*Invited Commentaries describes the author's personal experience and own opinions and perspectives to the history of Danish involvement in the field of international and global health.*

# A HISTORY OF DANISH DEVELOPMENT ASSISTANCE FOR GLOBAL HEALTH

***By Klaus Winkel***

## A BIG HOSPITAL IN A CAPITAL

The first major Danish aid project was in the health sector. In the capital of Congo (now The Democratic Republic of Congo), Leopoldville – later to be known as Kinshasa – the Belgians had built a big hospital, which had become demolished during the turmoil following the independence in 1960. Denmark committed itself to converting the almost ruin to a fully equipped modern hospital, and – with this as the backbone – to implement a comprehensive programme in the Congolese health sector. The primary objective was to train hospital staff from almost all categories.

During the years 1963-1981 the Danes, who for a period of time filled 70 key positions, and their Congolese counterparts worked hard to make the programme successful – but against increasingly unfavorable odds. Zaire under president Mobutu was falling apart, and it became obvious that the sophisticated hospital was simply not sustainable under the given conditions. When the programme financing stopped and the last Dane left, the hospital was doomed.

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## PRIMARY HEALTH CARE – AND THE INDIA PROGRAMME

With the experience from Congo, the Danish aid authorities, (since 1970 named Danida) were ready to adopt the new policy introduced by WHO under its then Director-General, the Danish medical doctor Halfdan Mahler: Rather than establishing expensive hospitals in capitals, the emphasis should be on providing basic health care in rural areas. As the Danish aid programme became increasingly poverty oriented, primary health care grew to take a central role in the bilateral efforts, and in 1983 health received the largest share (36%) of bilateral funding.

For several years India was the primary target for health interventions, initially including TB prevention and family planning. Starting in 1981, ambitious programmes gave a boost to the provision of health care for the poor in Madhya Pradesh and Tamil Nadu. Danida also successfully supported nationwide programmes to fight leprosy and blindness and later TB and polio.

The leprosy programme in particular was innovative as it introduced the involvement of communities as well as the use of Danish blister packed medicines in Indian primary health care. All Danish health programmes in India came to an end as a result of the decision in 2001 to wind up most of Danish aid to India over a seven-year period.

## FOCUS ON AFRICA

Also in other partner countries, support for health had become a key component of the Danish programmes. The support took many forms, including schools for training of health personnel in Malawi, Tanzania, and Kenya; establishment of several district hospitals and a workshop for the maintenance of hospital equipment in Kenya and Tanzania; support to family planning and leprosy prevention/cure in Bangladesh; and the fight against onchocerciasis in Tanzania. In Botswana, Danish medical students, supervised by a Danish medical doctor, implemented a project on preventive health. Also, considerable investments

were made in reducing child mortality through vaccination programmes in Tanzania and Kenya.

As head of the Danida Mission in Dar es Salaam in the early 1980s, I got involved in what was probably the broadest range of health interventions in any partner country – and certainly one of the most expensive ones. This was primarily due to the scale at which Denmark supplied drugs to the Tanzanian health sector starved for all types of supplies as a result of the catastrophic lack of foreign exchange.

In addition to what is already mentioned, Danida supported a mental health programme including training of staff and the expansion of psychiatric institutions. To my knowledge it was the first example of a major Danish support in the field of mental health. Another mental health programme was later introduced in Bhutan.

A dental health programme focused on the improvement of preventive dental treatment, and a plant was built to produce intravenous solutions. With almost no foreign exchange it made little sense to import what was almost 100% water. Separate projects aimed at enabling the authorities on Zanzibar to implement on the island most of what Danida did in the mainland.

In neighbouring Kenya, Danida supported a comprehensive, integrated programme to strengthen the health service in rural areas and reduce the high rate of population growth. Among the many components were the improvement of village health clinics and the building of a school for health visitors.

Malnourished children is to this day a severe problem all over tropical Africa and was alarming in Kenya at the time. A fine attack at the problem, and a rather innovative one I believe, was made with the establishment of district centres where mothers with malnourished children could get help and learn about nutrition and child health. The support also included training of the centres' staff. Based on a study which showed that the children gained weight during their stay at the centres but lost it again once they returned home, the programme was redesigned

into the Community Based Nutrition Programme, and its success has been documented in a number of international journals.

## FURTHER EXPANSION IN THE 1990s

Support for health remained a high priority during the 1990s and Danida was involved in the health sector in 16 countries. In many cases Danida continued to support the ongoing projects and programmes but at higher levels of funding. In Uganda, Danida (through the Danish Red Cross) helped to reestablish the essential drugs system following the total breakdown of the health sector under Idi Amin's rule.

To address the new and scary threat to health and lives especially in Sub-Saharan Africa, projects to fight HIV/AIDS were implemented in Tanzania, Uganda, Zambia, Zimbabwe and Mozambique. In Egypt, a major programme was implemented to improve primary health care in the poor Northern district of Edfu, and in Palestine support was provided to upgrade two hospitals. The already considerable support to the Indian health sector was expanded by a large contribution to the implementation of a successful campaign to control TB and to eradicate polio.

## SHIFT IN THE AID PARADIGM

During the 1990s, it was increasingly felt that the huge number of more or less uncoordinated projects and programmes implemented according to the different rules of individual donors had become too much of an administrative burden for both the donors and the recipients countries. In line with several other donors, Danida therefore decided to move from projects to what was termed '*Sector Programme Support*' (SPS). Substantial commitments were now made to a given sector for a period of typically five years and, in principle, only a smaller part of the funds were earmarked to specific activities ('components'). The support was provided as general support to the government budget for the specific sector and how the money was spent was agreed upon in a 'policy dialogue' between the government and the donor.

While Danida had for several years been providing funding for government programmes, and through the government systems in India (Leprosy Blindness and TB control), within a few years in 1990s most of Danida's support to the health sector was provided as SPS, following agreements with Ghana, Kenya, Mozambique, Tanzania, Uganda, Zambia, and Zimbabwe. In most cases, however, a good deal of the funds continued to be earmarked.

Support for primary health care in Bhutan was implemented according to an agreement signed already in 1990, which may be considered a forerunner to SPS – and in line with the India experience. For these countries Danida committed a total of DKK 1.4 billion to be spent over periods of 4-5 years.

This massive move from project/programme support towards SPS may be seen as a rather bold, large scale experiment, and it would be interesting to look closer at the results. However, there has been relatively little evaluation of the SPS. One of the few evaluations is a joint (multi-donor) external evaluation of support for Tanzania's health sector during 1999-2006. The efforts of the 20 official donor agencies involved were more or less integrated with the efforts of the Tanzanian government, and the evaluation therefore dealt with the health sector as a whole. It resulted in a report which no doubt was very useful for the government and it suggested that the donors as a group were on the right track. No light, however, was shed on the performance of the individual donor, and the large Danish stake was invisible.

The same applied to Danish aid to Bhutan's health sector in the evaluation of the country programme 2000-2009. This in spite of the fact that Danida was the dominating partner in the sector in many years, helping Bhutan to achieve remarkable improvements in its health sector. In contrast, an evaluation of all Danish aid to Uganda in 1987-2005 provides a good insight into the generally very positive results of the significant contributions to the health sector, including three consecutive health SPSs.

The fact that it has become more difficult, often impossible, to attribute the outcomes of the Danish contributions does of

course not necessarily mean that they have made less difference in the overall picture. The paradigm shift has resulted in Danida's attention being moved from the operational level to the overall coordination and policy, where Denmark has played a very active role in the field of health.

As an important example should be mentioned the support of HIV/AIDS programmes, both within SPSs and through global programmes, where Danish contributions have remained substantial since the 1980s. In particularly good harmony with the overall Danish aid strategy, "The Right to a Better Life", is the high degree to which Danida has been engaged with attention and funds to programmes on sexual and reproductive health and rights (SRHR).

## HEALTH RESEARCH

Since the beginning of the Danish aid programme, support has been provided to research to find new solutions to development problems. For several years the support was modest and mostly targeted to Danish researchers and research institutions. The late 1980s saw a significant increase in the allocations and a new programme to enhance research capacity in partner countries, ENRECA, was introduced. This opening was met with a very positive response from the research community, particularly within health researchers, who for many years received the largest part of the research funds.

Most of the ENRECA health projects built on groups of researchers who had benefitted from previous support for Danish research and established good contacts with research institutions in partner countries. A particularly strong Danish basis within malaria research led to two projects in Tanzania and one in both Ghana and Mozambique. Outside the ENRECA programme, Danish malaria research based in Statens Serum Institut (SSI) has resulted in a promising vaccine candidate now undergoing clinical trials in four countries in Sub-Saharan Africa.

Other successful ENRECA health projects addressed research capacity development (research, primarily PhDs, being the

means to the end) within oral health (Madagascar), new drugs against hepatitis (Egypt), ethnofarmacology (India), primary health care (Nepal), community and health systems (Uganda), and reproductive health (Vietnam).

Spearheaded by DBL - Institute for Health Research and Development, an ambitious project was implemented in Kenya involving five institutions from both countries and covering several research fields, notably within nutrition and vector borne diseases.

In Guinea-Bissau against tuff odds, a group headed by Peter Aaby managed to establish, almost from the scratch, significant research capacity, leading to spectacular findings in the non-specific effects of child immunization.

Also with ENRECA funding, a health research network was established, eventually paving a way to the independent thinknet Global Health Minders.

## MULTILATERAL CHANNELS

A large share – for many years about 50% - of Danida´s support for programmes related to the health sector has been channeled through international organizations. The list of recipients over the years is long, the following being the most important since 2010: UNFPA, UNICEF, GFATM, IPPF, UNAIDS, WHO, and GAVI. It is not possible, within the limits of this brief, to do justice to what Denmark and the many Danes involved have achieved in the field of global health by supporting, working for, and interacting with these institutions. The health experts among Danida staff have made significant contributions to the development of the policies of these institutions, and several have played important roles in the design and implementation of the programmes.

It must suffice here to mention just one example: The Essential Drugs Programme (EDP). In 1978 WHO under Halfdan Mahler published a list of a limited number of the essential drugs required to treat by far most of the diseases in poor countries. Buying these drugs as generics, i.e. not under commercial brand names, and in big quantities would make it possible to cover the

most vital needs at low prices. The pharmaceutical companies were not happy and stalled the programme.

Successful pilot programmes, financed by Danida, were implemented in Kenya and Tanzania, and to further assist in breaking the deadlock at the WHO level, Danida in 1982 donated DKK 5 million to the programme. With the employment of the Danish medical doctor Ernst Lauridsen as head of the responsible WHO office, reporting directly to Mahler, the programme took off in a big way: within few years about 100 developing countries switched to buying drugs according to the WHO list. Unfortunately, Mahler's successor yielded to the influence of the companies. For a number of years the WHO programme suffered, and instead the World Bank and UNICEF took the lead. The EDP concept has saved millions of lives and remains one of the clearest successes in the history of development assistance for global health, and the drug policies of many countries still remain based on the concept.

Among the more recent examples are Denmark's active role in UNAIDS and GFATM.

## POLICIES AND GUIDELINES

During the first approximately 20 years of bilateral Danish aid, the programme as a whole and the nature of the individual activities took shape in a rather ad hoc manner. Except for the choice of partner countries and the move towards being increasingly poverty-oriented, Danish development assistance developed without being closely governed by specific policies and guidelines. This still applies when it comes to composing the sector-wise country programmes. Thus, it has never been centrally decided how much of the overall Danida programme should be spent on e.g. health. The composition of country programmes depends primarily on the local needs, the division of labour between donors – and of Danida's desire to be involved in only 2-3 sectors in each partner country.

This changed in the 1980s. First were introduced precise guidelines on how to prepare and implement given aid activities,

irrespective of sector. They were followed by guidelines for the design of projects and programmes in the various sectors, including one on health.

In 2009, an excellent and quite elaborate “Guidance Note on Danish Development Assistance to Health” was introduced. It describes the global health situation at the time, outlines likely future trends in health and disease, and provides an overview of how Danida intends to react to the challenges.

As stated in the overview, improving health requires action over a broad front of economic, social, cultural, and environmental determinants. ‘*Political’* could be added to this list, perhaps even as the most important of them all, and this is in fact acknowledged in the context of ‘*policy dialogues*’. The other overriding objectives deal with universal access to quality health services, effective international response to health needs of the poor, and a coherent approach to health development in all Danish development assistance. We have indeed come a long way from the big hospital in Kinshasa.

More specifically according to the Guidance Note, Danish aid shall facilitate health systems strengthening in a context of a revitalized primary health care strategy, as adopted in each partner country. Particular attention is given to sexual and reproductive health and rights as well as to HIV/AIDS, and these two areas are guided by separate strategies. New areas to be considered in future support will include malnutrition, mental health, traffic injuries, neonatal mortality, urban health, non-communicable diseases, and health in humanitarian crises.

In order to work towards country ownership and a well-coordinated assistance from external partners, Danida- funded programmes will increasingly include Sector Budget Support (SBS), implying less room for the earmarked activities that were allowed in the SPS approach.

The Guidance Note has much to say about *research for health*. Already the wording indicates that a paradigm shift has taken place compared to the traditional notion of health research. The scope of health research is widened to understand the impact on

health originating in any sector, to assist in developing inclusive interventions, and to contribute to the achievement of health equity and better health for all. Increasingly, emphasis is put on developing national health research systems, which is vital to a nation and enables the country to share and contribute to the stock of global public goods. For Danida this implies, among other things, that the research supported should be aligned with national institutions´ policies, strategies, and priorities, and that Danida support should increasingly be driven by the demand from the South.

Support will be continued for multilateral health research such as IPM (microbicides) and IAVI (aids vaccine).

## THE MANY DETERMINANTS OF HEALTH

As indicated by the Guidance Note, almost everything in a country affects the state of the population's health. The strongest negative factor is poverty, which again has countless roots. The focus on poverty reduction in the Danish aid programme can be said to be its most significant feature when it comes to improving health in partner countries.

In a more direct manner Danida has almost from day one improved health through interventions in sectors 'neighbouring' to the health sector, and often with a quite substantial funding. Improved access to safe drinking water and improved sanitation have loomed large in many country programmes, and – with varying emphasis over time – support in many different ways has been provided to agricultural development.

The lack of food security is responsible for a very large share of ill health in poor countries. The fact that almost 40% of the children under five years old in Sub-Saharan Africa are malnourished speaks for itself. For many years support for education was a flagship in Danish aid, and the importance of education, notably for girls, to improve health including reproductive health is well established.

## TODAY

Denmark's bilateral support to health sectors is presently confined to five countries receiving together approximately DKK 430 million per annum. This corresponds to approximately 7% of the bilateral programme in 2015.

In Tanzania, although with a smaller share than before, most funding is provided to the government's health programme and as basket funding, meaning that the means are pooled with those of other donors. In addition, contributions are made to Private Public Partnerships and local NGOs, including to faith-based health facilities. The Ghana programme, which will be phased out towards 2016 after a series of five SPSs, resembles that of Tanzania. In Mozambique, cooperation with the government, partly through basket funding, comprises implementation of the national health sector strategy and the prevention of chronic malnourishment. Support of civil society organizations aims at mobilizing the population for health promotion.

In Kenya, a new Health Sector Programme Support starting in 2015 will support the government's health reform and the process of devolution to counties. Also, support will be provided to the supply of drugs and to SRHR. As is the case with other programmes, more focus will be on equity, vulnerable groups, and on a rights-based access to health services. The funds to Myanmar, which is only about one third of the other four programmes, are channeled primarily through a multi-donor fund, focusing on reducing child and maternal mortality, and combating HIV/AIDS, TB and malaria.

## A FEW CONCLUDING OBSERVATIONS

Support for health has dwindled over the years as a share of Danish development assistance, but this does not necessarily mean that improving health is considered less important. Rather, that it has become crowded out as a result of the ever increasing number of objectives for Danish aid, and that the many determinants of health, outside the health sector, are being addressed by a variety of interventions.

The shift away from projects and programmes in favour of SPS and SBS has made Danish contributions less visible, often invisible, leaving fewer good stories for the Danish tax payer – and less meat for the history of the results of Danish aid for global health.

The shift also has led to much fewer Danish health experts being involved in the programmes causing a weakening of the Danish resource base for global health. This very much applies to Danida itself: previously around five health specialists were attached to the headquarter, today only one. The extent to which the general reduction – actually shortage - of staff at headquarters is a consequence or a cause of the shift in aid paradigm is not clear to this author.

The close down in 2012 of the flagship of Danish research for global health, DBL – Centre for Health Research and Development, has also contributed to the weakening of the resource base. To what extent new types of research support will make up for the loss of the ENRECA programme in 2010 is too early to judge.

The concluding remark, however, should be on a positive note: the shift in the forms in which Danish aid for the health sector has been provided makes it better integrated in local health systems, better coordinated with assistance from other donors, and – probably – associated with lower overall transactions costs.

This brief owes much to important input from Charlotte Kanstrup, Senior Adviser, Health, SRHR, and HIV/AIDS in Danida, and Esben Sønderstrup, former Chief Technical Adviser, Health, Danida.