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SURVIVE AND THRIVE:

Analysing the crucial role of the UK in global maternal, newborn, and child health

ANNEX 3. FOCUS ON PRIMARY HEALTH CARE

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This annex informs and supports the UNICEF UK report *Survive and Thrive: Analysing the Crucial Role of the UK in Global Maternal, Newborn, and Child Health*. It presents focused analysis of the UK's engagement in strengthening primary health care systems between 2016 and 2023. Primary health care was selected as one of three core domains for in-depth analysis because of its direct and measurable impact on maternal, newborn, and child health (MNCH) outcomes, and its value as a strategic indicator of progress across the broader MNCH landscape. This annex focuses on primary health care, while Annex 1 addresses immunisation and Annex 2 examines nutrition. Further details on methodology can be found in the main report.

1.0 SUMMARY

UK support for PHC has been broad but inconsistently applied

This annex examines trends in UK support for primary healthcare (PHC) and its impact on maternal, newborn and child health (MNCH), building on the analysis presented in Annex 1 (Vaccines) and Annex 2 (Nutrition).

Vaccines and nutrition, both core components of PHC, have clear trajectories between 2016 and 2023. Vaccine support remained consistently strong, while nutrition investments fell after 2020. By contrast, PHC encompasses a very broad set of delivery platforms, investments, and institutional channels that received variable amounts of political and financial support during this period.

Tracking PHC support was further complicated by the fact that PHC was not always explicitly referred to in strategic or programmatic documents. When broader terms like "health system strengthening" were used, it was at times unclear how and whether MNCH needs at the community-level were being addressed.

Nonetheless, some important patterns are visible. At the start of the review period in 2016, UK bilateral support for primary health care, particularly for basic services, was relatively strong. However, this support declined sharply between 2016 and 2023, with many programmes closed or significantly scaled back. Trends across multilateral funding were mixed: the UK reduced its contributions to certain PHC-relevant platforms like the Global Fund and the Global Financing Facility (GFF), while maintaining support to broader system-level actors such as the World Health Organization (WHO) and the International Development Association (IDA).

At the same time, health research saw a relative uptick in UK aid spending which presents a shift in apparent priority setting that carries some risk. Our analysis concludes that the value of research depends on its connection to delivery systems capable of translating evidence into real-world impact. Some of these delivery systems were undermined by cuts to aid.

Taken together, the UK's evolving support for PHC reveals a tension between strategic ambition and delivery realities. This annex examines in more detail how policy framing, financing patterns, and programmatic decisions have shaped the UK's PHC footprint and what may be at risk for mothers, babies, and children in the absence of renewed investment.

2.0 WHY PRIMARY HEALTH CARE MATTERS

Primary health care (PHC) is the foundation of a strong health system. It includes first level care received in communities, including check-ups during pregnancy, childhood immunisations, and treatment for common illnesses.

It is also an internationally endorsed approach[1] to organising health services that are equitable, community-based, and centred on people's needs throughout their lives.

Investments in PHC offer excellent value for money: Detailed in-country reviews in Kenya[2] and the Maldives[3] have found that every $1 invested in PHC can save $16. In Kenya, economic value came from reducing future spending on conditions that cause childhood illness and place strain on families, such as stunting, TB, malaria, anaemia, and maternal health complications. In the Maldives, returns were driven by investment in a strong PHC system delivering services like immunisation and antenatal care which contributed to a healthier population and reduced reliance on costly hospital treatment.

Yet despite its promise:

- More than half of the world's population, around 4.5 billion people, are not fully covered by essential health services.[4]

- Each year, over 4.5 million women and babies still die during pregnancy, childbirth, or the first weeks of life.
- 4.8 million children die before reaching their 5th birthday [5] —most from preventable causes.[6]

3.0 UK POLICY APPROACH

3.1 Inconsistent visibility of PHC across review period

The UK's commitment to Primary Health Care (PHC) that "leaves no one behind" was evident across the review period. It was reflected in direct programmatic investments (particularly between 2016 -2020) and a broader strategic policy shift toward integrated health systems post 2020 – both of which align with core PHC principles.

However, PHC was not always clearly or consistently framed. At times, visibility was reduced, making it difficult to assess the extent to which policy commitments were grounded in the specific service needs of communities, especially in relation to maternal, newborn, and child health (MNCH) (see Box 1).

In several key documents, PHC was either not explicitly mentioned or was folded into the broader category of Health Systems Strengthening (HSS). HSS typically refers to the process of improving the components and performance of health systems, which may include areas like service delivery, health workforce, information systems, access to essential medicines, financing, and leadership/governance. While HSS typically encompasses PHC, it is not guaranteed. Sometimes HSS may refer to investments in broader system-level reforms or in emergency preparedness, such as pandemic surveillance systems or stockpiling medical supplies. These kinds of investments are important and connected to PHC, but use of broad terms can shift the focus away from the specific services that communities urgently need, particularly those targeted at mothers, babies, and children.

An example of this framing can be found in the UK's 2021 Integrated Review – a major government strategy document outlining foreign, development, and security policy. In this review the government pledged support for "health systems and access to new health technologies" through Official Development Assistance (ODA) but made no specific reference to PHC or MNCH. More recent UK strategies and frameworks, such as the International Women and Girls Strategy,[7] reflect PHC principles more clearly, particularly in their focus on equitable access to essential health services for women and girls though the document stops short of explicitly using the term "primary health care."

As a result, tracking PHC-specific commitments and assessing their translation into measurable outcomes for MNCH is challenging and relies on interpretation across intersecting development agendas than on clear policy signposts.

Box 1. Why Naming Primary Health Care (PHC) Matters for MNCH

Using the term "Primary Health Care (PHC)" in strategy documents and integrating it in impact measurement is important because:

- **PHC is more than a list of services.** For maternal, newborn and child health (MNCH), PHC is the essential delivery platform: it brings care closer to communities, supports continuity across the life course, and ensures services are people-centred and integrated.
- **PHC is a globally endorsed model.** From the 1978 Alma-Ata Declaration to the 2018 Astana Declaration, PHC has been recognised by WHO, UNICEF, and governments worldwide as the foundation for equitable, people-centred health systems. It is central to Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (especially SDG 3).
- **Consistent language enables alignment.** By explicitly naming and measuring PHC, donors and governments can better align strategies, financing, and reporting. The Lusaka Agenda (2023) calls for global partners to support country-led PHC systems — and using shared terminology is a first step toward avoiding duplication, fragmentation, and vertical approaches that undermine coherence.
- **It strengthens accountability.** Naming PHC supports clearer monitoring, funding alignment, and transparent impact measurement.
- **PHC is a core part of health system strengthening (HSS), but naming PHC explicitly helps keep community-level priorities — like maternal, newborn and child health — at the forefront.** Without that focus, these needs can be diluted or overlooked in broader system reforms.

3.2 Integration: Clearer commitments to PHC and MNCH in UK policy (2021–2023)

Whilst definitional and visibility challenges persisted during the review period, there were also clear instances when the UK made its commitment to Primary Health Care and maternal, newborn, and child health more explicit.

A suite of policy documents released at the end of 2021 placed integration of health services, a core principle in PHC, at the heart of the UK's strategic global health policy. In this context, integration focuses on the co-delivery of key health services through shared primary care platforms, such as developing resilient and well-staffed local clinics that can provide communities where they are with the range of health services, they need from immunisations to antenatal care.

The *Health Systems Strengthening (HSS) for Global Health Security and Universal Health Coverage* Position Paper Identified "strong primary health care (PHC) and community health systems that link to other levels of care effectively" as a priority, recognising its value at a local level:

"Primary health care is not only the first, but often the only, port of call for communities."[8]

The Ending Preventable Deaths (EPD) of Mothers, Babies and Children by 2030: Approach Paper Framed PHC as central to reducing maternal and child mortality, committing the UK to:

"Champion the 'backbone' of the systems that are needed to end preventable deaths, including community and primary care, supply chains, midwifery, health financing and vaccines."[9.]

This approach was strongly welcomed by the MNCH community and centred specific needs of children, babies, and mothers even more strongly in UK global health as well as wider development priorities

In 2023, the Global Health Framework (2023–2025) was published, this affirmed a PHC focus going forward, stating that:

"We will work through our bilateral and multilateral programmes and partnerships to promote joined-up approaches to health system strengthening with Primary Health Care at their heart."[10]

These documents reflect an improved coherence and distinctive UK approach, one that avoids fragmented, vertical programming in favour of more holistic models. By embedding MNCH within PHC and system-wide strategies, the UK began to carve out a role as a leading integrator in global health, capable of aligning policy vision with delivery.

3.3 Global Policy Influence: The Lusaka Agenda (2023)

In recent years, the UK contributed strongly to PHC-aligned global reforms. In 2023, the *Future of Global Health Initiatives* (FGHI) process brought together global, regional and national health stakeholders to reflect on how global health initiatives (GHIs) can be optimised to best support national health priorities and countries' progress towards universal health coverage. This resulted in the Lusaka Agenda[11] which outlined five strategic shifts for the long-term evolution of global health programmes. The first of these proposed shifts recognised the importance of PHC within the global health ecosystem, suggesting the global community should:

"Make a stronger contribution to primary health care (PHC) by effectively strengthening systems for health: GHIs more effectively support integrated delivery of services, aligned behind one national plan, and coherently invest in strengthening resilient health systems, including at community level, in order to meet individuals' holistic health needs and have public health impact."[12]

The Lusaka Agenda was endorsed by multiple African governments and Africa CDC [13] as a pivotal step toward country-led, PHC-centred health systems.

British contributions were significant with the FCDO deeply engaged in the steering committee, UK institutions sitting on the research consortium, and the process facilitated by the Wellcome Trust. This role demonstrates how the UK's diplomatic and convening power has developed and can be further harnessed to support a more equitable and effective global health architecture going forward, ensuring this takes into account the specific needs of mothers, babies, and children.

4.0 DELIVERY IN PRACTICE

Bilateral and Multilateral Investment

4.1 A thriving UK knowledge sector

The UK's academic and research institutions, together with its life sciences industry, represent a distinctive and globally respected pillar of the UK's contribution to PHC. When closely connected to programmatic investments, this knowledge sector has shaped global practice and standards and delivered measurable impact at a programmatic level for maternal, newborn, and child health (MNCH).

UK academic institutions, including the London School of Hygiene & Tropical Medicine, The Liverpool School of Hygiene and Tropical Medicine, University College London, and the University of Edinburgh, and others, played a key role in advancing research that supports primary health care delivery for maternal and newborn health during the review period.

Initiatives such as the Making it Happen Programme[14] (improving maternal and newborn outcomes in emergency obstetric and newborn care), EN-BIRTH [15] (measuring coverage of life-saving newborn care), the WOMAN Trials [16] (on the prevention of maternal death from postpartum haemorrhage), the DIPLOMATIC study[17] (improving quality of intrapartum care in African health facilities) and Evidence for Action to Reduce Maternal and Neonatal Mortality in Africa (E4A)[18] generated evidence that directly informed global standards and program design. These studies and programmes have helped shape more effective, evidence-based interventions within PHC systems, particularly at the point of care in facilities and communities.

4.2 Reaching the last mile with exceptional bilateral programmes

Efforts to improve PHC for remote and underserved mothers, babies and children – the "last mile" – was visible in both bilateral and multilateral programmatic work, particularly in the period up until 2020. The UK led targeted and impactful investments, that specifically targeted unvaccinated children in the hardest to reach settings, such as the Sudan Health Pool Fund (see case study 1) and the Saving Lives in Sierra Leone programme (see case study 2).

Long-term programmes and investments were particularly critical part of the UKs aid portfolio, reflecting the complexity of reaching the most vulnerable populations. For example, the UK ran the Maternal, Newborn and Child Health Programme (MNCH2) in Nigeria between 2013 and 2020, building on more than a decade of DFID country knowledge and experience. Operating across six northern states, MNCH2 delivered over 6.3 million quality MNCH services, saving an estimated 60,000 children's lives by 2019. [39] In its final phase, the programme supported the rollout of Nigeria's Basic Health Care Provision Fund, supporting a broader shift toward domestically financed PHC and more sustainable delivery of MNCH services.[19]

4.3 Sharp drop in investment in support for basic services

The most significant challenge during the review period was a sharp drop in funding, particularly true for bilateral investments. From 2020 onwards, many bilateral PHC-focused programmes were closed or reduced due to aid budget cuts (see case study 3). This disrupted progress and limited the UK's ability to deliver and demonstrate sustained impact, especially for women and children.

Compounding these cuts, the share of child-focused bilateral health spending dropped significantly over the last decade due to the types of health expenditure more likely to support MNCH outcomes declining in importance. For example, the relative share of bilateral health spending going to basic health

services fell from around 15% in 2016 to under 5% in 2023. In the same period, the relative share of spending going to medical research grew from 10% to over 30%, with less than a fifth of this spending being focused on children. This analysis draws on project-level UK aid data and represents new calculations based on the dataset and methodology referenced in UNICEF UK's report *'Leave No Child Behind: Tracking UK Aid for Children'*.*

4.4 UK Investment in Multilaterals Supporting PHC for MNCH

The UK has historically played a leading role in financing global health multilaterals that are essential to the delivery of primary healthcare (PHC), particularly for maternal, newborn, and child health (MNCH).

Although the term "PHC" was not always explicitly used, business cases and performance agreements with multilaterals from across the period consistently underscored two core aims of DFID and then UK FCDO:

1. To strengthen foundational systems that enable effective PHC delivery.
2. To pursue those goals through coordinated international action that can amplify results and ensure the UK does not have to act alone.

This is clearly articulated in the UK's 2017 performance agreement with the World Health Organization (WHO), which called on WHO to *"Promote systems strengthening behaviours and provide evidence-based guidance to countries" — including national planning."* It also reaffirmed the UK's commitment to multilateral collaboration: *"The UK will be a strong voice and global influencer, but real progress will only be realised through concerted international action."*

During the cuts to aid between 2020 and 2021, multilateral institutions were relatively protected compared to bilateral programmes. This may reflect the UK's strategic emphasis on multilateralism as a mechanism for global influence and shared responsibility. However, this protection was uneven (see case study 4). While some institutions saw stable or increased support, others – such as the Global Fund and the Global Financing Facility (GFF) – faced significant reductions, with direct implications for PHC delivery. A coherent UK multilateral strategy that integrates an explicit focus on PHC for MNCH and ensures balanced support across institutions will be critical to avoiding the reversal of global health gains in the years ahead.

* This analysis is based on data from the OECD Development Assistance Committee (DAC) Creditor Reporting System (CRS), using project-level information to assess UK bilateral official development assistance (ODA) spending. The methodology follows the approach used in UNICEF UK's 2024 report *Leave No Child Behind: Tracking UK Aid for Children*, which identifies child-focused aid by analysing sectoral allocations, aid channels, and project descriptions. Further detail on the data sources, definitions, and coding process can be found in the Annex of the UNICEF UK report. UNICEF UK. (2024). *Leave No Child Behind: Tracking UK Aid for Children*. https://www.unicef.org.uk/wp-content/uploads/2024/05/Leave-No-Child-Behind-Tracking-UK-Aid-for-Children.pdf

Case study 1. South Sudan Health Pooled Fund Phase 3 2016-2025– Delivering Integrated PHC for Women and Children

The UK government, through the Foreign, Commonwealth & Development Office (FCDO), is leading the South Sudan Health Pooled Fund Phase 3 (HPF 3). This multi-donor initiative aims to provide essential health services to approximately 10 million people, covering about 80% of South Sudan's population.

The HPF focuses on strengthening primary health care (PHC) by integrating services such as maternal, newborn, and child health (MNCH), nutrition, immunisation, and disease prevention.

Key achievements of the HPF included:

- **Maternal and Newborn Care:** The programme supported safe deliveries and antenatal care, contributing to reductions in maternal and neonatal mortality rates.
- **Child Health Services:** HPF facilitated immunisations and treatment for common childhood illnesses, improving child survival rates.
- **Nutrition Support:** The fund addressed malnutrition through community-based programs, enhancing the nutritional status of children and pregnant women.
- **Health System Strengthening:** Investments were made in training health workers, improving supply chains, and enhancing health information systems to ensure sustainable service delivery. [20]

Case study 2. Saving Lives in Sierra Leone (2016–2023): A UK-funded Last Mile Programme

"Saving Lives in Sierra Leone" [21] was a UK-funded bilateral programme designed to reduce preventable maternal, newborn, and child deaths in one of the world's most challenging health contexts.

Equitable access was central to the programme's approach. Implemented across multiple districts, including remote rural and riverine areas, it trained and deployed thousands of frontline health workers, with new graduates deployed to underserved communities. Village-level healthcare was expanded through youth-led outreach, community health worker networks, mobile clinics, and ambulance services to overcome access barriers and improve referrals.

British expertise and partnerships

Delivered through a consortium managed by FCDO, the programme brought together UK-based institutions and global agencies. Notably:

- King's College London provided NHS-linked clinical expertise
- British doctors and midwives worked alongside Sierra Leonean colleagues to build capacity in hospitals
- NGOs like the International Rescue Committee UK, Concern Worldwide, and Options led community and behavioural interventions
- UNICEF and UNFPA supported essential supplies and training
- British technical partners such as Mott MacDonald and Oxford Policy Management focused on health systems strengthening, including blood services and emergency transport systems modelled on NHS best practices.

Innovations and impact

The programme heightened quality and reach of maternal, newborn, and child health care services nationwide. This included introduction of integrated service delivery models, combining community outreach with hospital upgrades. Thousands of new health workers were trained, including the number of qualified midwives growing from under 100 to nearly 1,600. Efforts like radio-based family planning education, youth peer support, and improved blood transfusion capacity helped tackle key causes of maternal mortality. As a result, the maternal death rate fell from 717 to 443 per 100,000 live births.

Budget reductions

The programme faced two major funding cuts. In 2020–21, spending was held at ~£27 million. In 2021–22, it was halved to £13 million, remaining at that level into 2022–23. This led to significant reductions in the operational support provided to district health management teams (DHMTs), including in hard-to-reach communities, and the discontinuation of the community sensitisation component of the programme led by Restless Development.[22]

Case study 3. UK partnerships for health systems: Missed opportunity for Primary Health Care

In December 2019, the UK's Department for International Development approved £46 million for the UK Partnerships for Health Systems (UKPHS) programme, implemented by the Tropical Health and Education Trust (THET), now Global Health Partnerships.[23] Spanning 2020–24, the programme aimed to mobilise NHS staff and UK health institutions to train over 78,000 healthcare workers across low- and lower-middle-income countries. Its scope included strengthening maternal and neonatal care, improving child health services, and supporting frontline health workers – core components of primary health care (PHC).

UKPHS embodied the UK's bilateral strength in technical assistance and knowledge sharing, aligning with PHC principles such as capacity-building, community-level service delivery, and people-centred care. By deploying British expertise in partnership with local health institutions, it offered a scalable model for strengthening PHC and delivering better maternal, newborn, and child health (MNCH) outcomes in underserved settings.

However, the programme was abruptly cancelled in April 2021, less than two years after its launch, as part of broader UK aid budget cuts.[24] This decision came despite earlier assurances that ODA reductions would be temporary. The cancellation not only halted progress on health workforce development but also undermined trusted partnerships between UK institutions and frontline providers in vulnerable countries at a time when strong PHC systems were most needed for pandemic resilience and continuity of essential MNCH services.

Case study 4. Uneven Support for Multilaterals

The Global Fund to Fight AIDS, TB and Malaria

The Global Fund supports PHC delivery including but not limited to; financing community health workers, distributing malaria prevention tools to pregnant women and children, and strengthening diagnostics in primary care.

UK support: Fell from £1.4 billion (2020–2022) to £1 billion (2023–2025). This was a reduction of approximately 30%, announced in late 2022 ahead of the Fund's Seventh Replenishment.

Impact: The decision drew widespread concern, with advocates warning of severe consequences for health outcomes. Mike Podmore, Director of STOPAIDS, called it *"a disastrous decision that risks 1.54 million potential lives lost and over 34.5 million new transmissions across the three diseases," potentially setting back years of progress.*[25]

The Global Fund later confirmed that, in light of constrained funding, countries would need to reprioritise and delay non-essential investments to protect core HIV, TB, and malaria programmes during Grant Cycle 7 (2023–2025).[26]

The Global Financing Facility (GFF)

The GFF strengthens PHC systems for women, children, and adolescents through country-led investment cases, focusing on maternal care, adolescent health, nutrition, and family planning.

UK Support: Provided £250 million between 2015 and 2021, including £50 million pledged at the 2018 replenishment. However, no new pledge was made in 2021. This pause occurred just as the GFF was seeking to raise $1.2 billion by the end of 2021 to protect essential health services and strengthen PHC systems in the wake of COVID-19.[27] At this time, more than 60 countries were off-track in meeting the global goals for maternal, newborn, and stillborn mortality reduction, and 4.5 billion people were not fully covered by essential health services.

In October 2023, the UK pledged £80 million over five years to the GFF's *Deliver the Future* campaign. This amounted to a dramatic reduction compared to previous levels of support.

Impact: The UK's reduced and delayed commitments have had cascading effects, weakening both its leadership among donors and the GFF's ability to leverage additional financing. Each GFF dollar typically mobilizes around $7.56 in World Bank lending (through the International Development Association and the International Bank for Reconstruction and Development),[28] meaning the UK's funding reduction likely curtailed co-financing by a multiple of the original cut.

World Health Organization (WHO)

WHO provides global technical leadership for PHC and MNCH through standard-setting, workforce guidance, and support for PHC integration into UHC strategies.

UK support: Though the WHO has faced considerable funding constraints during our review period the UK has been a consistently strong supporter across all its major funding streams. For example, in 2018–2019, the UK contributed a total of US$ 464 million, comprising US$ 65 million in core voluntary flexible funding (unearmarked contributions), US$ 43 million in assessed contributions (mandatory dues paid by all member states), and US$ 356 million in specified voluntary contributions (earmarked funding). The UK has been recognised as a leading donor to Core Voluntary Contributions (CVCs) stream in particular. The UK was the largest contributor to this stream in 2022–2023, providing $230.3 million. This is significantly ahead of Germany ($33.7 million) and Sweden ($23.1 million), the next two largest donors.[29]

Impact: The UK's support has strengthened WHO's ability to respond quickly to country needs, address funding gaps, and sustain essential services such as PHC. Dr Tedros Adhanom Ghebreyesus, WHO Director-General, has emphasized the importance of core voluntary contributions, noting they give WHO "the flexibility we need to carry out our mission and mandate." In the post-COVID context, continued UK investment has helped maintain WHO's capacity to support countries in rebuilding equitable, integrated PHC systems.

International Development Association (IDA), World Bank

IDA finances core health system infrastructure in low-income countries. This is relevant to PHC because it can include PHC facility upgrades, health worker deployment, and improved supply chain systems.

UK support: During the IDA17 to IDA19 period (2014 to 2020), the UK was consistently the largest bilateral donor, contributing around 12 to 13% of total donor funding.[30] In IDA20 (2021 to 2023), the UK committed £1.414 billion, which represented a 54% reduction from its IDA19 pledge but was still a significant contribution, with the UK becoming the third largest donor. This was followed by a renewed commitment of £1.98 billion for IDA21 (2024 to 2026), marking a 40% increase from the previous cycle commitment of £1.98 billion for IDA21 (2024 to 2026), a 40% increase from the previous cycle.

Impact: While not a health-specific mechanism, the UK's renewed and increased commitment to IDA21 signals a strategic opportunity to reinforce the foundations of PHC such as infrastructure, workforce, and supply systems. When aligned with targeted mechanisms like the GFF, IDA investments can significantly amplify the reach and resilience of primary health care in low-income countries.

5.0 CONCLUSION

PHC is where lives are saved or lost and the case for investment is clear

Primary health care is the foundation of any resilient, equitable health system and where the UK's investments have the greatest potential to deliver impact for women, children, and communities. When supported consistently, PHC platforms have enabled the UK to reach the most vulnerable with life-saving maternal and child health services, from antenatal care to vaccinations and newborn treatment. UK-funded PHC programmes have built local capacity, strengthened health worker networks, and proven that integrated, people-centred care works.

Yet, inconsistencies in policy framing and funding have undermined this potential. The shift away from service delivery toward research, and the abrupt closure of frontline programmes, left critical gaps in care and weakened trust in the UK's development leadership. Recommitting to PHC clearly, explicitly, and with sustained investment offers the UK an opportunity to rebuild delivery capacity, close equity gaps, and lead globally in advancing universal health coverage through practical, high-impact action

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