



COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, 22.03.2002
COM(2002) 129 final

**COMMUNICATION FROM THE COMMISSION
TO THE COUNCIL AND THE EUROPEAN PARLIAMENT**

Health and Poverty Reduction in Developing Countries

EXECUTIVE SUMMARY

This Communication is formulated in the context of the affirmation of poverty reduction as the central goal of the Community's overall development effort and evolving approaches to development assistance. It details the relationship between health and poverty; it outlines critical elements of a coherent development approach to improve health and well-being; and it establishes, for the first time, a single Community policy framework to guide investment in health, AIDS, and population within the context of overall European assistance to developing countries.

Health targets feature prominently in the Millennium Development Goals to which the Community, the Member States and the global community are committed. There is increasing consensus on the key principles that promise more effective development assistance, sustainable development and better health outcomes for the poor with new approaches being undertaken at the country and global level to this end. Key principles include: greater ownership and participation of developing countries in framing aid policies; reducing the administrative burden on political and administrative systems through increasing donor co-ordination; use of common pooled funding approaches with partner countries responsible for designing their own development policy in consultation with all stakeholders (Poverty Reduction Strategy processes); the further untying of aid; decentralisation and the need for donor countries to move towards 0.7% GNP target. This health and poverty policy is built around these key principles and as such attempts to contribute to achieving the Millennium Development Goals.

This Communication proposes four objectives of future Community support: 1) to improve health, AIDS and population outcomes at country level, especially among the poorest; 2) to maximise health benefits and minimise potential negative health effects of EC support for other sectors; 3) to protect the most vulnerable from poverty through support for equitable and fair health financing mechanisms; and 4) to invest in the development of specific global public goods.

Past EC investment to improve health outcomes has been substantial and the present portfolio exceeds Euro 1.4 billion. The clear link between improved health and poverty reduction warrants further investment building on this extensive experience.

The country level will remain the focus of future health investment while the EC will engage at the regional and global level where it can add particular value. At the country level the Community will employ a range of complementary interventions including: macroeconomic support linked to improved health outcomes; support to sectors that have a wider impact on health outcomes, and direct support to the health sector. The Community will aim to speak with one voice at all levels and will identify more effective ways of working with all development partners including the private sector.

Particular challenges include the implementation of pro-poor health policies, making health systems more equitable, assuring an environment that is compatible with a high standard of human health, expanding social protection, the operationalisation of new public/private partnerships for health, the need for greater investment in specific global public goods and the monitoring of performance, results and outcomes.

The Council and the European Parliament are invited to work with the Commission to take forward the directions set out in this Communication to contribute to sustained support for health and poverty in developing countries.

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1. INTRODUCTION

Health is a key determinant of economic growth and development while ill health is both a cause and effect of poverty. At the beginning of the 21st century global health is much worse than it could be. The world's developing countries suffer a huge burden of disease, much of which is preventable or manageable using available interventions. This toll of ill health and premature death affects the poor disproportionately. In many countries the situation is deteriorating with, in the most affected countries, reversal of the health and development gains of recent decades. This decline constitutes a public health crisis and a major development challenge to the international community. Improving the health of the poor is both a vital contribution to efforts to reduce poverty and a moral imperative.

Current policy guidance for investment in health, AIDS and population activity is set out in a series of Community Communications and Resolutions dating from 1994. The evolution of development assistance approaches in the European and global contexts and increasing clarity of the relationship between health and poverty warrants a revision of guidance. The EC Development Policy of 2000 established poverty reduction as the overarching aim of the Community's development assistance. The Community's approach to sustainable development clearly puts an emphasis on health as an indicator of improved socio-economic outcomes and as a prerequisite for the necessary socio-economic balance that underlies sustainable development. The increasing convergence of development objectives across the EU around the Millennium Development Goals offers an opportunity for a stepped-up co-ordination of Community and Member States' policies and approaches in health.

EC investment in knowledge and support for health, AIDS and population policies and programmes in developing countries has been substantial with a current EC health and development portfolio of Euro 1.4 billion (section 6). This extensive experience warrants continued and increased investment to improve health outcomes through a multi-sectoral approach at the country level and through additional efforts at the regional and global level.

This Communication details the relationship between health and poverty. It outlines critical elements of a coherent development approach to improve health and well-being; and it establishes, for the first time, a single Community policy framework to guide future support for health, AIDS, population and poverty within the context of overall EC assistance to developing countries¹.

2. HEALTH AND POVERTY-THE CASE FOR INVESTING IN HEALTH

The poor are deprived of resources, opportunities and from realising their potential. They live in insecure and marginal conditions and have a limited ability to withstand shocks. Almost half the world's population lives on less than USD two per day. Limited access to education restricts options for employment and access to information that could improve their well being. Geographical and social exclusion further limits access to jobs and markets. Poor health and premature death due to malnutrition, poor hygiene, lack of clean water, unhealthy lifestyles and inadequate health care represents a significant loss of human capital. All social indicators are worse for the poor with women and girls often the most disadvantaged.

¹ DAC List of Developing Countries and Territories. ODA recipients as of January 2001

The health of individuals and populations is a major determinant of economic growth and social development. There is a strong correlation between investments in public health, better health outcomes and economic growth. Better health improves the quality of life, expands opportunities and safeguards livelihoods. There is a similar link between the state of the environment and the health of the people exposed to that environment. As health improves parents invest more in education. Improved intellectual development and physical well-being leads to higher labour productivity, increased per capita income and extends the economically productive life of individuals. Health improvements lead to lower rates of fertility and reduced dependency ratios. Infant and child mortality rates are particularly sensitive to economic security with low levels of infant mortality correlating well with higher levels of economic growth and reduced rates of population increase. A healthy population can improve social wellbeing and macroeconomic stability through increasing tax revenues and reducing the burden of health related expenditure.

Poor health drives poverty, acting through a variety of direct and indirect mechanisms. Ill health, malnutrition and high fertility cause households to become or remain poor. The poor have the highest burden of communicable diseases, the highest levels of fertility, often to compensate for high childhood death rates, and the highest rates of child and maternal mortality. They have the least access to formal health care and tend to under-utilise available health services, particularly preventive services, which may not be seen as responsive to their immediate needs. The poor have little capacity to cope financially with catastrophic illness, which can precipitate debt and deep poverty from which it is difficult to escape. In East Asia, 50% of household financial crises are triggered by such events. The poor are also most vulnerable to natural and man-made environmental shocks. Often they live in ecologically fragile areas and such shocks can push them into deeper poverty.

A heavy disease burden reduces economic growth and further limits the resources available to governments to invest in public health, or poverty reduction efforts. The World Bank estimates that many African countries may lose 0.5-1.2 % per capita growth annually due to HIV/AIDS alone yet the total impact may not have been fully calculated. Malaria in sub-Saharan Africa is the direct cause for a 7.4% loss of total GNP. There is a growing awareness, further documented through the detailed work recently carried out by the Commission on Macroeconomics and Health of the WHO (CMH)², that the extent and duration of these effects are significantly more profound than previously realised. The total return on health investments in developing countries is estimated by the CMH at 18% per annum. The CMH further calculates conservatively that a major global effort to tackle avoidable diseases would generate at the very least USD 168 billion per year in extra revenue. More specific estimates demonstrate for example annual global savings of USD 1.5 billion per year once poliomyelitis has been eradicated and all control measures stopped³. These estimates do not include the additional benefits of improved prospects for economic growth.

3. THE GLOBAL HEALTH ENVIRONMENT

Improvements in global health but uneven benefits and new threats

² *Commission on Macroeconomics and Health, Interim Report*, October 2001, *Final report* December 2001.

³ Economic analyses of disease eradication remain problematic and somewhat controversial. This figure stems from the most comprehensive analysis available even though focused primarily on the costs and benefits in industrialised countries. From: Theme Papers, Disease eradication as a public health strategy: WHO 2000, 78(3)

The past 40 years have seen **unprecedented improvements** in global health. Life expectancy, particularly in the developing countries, has risen, fertility has fallen, infant and child death rates have halved, malnutrition rates have declined by one third, and the percentage of the population with access to safe water has doubled to 70%. There have been notable public health successes; smallpox has been eradicated and polio may soon follow. **Yet the benefits have not been equally shared.** In much of the developing world, infant mortality still remains 20 times that of developed countries, malnutrition and disease are rife and half of the population has no access to safe water and sanitation.

Globalisation offers enormous potential but also introduces considerable challenges to all societies, developed and developing. Health may be further improved through the increased sharing of knowledge, wider access for developing countries to world markets, increased investment in health, education and food security, and the development of new life-saving technologies. However, there are also social, environmental and health threats such as the HIV/AIDS pandemic, the rapid increases in microbial resistance and the emergence or re-emergence of infectious diseases, the migration of skilled labour, environmental degradation, the undermining of traditional practices and access to affordable drugs. The **sustainable development challenge** is the most acute in developing countries. Insufficient determination to tackle stark inequalities between countries and within them is not just a failure in itself, it could also undermine progress achieved thus far.

Conditions influencing health and well-being of the poor

The most substantial proportion of the disease burden of the poor is represented by a continuing high toll of illness and premature death from a small number of preventable or manageable conditions:

1) **communicable diseases** including HIV/AIDS, malaria, tuberculosis, acute respiratory infections, diarrhoeal diseases, parasitic diseases and vaccine preventable diseases, which all affect the poor disproportionately; 2) **reproductive health** including sexually transmitted infections, abortion and maternal health affecting poor women most; 3) **nutritional deficiencies** affecting poor children most; 4) **lifestyle related illness**, particularly those caused by the increasing use of tobacco in developing countries. The characteristics and scale of these conditions are elaborated in annex 3.

Additional concerns contributing to the burden of diseases and well-being of the poor are the following:

High levels of population growth place enormous stress on societies including many of those bearing the heaviest disease burden. World population has tripled from 2 billion to 6.1 billion over the past 70 years⁴ and will reach 9.3 billion by 2050 with 95% of the growth in developing countries. Rapid population growth leads to reduced family investment in each child, affecting health and education prospects, lower levels of food production and damage to the environment. There will be increased numbers of the elderly, the poor and large numbers of youth under 18 years, who constitute 50% of the population of developing countries.

The health and gender divide. Some 70% of the world's poor are women and girls⁵. They experience more ill health, are less likely to benefit from health services and endure a cycle of

⁴ UNFPA, *The State of the World Population*, 2001

⁵ UNDP, *Human Development Report: Gender and Human Development*, 1995

ill health, child bearing with high morbidity and mortality, and hard labour. Maternal outcomes in pregnancy represent the starkest example of continuing gender and health status inequity. For every maternal death there is additional disability, continuing ill health and long lasting impact on the family. There is a strong correlation between female education and use of (reproductive) health services, health status and child mortality of future generations, yet girls remain less likely to be educated than boys. Education positively influences gender relations and the ability to make informed choices.

Environmental factors are responsible for 20% of the total disease burden in the developing world and for 30% in sub-Saharan Africa. Lack of access to affordable safe water and sanitation is a major cause of ill health and life threatening disease in developing countries. Water related diseases kill an estimated three million people annually, mostly young children and improving access to safe water is the most important health priority for the poor. Without targeted action to encourage improved supply and use of energy, rising population will lead to higher levels of greenhouse gas emissions, as energy consumption increases; this will further contribute to climate change. A consequence will be the increased spread of vector born diseases, including perhaps the return of malaria to areas where it has previously been eradicated, increased risks of flooding, land degradation and conflict.

The increasing use of fertilisers and pesticides, needed to produce greater crop yields, will further disturb the ecological balance. The global loss of bio-diversity is also undermining health and productive capacity. The burning of traditional biomass for cooking and heating accounts for over half of the energy consumed in many developing countries and presents a major health hazard, particularly for women and children, due to poor indoor air quality from the resulting smoke. The absence or lack of control over the environmental impact of industrialisation can lead directly or indirectly to additional threats to people's health. All of these negative trends have a disproportionate impact on current and future livelihood opportunities of the poor who are over-reliant on income from primary environmental resources.

Current investment in health in developing countries influencing interventions including public health, personal health services and education is insufficient and often ineffective. Developing countries face difficult choices where budgets fall far short of the minimum required to deliver a minimal health system to the population. Policies and plans are often over-ambitious, under-resourced and fail to prioritise interventions for the best returns to health outcomes and poverty reduction. A clearer view is emerging of the costs needed to provide health services. The CMH estimated that USD 30-40 per capita per year in public investments would be needed to deliver a very minimal health system able to significantly reduce avoidable deaths in low-income countries⁶. The WHO arrived at a figure of USD 60⁷ for a more comprehensive health system. This compares with an average level of expenditures among the 49 least developed countries (LDCs) of USD 11 per year⁸. While there are wide variations, resources clearly fall far short. The commitment of African leaders at the Abuja Summit⁹ to allocate 15% of national budgets to health is widely commended. However, the process of increasing domestic revenues and using these for social sectors will need to be

⁶ *Commission on Macroeconomics and Health*, 2001. Note: this does not include important elements such as family planning, tertiary hospitals and emergencies, which would also need to be part of any fully functional health system. Low income countries – per capita GNP less than USD 760 in 1998

⁷ *World Health Report*, 2000

⁸ *Commission on Macroeconomics and Health*, 2001. Note: this includes total investments from the public and private sectors and from donors

⁹ African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, April 2001

supported by far greater efforts of the international community, until a sustainable level of development has been reached.

4. TOWARDS MORE EFFECTIVE DEVELOPMENT ASSISTANCE IN HEALTH

Poverty reduction as a central goal and clear international targets

Health, and the need to dramatically improve health outcomes for the poor, is high on the international development agenda and has featured prominently in major **international development fora** of recent years, including UN conferences and Special Sessions of Cairo, Beijing and Copenhagen, New York and the G8 summits. The Johannesburg Summit is another opportunity to reinforce the links between health and sustainable development at a global level, and in particular to demonstrate the EU's experience with sustainable development. More recently the members of the World Trade Organisation have affirmed that the TRIPS¹⁰ agreement does not and should not prevent Members from taking measures to protect public health.

Most governments and international organisations are committed to achieving a set of eight ambitious and interrelated **Millennium Development Goals (MDGs – annex 1)**. Central to these goals is the reduction in the proportion of people living in extreme poverty by one-half by 2015. Health targets feature prominently highlighting the link between overall poverty reduction and health investments. Current trends suggest that the goals can only be met with more effective use of existing interventions, alongside major increases in investment and the application of more effective public health approaches and incentives. Further work on meeting the goals and targets, and translating the international commitment into a strategy with intermediate and national health indicators is an ongoing process, which requires constant monitoring and regular evaluation. This is further elaborated in section 6 below.

Improving development effectiveness in health

Development approaches

A variety of approaches now being put into practice both at the country level and at the global level, offer the potential for delivering more effective development assistance and improved health outcomes for the poor. More explanatory details on the development approaches are included in annex 4.¹¹

At the country level, **increased ownership, good governance and stewardship** are critical pre-requisites for development effectiveness and efficiency. The potential for greater **policy coherence** across sectors is provided by the increasing adoption of **Poverty Reduction Strategies** (reflected in national development frameworks or, where applicable, in **Poverty Reduction Strategy Papers (PRSPs)**) as the framework to guide development assistance by all donors. The PRS provide an opportunity to ensure that relevant policies and investments in **sectors that have an impact on health**, e.g. education; food security and safety; safe water and sanitation; clean household energy sources; taxes, trade and investment policy and micro-

¹⁰ |Agreement on Trade Related Aspects of Intellectual Property Rights and WTO Ministerial Declaration on the TRIPs Agreement and Public Health adopted at Doha on 14 November 2001, paragraph 4

¹¹ For more background on key principles to fulfil the poverty and development commitments enshrined in the United Nations Millennium Declaration, see the report of the *High-Level Panel on Financing for Development*, prepared by E. Zedillo, UNGA 55th Session, 26.7.2001

credit, are coherent and work towards better health. At the global level there is a need to promote **policy coherence in international development policies and institutions** and within multilateral rules and treaties in trade and investment, economic development, environment, intellectual property protection and labour policies.

The increasing support for **sector-wide approaches (SWAp)** offers further potential to increase the effectiveness and efficiency of aid although experience of such approaches is still limited and they are not inherently pro-poor. Harmonising donor operational policies and procedures, better targeting of aid, donor concentration where each can add the greatest value, further **untying of development aid** and deeper **debt relief**¹² are also needed to increase aid effectiveness. Information and communication technologies could be used as a tool to improve the efficiency in the management of resources and establishment of appropriate information systems as well as in health care delivery services, notably through distance applications.

Pro-poor health policies

Governments must **ensure that health policies are co-ordinated and pro-poor**. The supply of accessible personal and non-personal health services, the promotion of policies in other sectors that have an impact on health with particular benefits for the poor, and fair financing mechanisms that reduce the burden of health service utilisation are all part of a pro-poor health policy.

Pro-poor strategies include targeting services on the poor, combating diseases of poverty and/or reallocating resources in favour of poorer geographic areas. Classic public health interventions are inherently pro-poor. Examples are environmental control, provision of public information on health risks, regulation of health service providers, food fortification programmes, and ensuring safe water and workplace safety.

The expansion of social protection, including **fair and equitable financing mechanisms** should remove barriers, encourage use of services by the poor and protect them from the risks of impoverishment due to health expenditure. In most poor countries health care is insufficiently financed through taxation. The limited resources available have led many countries to introduce an element of cost sharing with safety nets to ensure that basic services remain affordable. Out of pocket payments by the poor should gradually be reduced and risk pooling expanded through community, private, social, and national insurance schemes. It is important to ensure that public spending is focused on those activities most likely to contribute to improved health outcomes for the poor and that budget allocations reflect population distribution, the burden of disease, the cost of service delivery and poverty levels.

A healthy environment

Ill health can be improved through a better control of the environment, especially the quality of water and air, and through increased aid aimed at managing pollution caused by industrialisation, which is often poorly controlled.

Encouraging corporate responsibility

¹² The continuing debt burden impedes development efforts and the Heavily Indebted Poor Countries Initiative (HIPC), launched in 1996, aims to provide debt relief to the worlds poorest and most heavily indebted countries with debt savings allocated to investments in the social sectors

Recent years have seen substantial growth in the movement of capital around the globe, bringing Foreign Direct Investment to more than three times the level of development aid. Transnational corporations can make a significant contribution to economic development in developing countries. The positive impact of these investments on sustainable development overall, and on social standards in particular, can be optimised through appropriate regulation, which encourages corporations to adhere to higher standards of corporate social responsibility. One way in which good practice could be stimulated is through encouraging European companies to work with the OECD guidelines for foreign investors¹³.

Reversing the decline in overall development aid

There is a new and concerted effort by the Community and its Member States to meet the long-standing commitment to allocate 0.7% of GNP for development (Council Declaration November 2001). Aid levels have declined for much of the 1990s so that by 2000, donors directed only 0.22% of GNP (USD 53.06 billion)¹⁴ to development efforts. The EU contributes 0.33% of GNP (USD 25.4 billion). Not enough of this development support has been allocated to the countries that need it most – aid to the poorest countries in 1999 accounted for only 0.06% of donors GNP. Realising the 0.7% target could release an additional USD 125 billion annually. World Bank estimates suggest that the central goal of halving poverty by 2015, would require a rapid doubling of ODA flows.¹⁵

Investments in global public goods

There is growing recognition of the importance of specific global public goods (GPGs), particularly in relation to the need to boost research and development in new products. This will require incentives to industry, new innovative approaches and partnerships and new financial instruments. At present less than 10% of health research budgets by both the public and private sectors is devoted to health problems in developing countries. Only 2% of global research and development funding is devoted to research on major communicable diseases.¹⁶ However, investments in the development of, for instance, an AIDS vaccine or in polio-eradication demonstrate how resources can benefit all societies and therefore should not only come from existing development assistance or public funding. Urgent needs include vaccines and new drugs and diagnostics for HIV/AIDS, malaria and TB. The EC Programme for Action on Communicable Diseases advocates a strong focus on GPGs alongside other actions in the area of improving impact of existing interventions, and the affordability of medicines. EC financing for clinical development of AIDS and malaria vaccines in the last Framework Programme is a good example of EC investment in GPGs as well.

Public-private partnerships

A growing number of global **public-private partnerships** have emerged to address the major public health challenges and respond to specific concerns. Examples include the recent STOP TB partnership, Roll Back Malaria, the International AIDS Vaccine Initiative (IAVI) and the Medicines for Malaria Venture. Many of the European Vaccine R&D clusters funded under the Fifth Framework Programme are effective public-private partnerships with one or several private industry partners. The philanthropic Gates Foundation has largely funded the Global Alliance for Vaccines and Immunisation (GAVI), which is revitalising international

¹³ OECD Guidelines for Multinational Enterprises: Revision 2000

¹⁴ *Development Assistance Committee (DAC) of the OECD*, April 2000

¹⁵ *Financing for Development*, Report prepared by World Bank and IMF, August 2001.

¹⁶ Global Forum for Health Research, 1999

vaccination efforts. The recently established Global Fund to fight HIV/AIDS, Tuberculosis and Malaria is the latest such international partnership. Some of these partnerships have begun to produce results, however there remains the danger that a multitude of different systems, each focusing on a different issue or disease will pose problems of coherence.

Public-private partnerships in general are playing an increasing role at the country level, reinforcing country processes and building up equitable health systems.

5. THE CONTRIBUTION OF THE EC TO BETTER HEALTH

The objective of the **European Community Development policy**¹⁷ as set out in the Joint Declaration of November 2000 (annex 6) is to contribute to the reduction of poverty through support for sustainable economic, social and environmental development and the integration of developing countries into the world economy. The **key principles** of assistance and pro-poor policies to establish the right environment for growth and poverty reduction are outlined in section 4. This section highlights a set of Community priorities to achieve better health at country, regional and global level and new ways of working with Member States and other partners including multilateral agencies, the UN, civil society and the private sector.

EC health and poverty policy framework - increased investment for better health outcomes

The **current EC policy guidance for support for health, AIDS and population** activities is set out in a series of Communications and Resolutions dating from 1994 (annex 2). Support has evolved over the years from an initial focus on health infrastructure development to the provision of basic health services, institutional strengthening and human resource development. Specific support for HIV/AIDS policy and programmes has been a constant feature while broad-based support included essential drug procurement, rehabilitation, health financing and health systems strengthening.

More recently, the EC has gained experience in-country with sector wide approaches and pooled or basket funding with other donors, and globally with policy and strategy formulation, actively contributing to influencing international policy and external coherence. The Commission has increasingly played a co-ordination role at EU level for health and development issues, and has developed close co-operation with civil society and dialogue with the private sector. The EC Programme for Action on Communicable Diseases in the Context of Poverty Reduction published in February 2001 reflects this effort.

The overall objectives of EC health and poverty policy are to:

- improve health, AIDS and population outcomes at country level, especially among the poorest;
- maximise health benefits and minimise any potential negative health effects of EC support for other sectors;
- protect the most vulnerable from poverty through support for equitable and fair health financing mechanisms;
- invest in the development of specific global public goods.

¹⁷ *The European Community's Development Policy, Com (2000) 212*

To achieve the above, the EC has identified a set of inter-linked and mutually reinforcing priorities where EC interventions add particular value. The country level will remain the major focus of EC investment in health, and support for activities at the regional and global level, will reinforce and complement the health related objectives of the countries and communities. Overall, EC interventions are expected to increase. Moreover, the Community will increase efforts to speak with one voice (Community and its Member States) at country and regional level and within international fora.

Country level focus

The Community has strong and long-term partnerships with, and presence in, most developing countries. The Community will provide long-term support to policies and practices that promise the best health outcomes for the poor and will prioritise actions against the following health concerns that disproportionately impact upon the poor:

- promotion of public health - in particular prevention efforts, including education and information about the spread of diseases, and tobacco control;
- strengthening of health systems to improve the access to quality services;
- ensuring pro-poor systems of health financing and social protection.
- communicable diseases - in particular HIV/AIDS mainstreaming, malaria and TB;
- reproductive and sexual health and rights - in particular maternal health.

The above concerns will be addressed through:

- following a comprehensive approach in country level programming, linking as far as possible all resources and instruments in support of a nationally owned health policy framework;
- reinforcing macro-economic policy dialogue in-country, addressing social sectors, in particular health and education, to protect and where possible increase social sector budgets and to work to make their distribution made more equitable;
- ensuring that Country Strategy Papers (CSPs) reflect the basic principles of EC support for health, AIDS and population in developing countries¹⁸;
- ensuring coherence in policy planning, programme and project design and implementation, between health and other sectors that particularly influence health outcomes;
- maintaining and where possible increasing support for health in developing countries;
- reinforcing support for human resource development and institutional capacity building;
- enhancing support for monitoring national social sector budget allocations and improvements in health outcomes as part of the PRSP process;

¹⁸ See programming guidelines: EC Support for Health, AIDS and Population, October 2001

- support for knowledge generation and management, capacity building and dissemination of best practice built on evidence-based approaches in developing countries.

Community assistance will target low-income countries¹⁹ though prioritisation will be flexible and also take into account non income-based criteria. In middle-income countries²⁰, emphasis will be to reform health systems to become more equitable and efficient, alongside support for populations with poor health outcomes.

The Community will work closely with development partners including government, civil society and the private sector and, where appropriate, will encourage regular fora for stakeholder consultation. It will maximise opportunities for joint working with Member States and other donors.

The country specific approach, level of support and instruments used (annex 5) will be further defined by the quality of macroeconomic and budget management, the degree of aid dependence, the quality of sector level policies and management within the country. Budget support, social sector support, programme- and project support can be complementary as long as they support a nationally defined policy framework. Where budget support is not appropriate, Community funding will support programmes and projects within the context of a national framework and will focus on capacity building. Where a national framework is not in place, the Community will facilitate the evolution towards a sector wide approach. In most developing countries, the Community will, during an interim period of capacity and confidence building, maintain a mixed portfolio (project, pooled sector funds, earmarked budget support).

In the light of the ongoing reform of the Commission's External service, including the deconcentration of the management of external assistance, it is expected that EC Delegations will be reinforced to meet the requirements in the area of social development.

Regional added value

The European Community embodies the EU's collective experience of regional integration. The Community has a particular role to play in supporting regional integration to address cross-border challenges. Past and current regional EC support includes HIV/AIDS in Southern Africa, malaria prevention in South East Asia, reproductive health in Asia and vaccination and pharmaceutical policy and practice in West Africa. The following areas where a regional approach may particularly add value are prioritised for EC support:

- experiences in health sector reform and health care delivery approaches and tools linked to public health priorities; decentralisation, human resources development, monitoring and assessment of performance in social development;
- demographic surveys, integrated disease surveillance and epidemic preparedness;
- issues related to pharmaceutical policy including drug regulation, regional procurement and capacity building for implementation of the TRIPS agreement;

¹⁹ Low income countries – per capita GNP less than USD 760 in 1998

²⁰ Middle income countries-per capita GNP USD 761-3030 in 1998 (lower middle income) and USD 3031-9360 in 1998 (upper middle income)

- support for research, development, provision and protection of public goods, in particular AIDS and malaria vaccines, but also knowledge and education, food security, environment, peace and security, financial stability.

The above areas will be addressed through:

- providing input into Regional Economic Partnership Agreements to ensure that health issues are adequately addressed;
- support for critical analyses of the capacity of regional institutions;
- developing partnerships with governments, regional institutions, multilateral and bilateral agencies, the UN, civil society groups, development banks and the private sector;
- support for knowledge generation and management, capacity building and dissemination of best practice built on evidence-based approaches.

Existing Community financing instruments provide adequate support for regional activities. The EC will explore the provision of regional technical support through collaborative arrangements with Member States. Past and current experience whereby interested Member States second regional health experts to an EC Delegation, has proven to be highly effective and further arrangements will be explored. Other accompanying measures towards a sector wide approach in line with strategies for poverty reduction will be explored as well.

Co-ordination, complementarity and synergy with Member States

The Member States have drawn from their differing histories and experiences in framing development policy. This has led them to adopt a range of approaches to improving health outcomes in developing countries (annex 6). Areas of relative strength and expertise vary correspondingly, but there is a strong degree of complementarity and synergy between them and taken together with the Community they represent a rich pool of knowledge, resources and experience to draw from.

While differences in approaches and instruments remain, there is increasing convergence around the Millennium Development Goals. As EU-wide collaboration in health deepens, greater consensus and increased levels of co-ordination and complementarity will provide opportunities for building on best practice and maximising the impact of European development assistance in health.

At the **country level**, policy and programming co-ordination should be assured through the country strategy process. The **Country Strategy Paper** is the main multi-annual instrument for guiding, managing and reviewing EC development assistance. It builds on the existing national development framework, including the PRSP where applicable. It is developed with governments and in consultation with Member States, other donors and civil society. Partnership, co-ordination and co-financing opportunities between EU Member States are increasing as policy shifts towards sectoral support mechanisms and in some countries to budget support. Strengthened EC partnership in-country will aim to facilitate operational co-ordination, the harmonisation of procedures, joint monitoring, and - eventually - unified financial support.

At **headquarters and delegations level**, the co-ordination experience of recent years through expert groups and partnerships with multi-laterals has had tangible results. The established

EC Health, AIDS and Population Experts Group, which allows informal discussion on priority issues and consultation on policy and strategy development, should be further developed. The concerted efforts in international policy dialogue should be further maximised. Recent joint achievements include progress on untying aid and the establishment of the common EU research platform for communicable diseases. The initiative to establish the EC Programme for Action against major Communicable Diseases is a further example of strong EC co-ordination.

The EC will prioritise the following areas of work on complementarity and co-ordination with the Member States:

- identifying practical steps for improved coherence between EC sector policies and activities;
- increasing EC participation in public/private partnerships and in other donor partnerships;
- strengthening operational co-ordination between EC and Member States in developing countries.

The above areas could be addressed through:

- identifying the respective comparative advantage of the European Community and its Member States in health and poverty and preparing a proposal on how best to share responsibilities and work programmes in order to maximise EC complementarity at country and global level;
- strengthening the Commission's role in EU policy co-ordination in health and social sectors and in ensuring the complementarity of Community aid;
- sharing information and know-how through systematic networking in close partnership with developing countries. The establishment and maintenance of an EC health and poverty web-site and a public access database providing information on health interventions of the EC and Member States is one example of possible activities to explore;
- strengthening the work of the EC and the Member States Health Experts Group at headquarters level;
- establishing in-country regular fora and joint missions for EC co-operation in health. EC and Member States' aid institutions de-concentration should facilitate in-country co-operation with increased number of skilled and directly responsible staff in place;
- maximising the use of skilled Member States staff with a range of expertise on health issues, by improving their allocation and, where appropriate, by pooling them to obtain a critical mass of European health and poverty expertise at country and regional level;
- awareness building and guidance for staff working in non-health sectors in order to increase accountability towards health and poverty.

A stronger emphasis on ensuring a full and active Community/Member States partnership in health, population and poverty requires flexible financing instruments and matching human resources.

Global level input – working with international partners

As highlighted in section 4, the European Community and its Member States share a responsibility to uphold the principles of international agreements such as the Cairo (1994), Copenhagen and Beijing (1995) Programmes of Action, the UNGASS HIV/AIDS Declaration, and to contribute towards achieving the Millennium Development Goals. Community initiated or funded work has influenced international policy in the area of health. EC investments have also supported global knowledge generation and capacity building, such as the HIV/AIDS policy research partnerships established with the World Bank and UNAIDS.

The Community is a substantial donor to the United Nations agencies²¹ and participates actively in the work of the G8. Strong transnational relationships with particular partners such as the US, Canada and Japan have enhanced the impact of EC health and poverty principles in international debates, and have advocated the scaling up of resources needed for health in developing countries. The Commission is playing an active role in co-ordinating a EU approach in the negotiations around the Global Convention on Tobacco, initiated by WHO. The impact of the Convention on developing countries is of utmost importance.

The new global health and poverty agenda requires strengthened international partnerships with key agencies. To this end the following areas are prioritised for EC support:

- continued EC focus on global initiatives related to specific global public goods, communicable diseases, reproductive health, tobacco, fair financing and social protection;
- a coherent response across other policy areas where the EC has competence, including trade, research and development, education, food security, agriculture and environment;
- active involvement in the development and operationalisation of public/private global initiatives such as the Global Fund to fight HIV/AIDS, TB and Malaria;
- maintain a high health and poverty profile within the G8 and other international fora;
- explore and further develop partnerships with International Development Banks and specialised UN agencies and engage with other international organisations;
- continue to work closely with the WHO on health policy, pharmaceutical policy, normative issues and with UNAIDS on the specifics of HIV/AIDS policy and operations;
- continue to work, through country and regional partnerships for service delivery and commodity supply, with UNFPA and UNICEF;
- strengthen Commission input in the Development Assistance Committee (DAC) of the OECD;
- work closely with the World Bank within the framework of support for PRSPs, and on health and poverty policy, programming, research and operations in developing countries;

²¹ Improving co-ordination with the UN is a Community priority with development assistance the initial focus for closer working. See for more detail: Communication from the Commission to the Council and the European Parliament on Building an effective partnership with the United Nations in the fields of Development and Humanitarian Affairs (April 2000)

- Enhanced co-operation with, and support for, global public/private partnerships such as GAVI, IAVI and others will be further explored.

The above areas will be addressed through:

- increasing efforts to speak with one voice (Community and Member States) at international fora²²;
- strengthening efforts to present, explain and project Community policy priorities in the global context;
- increasing Community presence and input into different governing bodies of the UN entities and other international fora;
- exploring opportunities to work with the private non-for-profit and for-profit sectors.

In order to use the possibility to create innovative partnerships with different actors, and to contribute, where appropriate and duly justified, to global initiatives, Community financing instruments may need to be revisited. A first attempt has been made through the ongoing proposal for revision of the regulation of a special budget line for poverty diseases (B7-6211), which is expected to be adopted in 2002 and incorporates financial support for full Community involvement at the global level.

Civil Society and Non Governmental Organisations

The NGO community has been a powerful advocate, influencing recent action on debt relief, drug affordability and patent issues and has acted as a barometer on the effectiveness and failures of development assistance. The Commission will further strengthen work with NGOs/CSOs to advocate and influence policy dialogue and strategy on major development and health issues.

At the country level, the EC will continue to include NGOs/CSOs in programmes as important service delivery and outcome or performance monitoring partners. A substantial part of EU investment flows through programmes and projects with the non-for-profit private sector (annex 5). The Commission will continue to work on ensuring coherence between the work of NGOs/CSOs and governments, donors and other partners. It will establish an EC and Civil Society Working Group on Health and Poverty. The intention is to strengthen and maintain a confident working relationship between the Commission and civil society representatives. This constitutes a recognition that there are ways and means for the Commission to further improve transparency and openness, particularly in the area of policy. Meetings may be organised on a bi-annual basis, including all stakeholders, i.e. NGOs/CSOs, business and trade union representatives, MEPs and representatives of Member States and are not to overlap with other existing regular fora for Community/civil society consultation.

Private sector

The HIV/AIDS epidemic has led many transnationals, private companies and investors in developing countries to review and extend their involvement in health and social protection. The private sector could still make a far greater input to health in developing countries

²² A higher degree of consistency in EC and Member State positions in international fora is foreseen by the EC treaty article 180.

through, for example, the Global Fund to fight HIV/AIDS, TB and Malaria, increased commitments to work on corporate responsibility and the promotion of the wide application of tiered pricing.

Community work with the private for profit sector has been limited to date and started to take a more active approach under the EC Programme for Action on Communicable Diseases in the Context of Poverty Reduction (February 2001). Greater attention will be given to developing mechanisms for collaborating with this group, in particular in the following areas:

- New incentives are being discussed to engage transnationals and other private companies in the development of global public goods;
- Enhanced co-operation with private investors to improve their responsibility for health in developing countries;
- Exploring options to increase capacity in developing countries for local production of pharmaceuticals. Viable projects will be supported through existing private sector investment facilities facilitated by the EIB.

European companies will be encouraged to work with the OECD guidelines for foreign investors and monitor performance to this end.

6. MONITORING INVESTMENT AND IMPACT OF EC DEVELOPMENT ASSISTANCE IN HEALTH

Community development assistance for health, AIDS and population has evolved from an initial focus on investment in discrete projects to sector support and general budget support. Monitoring is similarly shifting from a focus on specific Community inputs and outputs to assessments of performance against a sector or national development framework. These assessments are undertaken jointly with all development partners. There is a further shift in focus to monitor higher global level outcome measures rather than inputs and outputs, although the latter remain important intermediary measures.

Monitoring performance against the national development framework allows development partners to best understand and address the underlying constraints that limit effective implementation of poverty reduction and pro-poor health policies and strategies.

The Commission will work with development partners to define effective approaches to monitor sector and thematic objectives at the country and global level.

Country level: linking inputs to performance and outcomes in health

Health systems in many developing countries are resource starved. Developing countries themselves will need to mobilise much of the increased investment for better health outcomes. Initiatives such as that of African Governments (Abuja 2001) to commit 15% of national budgets to health are to be commended, yet in most low-income countries the international community will need to complement country level public and private investments with long-term financial support. Many countries will require technical support and capacity building rather than major financial transfers.

Countries and their development partners will need to monitor all inputs including public, private (a significant proportion in many countries) and donor resources. Country monitoring

frameworks need to assess total investments in health including direct support to the health sector and support to other sectors influencing health and macroeconomic support.

- Through policy dialogue at country level the EC will contribute to attaining appropriate levels of investment to improve health outcomes. The EC will thereby draw on a number of instruments including macro-economic support, debt relief linked to social sector budgets, and finance for specific initiatives and clearly identified funding gaps.

Country strategies seldom present a coherent analysis of how programme, sector or macroeconomic support will translate into improved health outcomes for the poor. The response is often direct investment in the health sector without consideration of whether alternative interventions in other sectors could have a greater impact on diseases of the poor or on global health.

To build a basis for budget and sector review processes many countries are in the process of establishing benchmark indicator sets to measure health system performance and progress in meeting defined health outcomes in the context of poverty reduction and the Millennium Development Goals. Such indicators typically reflect a mix of input, output, outcome, and process, and to a lesser extent impact data. While sometimes imperfect, country specific indicators are being improved as experience is gained and capacities developed.

Indicators will need to be evaluated for their value in assessing improvements in health outcomes for the poor. The Community intends to link future disbursement to performance against targets agreed with countries and their partners. Defining a limited number of outcome indicators poses formidable challenges of measurement where statistical systems are poorly developed and also may present perverse incentives to focus only on the key areas by which performance will be measured.

- The EC will test the utility of intermediate indicators in a number of countries where future support will be provided as macroeconomic and /or sector support.
- The Commission will take forward work on intermediate indicators with Member States and within the context of the DAC/OECD.

Routine statistical systems are commonly flawed and limited to public sector providers and the non-for-profit sector. Aggregate data can conceal wide variations and deep inequities and are often not linked to policy making or financial allocations. However some countries are improving the management of information and performance monitoring through the disaggregation of data (by gender, income level, geographic area, service provider), through detailed analysis and feedback to providers and through interaction with policy makers.

- The Community will further facilitate work to strengthen monitoring systems and capacity in co-operation with countries and other key partners.

Investments at the regional and global levels

New global level partnerships offer increased potential for additional and more efficient resource flows linked to better health outcomes. There is no effective system to monitor total health related investment. The Millennium Development Goals are high level indicators and represent an agreed international point of reference. Multiple efforts are underway within the development community to establish a limited set of core intermediate-level indicators for use by development partners. Global health outcomes are monitored by WHO.

- The EC will play an increasing role in strategic areas where the EU can make a difference in reaching the Millennium Development Goals.
- The EC will contribute to work on high level indicators with Member States and within the context of the DAC/OECD.

Monitoring Community aid management

Community assistance to health, AIDS and population activity reached a peak of over Euro 700 million in 1998 amounting to 8% of the Community budget. The total 1995-2000 portfolio amounts to over Euro 1.4 billion (annex 5). An evaluation of the current portfolio is ongoing. Early recommendations include: the need for differentiated approaches; the crucial role of deconcentration of EC aid; the need to continue institutional support to countries for the development of appropriate health strategies; the need for greater coherence, co-ordination and complementarity; and the need to develop an appropriate set of indicators to measure progress. This Communication incorporates these and other recommendations from previous evaluations of the EC AIDS/HIV Programme, and the use of special budget lines for AIDS and population.²³

EC health and poverty aid management will be further monitored through an ongoing process related to the budgetary process, portfolio reviews, sector and thematic evaluations and through the production of an annual performance report, presented in the annual report on the EC Development Policy. The mechanisms put in place and the guiding principles assuring the effective use of the results of reviews and evaluations will be further detailed in a specific work programme, following this Communication.

EC funding provided under this Community policy framework shall be subject to supervision and financial control of the Commission, in accordance with the usual arrangements laid down by the Commission under the provisions in force, particularly those in the Financial Regulation applicable to the general budget of the European Communities and the EDF Financial Regulation.

7. CONCLUSIONS AND RECOMMENDATIONS

This policy framework is the Community's overall response to commitments made by the international community to contribute to the Millennium Development Goals related to health and poverty. The Johannesburg Summit provides an opportunity to move forward this work, reinforcing the common goal of improving sustainable development. An effective EC response will require coherent efforts of the Community and its Member States in collaboration with partner countries, international and civil society partners, the private sector, the UN, other multilateral organisations and stakeholders.

The choice for the proposed policy poses different challenges to the Community. New ways of working and reinforced investment need to receive full attention. The search for greater coherence between policies, the choice to target health through other sectors, the commitment to link inputs to performance and outcomes in health, and to scale up investment and

²³ 'Evaluation de l'aide de la coopération Nord-Sud en matière de lutte contre l'expansion de l'épidémie du HIV/SIDA et aide aux politiques et programmes démographiques dans les pays en développement 1997 - 1999', by Jean-Claude Deheneffe, et al., November 2000; 'Evaluation of the EC AIDS/HIV Programme in developing countries', by Health Research for Action (HERA), December 1996.

resources where possible, the need to make Community instruments respond effectively and efficiently to the increasing demand can all not be addressed at once. The main challenge may well be the area of EU complementarity and division of work among the Community and its Member States, and increased Community co-operation with the Member States to act as one voice in development fora and partnerships.

This Communication will be supplemented with a comprehensive work programme, detailing the priorities for action and the required human and financial resources, compatible with the existing financial programming and instruments. The need for human and administrative resources shall be covered within the allocation granted to the managing DG in the framework of the annual allocation procedure.

Annex 1: The Millennium Development Goals

Millennium Development Goals (MDGs)	
Goals and Targets	Indicators
Goal 1: Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below \$1 per day 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children (under-five years of age) 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15-24 year olds
Goal 3: Promote gender equality and empower women	
Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	9. Ratio of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males of 15-24 year olds 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1 year old children immunised against measles
Goal 5: Improve maternal health	
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
Goal 6: Combat HIV/AIDS, malaria and other diseases	
Target 7: Have halted by 2015, and begun to reverse, the spread of HIV/AIDS	18. HIV prevalence among 15-24 year old pregnant women 19. Contraceptive prevalence rate 20. Number of children orphaned by HIV/AIDS
Target 8: Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures 23. Prevalence and death rates associated with tuberculosis 24. Proportion of TB cases detected and cured under DOTS (Directly Observed Treatment Short Course)
Goal 7: Ensure environmental sustainability*	
Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	25. Proportion of land area covered by forest 26. Land area protected to maintain biological diversity 27. GDP per unit of energy use (as proxy for energy efficiency) 28. Carbon dioxide emissions (per capita) [Plus two figures of global atmospheric pollution: ozone depletion and the accumulation of global warming gases]
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water	29. Proportion of population with sustainable access to an improved water source
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	30. Proportion of people with access to improved sanitation 31. Proportion of people with access to secure tenure [Urban/rural disaggregation of several of the above indicators may be relevant for monitoring improvement in the lives of slum dwellers]

Goal 8: Develop a Global Partnership for Development*	
Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally	<i>Some of the indicators listed below will be monitored separately for the Least Developed Countries (LDCs), Africa, landlocked countries and small island developing states.</i> <u>Official Development Assistance</u> 32. Net ODA as percentage of DAC donors' GNI [targets of 0.7% in total and 0.15% for LDCs] 33. Proportion of ODA to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 34. Proportion of ODA that is untied 35. Proportion of ODA for environment in small island developing states 36. Proportion of ODA for transport sector in land-locked countries <u>Market Access</u> 37. Proportion of exports (by value and excluding arms) admitted free of duties and quotas 38. Average tariffs and quotas on agricultural products and textiles and clothing 39. Domestic and export agricultural subsidies in OECD countries 40. Proportion of ODA provided to help build trade capacity <u>Debt Sustainability</u> 41. Proportion of official bilateral HIPC debt cancelled 42. Debt service as a percentage of exports of goods and services 43. Proportion of ODA provided as debt relief 44. Number of countries reaching HIPC decision and completion points
Target 13: Address the Special Needs of the Least Developed Countries Includes: tariff and quota free access for LDC exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	
Target 14: Address the Special Needs of landlocked countries and small island developing states (through Barbados Programme and 22nd General Assembly provisions)	
Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	
Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	45. Unemployment rate of 15-24 year olds
Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	47. Telephone lines per 1000 people 48. Personal computers per 1000 people <i>Other Indicators TBD</i>

* The selection of indicators for Goals 7 and 8 is subject to further refinement

Annex 2: The Evolution of the EC's Health, AIDS and Population Policy (1990-2000)

Health

(Commission Communication – COM (94) 77)

Strategic priorities:

- (1) to ensure that the health dimension is taken more fully into account in development policies, particularly in structural adjustment programmes;
- (2) to help correct structural imbalances in health systems, by directing action to basic services;
- (3) to facilitate institutional reform by building capacity at central level and supporting decentralisation;
- (4) to help countries develop systems to measure and mobilise resources more efficiently.

HIV/AIDS

(Commission Communication – COM (94) 79)

Strategic priorities:

- (1) to reduce the spread of the epidemic while preventing discrimination and exclusion of people at risk of infection or living with HIV and AIDS;
- (2) to enable the health sector to cope with additional burden of HIV/AIDS;
- (3) to lessen the impact of the epidemic on economic and social development;
- (4) to increase scientific understanding and know-how.

(Council Regulation - 550/97 – currently under revision as a basis for EC support for ‘poverty diseases’ HIV/AIDS, malaria and TB)

Strategic priorities:

- (1) to reduce the transmission of HIV/AIDS and the spread of other diseases capable of being transmitted sexually or perinatally;
- (2) to reinforce health and social services so they can cope with the growing demands of the epidemic;
- (3) to help governments and communities to assess the epidemic's impact on different economic and social sectors and to define and implement strategies to cope with it;
- (4) to develop scientific understanding of the epidemic and the impact of measures, with a view to improving their quality (while excluding basic research).

Population

(Council Regulation - 1484/97 – currently under revision as a basis for EC support for ‘reproductive and sexual health and rights’)

Strategic priorities:

- (1) to enable women, men and adolescents to make a free and informed choice about the number and spacing of their children;
- (2) to contribute to the creation of a socio-cultural, economic and educational environment conducive to the full exercise of that choice;
- (3) to help develop or reform systems in order to improve accessibility and quality of reproductive health care.

Communicable Diseases

(Commission Communication - COM(2000) 585 and COM (2001) 96)

Core areas for accelerated action:

- (1) Reaching optimal impact of existing interventions, services and commodities targeted at the major communicable diseases affecting the poorest populations;
- (2) Increasing affordability of key pharmaceuticals through a comprehensive and synergistic global approach;
- (3) Increasing investment in research and development of global goods targeted at the three major communicable diseases.

Annex 3: Major Causes of Morbidity and Mortality in Developing Countries

HIV/AIDS threatens to be the worst pandemic in world history. 40 million people live with HIV and AIDS has caused more than 22 million deaths. An additional five million people are infected each year. Almost one third of those with HIV are also infected with TB. HIV/AIDS affects individuals, households, communities and societies. It strains health and education systems, and retards economic growth. Most countries have failed to deal with the problem effectively and infection rates continue to rise. There are now 14 million AIDS orphans in Africa with estimates of 40 million by 2010. The advent of effective treatment regimes has widened disparities in HIV outcomes between rich and poor societies and between individuals. HIV threatens all countries and societies. The fastest growing epidemic is in Eastern Europe and the Caribbean is the second most affected region after Africa.

Fifty years after the introduction of effective treatment, **tuberculosis (TB)** still causes two million deaths annually and remains, allied to HIV/AIDS, the leading cause of death in adults. A course of effective treatment costs as little as USD 10 yet only one quarter of patients world-wide receive appropriate care. The TB problem is not confined to the poorest countries. In countries of the former Soviet Union, 10% of the prison population has active TB and infection rates are a hundred times those of the general population. Multi-drug resistant forms of TB (MDRTB) are common and have now been reported in 100 countries.

Malaria causes 500 million episodes of infection and over one million deaths annually, with most in Africa where malaria control efforts in many countries have all but collapsed. Transmission has returned to previously controlled areas and resistance to standard treatments is increasing.

Acute respiratory infections and diarrhoeal diseases remain major causes of ill health and mortality, particularly in children. Both cause and result from malnutrition. Diarrhoeal diseases reflect poor hygiene and limited access to clean water. Vaccine preventable diseases cause three million deaths each year.

Nearly half of child mortality in low-income countries can be linked to **malnutrition**, which contributes to infant, child and maternal morbidity, decreased learning capacity, lower productivity and mortality. Reducing malnutrition and addressing specific micronutrient deficiencies are key elements of poverty reduction.

Reproductive and sexual health and rights remain a key public health concern. Maternal and perinatal causes alone lead to the loss of 600,000 women and several million new-borns each year. Maternal deaths are a stark reminder of the inequalities between, and within, countries. Most are caused by birth-related complications and most are avoidable using existing inexpensive technologies. In 2000, WHO estimated that maternal conditions were second only to HIV/AIDS in their contribution to the global burden of disease. Despite major achievements in increasing access to contraceptive information and commodities there remains a massive gap in ensuring access to wider reproductive rights.

Lifestyle related causes of ill-health are becoming much more prevalent in developing countries. Populations with a major communicable disease problem, often face an added burden due to the rising impact of non-communicable diseases such as heart disease and diabetes. Particularly important are tobacco related illnesses (cancer, cardio- and cerebro-vascular diseases, and lung disease) which caused over four million deaths in 1998, two thirds of which were in developing countries. Tobacco related deaths are projected to double over the next 20 years. Many countries also face a rising toll from the negative health effects of high-risk sexual behaviour, drug abuse including alcohol, violence, conflict and road accidents. Mental illness is in many developing countries a neglected and very common cause of ill health.

Annex 4: Development approaches

Good governance is first and foremost an issue at the national level. Democracy and the rule of law are necessary prerequisites for sustainable development. Up to now the political response to governance challenges has proved insufficient on any level – national, European and international, public or private. **Inadequate domestic policies** in many countries, including developing countries, have contributed to the widening of the gap between the poor and the rich. Likewise, the lack of balance between global market forces on the one hand and global governance institutions on the other, has resulted in what one could call a ‘**global governance gap**’. Both factors breed discontent and conflict and undermine sustainable development. One particularly significant aspect of poor governance is **corruption**, which not only has damaging effects on a country’s own political system and economy, but also deters foreign investment and has negative spill-over effects into other countries, through money laundering and international crime.

Ownership, political commitment and leadership and effective planning are needed to drive forward a process of sector reform, to ensure adequate finance, from both government and donors to prioritise investments and fair resource allocation within the health sector. At the same time, efforts are needed to ensure accountability, encourage the broad participation of stakeholders including civil society in policy dialogue, in service delivery and in monitoring performance. The failings of past health systems have led to a re-appraisal of the traditional role of government as the main provider of services. It is increasingly acknowledged that a more effective role for government is that of ‘**stewardship**’ whereby the state assumes responsibility for oversight, regulation and quality control of the whole sector with multiple providers sharing responsibility for service delivery.

Policy coherence within the EU. Domestic EU policies may have negative spill-over effects on other countries, notably in the developing world. In several important areas existing EU policies conflict with health and poverty objectives. Policy coherence has **several dimensions**: coherence of policies pursued in different international organisations, coherence between external policies; coherence between external policies and the external effects of domestic policies; coherence between community policies and Member State policies; coherence within one single policy area. This makes it a politically challenging concept, and therefore difficult to operationalise.

National development strategies to reduce poverty are increasingly elaborated in a **Poverty Reduction Strategy Paper (PRSP)**. This comprehensive country-led framework is to ensure that all investments, government and donor, in relevant sectors including health are complementary and work towards the same overall goal of reducing poverty. Donors, including the EC, are progressively linking their assistance to such country driven strategies that are increasingly developed with the engagement of civil society and the private sector. The PRSP provides the opportunity for interventions to be prioritised in such a way as to reduce poverty with an increasing proportion of external assistance channelled through the national budget.

Sector wide approaches (SWAP) characterise a potentially more effective and efficient method of working between government and donors. All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all funds. This approach has evolved from two directions: interest to improve the allocation of the national budget and of donor flows between, and within sectors, and from concern that the traditional project approach has not produced sustainable improvements in services. Whilst there are positive early experiences most SWAPs are at an early stage of implementation. One of the main challenges is to ensure pro-poor targeting within SWAPs.

The untying of aid. Following the recommendations of the OECD/DAC, there is general agreement within the EU to explore options for the further untying of development aid as a means of improving its efficiency and effectiveness. The EU has initiated this process in relation to services and commodities essential to the fight against HIV/AIDS, tuberculosis and malaria.

Annex 5: Major Financing Instruments for EC Support of Health, AIDS and Population

European Development Fund (EDF)

The mainstay of EC Co-operation to the 77 ACP countries is provided through the European Development Fund (EDF). The Cotonou Agreement (2000) lays the foundation for the five-yearly financing protocols for 9th EDF (2002-2006).

Economic and Technical Co-operation with Asia and Latin America

Economic and technical co-operation with Asia and Latin America is embedded within an framework Council Regulation, adopted in 1992. In addition, co-operation agreements were signed on a sub-regional or country-by-country basis and cover co-operation as well as trade. Aid disbursed on an annual basis comes directly out of the Community's own budget. Overall, some 18 countries in Latin America and 17 in Asia benefit from EC aid under the co-operation programme, which is mainly financed through budget headings B7-300 (Asia) and B7-310 (Latin America). The regulation is currently under revision. An agreement with Mexico has been expanded into a more complex partnership and others with Mercosur and Chile are under a new negotiation process. Overall regional and per country strategies are being re-designed in order to better focus on priority interventions differing from country to country.

Co-operation with the Mediterranean under the MEDA programme

The Euro-Mediterranean Partnership was inaugurated by the November 1995 EU ministerial conference in Barcelona. This Partnership stresses the importance of the human aspect of relations between the two regions. Health plays a prominent role in efforts to promote sustainable development and overall well-being, backed by considerably increased financial aid. The MEDA Programme is the principal financial instrument of the EC for the implementation of the Euro-Mediterranean Partnership.

HIV/AIDS and Population Special Budget Lines

To complement the principal financial and technical co-operation instruments, special Community thematic budget lines have been used to support key policy and strategy development work in HIV/AIDS and population. These funds are designed to support the testing out of innovative methodologies and strategies as well as the generation of knowledge in gaps of understanding. The regulations for these budget lines are currently under revision and represent a focus on the implementation of the EC Programme for Action on Communicable Diseases, including a contribution to the Global Fund to fight HIV/AIDS, malaria and tuberculosis, and on EC support for reproductive and sexual health and rights.

NGO Co-Financing

Established in 1976, the NGO Co-financing line has come to play an increasingly important role in supporting health, AIDS and population work over recent years. It has been a flexible mode of funding for European NGOs who, in collaboration with their developing country partners, are seen by the EC as a particularly effective means of reaching the poorest and most marginalised communities. Around 25% of all NGO Co-financed projects are currently health targeted.

Humanitarian Aid

EC humanitarian aid covers a broad range of interventions, including the provision of emergency relief to victims of wars and natural disasters, assisting with refugees and carrying out short-term rehabilitation and construction work. In 1993 ECHO (the European Community Humanitarian Office) assumed responsibility for the management of non-food humanitarian aid and funding to this area increased strongly from that year onwards. Health and medical assistance has always taken up a very important proportion of all humanitarian aid.

Research

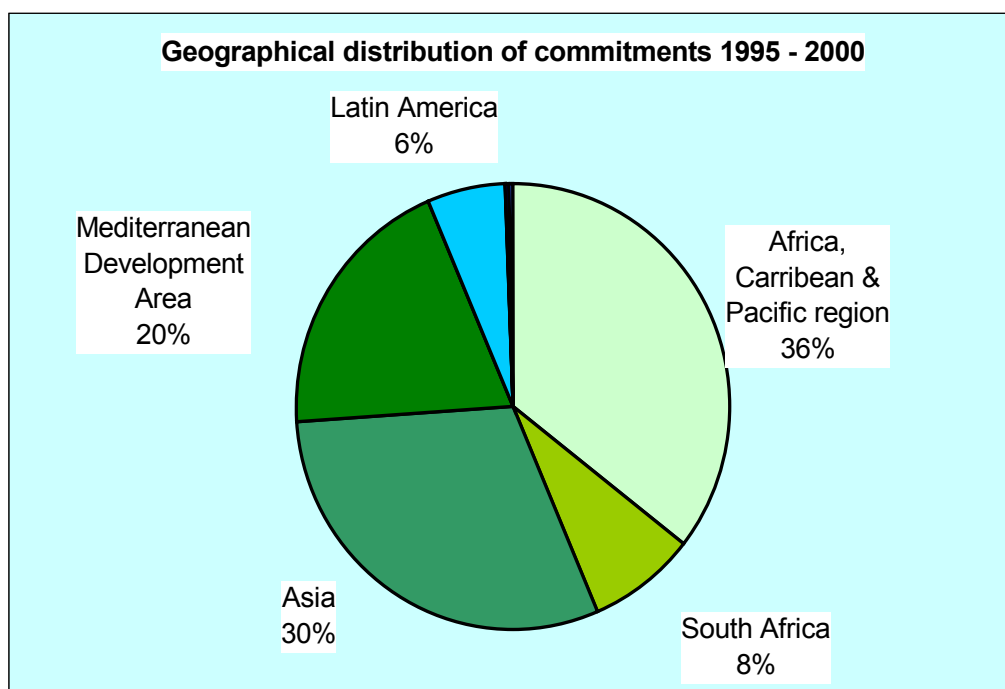
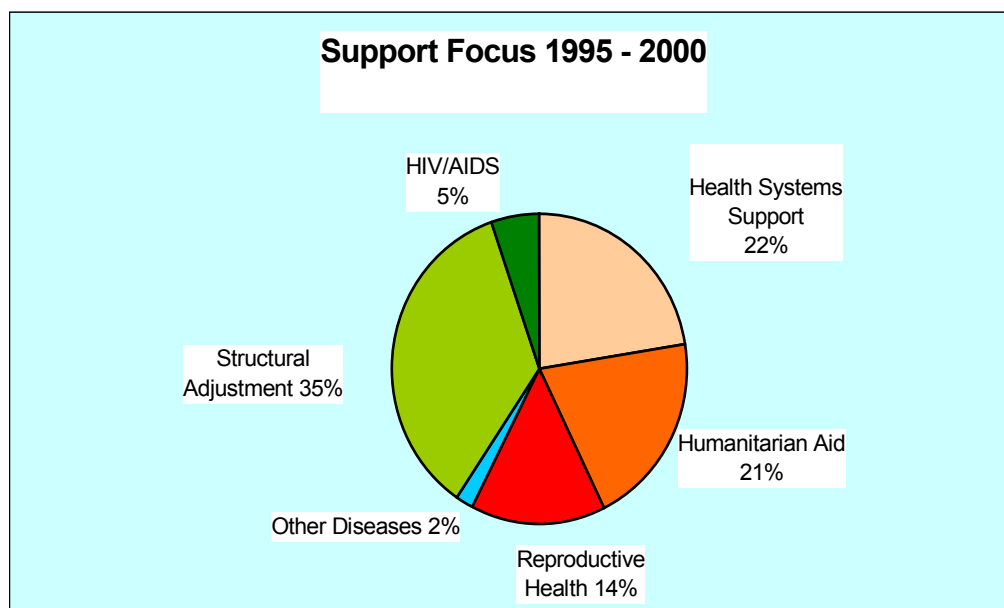
The EC supports research geared towards the health problems of developing countries within its Framework Programme budget. In the past, during the fourth Framework Programme, funding was provided through the EC International Collaboration Programme (INCO-DEV), which emphasised active collaboration in research between scientists from both developing country and European institutions on the basis of equal partnerships. Under the INCO more than 300 health related partnership projects have been funded, including HIV vaccine work in China and Tanzania, and Tuberculosis vaccine R&D in Zambia and Ethiopia.

As part of the Fifth Framework Programme, activities continued in the following programmes: 'Confirming the International Role of Community Research' and 'Improving Human Potential'. A specific initiative has been set up to increase malaria vaccine testing: the European malaria Vaccine Testing Network. The share of EC funded malaria drugs projects is also increasing. In addition, funding is available to support the participation of researchers from developing countries in EC financed research projects.

Portfolio

Community assistance to health, AIDS and population activity reached a peak of over Euro 700 million in 1998 amounting to 8% of the Community budget. The total 1995-2000 portfolio amounts to over Euro 1.4 billion. This figure represents EDF, South Africa, and ALAMEDA financing, including targeted budget support for the period 1995 - 2000. It does not include NGO co-financing, other special budget lines, research, non-targeted budget aid, humanitarian aid management by ECHO. The Euro 1.4 billion includes 36% committed to interventions in the ACP region, 8% to South Africa, 30% to Asia, 20% to the Southern Mediterranean (MEDA) and 6% to Latin America. A further breakdown by instruments and themes shows: 22% was allocated for health systems support, 21% for humanitarian aid (outside ECHO), 14% for reproductive health, 5% for AIDS, 2% for other diseases. An estimated 35% of the total portfolio was committed under the 'Structural Adjustment' heading. From: *'Evaluation de l'aide de la CE dans les pays ACP/ALA/MED dans le domaine de la sante'*: by Dr Paud De Caluwe, Jean-Claude Deheneffe, Marlene Abrial, Helene Ryckmans, Delphine Huybrecht, Jean-Pierre d'Altillia; Participating institutions: COTA, AEDES, GRET, IIED. Draft report released on 17.1.2002.

Type of commitments and geographical distribution in Health, HIV/AIDS and
Population investments
Total portfolio: Euro 1.4 billion (1995-2000)²⁴



²⁴

This does not include NGO co-financing, other special budget lines, research, non-targeted budget aid or humanitarian aid managed by ECHO.

**OVERALL COMMITMENTS RELATED TO HAP PROJECTS/PROGRAMMES
FOR 1995-2000 FUNDED THROUGH EDF & ALAMED FINANCIAL &
TECHNICAL COOPERATION INSTRUMENTS²⁵**

Region	Commitments Total Euro Million	Disbursement Total Euro Million	Disbursement versus Commitment Total
Asia	408,620	36,657	31.03%
Latin America	111,127	28,128	25.31%
Mediterranean	285,160	126,813	12.86%
ACP (incl. South Africa)	584,970	126,449	21.62%
Overall Total	Euro 1,389,877 million	Euro 318,047 million	22.88%

²⁵

Inventory EuropeAid Office, 7.3.2001. This list does not include interventions funded through other instruments such as budget aid (including structural adjustment), NGO co-financing, research, refugee budget lines or ECHO nor does it include funding of health programming under PHARE or TACIS.

Annex 6: Summary of Community Development Policy Framework, EU Member State investments and development policies in health

Community development policy

EC development policy identifies a limited number of areas selected for their potential contribution towards poverty reduction and for which Community action provides added value. The six EC development priority areas are: transport; support for regional integration; links between trade and development; support for macroeconomic policies and promotion of equitable access to social services; food security and sustainable rural development; institutional capacity building. Health and education are included within the priority area: *support for macroeconomic policies and promotion of equitable access to social services*. The **Joint Statement of the Council and the Commission** of November 2000 highlights an **emphasis on the social sectors**: *'In line with the macroeconomic framework, the Community must also continue its support to the social sectors (health and education), particularly with a view to ensuring equitable access to the social services.... In view of the global dimension of the communicable disease situation and its impact on poverty accelerated action by the Community and its Member States, targeting its various dimensions, must be considered an absolute necessity.'* The Statement gives a clear mandate to the Commission for coherence and sustainable development: *'There must be greater coherence between the various Community policies focused on sustainable development. The way to achieve this is to make a systematic and thorough analysis of any indirect effects of measure in especially sensitive areas and to take development problems into account in the Commission decision making process'*. In most countries EC development assistance is to be **limited to one or two sectors, and possible macroeconomic support**. Given this limitation, direct social sector support, in particular for health, may not always feature prominently within the EC assistance package for developing countries. However the total Community contribution to health in developing countries, through macroeconomic support and through support for other sectors will remain substantial.

Total EU Member States investments in health in developing countries

Member State	Total ODA/GNP 2000	Total health commitments of ODA - 1999 ²⁶	Member State	Total ODA/GNP 2000 - %	Total health commitments of ODA - 1999	Member State	Total ODA/GNP 2000	Total health commitments of ODA - 2000
Austria	0.25	13.4	Germany	0.27	2.8	Netherlands	0.82	5.0
Belgium	0.36	12.9	Greece	0.19	4.3	Portugal	0.26	3.0
Denmark	1.06	14.0	Ireland	0.30	10.1	Spain	0.24	6.0
Finland	0.31	6.4	Italy	0.13	5.2	Sweden	0.81	4.2
France	0.33	3.8	Luxembourg	0.70	14.5	UK	0.31	5.8

Members development policies in health

²⁶ OECD-Aid by Major Purposes, 1999: <http://webnet1.oecd.org/xls/M00002000/M00002855.xls>

Member State	Focus on priority diseases / burden of diseases of the poor	Multi-sectoral approach	Fair financing	Global level
Austria	Data not available (N/A.)	N/A.	N/A.	N/A.
Belgium Reference: Ministry of Foreign Affairs, International Trade and International Co-operation New sector policy paper on “International Co-operation in the Health sector” in preparation, 2002 -2006	Strengthening of health systems (SWAP, Health Sector Reform, Decentralisation) Integration of activities for the Prevention and Control of major infectious diseases within the Basic Health Services as well as special emphasis on Reproductive, Maternal and Child Health AIDS/STI control and management	Health is mainstreamed in the strategic papers on education, social economy and infrastructure, and to a limited extent also in those on peace building and international co-operation; the environment, agriculture and food security	Operational research and support to micro-credit and health care financing Support to community financing systems and mutual healthcare insurance companies adapted to local circumstances and managed by the local population	Advocacy for increased donor and national support for better access to health care Advocacy for enhanced access to medicines Global research on drugs and vaccines especially for the neglected diseases
Denmark (DANIDA) Ministry of Foreign Affairs, DANIDA, DANIDA Sector Policies “Health” November 2000	Prevention of HIV/AIDS, Respiratory Tract Infections, Diarrhoeal diseases, TB, Malaria, maternal mortality; prevention of malnutrition in children; Immunisation, Sustainability of achievements; Poverty alleviation; Gender equity; Disease control Health system reform; Public-Private partnership; SWAP; Drug Supply and Management Respond to emerging threats such as chronic diseases	N/A.	Reorganisation of the public financing to ensure that priority areas are effectively financed and subsidies properly targeted Reduction of impoverishing impact of health events; development of modalities for exemptions and for risk-sharing	N/A.
Finland Ministry for Foreign Affairs, Development Co-operation: “Women, men and development: Gender equality in Finnish Development Co-operation”(1999) “Humanitarian Aid in Finnish Development Co-operation” July 1999 “Finland’s Development Co-operation 2000” Annual report	N/A.	N/A.	N/A.	N/A.
France	Communicable diseases- HIV/AIDS, TB and malaria Trypanosomiasis	N/A.	Development of sustainable health-financing strategies	N/A.

“L’action de la France en matière de Coopération, d’Aide au Développement, de Traitement de la dette et de lutte contre la pauvreté” (mars 2000)	Strengthening health systems through reform, decentralisation, human resource development pharmaceutical policy			
Germany (GTZ) “Investing in health for Poverty reduction, Economic development and Social Security” Proceedings of the Summer Seminar on the GTZ Health and Population Section, September 2001 “Promotion of initiatives to eradicate Female Genital Mutilation” “Responding to HIV/AIDS in the Developing World, the GTZ contribution: 15 years of experience-an overview” June 2001 “HIV/AIDS Threat and Prevention in marginalised ethnic groups” June 2001	Establish functional health systems, primary health care Provide quality preventive, curative and promotive services, including MTCT and prevention among marginalised ethnic groups Decentralisation and community participation to improve health of the poorest populations; Disease control; Reproductive and sexual health, women Promotion of initiatives to eradicate Female Genital Mutilation	Primary environmental care Integration of HIV/AIDS activities into non-health projects (workplace, vocational schools, parent associations, primary school pupils) Private-Public partnerships	Development of sustainable health-financing strategies Private-Public partnerships Promotion of Social Health Insurance	N/A.
Greece “Statement on United Nations General assembly on HIV/AIDS” June 2001	Increased access to health services for the poor, including primary care and drugs Communicable diseases (HIV/AIDS, Malaria, TB), especially for prevention and fight against HIV/AIDS Improve child, women and reproductive health	Multi-sectoral approaches involving health, education and poverty	Development of sustainable health-financing strategies	Support for the World Health Organisation, UNICEF, UNAIDS, UNPFA Access to medicines
Ireland Ireland Aid Strategy and Guidelines for the Health Sector 2000 A HIV/AIDS Strategy for the Ireland Aid Programme 2000 Guidelines for Ireland Aid support to	Health System strengthening at national and sub-national level Support for the prevention/control of communicable diseases, reproductive health, human resource development; information and surveillance Support for decentralised health service delivery and the	Mainstreaming of HIV/AIDS into all sectors Consideration of health impacts of Ireland Aid support to other sectors	Ensuring Ireland Aid support is within National Budgets Facilitating the development of MTEF and Health Financing Strategies Support for piloting of cost	Advocacy role within UN, EU and other international organisations Support for International Initiatives and some Public-Private Partnerships Support for multilateral agencies

Water and Sanitation 2000 <u>Promoting Ireland's Interests: strategy statement of the Department of Foreign Affairs 1998 – 2000</u>	strengthening of community based initiatives Supporting the prevention of HIV/AIDS the mitigation of its impact through institutional, mainstreaming and targeted responses		recovery schemes	such as WHO, UNICEF, UNAIDS
Italy Ministry of Foreign Affairs, Development Co-operation Department "Linee guida della cooperazione italiana sulla riduzione della povertà" October 1999	N/A.	N/A.	N/A.	N/A.
Luxembourg Ministère des Affaires Etrangères du Grand-Duché de Luxembourg / Direction de la Coopération au Développement : - Une stratégie pour la coopération luxembourgeoise 1997 - La lutte contre la pauvreté dans la coopération luxembourgeoise - Rapport annuel 1999	Continue current investments in Human Resources, particularly in Education and Primary Health Care	« Integrated actions » for fighting poverty at several levels (health, transport, agriculture, water, family planning, women's roles, microcredits)	N/A.	Partnership with UNFPA, WHO, UNRWA, OECD (DAC guidelines)
Netherlands Sector-wide approaches for health development: Dutch field experiences in international co-operation (1999) Dutch policy and practice in reproductive health (1999) Water supply and sanitation in developing countries (1998) Nutrition: interaction of food, health and	Tackling poverty related health problems Improving reproductive and sexual health Strengthening health systems Reduce the spread of HIV/AIDS and mitigate the effects on individuals and societies	Mainstream health concerns in other sectors Collaboration with other departments to enhance and support intersectoral actions Multisectoral issues (e.g. reproductive health, nutrition, water and sanitation) in health SWAPs	N/A.	Support for multilateral organisations, including WHO, UNFPA, UNAIDS, UNICEF, World Bank Global health initiatives Global public goods Access to medicines, WTO/TRIPs

care (1998) Progress report on HIV/AIDS (1998, 2002 in prep) Poverty and HIV/AIDS (2001) Poverty and health (2001)		Mainstreaming HIV/AIDS		
Portugal Ministry of Health “Health a compromise – a health strategy at the turning of the century (1998-2002)” “Guidelines Health – contribution for the great plan options”, 2001	Priority on reducing health differences among the population Strategy to improve access to the National Health System by the poorest populations and migrants Health programs and projects on Family Planning, Vaccinations, HIV/AIDS, Tuberculosis, Addictions Co-operation programs based on formation and co-operation for development	Surveillance on water and sanitation quality Surveillance on environment pollution Promoting Health Schools	Co-operation with the Ministry of Labour and Solidarity	Supports for the World Bank, WHO, UNAIDS, UN, UNICEF
Spain	N/A.	N/A.	N/A.	N/A.
Sweden (SIDA) “Handbook for Mainstreaming Gender in the Health Sector”, June 1997 "Investing for Future Generations. Sweden's International Response to HIV/AIDS", 1997 “Policy for development Co-operation, Health Sector” June 1997 “Strategy for Development Co-operation, Sexual and reproductive Health and Rights” 1997 “Position Paper: Population, Development and Co-operation” 1997	Health system development To ensure coverage for health services of acceptable, cost effective, quality, equity and gender equity; public-private financing Improvement of sexual and reproductive health rights Public health; Immunisation and child health; Drug policy and rational use of drugs	Strengthened role for health sector in influencing health-related policies of other sectors Initiation of multi-sectoral approaches	Development of sustainable health-financing strategies	N/A.

“Facts and Figures 2000: Health and Development”				
UK (DFID) DFID “Better Health for Poor People- Strategies for Achieving the International development targets” November 2000	Addressing priority health problems of poor people Investing in strong, efficient and effective health systems Promoting a more effective global response to HIV/AIDS Creating social, political and physical environments to improve health Improve reproductive and sexual health Improve child health Maternal health Millennium Development Goals	Increase access to clean water and sanitation Mainstreaming HIV/AIDS Education	Budget support SWAPS Poverty and Health	Investment in new knowledge generation through WHO and directly funded programmes Global Public Goods Access to Medicines Support for UNICEF, UNFPA, UNAIDS, IPPF

An early assessment of the above leads to the following conclusion: Most Member States have well elaborated health policies for developing countries and some have re-formulated their policies in the context of poverty reduction. Most Member States primarily focus on efforts at the country level in order to improve health outcomes for the poor and some play a key role at the global level. Less attention is given to policy coherence at the country and global level. Few Member States highlight the potential for a multi-sectoral approach in health, beyond HIV/AIDS. Few Member States concentrate on equitable and fair financing and the investment in global public goods.