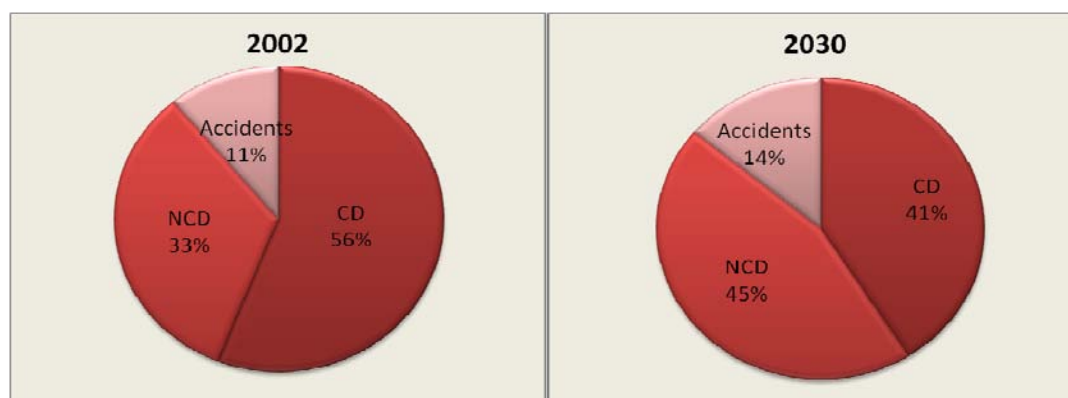
Tobacco consumption is one of the world's leading causes of death, responsible for about 5 mn deaths in 2003 mainly in low-income countries. This figure will double in 20 years unless effective interventions are instituted soon. The WHO Framework Convention on Tobacco Control constitutes a promising move towards this end.

Communicable diseases still dominate the disease burden in low-income countries. Lower respiratory tract infections, diarrhoeal diseases, HIV/AIDS, tuberculosis, and malaria are among the top ten causes of death globally. The burden of disease is especially daunting in developing countries where the burden of chronic illnesses is growing rapidly on top of the burden of unresolved infectious diseases. This change is commonly referred to as the epidemiological transition or the double burden of disease. Figure 1 shows the projected transition in low-income countries from 2002 to 2030.

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<sup>16</sup> World Health Organization (2002) *World Health Report 2002: Reducing Risks, Promoting Healthy Life*, WHO.

**Figure 1: The proportional distribution of disability adjusted life years (DALY) contributable to infectious diseases (CD) and non-communicable diseases (NCD) for low-income countries**



Source: Dan W. Meyrowitsch and Ib C. Bygbjerg (2007) *Global burden of disease – a race against time*, Danish Medical Journal No.1 February 2007 Vol. 54 Pages 32-4.

Urbanization, climate change and migration are new and very rapidly growing factors that can influence health more profoundly in the future. Urban crowding cause ill health since people moving to the cities tend to live in poor housing with inadequate water and sanitation facilities, see table 1. Explosive urbanisation affects large numbers of people and turn cities into humanitarian disaster areas. Forced migration, be it climate or conflict related, is also closely linked to these issues.

Climate change and increasingly adverse weather conditions may have several impacts on health, among which are the consequences of flooding in urban slums. Effects on harvest by drought and changes in the pattern of rain will have nutritional implications.

**Table 1: Infant and under-five mortality in Kenya and Denmark**

| Location                       | Infant Mortality Rate (IMR) | Under-five Mortality Rate (U5M) |
|--------------------------------|-----------------------------|---------------------------------|
| Denmark*                       | 4                           | 4                               |
| Kenya, national                | 76                          | 113                             |
| Rural                          | 79                          | 117                             |
| Urban                          | 61                          | 94                              |
| Nairobi**                      | 39                          | 62                              |
| High-income areas (estimate)   | Likely < 10                 | Likely <15                      |
| Informal settlements (average) | 91                          | 151                             |
| Kibera slum                    | 106                         | 187                             |
| Embakasi slum                  | 164                         | 254                             |

IMR = Deaths per 1000 new born; U5M = Deaths per 1000 children.

\*Denmark: Data is from 2003, web sources accessed 9<sup>th</sup> of February 2009: <http://www.statistikbanken.dk/> & [http://globalis.gvu.unu.edu/indicator\\_detail.cfm?IndicatorID=26&Country=DK](http://globalis.gvu.unu.edu/indicator_detail.cfm?IndicatorID=26&Country=DK)

Data from Kenya is from the DHS survey, 2003, Webservice accessed 5<sup>th</sup> of February, 2009: <http://www.statcompiler.com/tablebuilderController.cfm?userid=259575&usertabid=281643>

\*\* Data from Nairobi is from 2000: African Population and Health Research Center (APHRC) (2002) *Population and Health Dynamics in Nairobi's Informal Settlements*. Nairobi: African Population and Health Research Center.

Rapid population growth impedes economic and social growth especially in the poorest countries. Causes of high fertility rates are complex and decreases in fertility only affect

population growth with decades of delay. Decreased fertility is commonly associated with a combination of economic growth, improved social security, equity and access to health services. The major challenge is to reduce fertility through the promotion of sexual and reproductive health and rights. Family planning is an essential strategy in this context. Lower fertility will reduce infant and maternal death and morbidity, as well as advance environmental sustainability and help reduce poverty<sup>17</sup>. In turn it will spur improvements in major health indicators.

The long-term health effects of armed conflicts and chronic crises and other disasters such as extreme weather conditions, epidemics, crop failures, and famines need special efforts to secure health in the affected populations.

## *2.2 Trends in health – what the future holds from now to 2030*

Over the past 50 years average life expectancy at birth has increased globally by almost 20 years from 46.5 years to 64.3 years (66.0 years for women and 63.2 years for men) and relatively more so in developing than in developed countries. However, due to increasing inequity between and within many countries a large life expectancy gap still exists and is increasing between the poorest and richest population groups. Increases in adult survival have been drastically reversed in parts of sub-Saharan Africa, where mortality rates exceed those of 30 years ago, in particular due to the AIDS epidemic.

It has been estimated that the top ten disorders, measured in Disability Adjusted Life Years (DALYs), by 2030 include a mix of non-communicable and communicable diseases as shown in Annex 1. The epidemiological transition in low-income countries will significantly change the future disease pattern. Two remarkable changes draw the attention: unipolar major depression and traffic injuries will move upwards to become number one and three on the top ten list.

Data on progress in relation to MDG health goals show that in 2004 the proportion of undernourished children/people has increased in 11 of the 43 countries in sub-Saharan Africa, where data was available. Unless progress is accelerated, sub-Saharan Africa will not reach the MDGs 4, 5, and 6<sup>18</sup>.

It is estimated that at least 30% of the disease burden in developing countries is the result of less than five of the major risks to health outlined above. Malnutrition alone accounts for over three million childhood deaths a year in developing countries and is a contributing factor of up to 50% of childhood death<sup>19</sup>, cf. Fig.2.

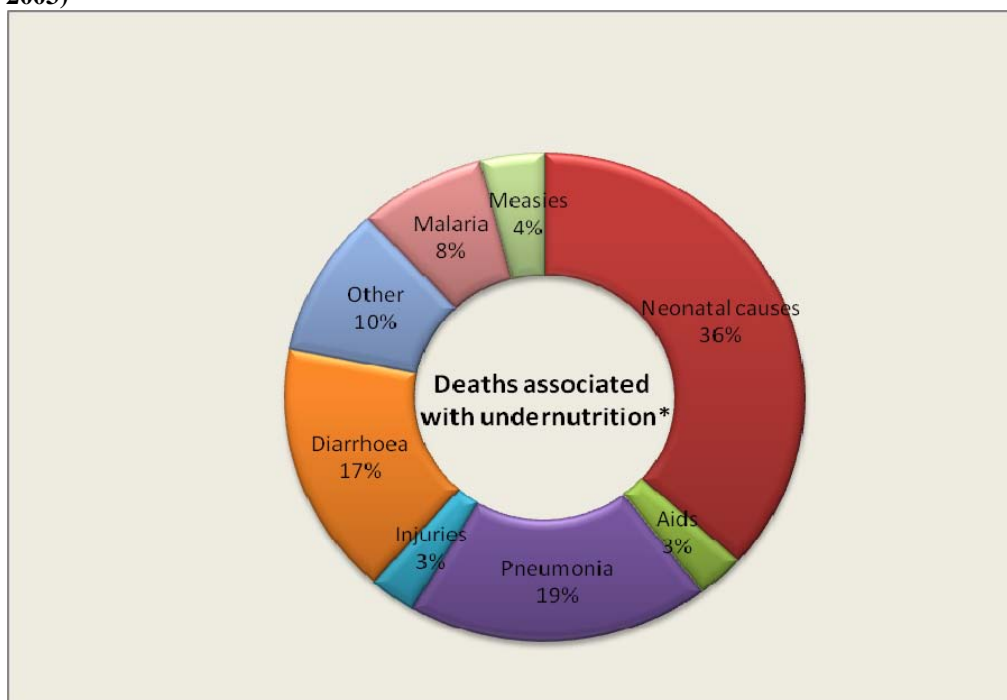
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<sup>17</sup> United Nations Population Fund (2007) *UNFPA Annual Report 2007*, UNFPA.

<sup>18</sup> United Nations (2008) *Millennium Development Goals Report 2008*, UN.

<sup>19</sup> United Nations System Standing Committee on Nutrition (SCN) (2004) *5th Report on the World Nutrition Situation: Nutrition for Improved Development Outcomes*, UN.

**Figure 2: Major Causes of Child Mortality. Global distribution of under-five deaths by cause (2002-2003)**



\*Undernutrition has been estimated to be an underlying cause in up to half of all under-five deaths.

Source: [http://www.unicef.org/progressforchildren/2007n6/index\\_41802.htm](http://www.unicef.org/progressforchildren/2007n6/index_41802.htm)

In total about 10 mn children die annually before they reach the age of five, and approximately half of these deaths occur in Sub-Saharan Africa. Easily curable diseases like pneumonia and diarrhoea cause nearly all child deaths. However, only one out of four caregivers knows the symptoms of pneumonia, and only one out of three children suffering from diarrhoea receives the appropriate treatment<sup>20</sup>. More than one-third of the under-five child deaths occur during the neonatal period (i.e. the first 28 days of life after birth) and while under-five mortality has declined, neonatal mortality has remained constant during the last decade. Most of these deaths are preventable. It has been estimated that scaling-up a minimum package of health interventions could reduce infant mortality by 30% and maternal mortality by 15% at a cost of USD 800 per life saved.

Progress on the MDG goal 5 on maternal mortality is particularly disappointing, reverse trends being observed in many low-income countries. Annex 2 shows the maternal mortality by region in 1990 and 2005. The mortality in Africa is more than double the rate in Asia.

HIV/AIDS is today one of the major causes of morbidity and mortality in low-income countries. It is estimated that 2.1 mn deaths occurred in 2007, 2.5 mn people became newly infected and that 33.2 mn people were living with HIV<sup>21</sup>.

Annex 3 shows major trends in prevalence of HIV infection among adults 1990 – 2007. Many countries are far from achieving universal access to HIV/AIDS services.

<sup>20</sup> United Nations Children's Fund (2008) *The State of the World's Children 2008*, UNICEF.

<sup>21</sup> United Nations General Assembly, 62nd session, agenda item 4 (2008) *Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS. Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals*, Report of the Secretary General, UN.

Obstacles include weak health systems, a critical shortage of human resources and lack of sustainable funding. In recent years there has been a large influx - though inadequate - in aid for HIV/AIDS that is larger in some countries than the entire government health budget. Other public health needs are neglected due to the amount of financial and human resources directed towards this single disease.

### 2.3 National health systems. Challenges and opportunities

At the same time as financing for health, especially HIV/AIDS-related, is improving, major challenges to scaling-up effective interventions are encountered. These include weak national health systems. A health system consists of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. It includes efforts to influence determinants of health as well as more direct health-improving activities. A strong health system has six elements (Box 5): health services, health workforce, health information, medical products and technologies, health financing, and leadership and governance. All these elements must function well to ensure a quality health service that reaches the entire population with promotive, preventive, curative and rehabilitative health services. For many years much development assistance to health has focused on single disease programmes and single interventions. There is now a growing recognition that such programmes encounter bottlenecks that are the result of malfunctioning health systems. The international community must support an agenda where full synergy is ensured between efforts to strengthen health systems based on an invigorated PHC approach and single disease control programmes. This entails universal access and coverage based on needs, health equity as part of social justice, community participation, and intersectoral approaches, the pillars of PHC. A strong and sustainable health system is fundamental to achieve synergy between these approaches. Among the major problems currently encountered is a global human workforce crisis where the staff needed to enhance health system performance is grossly lacking due to low output of health training institutions, rapid attrition of staff and migration to better paid jobs in and outside the country, notably on large HIV/AIDS programmes. There are 2.3 health workers per 1.000 population in Africa

#### **BOX 5**

##### **The six building blocks of a health system**

1. Good health services are those which deliver effective, safe, quality personal and non-personal health interventions.
2. A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances
3. A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
4. A well-functioning health system ensures equitable access to and use of essential medical products, vaccines and technologies of assured quality.
5. A good health financing system raises adequate funds for health, and protects from financial catastrophe or impoverishment. It provides incentives for providers and users to be efficient.
6. Leadership and governance involves ensuring strategic policy frameworks, effective oversight, coalition-building, regulation, attention to system-design and accountability.

*Source: WHO (2007) Everybody's Business: Strengthening Health Systems to Improve Health Outcomes. WHO'S Framework for Action, WHO. (Slightly abbreviated)*

compared to 33.3 in Denmark. WHO has identified a workforce density threshold below which high coverage of essential interventions, including those necessary to meet the health-related MDGs is very unlikely. Based on recent estimates, there are 57 countries with critical shortages equivalent to a total deficit of 2.4 million doctors, nurses and midwives<sup>22</sup>. Incentives are needed to retain health staff in these countries. At the same time efforts to introduce guidelines for the free movement of health workers need to be supported.

Other strong challenges are posed by inadequate health information systems, lack of financial resources and the stewardship required to implement pro-equity health policies and efficient management. Government budgets in low-income countries typically allocate 5 - 15% of their national budgets to health (see Annex 4), a significant proportion of which is from external sources. Furthermore, WHO has estimated that 50% of the external funding for health is provided outside the government budget in many African countries. However, most health care financing is out-of-pocket expenditure, which can be ill afforded, and catastrophic health events often create new hopelessly poor families.

Comprehensive national health plans now guide the implementation of health services in most developing countries as integrated components of national development plans. The plans set out major national priorities and related funding. However, priority setting and funding can be skewed towards interests of specific partners thereby distorting investments in health. This is particularly true when funding is provided off-budget or off-plan.

In recognition of this problem the Paris Declaration emphasizes the need for partners to respect national plans and to support coordination efforts towards the implementation of the plans. The challenge for the national governments is to take full ownership of national plans and enforce the coordination of partner assistance.

The leadership and governance of health systems is one of the most complex of the essential health systems elements. It is a challenge for governments to provide vision and direction for the entire health system and oversee implementation of established health policies. Key roles for national governments in this respect include development of health sector policies and frameworks, design and implementation of regulatory frameworks, supporting greater accountability, generating and interpreting information, working with the private for-profit and not-for-profit sectors and with external partners. A daunting challenge is to address health in an intersectoral fashion ensuring that health aspects are considered in all relevant sectors.

Included in health systems, but not given so much attention, are the 40-50% of health care services that are provided by private institutions (both profit and not-for-profit) including faith-based organizations. Their services are often better than government services, many non-profit institutions operate in the most remote and poor parts of the country, and they face difficult competition from free government services because they have to charge fees to sustain operations. The private sector is often absent in the policy debate and in the design of health systems and operates independently of the government system.

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<sup>22</sup> World Health Organization (2006) The World Health Report 2006: Working together for health.

## Chapter 3. Health and Development Assistance in a Danish Perspective

### 3.1. Danish assistance to health development

Danish development assistance started just after the Second World War, and support to health improvements has been a significant part of Danish assistance since then. Among the early activities was the International Tuberculosis Campaign; later health assistance concentrated on a hospital and nursing training project in Congo that provided valuable lessons for future support to health.

Denmark's bilateral and multilateral assistance to health has evolved dramatically since then. A significant proportion of the development assistance has been used for training of health staff, both in their home countries and in Denmark, as well as for strengthening the Danish resource base. Health research has also been funded since the early days and will continue to be funded to increase the effectiveness of and evidence base for health interventions.

Denmark provided DKK 14 bn corresponding to around USD 2.8 bn in total development assistance in 2007. DKK 9 bn or USD 1.8 bn was provided as bilateral assistance, of which half was allocated to Africa.

The bilateral assistance to the health sector totalled USD 125 mn in 2007. Multilateral assistance to health amounted to approximately the same; total transfers to health development thus corresponded to 9.1% of total development assistance. The education and the water and sanitation sectors, contributing to health development, are allocated approximately 8% each.

### 3.2 Objectives and priorities

The overall objective of Danish development assistance is to reduce poverty. Gender equity, environment, and good governance including respect for human rights and democracy are cross cutting issues in the fight against poverty and in the development assistance to health<sup>23</sup>.

Denmark is a strong supporter of the new aid effectiveness agenda that was laid down in the Paris Declaration in 2005. This means that Denmark will:

- Strive to tailor assistance more effectively to the government systems and procedures of recipient countries
- Concentrate assistance on fewer, but larger bilateral programmes
- Press for a more rational division of labour between donors
- Increase the use of sector budget support.

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<sup>23</sup> Ministry of Foreign Affairs of Denmark (2007) *A World for All: Priorities of the Danish Government for Danish Development Assistance 2008-2012*, Danida.

The goal is to improve the efficiency and effectiveness in the utilization of internal and external resources.

The health aspects of Danish development assistance are underpinned by two specific strategies: “Promotion of sexual and reproductive health and rights”<sup>24</sup> and “Denmark’s support to the international fight against HIV/AIDS”<sup>25</sup>.

Denmark emphasizes the need for sustainability to be built into its development assistance programmes. Long-term funding aligned to national development plans is therefore a priority modality. At the same time it is emphasized that continuity and perseverance are part of the response to the new challenges.

Denmark will seek to improve health in the developing world with a focus on poor and underserved populations. The following objectives guide Danish development assistance to health.

- 1. Address economic, social, cultural, and environmental determinants of health**
- 2. Strengthen health systems to provide universal access to quality health services, including information & education, with focus on social equity and gender equality**
- 3. Contribute to an effective international response to health needs of poor and marginalized populations**
- 4. Ensure a coherent approach to health development in all Danish development assistance.**

Denmark prioritizes broad assistance to strengthen health systems based on the PHC principles in recipient countries and promotes coordination of all activities within national health plans that are consistent and coordinated with poverty reduction strategies. Health system support and intersectoral approaches in programming are based on the following principles:

- Leadership by the recipient government
- A single national comprehensive programme and budget framework
- A formalised process for development partner coordination and harmonization
- Enhanced use of national systems for programme design and implementation, financial management and monitoring and evaluation.
- Strengthen the link between public health systems and community support mechanisms

Danish development assistance facilitates health systems strengthening in the context of a revitalized PHC strategy<sup>26</sup>, as adopted in each country, ensuring that health systems contribute to health equity and social justice primarily by moving towards universal

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<sup>24</sup> Ministry of Foreign Affairs of Denmark (2006) *The Promotion of Sexual and Reproductive Health and Rights. Strategy for Denmark’s Support*, Danida.

<sup>25</sup> Ministry of Foreign Affairs of Denmark (2005) *Strategy for Denmark’s Support to the International Fight against HIV/AIDS*, Danida.

<sup>26</sup> World Health Organisation (2008) *World Health Report 2008: Primary Health Care – Now More Than Ever*, WHO.

access and social health protection. Such initiatives should reorganize health services as primary care around people's needs and expectations, so as to make them more socially relevant and more responsive to the changing world. They should work toward healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across all sectors that influence health. Intersectorality will be pursued at both central and district levels.

Emphasizing active involvement of the civil society in health-related issues and ensuring effective coordination with civil society organizations will advance these principles. Health centre management through local health committees is an example of stronger involvement of civil society.

In the coming years special attention will be paid to the health workforce crisis. Unless other donors adequately address this issue, Denmark will enhance its strategic support to capacity building of health staff in the sector programme and will look for synergy between i.e. support to HIV/AIDS and human resource strengthening.

Equity in health care provision is a cornerstone in Danish health sector support. An important strategy towards improved coverage and universal access to health services is to reduce out-of-pocket spending and ensure social protection against catastrophic health expenditures. A mix of financing mechanisms is needed in most countries in order to achieve this aim. User fees have been shown to represent an obstacle to access to health services for the poor, and abolition of user fees for

pregnant women and children has shown good results in many countries because of the increased utilisation rates. However, abolition of user fees is a strategy that cannot guarantee quality of service and be a stand-alone strategy. Its implementation should always be assessed at the country level, be a result of a national policy decision and be accompanied by provision of adequate human resources and availability of essential medicines. In countries where Denmark gives health sector assistance, Denmark will support national initiatives to ensure universal coverage and to make primary health care free for children and pregnant women at the point of service.

#### **BOX 6:**

##### **Danish SRHR strategy.**

Denmark will work with its development partners (national governments, multilateral and bilateral organizations, NGOs and other civil society organizations) to:

- Promote SRHR and the full implementation of the ICPD PoA in international fora, agreements and resolutions;
- Continue to draw more donors and strategic partners into development coalitions around SRHR, in order to ensure greater political and financial commitment and reduce opposition;
- Continue to support the EU's leadership role in promoting SRHR issues;
- Continue to influence political and technical norm-setting organizations to further promote gender equality and SRHR;
- Strengthen dialogue on SRHR in the Executive Boards of UN organizations and with and among the organizations;
- Strengthen UN organizations at country level to further the fulfillment of their mandates vis-à-vis SRHR and the ICPD-agenda;
- Continue to support international and regional NGOs working with SRHR, HIV/ AIDS and gender equality;
- Emphasise the need to include SRHR in humanitarian responses to crisis situations.

*Source: Ministry of Foreign Affairs of Denmark (2006) The Promotion of Sexual and Reproductive Health and Rights. Strategy for Denmark's Support, Danida.*

Denmark has identified two health issues that require particular attention: 1) Sexual and reproductive health and rights, 2006 and 2) HIV/AIDS, 2005. Specific strategies guide Danish support towards these areas (see boxes 6 and 7). While specific Danida strategies exist for these areas, Danida normally relies on evidence-based disease control strategies produced by international organisations such as WHO and UNICEF.

In addition to sector programme support and specific projects, the Danish government is committed to contribute substantially to the global fight against HIV/AIDS. The aim is to provide DKK 1 billion annually by 2010. Denmark will provide assistance to fill the gaps where other donors are less active, e.g. rights and access of vulnerable groups such as homosexuals and drug users. It will promote use of AIDS money for strengthening supply chain management and human resource strengthening such as training of nurses and other key health staff. Danish support will assist in capacity building and coordination mechanisms to make the large funds work towards achieving broader health outcomes.

The HIV/AIDS and SRHR strategies will serve as overall guidance for Danish development assistance and will not reduce the attention to core areas of Danish health sector support such as immunization, child health and provision of essential drugs. The two strategies will be used in the policy dialogue with partner countries to support them in ensuring that national strategies and plans incorporate effective measures to improve sexual and reproductive health.

In recognition of the predicted changing disease pattern, new areas that will be considered in future support will include malnutrition, mental health, traffic injuries, neonatal mortality, urban health, chronic non-communicable diseases and health in humanitarian crises.

Malnutrition is a contributing factor to most cases of child deaths in poor countries, as illustrated in Figure 2. Over the coming years non-communicable diseases, mental health and injuries will move towards the global top five diseases in terms of DALYs lost (see Annex 1). Neonatal mortality constitutes a key area in child mortality. Major efforts are needed to change these trends if progress towards the MDGs in the poorest countries is to be accelerated.

## BOX 7

### The Danish HIV/AIDS strategy

As part of the support for reaching the internationally set targets for the efforts to combat HIV/AIDS, Danish assistance should contribute to:

- Strengthening national planning and implementation of HIV/AIDS programmes, including supporting efforts aimed at improving coordination and harmonisation of the response at country-level.
- Increasing focus on women and strengthening the linkages between gender equality, sexual and reproductive health and HIV/AIDS programmes.
- Increasing focus on the synergies between HIV prevention and treatment.
- Increasing focus on young people and on children orphaned or made vulnerable by HIV/AIDS.
- Strengthening the involvement of the civil society in the planning and implementation of the HIV/AIDS response.
- Fighting stigma and discrimination.

*Source:* Ministry of Foreign Affairs of Denmark (2005) *Strategy for Denmark's Support to the International Fight against HIV/AIDS*, Danida.

Denmark will raise the problems related to these focus areas in the future policy dialogue with Ministries of Health and with other Ministries – pursuing an intersectoral approach to health - in sector programme countries.

### 3.3. Health Care Financing

Supporting national health programmes is a key strategy for Denmark and like-minded donors in an effort to work towards country ownership and a well-coordinated assistance from external partners. Such sector-wide approaches must be lead by the receiving government; they have three common objectives:

- To broaden ownership by partner governments over decision making with respect to sector policy, sector strategy and sector spending.
- To increase the coherence between sectoral policy, spending and results through greater transparency, through wider dialogue and through ensuring a comprehensive view of the sector
- To reduce the government transaction costs associated with the provision of external financing, either by direct adoption of government procedures or through progressive harmonisation of individual development partner procedures while, at the same time, ensuring good governance and accounting.

Increasingly, Danida-funded programme support includes Sector Budget Support (SBS) as the preferred funding modality. According to OECD/DAC<sup>27</sup>, budget support is defined by the fact that the donor funds are channelled to the partner government's national treasury and thereafter managed in accordance with the government budgetary procedures. This definition explicitly excludes funds transferred to the national treasury for financing programmes or projects managed according to different budgetary procedures from those of the partner country.

In future programmes SBS will be selected by default, i.e. those responsible for programme formulation must argue why SBS has not been used if that is the case (“reversed burden of proof”). A less aligned funding modality will have to be argued for. This does not mean, however, that SBS is the only support modality. While most of the funding provided to the health sector in a given country will be SBS, Danida-funded health sector programme support will continue to use a combination of modalities tailored to the specific country context in line with the Accra Agenda for Action. SBS to the government strategic plans may be supplemented by earmarked support to e.g. private sector or civil society organisations, both of which might face considerable difficulties in getting access to the Danish support if it had to be channelled through the government system. SBS will also be supplemented by Technical Assistance to help strengthen health systems and the capacity in the MOH to manage the government funds including SBS.

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<sup>27</sup> Organisation for Economic Co-operation and Development (2006) *Harmonising Donor Practices for Effective Aid Delivery: Budget Support, Sector Wide Approaches and Capacity Development in Public Financial Management*, DAC Reference Document Vol.2, 28 p, OECD/DAC.

### 3.4 Mechanisms for Danish Development Assistance

Bilateral assistance to health focuses on a small number of priority countries, cf. Table 2. Sector programmes that adopt a broad approach to health will continue to be the preferred modality. Bilateral assistance is largely decentralized to the Danish embassies in developing countries which have a local grant authority to support local programmes within a limit of DKK 5 mn.

**Table 2: Danida Health Sector Programme Support**

| Danida Health Sector Programme Support | Period      | Budget in DKK |
|--|-------------|---------------|
| Ghana HSPS IV                          | 2008 – 2012 | 425 mn        |
| Mozambique HSPS IV                     | 2007 – 2012 | 380 mn        |
| Tanzania HSPS IV                       | 2009 – 2014 | 910 mn        |
| Kenya HSPS II                          | 2007 – 2012 | 360 mn        |
| Uganda HSPS III                        | 2005 – 2010 | 416 mn        |
| Bhutan Social Sector Programme Support | 2007 – 2012 | 140 mn        |

Source: Health Sector Programme Support Documents, Danida.

Annex 4 presents the financial situation for the health sector in the six sector programme countries specifying the Danish budget allocations. Danida also funds sector programmes in education and water and sanitation, which contribute to health development.

Multilateral support to health is primarily given to the organisations shown in Table 3 below. Multilateral aid totalled DKK 650 mn in 2007 but varies over the years, as does the bilateral assistance; in later years the volumes of the two types of assistance to health have been roughly equal.

**Table 3. Multilateral assistance to health 2007-2013 in DKK mn (2009 prices)**

(Some organisations receive two-yearly contributions)

|        | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 |
|--------|------|------|------|------|------|------|
| UNICEF | 207  | 207  | 207  | 207  | 207  | 207  |
| UNFPA  | 230  | 230  | 230  | 230  | 230  | 230  |
| UNAIDS | 0    | 150  | 210  | 0    | 210  | 0    |
| WHO    | 0    | 40   | 80   | 0    | 80   | 0    |
| GFATM  | 175  | 175  | 175  | 175  | 175  | 175  |
| GAVI   | 25   | 25   | 25   | 25   | 25   | 25   |
| IPPF   | 0    | 165  | 0    | 250  | 0    | 250  |

Source:

Danish Ministry of Foreign Affairs of Denmark (2008) *Priorities of the Danish Government for Danish Development Assistance. Overview of the Development Assistance Budget 2009-2013*, Danida.

The document “Denmark’s Multilateral Development Cooperation Towards 2015” from August 2008<sup>28</sup> outlines Denmark’s strategy for the coming years. It is based on these principles:

- Poverty-oriented and long-term multilateral development cooperation engagement
- A more strategic and focused approach
- Fewer, but larger contributions
- More systematic, less automatic contributions
- Explicit strategy for influence

Co-operation with the multilateral organisations will be governed by specific organisational strategies<sup>29</sup>; Denmark has organisational strategies for UNICEF, UNFPA, and WHO, and new ones are being prepared (2009) for UNAIDS and GFATM. Henceforth, contributions to multilateral organisations will systematically be assessed on the basis of four parameters. The four parameters are *Partnership* (the organisation is serious in its partnership with the developing countries and other international organisations, and it is regarded as a constructive and effective partner in and by the poorest developing countries), *Relevance* (in relation to the objectives and priorities of Danish development policy), *Efficiency*, and *Dialogue and strategic influence*.

Multilateral assistance shall be coordinated with bilateral aid at the country level by active participation in donor coordinating mechanisms, alignment of organizational strategies with country operations and by increased coordination and sharing of technical assistance.

As a rule, Denmark will grant multi-annual core contributions and use earmarked contributions as the exception rather than the rule. In the organisations in which Denmark is a strong core contributor, Denmark will make it a priority to participate in the consultative donor groups and other working groups, which set the strategic directions. It is seen as important to provide significant technical input to the dialogue.

Denmark is concerned about the rapid growth in Global Health Partnerships (GHP). While the increase in funding volume is a much-needed addendum to ongoing support to improve health outcomes, it poses major difficulties in terms of distortion of national health priorities and budgets. It overstrains fragile government administrations and it makes major public sector reforms like decentralization more difficult to pursue.

Denmark supports some of the GHPs but will condition its support on increasing adherence to the Paris Declaration principles. Alignment with national policies and harmonisation with other donor support is considered essential; if these two principles are not followed, effectiveness of health sector support will not materialise. The development will be monitored closely and the best practice principles for GHPs

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<sup>28</sup> Ministry of Foreign Affairs of Denmark (2008) *Denmark’s Multilateral Cooperation Towards 2015*, Danida.

<sup>29</sup> Danish Ministry of Foreign Affairs of Denmark: *Multilateral co-operation Organisation Strategies of Danida*, Source: <http://amg.um.dk/en/menu/PoliciesAndStrategies/MultilateralCoOp/OrganisationStrategies/>

developed in the Paris process will be applied as part of the regular joint evaluations of the GHPs<sup>30</sup> at both global and national levels.

Danish assistance through NGOs constitutes app. 7% of the total assistance in 2006 or nearly DKK 1 bn. Major Danish NGOs that receive long-term support from the Danish Government include: The Danish Association for International Cooperation, Danchurchaid, Danish Red Cross, Save the Children Denmark, IBIS and Care Denmark. A host of other NGOs receives variable support for projects - many targeting health. For example, from 2003 to 2008 Denmark supported 16 projects on SRHR through 12 NGOs totalling DKK 142 million. There is no comprehensive overview of the health support channelled through NGOs, as many projects are mixed community development initiatives. Denmark will continue to fund health programmes through NGOs and will expect that this type of assistance will complement health sector programmes and be provided to fragile states as well as humanitarian crises.

Capacity building and technical assistance to Ministries of Health is an integral and essential component of Danish health sector support. It will be provided primarily in connection with sector programme support both on long- and short-term basis. Denmark funds bilateral and multilateral junior professional officers (JPOs) in order to strengthen the Danish resource base and to enhance Danish presence in international organizations.

Fellowship courses and stipends, some of the first tools of international development assistance, have traditionally played a small but important role in Danida's health sector support. Cooperation with Danish and developing country universities and knowledge management institutions in long-term and short-term courses on issues such as governance, capacity building, human disasters, HIV/AIDS and gender relations is a supplement to Danida's support to health.

The private sector, which comprises private for-profit health care providers as well as not-for-profit (often faith-based) NGOs that run health centres and hospitals, are part of the health sector. They have, however, traditionally been left out of the policy dialogue in the countries in which Danida funds sector programmes although they provide a substantial part of services, often in remote areas.

Denmark has formulated a strategy for the collaboration with civil society<sup>31</sup>, which identifies the long-term overarching objective of Danish civil society support as "contributing to the development of a strong, independent and diversified civil society in developing countries".

As stated in the civil society strategy, Danish development assistance emphasizes the role of civil society organizations in:

- i) Advocacy and holding governments responsible for their commitments and promises;
- ii) strengthening of community-based volunteer systems and safety nets for

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<sup>30</sup>Karen Caines, Michael Conway (2005) *Best Practice Principles for Global Health Partnership Activities at Country Level*, High Level Forum on the Health MDG's.

available at: [www.hlfhealthmdgs.org/HLFPresentationsIII/caines.ppt](http://www.hlfhealthmdgs.org/HLFPresentationsIII/caines.ppt)

<sup>31</sup> Ministry of Foreign Affairs. (December 2008) *Strategy for Danish Support to Civil Society in Developing Countries*

marginalized populations; iii) reducing HIV-related stigmatization and discrimination and iv) ensuring active involvement of the most vulnerable groups.

Danida promotes the involvement of the private sector and civil society organisations in the dialogue on health sector policy and strategy in the programme countries and explores ways of including it in sector programme support promoting intersectoral approaches towards better health outcomes. This could comprise funding and technical assistance to umbrella organisations on policy and strategy development, organisational strengthening and capacity building, including support to advocacy activities and studies on how to improve the functional relationship with the government services and ensure fair competition. Supporting corporate social responsibilities and partnerships are examples of such activities.

### *3.5 Supporting research for health.*

Denmark has supported research for health targeting developing countries for many years. Annex 5 includes information about Denmark's current activities and challenges in relation to research for health.

The annex emphasizes the need to focus on priority public health problems and build capacity for research in partner countries while ensuring that research for health is directed towards knowledge creation and getting knowledge into practice. The criteria developed to support Danish research institutions in partnership with institutions in developing countries are: 1) the *relevance* to and capacity for solving the operational problems identified, 2) the *effect* of the research on the society and 3) the *quality* of the research in terms of design and potential for capacity building. The criteria applied by Danida to decide on international research funding are: 1) relevance to development assistance, 2) research quality and 3) organisations and networks supported where the Danish research community has developed important capacity.

The Danish research community plays a key role in Danida-funded research in partnership with institutions from developing countries. Building capacity for research through partnerships with emphasis on Danish priority countries is an important component of the strategy.

Priority setting in the health sector of developing countries often lacks an evidence base. There is too little systematic collection and analysis of experience from the field; routine data collection systems are necessary to monitor and evaluate existing interventions and to test new interventions before they are launched on a larger scale. Clinical databases as well as other health information systems can supply some of this information, but they seldom comprise data that is disaggregated by wealth, sex and age. There is a specific need for community based longitudinal surveillance systems to support and strengthen the value of existing data and to tailor interventions with a poverty focus.

### *3.6. Monitoring and Evaluation*

Monitoring and evaluation is an integrated part of development assistance. Danida will adhere to agreed core indicators in national poverty reduction and health-sector

strategies and to the joint monitoring process of their impact and outcomes<sup>32</sup>. More Danida-specific indicators related to earmarked support for capacity building etc. are identified on a case-by-case basis depending on the focus of the sector programme concerned.

Monitoring should include reporting on four major areas:

- Determinants of health
- Health systems including inputs, processes and outputs.
- Health service coverage
- Health status

All countries should have a nationally defined set of health-related indicators. Annex 5 present a model list of 16 health performance indicators to be used in the process of selecting core indicators. The process of defining the core set of indicators needs to involve key national and international stakeholders in the country. The main challenge is to align indicators arising from diverse and specific demands of programmes.

The central parameter for child health in the 2015 MDGs is the reduction in under-five mortality, and one of the most important sources to monitor this is the repeated demographic health surveys. However, it has been argued that the number of children participating in the surveys is too small to capture the changes in child mortality that is expected by 2015. With the uncertainty of mortality figures in these surveys they may not detect a fall – or an increase - in mortality with five-year intervals<sup>33</sup>.

In addition to routine monitoring and evaluation, Danida conducts annual or biannual reviews of the sector programmes supplemented with evaluations as needed. Reviews of other projects take place regularly both in technical and financial terms. Denmark is also promoting the good practices for reporting and monitoring laid down by OECD in 2003<sup>34</sup>.

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<sup>32</sup> Ministry of Foreign Affairs of Denmark (2006) *Monitoring and indicators in the health sector Technical note*, Danida.

<sup>33</sup> Data from longitudinal demographic health surveillance research sites which follow child populations large enough to capture even smaller changes in child mortality are available through in the INDEPTH network on [www.indepth-network.org](http://www.indepth-network.org)

<sup>34</sup> Organisation for Economic Co-operation and Development (2003) *Harmonising Donor Practices for Effective Aid Delivery: A Good Practice Paper*, OECD/DAC.

## Annex 1: Distribution of DALYs, low and middle income countries, 2004

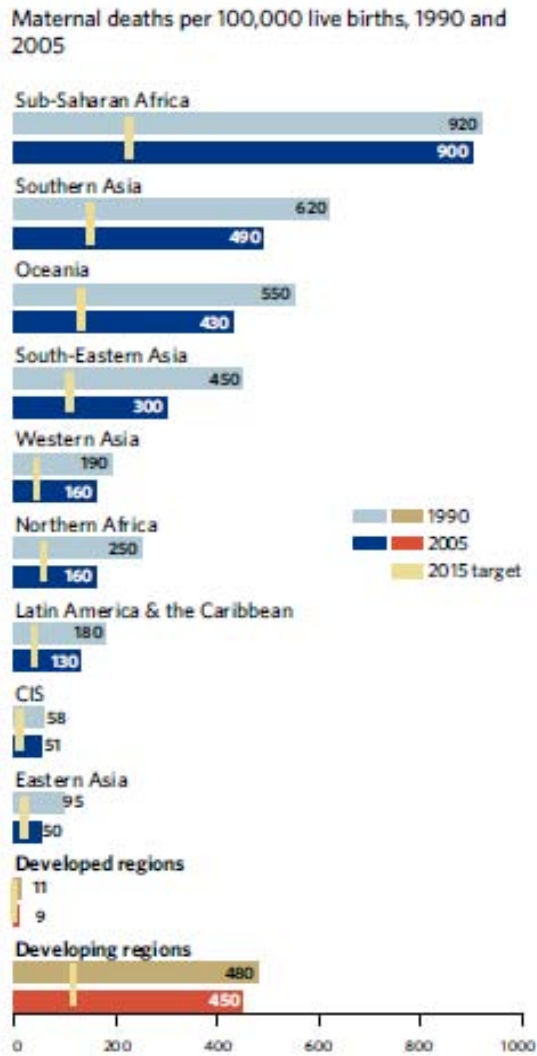
| 2004                                       |                     |      | 2030 |                     |  |
|--|---------------------|------|------|---------------------|--|
| Disease or injury                          | As % of total DALYs | Rank | Rank | As % of total DALYs | Disease or injury                          |
| Lower respiratory infections               | 6,7                 | 1    | 1    | 6,0                 | Unipolar depressive disorders              |
| Diarrhoeal diseases                        | 5,2                 | 2    | 2    | 5,8                 | Road traffic accidents                     |
| HIV/AIDS                                   | 4,1                 | 3    | 3    | 5,5                 | Ischaemic heart disease                    |
| Unipolar depressive disorders              | 4,0                 | 4    | 4    | 4,4                 | Cerebrovascular disease                    |
| Ischaemic heart disease                    | 3,9                 | 5    | 5    | 4,0                 | COPD                                       |
| Prematurity and low birth weight           | 3,1                 | 6    | 6    | 3,1                 | Lower respiratory infections               |
| Cerebrovascular disease                    | 3,0                 | 7    | 7    | 2,8                 | Hearing loss, adult onset                  |
| Birth asphyxia and birth trauma            | 2,9                 | 8    | 8    | 2,8                 | Refractive errors                          |
| Neonatal infections and other <sup>a</sup> | 2,8                 | 9    | 9    | 2,6                 | HIV/AIDS                                   |
| Road traffic accidents                     | 2,7                 | 10   | 10   | 2,1                 | Diabetes mellitus                          |
| COPD**                                     | 1,9                 | 13   | 13   | 2,1                 | Neonatal infections and other <sup>a</sup> |
| Refractive errors                          | 1,8                 | 14   | 14   | 2,0                 | Birth asphyxia and birth trauma            |
| Hearing loss, adult onset                  | 1,7                 | 16   | 15   | 2,1                 | Prematurity and low birth weight           |
| Diabetes mellitus                          | 1,1                 | 20   | 17   | 1,9                 | Diarrhoeal diseases                        |

\*\* COPD = Chronic Obstructive Pulmonary Disease

Source: World Health Organization (2008) *The Global Burden of Disease: 2004 update*, WHO.

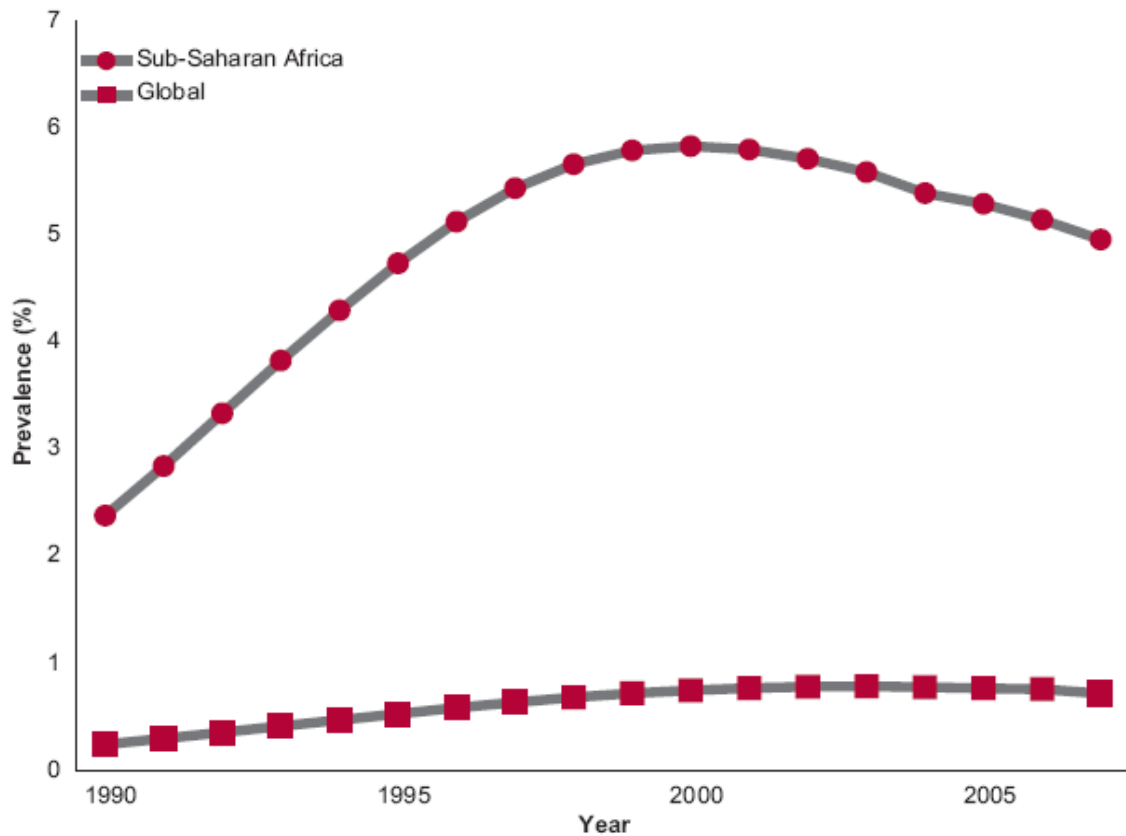
<sup>a</sup> This category also includes other non-infectious causes arising in the perinatal period apart from prematurity, low birth weight, birth trauma and asphyxia. These non-infectious causes are responsible for about 20% of DALYs shown in this category.

## Annex 2: Maternal mortality ratio by region, 1990 and 2005



Source: United Nations (2008) Millennium Development Goals Report 2008, p. 27, UN.

**Annex 3:** Prevalence of HIV infection among adults, 1990-2007:  
Comparing sub-saharan Africa and the global average.



Source: World Health Organisation (2008) *Ten highlights in health statistics*, Part 1, World Health Statistics.

## Annex 4: Selected indicators for health expenditures in Danida HSPS countries

Table 4.1 below presents the figures that can be found in various Joint Annual Health Sector Review reports or other country specific documents<sup>35</sup>. The figures are not necessarily immediately comparable. For example, some reports specifically include only discretionary expenditures when calculating % of government expenditures spent in the health sector, while others are less clear.

**Table 4.1. Selected health sector indicators for 2006.**

| Country    | Year    | MOH budget as % of government budget | Govt health exp per capita in USD | Total health expenditure per capita in USD | Average annual Danish support* per capita in USD |
|------------|---------|--------------------------------------|-----------------------------------|--|--|
|            |         |                                      |                                   |  | (social sectors)                                 |
| Bhutan     | 2005/06 | 9.8                                  | 24.0                              | 51.6                                       | 8.62   |
| Ghana      | 2006    | 18.0                                 | 14.0                              | 24.1                                       | 0.74   |
| Kenya      | 2005/06 | 7.0                                  | 12.0                              | 12.3                                       | 0.27   |
| Mozambique | 2006    | 9.0                                  | 7.0                               | 17.5                                       | 0.78   |
| Tanzania   | 2005/06 | 11.0                                 | 9.9                               | (2005) 11.6                                | 0.96   |
| Uganda     | 2005/06 | 9.0                                  | 10.0                              | 19.7                                       | 0.56   |

\* Rough estimate based on the calculation of the average per year of present programmes; see Table 2 in Main Text, and using population data for 2006 from WHO to arrive at per capita contribution. Sources: See footnote 27. Mozambique figure as reported by Ministry of Health<sup>36</sup> (personal communication).

Total health care expenditures per capita do not include private health sector expenditures. Further, in many cases it does not necessarily capture all donor expenditures as a significant proportion of these are off-budget and not necessarily reported even in specific surveys among donors. For example the off-budget share for Tanzania is estimated to be 20% for FY06.

WHO attempts to collect comparable information, in principle using the same definitions, but these figures also depend on the quality of the data submitted by reporting units. The figures from WHO are presented in Table 4.2. At least for some of them, the figures in Table 4.1 are more reliable.

<sup>35</sup> Bhutan Health Sector Review (March 2007), Ghana Joint Sector Review (June 2007); Kenya Joint Review Mission External Report (October 2006); Mozambique: LNM-PESS 2004 & Mozambique health sector indicators 2006-07 as reported by Ministerio da Saude (personal communication Bert Schreuder, 2007); IMF programs and health spending: Case study of Mozambique (April 2007); Tanzania Public Expenditure Review Update 2005; Tanzania Public Expenditure Review Update 2006 (September 2007); Uganda Annual Health Sector Performance Report, Financial Year 2006-2007 (October 2007).

<sup>36</sup> Data from Ministry of Finance reports somewhat lower figures than Ministry of Health. The exact reason for this discrepancy is not clear.

**Table 4.2. Selected health sector indicators 2005 from WHO**

| Country    | Year | MOH budget as % of government budget | Govt health exp per capita in USD | Total health expenditure per capita in USD | Total health expenditure per capita in international USD |
|------------|------|--------------------------------------|-----------------------------------|--|--|
| Bhutan     | 2005 | 7.7                                  | 13.0                              | 19.0                                       | 109  |
| Ghana      | 2005 | 8.4                                  | 13.0                              | 31.0                                       | 97   |
| Kenya      | 2005 | 7.9                                  | 9.0                               | 22.0                                       | 88   |
| Mozambique | 2005 | 9.1                                  | 10.0                              | 14.0                                       | 46   |
| Tanzania   | 2005 | 8.8                                  | 7.0                               | 14.0                                       | 33   |
| Uganda     | 2005 | 10.0                                 | 6.0                               | 21.0                                       | 133  |

Source: WHOSIS.

The trends in health sector expenditures were available in some reports. These are presented in Table 3a-c. Even within-country comparisons over time may have problems of consistency in definitions, but probably less than between-country comparisons.

**Table 3a. Percentage of total government budget for the health sector**

|            | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|------------|------|------|------|------|------|------|
| Bhutan *   | 11.2 | 8.3  | 7.6  | 7.5  | 9.8  | 8.6  |
| Ghana      | 9.3  | 9.1  | 8.2  | 15   | 18   | 15   |
| Kenya *    | 8.3  | 8.3  | 6.9  | 6.9  | 7    | 6.4  |
| Mozambique | 13.6 | 13   | 10.9 | 13.4 | 16.2 |      |
| Tanzania*  |      | 13.2 | 10.3 | 11.3 | 11   | 11.6 |
| Uganda *   | 8.9  | 9.4  | 9.6  | 9.7  | 9    | 9.6  |

\*) Fiscal year ending June 30. Mozambique trend figures include HIV/AIDS (IMF 2007).

**Table 3b. Government health care expenditures per capita in USD.**

|            | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | Budget 2008 |
|------------|------|------|------|------|------|------|-------------|
| Bhutan *   | 16.6 | 17.9 | 20.3 | 21.6 | 24.0 |      |             |
| Ghana      | 4.0  | 4.9  | 5.4  | 8.2  | 14.0 |      |             |
| Kenya *    | 6.1  | 6.1  | 6.4  | 6.5  | 10.9 | 13.8 | 13.8        |
| Mozambique | 4.8  | 5.6  | 6.0  | 5.8  | 5.4  |      |             |
| Tanzania*  | 4.6  | 5.2  | 5.9  | 7.5  | 9.9  | 10.3 | 13.8        |
| Uganda *   | 7.6  | 7.9  | 8.6  | 8.0  | 10.0 | 7.8  |             |

\*) Fiscal year ending June 30. Mozambique trend figures include HIV/AIDS (IMF 2007).

**Table 3c. Total health care expenditures per capita in USD.**

|            | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|------------|------|------|------|------|------|------|
| Bhutan *   | 36.7 | 27   | 30.5 | 31.5 | 51.6 |      |
| Ghana      | 8.1  | 10.5 | 13.5 | 19.0 | 24.1 | 28.1 |
| Kenya *    |      |      |      |      | 12.3 |      |
| Mozambique |      | 9.2  | 8.4  | 10.4 | 18.3 |      |
| Tanzania*  | 7.1  | 6.9  | 8.1  | 11.6 |      |      |
| Uganda *   |      |      | 10.5 | 10   | 19.7 |      |

\*) Fiscal year ending June 30. Mozambique trend figures include HIV/AIDS (IMF 2007).

It is often discussed whether the share of recurrent expenditures allocated to salaries are too high, leaving too little funding for drugs and supplies. The optimal level is, however, not known and would vary between countries. Nevertheless, it may be of interest to know the share in various countries. To the extent that these figures were available in the reports used for generating Table 1, they have been included in Table 4.

**Table 4. Salaries as percentage of total recurrent expenditures.**

|            | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 |
|------------|------|------|------|------|------|------|
| Bhutan *   | 35   | 36   | 35   | 39   | 35   |      |
| Ghana      | 54   | 49   | 48   | 52   | 59   |      |
| Kenya *    | 54   | 54   | 52   | 52   | 53   | 53   |
| Mozambique | 29   | 32   |      | 42   | 40   |      |
| Tanzania*  |      | 61   | 45   | 47   |      |      |
| Uganda *   |      |      |      | 47   | 50   | 52   |

\*) Fiscal year ending June 30.

## **Annex 5: Danish support to research for health**

### **Introduction**

Supporting research activities and research capacity building is part of Denmark's international development cooperation. Development research contributes to the ability to respond to the challenges of the Millennium Development Goals, but it must also be aware of challenges and problems that will appear in a longer perspective.

Support to development research aims at achieving coherence between development research, development assistance policy and practical cooperation. This also implies an emphasis on research that generates knowledge for promoting the general goal of poverty reduction.

Denmark has been investing substantial funds into research as an important component of its development assistance for many years. Research underpins quality, effectiveness and efficiency as well as better access to services in the health sector. Research can also help improve health equity and health systems and lead to the development of new drugs, vaccines, diagnostics and to evidence-based decision-making for preventive as well as curative health strategies.

The overall purpose of this annex is to present an overview of the Danish support to research for health and to highlight current challenges for research for health.

Section 1 reviews the global context of health research, including the paradigm shift from health research to research for health. The Danida perspective of research for health is presented in section 2, and the major challenges as well as the Danida approaches to address these challenges are presented in section 3.

There are three major target groups for this part of the guidance note: 1) *government, research institutions and civil society in partner countries* with whom Danida collaborates can find support and encouragement to integrate research for health in programmes and activities at various levels of their health system; 2) *research institutions and researchers in Denmark* can contribute to better health development effectiveness through research that complement development aid; 3) *staff of the Ministry of Foreign Affairs* both in Copenhagen and at the Danish Embassies in partner countries will find guidance on how Danish development assistance can support research for health and how research can support evidence based health development assistance.

### **Section 1. Global Perspectives on Research for Health**

#### *1.1 The context of research for health*

The importance of research for improving the health of people in developing countries is an essential issue for the entire development community. This has become evident in the context of the Millennium Development Goals (MDGs). The MDGs for 2015 are important global and national goals for alleviation of poverty and they comprise targets

for health improvements in developing countries<sup>37</sup>. In order to reach these goals there is a need to improve the evidence base for the effective implementation of the key strategies towards 2015 and beyond. The research agenda should, i.a. address a changing disease pattern caused by increasing urbanization, demographic transitions and climate change.

The international research community is rightly concerned with supporting developing countries in their efforts to achieve the MDGs by the target date of 2015. Growing recognition that these goals cannot be achieved independently of each other has led to calls for research to be increasingly broad-based, intersectoral and interdisciplinary<sup>38</sup>.

These calls endorse the shift in thinking about health research, which evolved at the beginning of this century resulting in a new paradigm known as research for health. The paradigm broadens the scope of health research and views its aims as follows<sup>39</sup>:

- To understand and address the impact on health of policies, programmes, processes, actions or events originating in any sector
- To assist in developing inclusive interventions that can help prevent or mitigate that impact (participation);
- To contribute to the achievement of health equity and better health for all (equity).

The development of this paradigm was prompted by the recognition that only 10% of health research funding was invested in diseases that affected 90% of the world's population (the 10/90 gap)<sup>40</sup>. Such inequity was alarming and at the 2004 Mexico Ministerial Summit on Health Research in 2004<sup>41</sup> all countries were urged to increase investment in health systems research. Another recommendation endorsed was that at least 5% of development assistance and 2% of national health budgets (as originally recommended by the Commission on Health Research for Development in 1990<sup>42</sup>) should be dedicated to research in order to address the '10/90' gap. By 2008 fewer than 10 countries globally have met this target.

Inadequate funding and the low priority given to research for health in developing countries are major global health issues. In these countries there is limited leadership and investments for research for health relevant to their needs, and partner funding does not always meet the countries own priorities.

In 2008 the Bamako Global Ministerial Forum on Research for Health endorsed a new vision for research for health and health equity. At this meeting intersectorality was identified as critical for targeting the determinants of health, as well as health problems

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<sup>37</sup> United Nations (2008) *The Millennium Goals Development Report 2008*, United Nations. Web source: [www.un.org/millenniumgoals](http://www.un.org/millenniumgoals)

<sup>38</sup> For example, adequate nutrition is a crucial input to achieving 5 of the 8 MDGs Web source assessed 24<sup>th</sup> January 2009: <http://www.un.org/millenniumgoals/>

<sup>39</sup> Web source assessed 24<sup>th</sup> January 2009: [http://www.globalforumhealth.org/more/000\\_\\_Research%20for%20Health%20.php](http://www.globalforumhealth.org/more/000__Research%20for%20Health%20.php)

<sup>40</sup> Web source: [http://www.globalforumhealth.org/Site/003\\_\\_The%2010%2090%20gap/001\\_\\_Now.php](http://www.globalforumhealth.org/Site/003__The%2010%2090%20gap/001__Now.php) Accessed 20<sup>th</sup> November 2008.

<sup>41</sup> Ministerial Summit on Health Research (2004) *The Mexico Statement on Health Research. Knowledge for better health: Strengthening health systems*. For more information, please see <http://www.who.int/rpc/summit/en/>.

<sup>42</sup> *Commission on Health Research for Development (1990), Cambridge, USA*

per se. The importance of ensuring that research priorities are determined by countries and not by global institutions was among other key conclusions. The summit issued a call for funders and development agencies “to better align, coordinate and harmonize the global research for health architecture and its governance” and “to improve coherence and impact, and to increase efficiencies and equity”<sup>43</sup>.

The Paris Declaration on Aid Effectiveness 2005<sup>44</sup> states that development cooperation through coordination can be more effective and should increasingly take into account partner countries’ priorities, systems and procedures. There is currently a growing and better understanding of how the declaration applies to research for health: through closer alignment with national plans and structures for research, and more coordination of research support between donors. This is a major challenge given the diverse nature of funding agencies of research for health. These range from bilateral donors that have endorsed the Paris Declaration to foundations whose goals are dedicated to research results without considerations for alignment and harmonization.

There is currently a positive global move supporting development of national research systems. A multi-donor initiative is being catalyzed by the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases (TDR) through its donor harmonisation process on research capacity strengthening known as ESSENCE<sup>45</sup>. The strategic plan to guide this initiative has been developed in accordance with the principles of the Paris Declaration, the revitalization of Primary Health Care and the drive to formulate new research strategies and guidelines for and by a number of key stakeholders, comprising both research agencies and donors (e.g. WHO, SIDA, DFID, Danida, Irish Aid).

In recent years public–private partnerships have gained growing popularity as mechanism for increasing access to essential drugs. With the creation of product development partnerships, such as the International AIDS Vaccine Initiative (IAVI) and Medicines for Malaria Venture (MMV), important changes in the landscape of research for health have taken place. A growing pipeline of vaccine and drug candidates has been established for a range of diseases that are of major importance for developing countries.

## *1.2 Key international stakeholders in research for health*

A number of different stakeholders are important for research for health. One key stakeholder, WHO, is currently finalising a new research strategy that could influence the future global priority setting in research for health. Four central elements constitute the fundamental components of this strategy: (i) priority setting (i) capacity of research systems (iii) standards and norms and (iv) the translation of research results into health policies and practices. The components provide a framework for global as well as national research for health.

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<sup>43</sup> From the Global Ministerial Forum on Research for Health (2008) *The Bamako Call to Action on Research for Health. Strengthening Research for Health, Development and Equity*. Web source assessed 24<sup>th</sup> January 2009: <http://www.tropika.net/svc/specials/bamako2008/call-for-action/call>

<sup>44</sup> Paris Declaration on Aid Effectiveness: Ownership, Harmonisation, Alignment, Results and Mutual Accountability (2005). Web source: <http://www.oecd.org/dataoecd/11/41/34428351.pdf>

<sup>45</sup> *ESSENCE on Health Research: Enhancing Support for Strengthening the Effectiveness of National Capacity Effort*, WHO (forthcoming in 2009).

The Council of Health Research for Development (COHRED) plays a crucial role in advocating and enabling research for health. This organisation works for the recognition of research for health as essential to the optimisation of health for all and the reduction of inequity and poverty. As a facilitating agency it also aims at strengthening research systems for health development.

The Global Forum for Health Research (GFHR) operates at the global level and provides evidence, tools and discussion forums for decision-makers in research funding and policy on research for health. This organisation links global partners within research for health for development, identifies international health priorities and advocates for increased funding to research for health to improve the health of poor populations.

Pharmaceutical companies contribute a major proportion of research for health through development of vaccines, drugs, devices and laboratory tests. The United States National Institute of Health (NIH), the Bill and Melinda Gates Foundation, the Wellcome Trust and the Rockefeller Foundation all provide substantial funding to a variety of health research areas. Bilateral donors provide critical funding especially to capacity building, neglected diseases and national research system strengthening.

### *1.3 National health research systems*

National health research systems (NHRS) are composed of the people and institutions whose primary research purpose is to generate high-quality knowledge that can be used to promote, restore or maintain the health status of populations. NHRS also promote the mechanisms needed to operationalise the findings from research<sup>46</sup>. Each country has its own system for supply of knowledge. A focus on strengthening of public research institutions provides a good foundation for the development of knowledge, human resources and experience of knowledge management strategies on a larger scale. Annex 1 presents a framework for the development of an NHRS.

National research capacity is not only vital to a nation, it also enables the country to share and contribute to the stock of global public goods. With sufficient research capacity a country is able to adapt higher education curricula to local demand articulated in country development strategies.

Figure 1 presents a matrix for supporting capacity building in research through a NHRS. The figure specifies the locus and the nature of specific interventions and can be used in any given context depending on the degree of development of the NHRS. In any given environment capacity exist in the form of individuals and institutions. However, much more is needed in terms of systems development to make national research sustainable, relevant, ethical and excellent. Research support and partnerships should aim to support all loci of interventions through multi-pronged approaches.

**Figure 1: Elements of national health research systems and categories of support to research capacity building<sup>47</sup>**

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<sup>46</sup> Council on Health Research for Development (2004) Biennial Report 2003 - 2004, Making health research work ...for everyone, COHRED, page 20

<sup>47</sup> Council on Health Research for Development (COHRED), January 2009.

| 'level' of development | locus of intervention<br>nature of intervention           | <b>individual</b>                    | <b>institution</b>           | <b>research system</b>                       | <b>socio-economic &amp; political</b>          | <b>international collaboration &amp; linkage</b> |
|------------------------|---|--------------------------------------|------------------------------|--|--|--|
| <b>1</b>               | <b>'capacity building'</b>                                | master level training                | grants management            | basis of NHRS                                | increase demand for research                   | good partnerships                                |
| <b>2</b>               | <b>'capacity strengthening'</b>                           | doctoral level training              | merit-based promotion system | research ethics review capacity              | civil society engagement                       | fair research contracting                        |
| <b>3</b>               | <b>'performance enhancement'</b><br><i>* equity-focus</i> | networking researchers, peer reviews | research communication       | monitoring & evaluation of output and impact | focus on health, equity & soc-econ development | focus on research competitiveness                |

*Explanatory notes:*

- 1) Each cell in this grid can contain many specific measures or activities; those listed are examples only.
- 2) The difference between 'capacity building', 'capacity strengthening' and 'performance enhancement' is not absolute. It refers to the level of prior development of national health research systems when the intervention starts and is mainly intended to take explicit note of the fact that in many countries, no matter how poor, research capacity does already exist and needs to be built upon.
- 3) The dotted vertical line indicates that most capacity building efforts in research focus on individuals and to some extent on institutions

## Section 2. Danish Perspectives on Research for Health

### 2.1 Danish Support to Research for Health

Denmark supports research for health in a number of ways:

1. Research applications financed on a competitive basis through the Consultative Research Committee for Development Research (FFU)
2. Bilateral health sector programmes and the embassy local grant authority
3. Support to international research organisations
4. Centre for Health Research and Development (DBL- KU-LIFE)
5. The Danish Research Network for International Health

Re. 1: Research funded through FFU

The Minister for Development Cooperation has appointed the *Consultative Research Committee for Development Research* (FFU). The FFU-members represent a broad range of Danish universities and other research institutions and they provide advice to the Minister on strategic issues in relation to development research.

Currently there are two distinct categories of FFU grants: larger research grants above DKK 5 mn with substantive elements of capacity building and individual PhD and post PhD grants below DKK 5 mn.

A special allocation of DKK 25 mn and DKK 50 mn has been allocated through FFU for research in medicine and health of particular relevance for developing countries in 2008 and 2009, respectively<sup>48</sup>.

Capacity building has been a major output of the Danida support to both Danish and international institutions. It has focused on individual capacity building, such as in the ENRECA programme, but institutional capacity enhancement is receiving growing attention. Capacity building is now fully integrated into the research support provided to development research by Danida.

Africa is by far the most important recipient of research for health support. Allocations for research for health over the past 10 years has mainly been provided to the following areas: 1) poverty related diseases such as malaria and TB, 2) HIV/AIDS, 3) health-related research in nutrition and water/sanitation, 4) neglected tropical diseases, 5) selected priority health programmes, and 6) health systems.

In the yearly call for applications the prioritized themes are advertised together with details on the criteria used. The general criteria applied by Danida on assessing research applications are: 1) *relevance*, 2) *effect* and 3) *quality*.

The importance of utilization of results is emphasized and up to 10% of the budget can be allocated to communicating research findings and thereby bridge the know-do gap.

The MFA receives, on average, 150 applications annually, including pilot projects and

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<sup>48</sup> Ministry of Foreign Affairs of Denmark (2007) *Danida's Annual Report 2007* (only available in Danish), Danida

initiative grants and roughly 30-35% are approved. Grants are primarily awarded within annual prioritized research themes in the yearly call. Preference is given to larger research projects implemented in collaboration between partners in Denmark and in developing countries.

In 2008 the administration of the FFU research funds, funds for the centers and networks and the international research was delegated to the Danida Fellowship Center (DFC). Ministry of Foreign Affairs is responsible for the political and strategic aspects of the development research.

#### Re.2: Research funded through bilateral programmes and embassies

Danida also supports research for health through the bilateral health sector programmes. Mozambique and Ghana use the largest amounts for research, namely DKK 3.5 mn and 2.2 mn, respectively.

#### Re.3: Research funded through international organisations

Denmark has provided support to several international organisations, first and foremost to TDR, but also to EMVI, AMANET, COHRED, GFHR, IAVI and IPM. Table 1 shows the budget allocations for these institutions since 2000.

**Table 1: Danida budget allocations for different organizations since 2000 in mio DKK**

|        | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|--------|------|------|------|------|------|------|------|------|------|------|
| EMVI   | -    | 0,2  | 0,8  | -    | -    | 1    | 1    | 2    | 2    | 2    |
| AMANET | -    | 0,6  | -    | 1    | 1    | 1    | 1    | 1    | 1    | 1    |
| IAVI   | -    | 15   | 10   | 10   | 10   | 10   | 10   | 10   | 10   | -    |
| IPM    | -    | -    | 1    | 4    | 5    | 7,5  | 10   | 10   | 10   | 10   |
| TDR    | 15   | 10   | 10   | 10   | 10   | 10   | 10   | 10   | 10   | 10   |
| COHRED | 0,8  | 0,8  | 1    | 1    | 1    | -    | -    | -    | -    | -    |
| GFHR   | -    | -    | 0,7  | 2    | 2    | -    | -    | -    | -    | -    |
| Total  | 15,8 | 26,5 | 23,5 | 28   | 29   | 29,5 | 32   | 33   | 33   | 23   |

Denmark is active in global agenda setting and has for example through its collaboration with GFHR been involved in the preparation of the Bamako Global Ministerial Forum on Research for Health and will continue to be active in global agenda setting<sup>49</sup>.

The continuous and consistent Danish contributions to international health research have made Denmark internationally recognised as a serious and reliable partner in health research. In addition, the Danish research capacity building efforts (e.g. DBL-LIFE and ENRECA) are widely acknowledged and have gained international recognition.

Denmark has initiated a process of focusing the support to the international research institutions. The overall aim is to provide multi-annual core funding to fewer organizations in order to be in a better position to monitor the work of the organizations.

<sup>49</sup> For more information, please visit [www.epb2008.dk](http://www.epb2008.dk)

#### Re.4: Research through DBL-KU-LIFE

In 2008 the Ministry of Foreign Affairs entered a 3 year performance contract with University of Copenhagen, Faculty of Life Sciences covering support to three centres: Danish Seed Health Centre for Developing Countries, Danish Centre for Forest, Landscape and Planning and Centre for Health and Development (DBL). The main objective of the support is to strengthen DBL's engagement in generating and managing health knowledge and in providing demand-driven support and facilitation for knowledge utilization in the South. DBL works primarily in Danida programme countries with health sector programme support or with sector programme support with relevance for health (e.g. environment, education, agriculture, water resources).

#### Re.5: The Network

The *Danish Network for International Health Research* facilitates coordination within the Danish research community – and partner institutions in the South - working on health and health related issues as well as the dialogue and interaction between research and development communities. Danida funds the secretariat of the network which facilitates information sharing, coordination, interaction and communication between researchers and to a lesser extent also between development programmes and researchers.

The Danish research community covers a wide range of research domains from basic research to participatory action research and capacity development. The breadth of research being undertaken provides a good resource base for the move towards research for health. Danish development research is primarily based at the universities and hospitals and it covers areas that go well beyond the bio-medical sphere. The Copenhagen School of Global Health is the most recent addition to the range of Danish institutions engaged in research for health.

## **Section 3. Future Challenges for Research for Health**

### *3.1 Challenges and opportunities*

Support to research for health needs to take into account a number of global and national challenges such as globalisation, the fragmentation of research initiatives and funding in many countries, the know-do gap between knowledge and practice, the spreading of research between too many projects, themes and geographical areas, the channeling of funds to northern institutions, good governance of research and the human and financial resource gaps.

Based on these challenges and the experiences gained over the past decade Denmark's support to research for health is guided by the following:

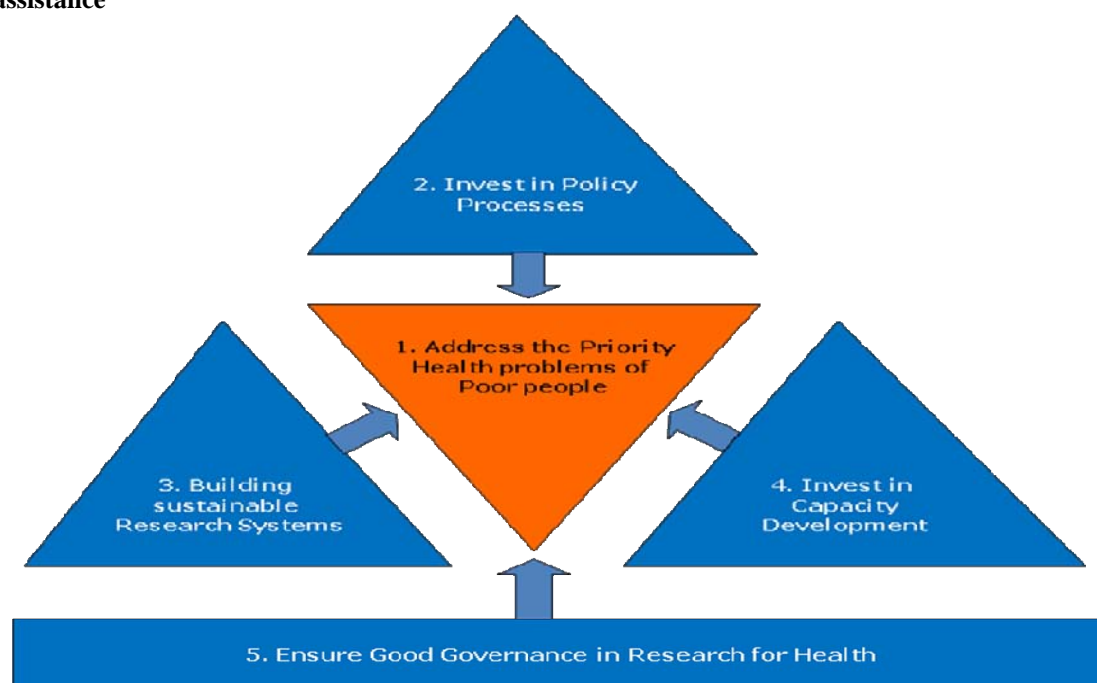
- Contributing knowledge that improves the effectiveness of the development assistance;
- Supporting research aligned with national institutions policies, strategies and priorities;
- Focusing on larger strategic research allocations;
- Communicating research results effectively and translating evidence into policy and policy into practice;

- Supporting NHRS strengthening;
- Pilot initiatives where priorities and themes are increasingly defined by partner countries.

Danish support to research for health aims at securing coherence between research for health, development assistance and practical application in the partner countries. Building strong capacity in the research institutions in the South requires a long-term timeframe, and will include partnership building with institutions in and outside of Denmark.

Figure 2 shows the conceptual framework that serve to shape the modalities for support to research for health.

**Figure 2: Support for research for health and health research systems in Danish development assistance**



These five key components, taken together and pursued at global, national and local level are expected to both create an enabling environment for research for health and provide guidance for reviewing and funding research for health. The overall goal is to positively influence the health and wealth of the people in the partner countries and reduce the inequity in health.

In practice, Danida's support to research for health is provided through a two-pronged approach including:

- I. Research of priority health problems of disadvantaged populations, and
- II. Support to an enabling environment which constitutes:
  - i. Investing in sustainable research systems for better health;
  - ii. Fostering capacity development through knowledge management;

- iii. Ensure good governance, public participation and gender equality in research for health; and
- iv. Investing in policy processes and promoting the alignment of research for health within NHRS

### *3.2 Research of the priority health problems of disadvantaged populations*

*Danida supports:*

- 1. Basic research in priority public health problems.
- 2. Operational research for health with a focus on the underlying causes of ill-health and inequity, e.g. social and environmental determinants of health as well as research into interventions, health systems and health policies.

The primary research focus is on poverty reduction and equity.

Through support to TDR, Danish research institutions can promote Danish research partnerships, and Denmark can ensure that a knowledge and resource base in the South is strengthened and maintained and new vaccines and drugs developed.

Significant health improvements come from research that is not directly related to the health sector but is addressing the social, economic and environmental determinants of health. Thus, more multi- and interdisciplinary research is needed and Denmark can influence the agenda setting of research funding accordingly and support research into determinants of health. Denmark will seek to impact the Global Health Partnerships, WHO, TDR, WB, UNICEF, UNDP, and UNFPA through active dialogue and funding in order to direct the focus of research towards ‘the causes below the causes’ of ill-health i.e. the social and environmental determinants of health.

### *3.3 Supporting an enabling environment for research for health through:*

#### **i. Investment in sustainable research systems for better health**

*Danida supports:*

- 1. Capacity development of individuals, organisations, institutions and systems in the Danida partner countries with emphasis on linkages to and dialogue with Danish institutions.
- 2. Development of national health research systems (NHRS), institutions and capacities.
- 3. Bridging the know-do gap aiming at bringing research results into practice.

Danida will strive to support research that is in line with the partner countries national policies and strategies. Where research policies and strategies do not exist, Danida will consider supporting national efforts to strengthen national health research systems. This process will also promote ownership of the cooperating partner. The process has already started through the development of a research strategy for HIV in Mozambique and through a decentralised pilot research project involving Tanzania and Vietnam.

Danida will move towards a more institutional approach to research for health in the South that builds on the framework of a developed national health research system

(Appendix 1). This will require an institutional development approach in selected partner countries in order to align the strategies of Danida-supported research for health better with country needs and priorities. Governments and research institutions in Danida partner countries will be encouraged to develop national health research systems and prioritize their research agenda.

Research will be further integrated as a modality in the Health Sector Programme Support (HSPS), primarily to support research systems as presented in Appendix I. This will require long-term institutional development in selected partner countries.

Research management will be strengthened through training courses in areas such as financial management, monitoring and evaluation in order to provide an enabling environment for research and capacity building.

## **ii. Fostering capacity development through knowledge management**

*Danida supports:*

1. Investments in knowledge management (KM) through stimulating the generation, access to, translation, dissemination, sharing and usage of knowledge.

Knowledge Management (KM) is an integral component of a NHRS and Denmark will assist partner countries in strengthening KM at national level through sector programmes and through health research projects implemented by both Danish and partner institutions. Promoting access to and use of health research findings is essential to good KM. The communication of research results and the optimization of processes that aim at integrating evidence into practise is a priority for Danida. Ensuring good communication between researchers, policy makers and civil society, both in partner countries and in Denmark is important.

## **iii. Ensuring good governance, public participation and gender equity in research for health**

*Danida contributes to:*

1. Promoting good governance, good practice and public participation in research for health
2. Promoting gender equality and sexual and reproductive health and rights in research for health

Good governance in research for health promotes easy access to research information, sets norms and standards and promotes accountable structures and systems. It includes civil society in research agenda setting, implementation, data dissemination and utilisation and monitoring and evaluation.

Good practice in research such as transparency, accountability and ensuring that ethical standards are being upheld are all-essential to maintain public trust and confidence in research. Inclusiveness is a key word in research for health and not least inclusion of civil society. Danida supports enhanced civil society participation in the entire research process.

It is well known that sexual and reproductive health and rights and gender are important issues of health. Danida is very active in promoting research for health on gender and engendering research for health through its support to UNIFEM, IPPF, UNDP and UNICEF. In the same line Danida supports research (through its support to IAVI, IWCH and IPPF) into sexual and reproductive health and the increased burden of diseases on women of HIV/AIDS.

#### **iv. Investing in policy processes and promoting alignment of research for health within NHRS**

*Danida l contributes to:*

1. The promotion of a more coordinated and aligned global support to institutions working in research for health.
2. The application of the guidelines of the Paris Declaration on aid effectiveness in research for health.
3. The promotion of investments in research for health by Global Health Partnerships through NHRS.

In global research for health policy there is a need for growing convergence around common themes such as priority setting, capacity strengthening, common standards and knowledge translation. Denmark is involved in global agenda setting on research for health both through bilateral, multilateral and NGO support.

Denmark participates at the global level of research for health through GFHR. GFHR works at global level and in collaboration with WHO and other partners. GFHR organises yearly meetings that get upgraded to ministerial meetings every four years and takes a leading role on the global agenda setting on research for health.

Through the support to TDR and the recent ESSENCE process<sup>50</sup> spearheaded by SIDA/TDR, Denmark supports alignment and harmonisation of research in accordance with principles of the Paris Declaration. Denmark also supports WHO, UNICEF, UNFPA, the Global Fund and other partnerships, EU and other international research institutions in ensuring that research is coordinated and focused on equity and poverty reduction.

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<sup>50</sup> Special Programme for Research and Training in Tropical Diseases (TDR) (2008) *ESSENCE on Health Research: Enhancing Support for Strengthening the Effectiveness of National Capacity Effort*, WHO (yet to be published).

# Appendix 1: Framework for Developing a National Health Research System

## NHRS Development

# FRAMEWORK FOR DEVELOPING A NATIONAL HEALTH RESEARCH SYSTEM

USING HEALTH RESEARCH TO IMPROVE POPULATION HEALTH, HEALTH EQUITY, AND DEVELOPMENT

- ▶ The starting point for strengthening a country's health research system is a clear picture of the current state of health research – and the areas where development should be targeted
- ▶ Using this view, countries can apply various approaches, tools and methods to implement a strategy of system strengthening
- ▶ Building support and ownership from all stakeholder groups is essential to successful system strengthening

| Stage of development   | Actions needed  |
|--|---|
| <b>Building the socio-political environment</b>                    |   |
| Political commitment to health research                            | Advocacy, awareness, data and discussion targeting policy makers and other influential stakeholders.  |
| Political & socio-economic climate                                 | Respect for human rights & investment friendly.   |
| <b>Level 1 needs – The foundations of a health research system</b> |   |
| Health research <u>priorities</u>                                  | Credible priority setting regularly updated   |
| Health research <u>policy framework</u>                            | Develop policies/policy framework for research and health research  |
| <u>National research management</u>                                | Establish mechanisms and structures appropriate to countries' existing structures and aspirations for research.   |
| <b>Level 2 needs – Initial policy goals</b>                        |   |
| Human Resources for Health Research                                | Develop a medium-long term human resources strategy and plan aligned with priorities.   |
| Stable, predictable research financing                             | Develop a medium-long term health research financing strategy, including donor alignment and harmonisation.   |
| <b>Level 3 needs – Optimising the health research system</b>       |   |
| Improving health research system components                        | for example:<br>- Research ethics.<br>- Research communication, including evidence to policy & practice.<br>- Peer review vs committee review.<br>- Merit-based promotion system.<br>- Community demands for research.<br>- Monitoring & evaluation of impact.<br>- Health systems research needs.<br>- Good research contracting.<br>- Technology transfer arrangements.<br>- Intellectual property rights.<br>- Institution building. |
| <b>Integrating the system</b>                                      |   |
| International collaborative arrangements                           | - bilateral<br>- regional<br>- international organisations<br>- donors / research sponsors  |
| Linking to other sectors   | - Science, technology and innovation<br>- Education<br>- Business and economic development<br>- Social services<br>- Agriculture  |

COUNCIL ON HEALTH RESEARCH FOR DEVELOPMENT (COHRED)

www.HealthResearchForDevelopment.org

COHRED

## **Appendix 2: Application Guide for FFU funds, 2009**

**Danish Ministry of Foreign Affairs  
Consultative Research Committee for Development Research (FFU)  
Application Guide, November 2008**

This guide is available at <http://www.dfcentre.com>

## Annex 6: Indicators

### Health Metrics Network's List of 16 Health Indicators used for Assessing the Performance of Health Information Systems

| <b>Mortality</b>  |
|---|
| 1. Child mortality (Probability of dying by age 5 years) (outcome)              |
| 2. Maternal mortality (outcome)   |
| <b>Morbidity</b>  |
| 3. HIV prevalence (outcome)   |
| 4. TB incidence (outcome)   |
| 5. Underweight in children (outcome)  |
| 6. Obesity in adults (outcome)  |
| <b>Health Service</b>   |
| 7. Measles coverage (output)  |
| 8. Skilled birth attendance (output)  |
| 9. TB treatment success rate under DOTS (output)                                |
| 10. Proportion of children sleeping under insecticide treated bed nets (output) |
| 11. General government expenditure on health per capita (input)                 |
| 12. Private expenditure on health per capita (input)                            |
| 13. Density of health workforce per 1,000 inhabitants (input)                   |
| 14. Smoking prevalence (outcome)  |
| 15. Condom use at higher-risk sex (outcome)                                     |
| 16. Improved water supply (output)  |

Source: Danish Ministry of Foreign Affairs (2006) *Monitoring and Indicators in the Health Sector*, Danida.

