



EPF Parliamentary Handbook

THE ROLE OF PARLIAMENTARIANS IN ADVANCING THE HEALTH MDGS

In support of Action for Global Health



**ACTION FOR
GLOBAL HEALTH**
FULL TRAINING
STRONG SYSTEMS
FAIR ACCESS

Abbreviations And Acronyms

AAA	Accra Agenda of Action	HQ	Headquarters
ACP-EU JPA	Africa Caribbean Pacific– EU Joint Parliamentary Assembly	HIV	Human Immunodeficiency Virus
AfGH	Action for Global Health	HSS	Health System Strengthening
APF	Assemblée Parlementaire de la Francophonie	IHP+	International Health Partnership and Related Initiatives
APPG	All-Party Parliamentary Group	ICPD	International Conference on Population and Development
CCM	Country Coordinating Mechanism	IFS	Instrument for Stability
CTL	Currency Transaction Levy	IPPF	International Planned Parenthood Federation
CSOs	Civil Society Organisations	IPU	Inter Parliamentary Union
CV	Curriculum Vitae	ITNs	Insecticide-treated nets
DAC	Development Assistance Committee	LDCs	Least Developed Countries
DCD	Development Co-operation Directorate	LLDCs	Land-Locked Developing Countries
DCI	Development Cooperation Instrument	MDGs	Millennium Development Goals
DSW Brussels	German Foundation for World Population, Brussels Liaison Office	MdM	Médecins du Monde
EAAM	European Alliance Against Malaria	MEP	Member of the European Parliament
EC	European Commission	MP	Member of Parliament
EDF	European Development Fund	MS	Member States
EIDHR	European Instrument for Democracy & Human Rights	NGOs	Non-Governmental Organisations
ENPI	European Neighbourhood and Partnership Instrument	NMS	New Member States
EP	European Parliament	NSCI	Nuclear Safety Co-operation Instrument
EPF	European Parliamentary Forum on Population and Development	OECD	Organisation for Economic Cooperation and Development
EPHA	European Public Health Alliance	ODA	Official Development Assistance
EPWG	European Parliament Working Group on Reproductive Health, HIV/AIDS and Development	PACE	Parliamentary Assembly of the Council of Europe
EU	European Union	PMTCT	Preventing from Mother-to-Child Transmission
FPFE	Spanish Federation For Family Planning	RBM	Roll Back Malaria Partnership
FTT	Financial Transaction Tax	RHSC	Reproductive Health Supplies Coalition
GAVI	Alliance Global Alliance for Vaccines and Immunisation	SAA	Stop AIDS Alliance
GBC	Global Business Coalition	SBS	Sector Budget Support
GBS	General Budget Support	SIDS	Small Island Developing States
Global Fund	Global Fund to fight AIDS, Tuberculosis and Malaria	SRHR	Sexual and reproductive health and rights
GDP	Gross Domestic Product	SWOP	State of World Population
GH	Global Health	TB	Tuberculosis
GHA	Global Health Advocates	UK	United Kingdom
GNI	Gross National Income	UN	United Nations
H4	'Health 4' Partnership	UNAIDS	The Joint United Nations Programme on HIV/AIDS
H8	Eight Global International Health Agencies	UNFPA	United Nations Population Fund
		UNICEF	United Nations Children's Fund
		USA	United States of America
		WHO	World Health Organization

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ActionAid

AIDOS

CESTAS

DSW Brussels (German Foundation for World Population)

European Public Health Alliance (EPHA)

Federación de Planificación Familiar Estatal (FPFE)

GAVI

The Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM)

Global Health Advocates (GHA)

Interact Worldwide

International HIV/AIDS Alliance

Médecins du Monde (MdM)

Médicos del Mundo

Millennium Foundation (MASSIVEGOOD)

Plan International

Roll Back Malaria (RBM)

Stop AIDS Alliance (SAA)

TB Alert

Terre des Hommes Germany

The World Bank

UNAIDS

UNDP

UNFPA

UNITAID

Welthungerhilfe

WHO

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About EPF

WHO WE ARE

EPF is a Brussels-based parliamentary network that serves as a platform for cooperation and coordination for the 28 all-party groups in Parliaments throughout Europe that focus on global health, and particularly on improving sexual and reproductive health and rights (SRHR) at home and abroad. EPF seeks to empower Members of Parliament (MPs) in Europe to meet their international commitments to advocate for population and development issues in a national, regional and international setting. By offering MPs a framework for cooperation and debate at a pan-European level, EPF and its network of member parliamentary groups across the continent are able to effectively mobilise the resources to achieve the funding and policy commitments of the Millennium Development Goals (MDGs).

Because Europe is home to 32 of the world's 43 governmental donors of development assistance, parliamentarians in Europe play a crucial role in making sure international funding commitments are met and programmes are available where they are needed the most. Domestically, these parliamentarians work to improve the health and rights of their countries' most vulnerable populations.

EPF's expertise derives from its exclusive focus on parliamentarians. Its core activities include conducting field visits to developing countries, supporting parliamentary activities, organising conferences on key topics, and providing training to develop understanding and expertise in SRHR, malaria, HIV/AIDS and other global health-related issues.

EPF provides a pan-European framework for parliamentarians to forge consensus and collaborate on resource mobilisation strategies. EPF also frequently works with United Nations (UN) agencies, inter-governmental organisations and national, regional and international non-governmental organisations (NGOs) that have an interest in working with parliamentarians.

EPF began as a project of the International Planned Parenthood Federation (IPPF) European Network. It was legally registered in Belgium and recognised by Royal Decree in 2000. In 2004, EPF became a fully independent not-for-profit organisation. In 2009, EPF became a member of the Action for Global Health (AfGH) Network.



WHAT WE BELIEVE

EPF believes that parliamentarians have the opportunity and the responsibility to promote global health and, particularly, SRHR and gender equality, which are core elements of human dignity and central to human development.

AFGH is a broad European network of NGOs advocating for Europe to play a more proactive role in enabling developing countries to meet the Health Millennium Development Goals by 2015.

About AfGH ⁽¹⁾

Established in 2006 by 15 organisations under the leadership of ActionAid, AfGH is a network of European NGOs based in Italy, France, Spain, Germany, the UK and Brussels working on different aspects of health advocacy for Europe to do more and better in order to achieve the health MDGs. It brings together organisations calling for the right to health to be a priority for all.

As a network of development and health organisations, AfGH offers a unique blend of expertise, collectively raising awareness on the need to achieve the health MDGs and promote the right to health in developing countries. It has established strong links with decision-makers and international agencies over the last four years.

AfGH's main actions take place in Europe, particularly Brussels and in the European Union (EU) Member States, targeting the media and decision-makers in the European institutions and key Member State governments. It develops policy analysis and research, engaging with other civil society groups both in Brussels and throughout the EU, to build advocacy alliances. Its messages and policy expertise are built through research in Europe and in developing countries, where the network benefits from the expertise and evidence provided by Southern partners of AfGH member organisations.

⁽¹⁾ Action for Global Health website: www.actionforglobalhealth.eu

AfGH PARTNERS

Brussels

- ActionAid:** www.actionaid.org
- DSW Brussels (German Foundation for World Population):** www.dsw-online.de
- EPF (European Parliamentary Forum on Population and Development):** www.epfweb.org
- European Public Health Alliance (EPHA):** www.eph.org
- Plan International:** www.plan-international.org
- Stop AIDS Alliance (SAA):** www.stopaidsalliance.org

France

- Global Health Advocates (GHA):** www.ghadvocates.org
- Médecins du Monde (MdM):** www.medecinsdumonde.org

Germany

- Terre des Hommes Germany:** www.tdh.de
- Welthungerhilfe:** www.welthungerhilfe.de

Italy

- AIDOS:** www.aidos.it
- CESTAS:** www.cestas.org

Spain

- Federación de Planificación Familiar Estatal (FPFE):** www.fpfe.org
- Médicos del Mundo:** www.medicosdelmundo.org

UK

- Interact Worldwide:** www.interactworldwide.org
- International HIV/AIDS Alliance:** www.aidsalliance.org
- TB Alert:** www.tbalert.org



Preface



THIS BOOKLET IS INTENDED FOR:

Members of Parliament

Parliamentary assistants

Secretariats of Parliamentary
committees

All-Party Parliamentary
Groups (APPGs)

NGOs and other actors
engaged in the promotion
of global health.

As we reach the mid-point in the countdown to 2015, there are several examples of progress and success in health service delivery in developing countries. However, current trends suggest that many low-income countries will not reach the MDG targets. In the past few years, with the emergence of numerous new global health partnerships and initiatives, the development aid architecture has changed and evolved significantly. This parliamentary handbook aims to help European parliamentarians to better understand the basics and the importance of Official Development Assistance (ODA), the new global health aid architecture, and the latest global health policies and innovative financing mechanisms.

This handbook presents an all-encompassing view of parliamentarians' role in EU decision-making in relation to global health, provides balanced examples of good donor practice, and makes strong recommendations for effective aid and the appropriate priority for health. It contains a guide to existing European commitments to global health and the role of parliamentarians in monitoring delivery of those commitments to the health-related MDGs.

About Global Health And The MDGs

'G'lobal health' is about achieving a worldwide improvement in health, a reduction in the disparities between the health services that people receive, and providing protection against global threats.⁽¹⁾ While global health challenges include the right to equitable and universal access to quality prevention, treatment, health care services and supplies via strong health systems, other key challenges that global actors, and particularly the EU, still need to address are leadership, universal coverage, coherence of policies and knowledge.

established eight Millennium Development Goals (MDGs), set targets for 2015, and identified a number of indicators for monitoring progress. All goals and their targets are measured in terms of progress since 1990.

When countries agreed that the MDGs should be achieved by 2015, a bargain was struck: while developing countries would have primary responsibility for achieving the goals, donor countries would have a particularly important role to play in supporting a global partnership for development. This includes commitments to increase both the quantity and the quality of aid to developing countries.

It has been established that the millennium development targets are inseparable and interlinked. Success in meeting the health MDGs, and realising the right to health, will only be achieved if these anti-poverty goals are addressed in a comprehensive way. This requires building strong systems for comprehensive and primary health care and addressing the social determinants of health through actions across all sectors, including gender inequity.

To date, progress towards health MDGs is uneven and largely off-track in most developing countries, and the prospect of fully achieving any of the MDGs by the target year of 2015 looks remote. Although some progress has been made to reduce child mortality (MDG4), close to 15% of children in sub-Saharan Africa still die before the age of five. New findings on maternal health are encouraging, but still a huge effort is still needed to save girls and women and to significantly reduce maternal mortality rates (MDG5). As for HIV/AIDS (MDG6), the number of people from developing countries receiving antiretroviral treat-

In September 2000, at the UN Millennium Summit, 189 heads of state adopted the UN Millennium Declaration and endorsed a framework for development. The plan was for countries and development partners to work together to increase access to the resources needed to reduce poverty and hunger, and tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.⁽²⁾ They



About Global Health And The MDGs

THE MILLENNIUM DEVELOPMENT GOALS:

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

MORTALITY RATES ESTIMATES AT A GLANCE

Infant deaths: 9,7 million children died before their fifth birthday in 2006

HIV/AIDS: There were 2 million AIDS-related deaths in 2008

Tuberculosis: 1,8 million people died from TB in 2008

Malaria: 1 million people die of malaria each year

Maternal mortality:

358 000 women die of pregnancy-related causes every year⁽⁴⁾

67 000 women die of complications resulting from unsafe abortion procedures each year

THREE OUT OF EIGHT OF MDGS FOCUS SPECIFICALLY ON HEALTH:

4. To reduce by two-thirds the infant death rate
5. To reduce by three-quarters deaths of women during pregnancy and childbirth
6. To reverse the spread of communicable diseases, such as HIV and AIDS, TB and malaria.

Six of the eight goals, and eight of the eighteen targets are directly health related.

Health was recognised as a vital driver of economic development, not just an indicator.

ment has increased ten-fold in the past five years, but still, HIV/AIDS remains the primary single cause of death in sub-Saharan Africa.⁽³⁾

Reporting on progress towards the MDGs has underscored the importance of working with countries to generate more reliable and timely data. Often the countries making the least progress are those affected by high levels of HIV/AIDS, economic hardship or conflict. The lack of priority given to health has undermined progress towards the achievement of the health MDGs. The major challenge now is to accelerate global efforts and scale up financial and political support. Parliamentarians play a key role in succeeding and overcoming these major challenges. Therefore, parliamentary commitment, mobilisation and support are needed more than ever.

⁽¹⁾ Communication from the Commission to the Council, the European Parliament and the European Economic and Social Committee and the Committee of the Regions on "the EU Role in Global Health", COM(2010)128 final.

⁽²⁾ World Health Organization (WHO) website: www.who.int/mediacentre/factsheets/fs290/en/index.html

⁽³⁾ UNAIDS, AIDS Epidemic Update, 2009.

⁽⁴⁾ WHO

⁽⁵⁾ www.mdgs.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList2008.pdf

OFFICIAL LIST OF MDG INDICATORS ⁽⁵⁾

All indicators should be disaggregated by sex and urban/rural as far as possible.

Effective 15 January 2008

GOALS AND TARGETS

(from the Millennium Declaration)

INDICATORS FOR MONITORING PROGRESS

Goal 1: ERADICATE EXTREME POVERTY AND HUNGER

TARGET 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

- 1.1 Proportion of population below \$1 (PPP) per day ⁽⁶⁾
- 1.2 Poverty gap ratio
- 1.3 Share of poorest quintile in national consumption

TARGET 1.B: Achieve full and productive employment and decent work for all, including women and young people

- 1.4 Growth rate of GDP per person employed
- 1.5 Employment-to-population ratio
- 1.6 Proportion of employed people living below \$1 (PPP) per day
- 1.7 Proportion of own-account and contributing family workers in total employment

TARGET 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

- 1.8 Prevalence of underweight children under-five years of age
- 1.9 Proportion of population below minimum level of dietary energy consumption

Goal 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

TARGET 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

- 2.1 Net enrolment ratio in primary education
- 2.2 Proportion of pupils starting grade 1 who reach last grade of primary
- 2.3 Literacy rate of 15-24 year-olds, women and men

Goal 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

TARGET 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

- 3.1 Ratios of girls to boys in primary, secondary and tertiary education
- 3.2 Share of women in wage employment in the non-agricultural sector
- 3.3 Proportion of seats held by women in national parliament

Goal 4: REDUCE CHILD MORTALITY

TARGET 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

- 4.1 Under-five mortality rate
- 4.2 Infant mortality rate
- 4.3 Proportion of 1 year-old children immunised against measles

About Global Health And The MDGs

Goal 5: IMPROVE MATERNAL HEALTH

- TARGET 5.A:** Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
- 5.1 Maternal mortality ratio
5.2 Proportion of births attended by skilled health personnel
- TARGET 5.B:** Achieve, by 2015, universal access to reproductive health
- 5.3 Contraceptive prevalence rate
5.4 Adolescent birth rate
5.5 Antenatal care coverage
5.6 Unmet need for family planning

Goal 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

- TARGET 6.A:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS
- 6.1 HIV prevalence among population aged 15-24 years
6.2 Condom use at last high-risk sex
6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
- TARGET 6.B:** Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it
- 6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
- TARGET 6.C:** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
- 6.6 Incidence and death rates associated with malaria
6.7 Proportion of children under 5 sleeping under insecticide-treated bednets
6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs
6.9 Incidence, prevalence and death rates associated with tuberculosis
6.10 Proportion of tuberculosis cases detected and cured under Directly Observed Treatment Short Course (DOTS, internationally recommended TB control strategy)

Goal 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

- TARGET 7.A:** Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
- 7.1 Proportion of land area covered by forest
7.2 CO2 emissions, total, per capita and per \$1 GDP (PPP)
7.3 Consumption of ozone-depleting substances
7.4 Proportion of fish stocks within safe biological limits
7.5 Proportion of total water resources used
- TARGET 7.B:** Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss
- 7.6 Proportion of terrestrial and marine areas protected
7.7 Proportion of species threatened with extinction
- TARGET 7.C:** Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation
- 7.8 Proportion of population using an improved drinking water source
7.9 Proportion of population using an improved sanitation facility
- TARGET 7.D:** By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers
- 7.10 Proportion of urban population living in slums ⁽⁷⁾

About Global Health And The MDGs

Goal 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

TARGET 8.A: 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

TARGET 8.B: Address the special needs of the least developed countries

Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

TARGET 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)

TARGET 8.D: 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 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

TARGET 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.

OFFICIAL DEVELOPMENT ASSISTANCE (ODA)

- 8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income
- 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)
- 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied
- 8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes
- 8.5 ODA received in small island developing States as a proportion of their gross national incomes

MARKET ACCESS

- 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty
- 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries
- 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product
- 8.9 Proportion of ODA provided to help build trade capacity

DEBT SUSTAINABILITY

- 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)
- 8.11 Debt relief committed under HIPC and MDRI Initiatives
- 8.12 Debt service as a percentage of exports of goods and services
- 8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
- 8.14 Telephone lines per 100 population
- 8.15 Cellular subscribers per 100 population
- 8.16 Internet users per 100 population

The Millennium Development Goals and targets come from the Millennium Declaration, signed by 189 countries, including 147 heads of State and Government, in September 2000 (www.un.org/millennium/declaration/ares552e.htm) and from further agreement by Member States at the 2005 World Summit (Resolution adopted by the General Assembly - A/RES/60/1, www.un.org/Docs/journal/asp/ws.asp?m=A/RES/60/1). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and the developing countries "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty".

⁽⁶⁾ For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

⁽⁷⁾ The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.

About Global Health And The MDGs

SOME KEY FACTS AND FIGURES – HEALTH MDGS ARE INTERLINKED

MDG4: to reduce by two-thirds the infant death rate

- Approximately 9,7 million children died in 2006 before their fifth birthday⁽⁸⁾
- Around 2 million children under five die from pneumonia each year
- The risk of a child dying before the age of five is 12 times higher in the developing world than in the most developed countries
- As many as 24,1 million babies are not vaccinated against common diseases⁽⁹⁾
- 200 000 newborn deaths occur each year due to malaria

MDG5: to reduce by three-quarters deaths of women during pregnancy and childbirth

- In sub-Saharan Africa there are 920 maternal deaths per 100 000 live births (compared to 14 in the most developed countries)
- Around 529 000 women die of pregnancy-related causes every year: one every minute
- 300 million women in developing countries suffer from pregnancy-related illnesses
- 125 to 200 million women would like to control their fertility but have no access to contraceptives (unmet needs)
- Around 700 million women between 15 and 49 in developing countries are at risk of unintended pregnancy
- One-third of women give birth by the age of 20
- Each year 2,2 million pregnant women infected with HIV/AIDS give birth
- Around 700 000 babies contract HIV/AIDS from their mother
- Malaria infection in Africa causes 400 000 cases of severe maternal anaemia contributing to maternal mortality
- Pregnant women are four times more likely than other women to contract malaria
- Complications due to unsafe abortion procedures account for an estimated 13% of maternal deaths worldwide – or 67 000 per year. This makes unsafe abortion the third highest pregnancy-related killer of women and girls⁽¹⁰⁾





MDG6: to reverse the spread of communicable diseases, such as HIV and AIDS, TB and malaria

- There were approximately 2 million AIDS-related deaths in 2008
- The number of people living with HIV worldwide continued to grow in 2008, reaching an estimated 33,4 million
- Half the world's population is at risk of malaria
- There are approximately 1 million deaths from malaria per year
- 3000 children die every day from malaria: one every 30 seconds
- 90% of malaria deaths occur in sub-Saharan Africa – mainly among women and children
- There were approximately 247 million cases of malaria in 2006
- Around 1,8 million people died from TB in 2008, including 500 000 people with HIV – equal to 4500 deaths a day⁽¹¹⁾
- There were 9,4 million new TB cases in 2008

⁽⁸⁾ UNICEF, Progress for Children, A World Fit for Children Statistical Review, Number 6, December 2007, www.unicef.org/progressforchildren/2007/n6/files/Progress_for_Children_-_No._6.pdf

⁽⁹⁾ Facts and Figures, GAVI Alliance website, www.gavialliance.org/media_centre/facts/index.php

⁽¹⁰⁾ WHO and Guttmacher Institute, Facts on Induced Abortion Worldwide, October 2007

⁽¹¹⁾ WHO, 2009, www.who.int/tb/publications/2009/factsheet_tb_2009update_dec09.pdf

Why ODA?

A. ABOUT DEVELOPMENT AID

Development aid or development cooperation (also called Official Development Assistance (ODA), technical assistance, international aid, overseas aid or foreign aid) is aid given by governments and other agencies to support the economic, social and political development of developing countries. It is distinguished from humanitarian aid by focusing on alleviating poverty in the long term, rather than alleviating suffering in the short term.

Most development aid comes from the industrialised countries, but some poorer countries also contribute. While the majority of development aid comes from government sources, other sources of aid include private organisations, charities, foundations, companies and NGOs, as well as remittances by individuals. The various development aid channels for health will be described in chapter VII.

Governments of the world agreed to commit 0,7% of developed countries' Gross National Product (GNP) to ODA for the first time in the 1970 UN General Assembly Resolution. Since then, world leaders have repeated their commitment to the 0,7% target in many international agreements over the years.

Today's key references for ODA are the statistics compiled by the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), which aims to measure aid. The DAC, initially called Development Assistance Group (DAG), consists of 23 of the largest aid-donating countries and the European Commission (EC).



DEFINITION OF OFFICIAL DEVELOPMENT ASSISTANCE (SINCE 1972)

ODA consists of flows to developing countries and multilateral institutions provided by official agencies, including state and local governments, or by their executive agencies, each transaction of which meets the following test: a) it is administered with the promotion of the economic development and welfare of developing countries as its main objective, and b) it is concessional in character and contains a grant element of at least 25% (calculated at a rate of discount of 10%).

Why ODA?

B. THE ORIGINS OF ODA AND THE CREATION OF THE OECD DAC ⁽¹⁾

The historical beginnings of ODA ⁽²⁾ are the development activities of the colonial powers in their overseas territories, the institutions and programmes for economic cooperation created under the auspices of the UN after the Second World War, the United States Point Four Programme and the large-scale support for economic stability in the countries on the periphery of the Communist bloc of that era. The success of the Marshall Plan created considerable optimism about the prospects for helping poorer countries in quite different circumstances through external assistance. The establishment of the DAC and Development Co-operation Directorate (DCD) of the OECD was an integral part of the creation of a network of national and international aid agencies and programmes and related institutions.

Since then, the OECD's mission has been to help its member countries to achieve sustainable economic growth and employment and to raise the standard of living in member countries while maintaining financial stability – all this in order to contribute to the development of the world economy. The DAC is the principal body through which the OECD deals with issues related to cooperation with developing countries.

⁽¹⁾ DAC in Dates, The History of OECD's Development Assistance Committee, 2006 Edition, www.oecd.org/dataoecd/3/38/1896808.pdf

⁽²⁾ The story of Official Development Assistance – A history of the Development Assistance Committee and the Development Co-operation Directorate in dates, names and figures by Helmut FÜHRER, OCDE/GD(94)67, OECD, Paris, 1996

SUMMARY PRESENTATION OF THE OECD DAC

The Development Assistance Committee (DAC) is a unique international forum where donor governments and multilateral organisations – such as the World Bank and the UN – come together to help partner countries reduce poverty and achieve the MDGs. This means seeking new ways of working to increase not only the quantity, but also the quality of aid – in other words, to improve aid effectiveness.

The DAC issues analysis and guidance in key areas of development and forges ties with other policy communities to coordinate efforts. Its members also work together through peer review to assess each others' aid policies and their implementation so as to promote good practice. The DAC's objective is to be the definitive source of statistics on ODA.

The DAC comprises 24 members (23 countries and the European Commission). Their policymakers and experts participate in working parties and networks that tackle major thematic areas in development, often in collaboration with representatives from partner countries and civil society institutions. The current DAC Chair is Mr. Eckhard Deutscher.

The Development Co-operation Directorate (DCD), one of the OECD's substantive directorates, acts as the secretariat for the DAC, providing technical expertise and operational capacity.

Why ODA?

C. KEY HISTORICAL MOMENTS AND THE EVOLUTION OF OECD DAC

"The DAC has always enjoyed the singular privilege of being the venue and voice of the world's major bilateral donors"

– **Michael Roeskau**, Director of the OECD's Development Co-operation Directorate

Since 1962 the OECD DAC has been publishing annual reviews of each member's development assistance efforts and policies (Aid Reviews). Throughout the years, the DAC agreed on directives for reporting aid and resource flows to developing countries on a comparable basis. Organising high-level meetings to review the results of aid, the DAC focused on improving and harmonising the financial terms of aid, both in view of the impact on developing countries' debt and of burden-sharing considerations. In 1969, the DAC adopted the concept of 'Official Development Assistance' and recommended the 0,7% target for ODA. For the first time, a DAC report published figures on 'ODA as a percentage of GNP'. In the 1970s DAC countries focused mainly on aid volumes while in the 1980s new emphasis was put on the evaluation of aid effectiveness leading to increased efforts to promote improved aid coordination and policy-based aid. In the 1990s, the DAC devoted major attention to the problems of ensuring improved policy coherence in the whole range of policies (good governance, etc.) in relations with developing countries and on the role of aid agencies. With the UN Millennium Summit in 2000, the international donor community achieved a universal commitment to specific international development goals known as MDGs. Over the last decade, the DAC has been extensively focusing on the analysis of all sources of financing for development and harmonising donor practices for effective aid delivery.

⁽³⁾ Portugal joined the DAC in 1960, withdrew in 1974 and re-joined in 1991.



THE 24 DAC MEMBERS AND DATE OF MEMBERSHIP AT A GLANCE

Australia (1966)
Austria (1965)
Belgium (1960)
Canada (1960)
Denmark (1963)
France (1960)
Finland (1975)
Germany (1960)
Greece (1999)
Ireland (1985)
Italy (1960)
Japan (1960)
Korea (2010)
Luxembourg (1992)
The Netherlands (1960)
New Zealand (1973)
Norway (1962)
Portugal (1960/1991) ⁽³⁾
Sweden (1965)
Switzerland (1968)
Spain (1991)
United Kingdom (1961)
United States (1961)
European Commission (1961)

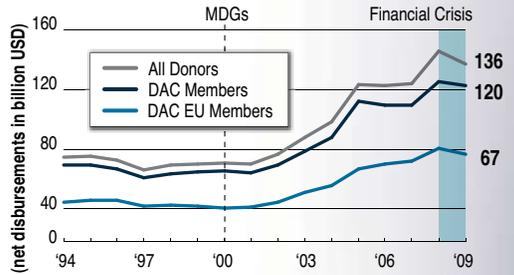
General And Health ODA

A. ODA IN 2009 WHERE DO WE STAND?

Most ODA comes from the 24 members of the DAC. The new OECD figures released on 14 April 2010 show continuing growth in development aid in 2009, despite the financial crisis. The total net ODA from the donors in the OECD DAC rose slightly (0,7% in real terms) to US\$119,6 billion, representing 0,31% of DAC members' combined GNI (See Figure 1). Excluding debt relief, the rise in ODA in real terms was +6,8%.

If debt relief and humanitarian aid are excluded, bilateral aid for development programmes and projects rose by 8,5% in real terms, as donors continued to scale up their core development projects and programmes. Most of the rise was in new lending (+20,6%), but grants also increased (+4,6%, excluding debt relief). In 2009, net bilateral ODA to Africa was US\$28 billion, representing an increase of 3% in real terms over 2008. US\$25 billion of this aid went to sub-Saharan Africa, which represents an increase of 5,1% over 2008.

Fig. 1: ODA Disbursements (1994-2009)



Source: EuroMapping 2010
All donors includes developed country governments, development banks and funds, UN agencies and other Development Institutions. DAC members refer to the 24 states who are currently members of the OECD's Development Assistance Committee

1. Donor Performance At A Glance

In 2009, the largest donors by volume were the United States, France, Germany, the United Kingdom and Japan (see Fig. 3). Five countries exceeded the UN ODA target of 0,7% of GNI: Denmark, Luxembourg, the Netherlands, Norway and Sweden (see Fig. 4).

Fig. 2: National ODA As % Of GNI (2009)

- ODA/GNI > 1%
- ODA/GNI > 0,70%
- ODA/GNI > 0,51%
- ODA/GNI > 0,17%
- ODA/GNI below all targets
- No data available
- Positive change
- No change
- Negative change



General And Health ODA

Fig. 3: Top Global ODA Donors

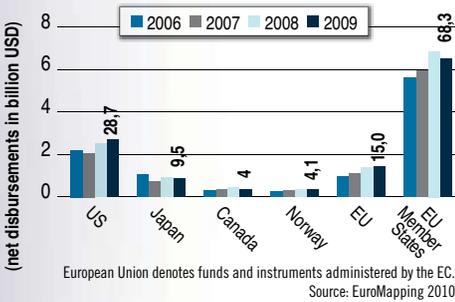
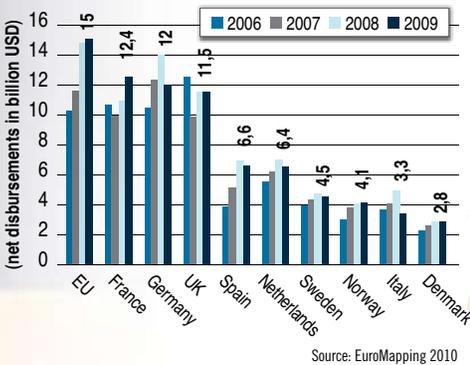


Fig. 4: Top European Donors



The largest percentage increases in net ODA in real terms were from Norway, France, the United Kingdom, Korea (which joined the DAC with effect from 1 January 2010), Finland, Belgium and Switzerland. Significant increases were also recorded in Denmark, Sweden and the United States. The combined net ODA of the 15 members of the DAC that are EU members fell slightly (-0,2%) to US\$67,1 billion, representing 0,44% of their combined GNI. The ODA of those countries represented 56% of total DAC ODA.

The OECD Secretary General, Angel Gurría, welcomed news of the further increase in ODA and urged donors to keep the momentum going in future years, despite their fiscal

challenges. The DAC Chair, Eckhard Deutscher, pointed out that a clear majority of DAC members are meeting their aid commitments, even in the face of the economic crisis. Though there has been an encouraging increase in ODA to Africa, Deutscher pointed out that this fell well short of the Gleneagles target of a US\$25 billion increase by 2010.

2. ODA Overview At A Glance

Europe remains the largest donor to global ODA. The aid programmes of the EU, its Member States and other European donors (Norway and Switzerland) account for almost 70% of all ODA. In comparison, the USA contributes 20%. Europe wields a major influence on development as the world's largest donor of ODA. The EC, which manages 20% of EU development assistance (and this alone now exceeds World Bank ODA), contributes to 10% of global aid.

3. What Are The Expected Aid Levels For 2010?

According to the OECD DAC, despite various shortfalls against commitments, ODA increased by nearly 30% in real terms between 2004 and 2009, and it is expected to rise by about 36% in real terms between 2004 and 2010. ODA as a percentage of GNI rose from 0,26% in 2004 to 0,31% in 2009 and is expected to rise to 0,32% in 2010. This is the largest volume increase ever in ODA over such a period and does not depend on the large increase in debt relief which boosted the aid numbers in 2005–07. The continued growth in ODA has shown that aid pledges are effective when backed up with adequate resources, political will and firm multi-year spending plans. ODA will continue to rise in 2010, unlike other financial flows to developing countries, which have fallen sharply since the onset of the global financial crisis.

General And Health ODA

OVERVIEW OF DONOR COUNTRIES AT A GLANCE

Top 5 donors (Volume of ODA)

1. United States
2. France
3. Germany
4. United Kingdom
5. Japan

The 0,7% ODA/GNI Club

Denmark (since 1978)
Luxembourg (since 2000)
Netherlands (since 1975)
Norway (since 1976)
Sweden (since 1974)

New/emerging donors

China, India, New EU Member States, Russia, Turkey

"Aid is less than 1% of government spending on average in OECD countries while there is still much effort needed to reach the Millennium Development Goals. This is a vital investment with big returns for the world as a whole"

Angel Gurría,
OECD Secretary General



"Aid financing remains vital to meet the MDGs (...) so all donors need to make the efforts necessary to meet their commitments"

Eckhard Deutscher, DAC Chair

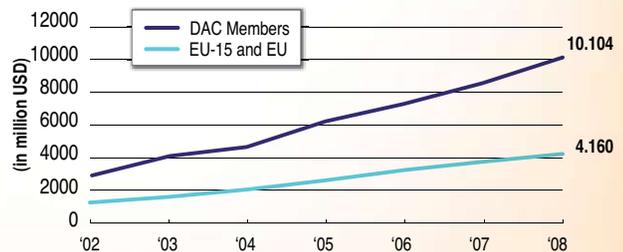
B. HEALTH ODA - WHERE DO WE STAND?

Despite significant private contributions, most funding for health initiatives around the world still comes from governmental donors, predominately through ODA. All donor countries have made significant strides in increasing health-related ODA, particularly since 2000, the year when the Millennium Declaration and the MDGs were adopted. In order to reach the health MDGs, 0,1% of EU donors' GNI should be allocated to support developing countries in addressing the health needs of their populations, as was recommended by the World Health Organization (WHO)'s Commission on Macro Economics and Health.

Between 2000 and 2006, health ODA increased by 287% among all donors, reaching US\$4,532 billion. Among European donors, health ODA increased by 253% over the same period, to reach US\$2,710 billion. In 2006, European donors accounted for 60% of all health ODA.

European donor support for health ODA is strong, yet unevenly divided among Member States. Until 2005, the EC, the UK and France accounted for over 43% of all European health ODA. Only in 2006 did the Netherlands, Germany and Sweden step up their efforts in health ODA spending. The same year saw a significant decrease in health ODA from the EC and a smaller decrease from France.

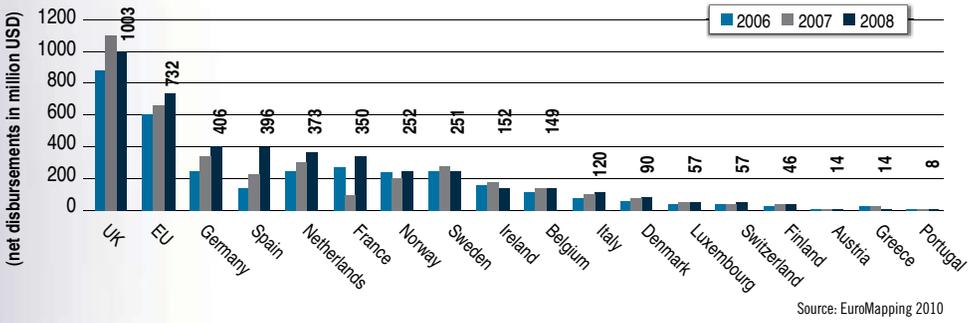
Fig. 5: Health ODA Efforts (2000-2008)



Source: EuroMapping 2010

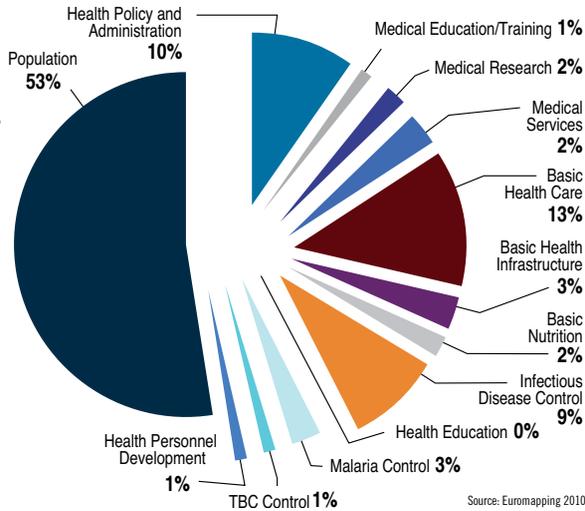
General And Health ODA

Fig. 6: European Health Expenditures (2006-2008)



1. What Is The Overall Picture For Global Health Spending?

Fig. 7: Breakdown Of Health Disbursements (2008) DAC Members And The EU



2. What Are The Health Needs In Developing Countries?

Fig. 8: Total Developing Country Health Resources Needs, Projected Funding & Resources Gaps: 2009-2015⁽¹⁾

	Resource Needs	Projected Funding	Resource Gap
Tuberculosis	Additional US\$38-44 billion	US\$23 billion	US\$15-21 billion
HIV/AIDS	Total US\$228 billion	US\$123 billion	US\$105 billion
Newborn, maternal, child & reproductive	Additional US\$79,4-137 billion	US\$11 billion	US\$68-126 billion
Human Resources for Health & Health Systems Strengthening⁽²⁾	Total US\$497 billion	US\$92 billion	US\$405 billion
Malaria	Additional US\$38 billion	US\$23 billion	US\$15 billion
Totals	US\$944 billion	US\$272 billion	US\$672 billion

⁽¹⁾ Source: Brook K. Baker (2009) The Long and Tortured Road to Adequate, Sustained, and Spendable Domestic and Donor Financing for Health.

⁽²⁾ Education and 2x salaries inclusive.



Which Countries Are eligible For ODA?

The World Bank divides countries into income groups based on their GNI per capita. According to this criterion each economy is classified as low income⁽¹⁾, middle income (subdivided into lower middle and upper middle), or high income. The DAC list of recipient countries⁽²⁾ is organised on objective needs-based criteria, including all low and middle income countries as defined by the World Bank's classification, except for those that are members of the G8 or the European Union (including countries with a firm accession date for EU membership).

The DAC List is reviewed every three years. Countries that have exceeded the high-

come threshold for three consecutive years at the time of the review are removed from the List. The next review of the DAC List will take place in 2011.

(1) World Bank www.data.worldbank.org/about/country-classifications

(2) History of DAC lists of aid recipient countries, OECD DAC website: www.oecd.org/document/56/0,3343,en_2649_34447_35832055_1_1_1_1,00.html

(3) Effective for reporting on 2009 and 2010 flows: www.oecd.org/dataoecd/32/40/43540882.pdf

(a) Antigua & Barbuda and Oman exceeded the high income country threshold in 2007. In accordance with the DAC rules for revision of this List, both will graduate from the List in 2011 if they remain high income countries until 2010.

(a) Barbados and Trinidad & Tobago exceeded the high income country threshold in 2006 and 2007. In accordance with the DAC rules for revision of this List, both will graduate from the List in 2011 if they remain high income countries until 2010.

(a) This does not imply any legal position of the OECD regarding Kosovo's status.

Fig. 9: Maps Of Countries According To Income Groups

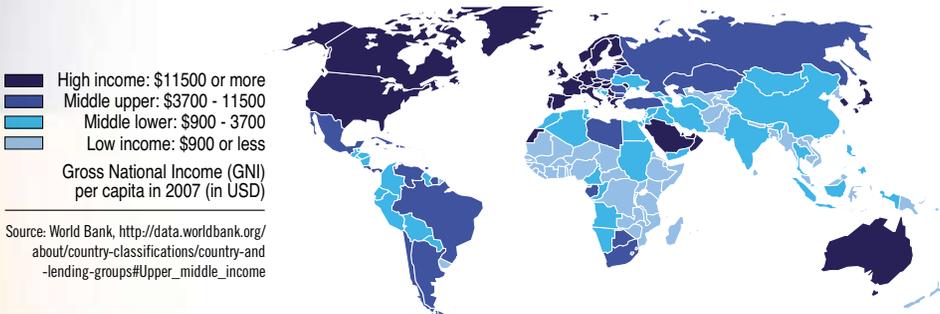
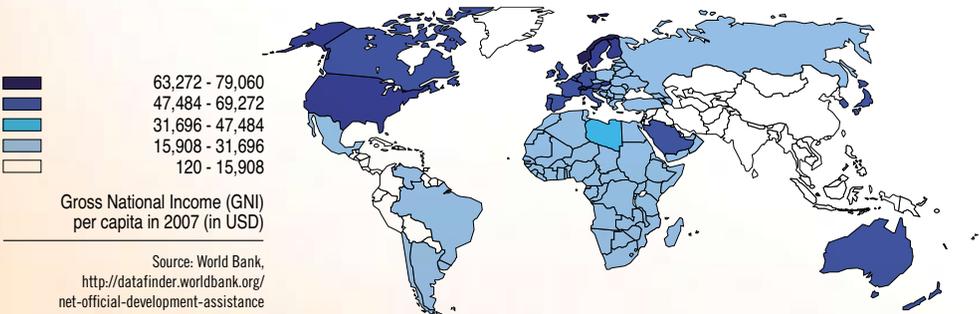


Fig. 10: Maps Of Countries According To GNI Per Capita



Which Countries Are eligible For ODA? 25

Fig.10: DAC List Of ODA Recipients ⁽³⁾

<p>LEAST DEVELOPED COUNTRIES</p> <p>Afghanistan Angola Bangladesh Benin Bhutan Burkina Faso Burundi Cambodia Central African Rep. Chad Comoros Congo, Dem. Rep. Djibouti Equatorial Guinea Eritrea Ethiopia Gambia Guinea Guinea-Bissau Haiti Kiribati Laos Lesotho Liberia Madagascar Malawi Maldives Mali Mauritania Mozambique Myanmar Nepal Niger Rwanda Samoa São Tomé and Príncipe Senegal Sierra Leone Solomon Islands Somalia Sudan Tanzania Timor-Leste Togo Tuvalu Uganda Vanuatu Yemen Zambia</p>	<p>Other Low-Income Countries (per capita GNI <US\$935 in 2007)</p> <p>Côte d'Ivoire Ghana Kenya A Korea, Dem. Rep. Kyrgyz Rep. Nigeria Pakistan Papua New Guinea Tajikistan Uzbekistan Viet Nam Zimbabwe</p> <p>Lower Middle-Income Countries & Territories (per capita GNI US\$936–US\$3705 in 2007)</p> <p>Albania Algeria Armenia Azerbaijan Bolivia Bosnia and Herzegovina Cameroon Cape Verde China Colombia Congo, Rep. Dominican Republic Ecuador Egypt El Salvador Former Yugoslav Rep of Macedonia Georgia Guatemala Guyana Honduras India Indonesia Iran Iraq Jordan Kosovo (c) Marshall Islands Micronesia, Federated States Moldova Mongolia Morocco Namibia Nicaragua Niue Palestinian Administered Areas Paraguay Peru Philippines</p>	<p>Sri Lanka Swaziland Syria Thailand Tokelau * ⁽³⁾ Tonga Tunisia Turkmenistan Ukraine Wallis and Futuna *</p> <p>Upper Middle-Income Countries & Territories (per capita GNI US\$3706–US\$11 455 in 2007)</p> <p>Anguilla * Antigua and Barbuda (a) Argentina Barbados (b) Belarus Belize Botswana Brazil Chile Cook Islands Costa Rica Croatia Cuba Dominica Fiji Gabon Grenada Jamaica Kazakhstan Lebanon Libya Malaysia Mauritius Mayotte * Mexico Montenegro Montserrat * Nauru Oman (a) Palau Panama Serbia Seychelles South Africa St. Helena * St. Kitts-Nevis St. Lucia St. Vincent and Grenadines Suriname Trinidad and Tobago (b) Turkey Uruguay Venezuela</p>
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Does ODA Deliver Results?

A number of countries have achieved major successes in combating extreme poverty and hunger, improving school enrolment and child health, and expanding access to clean water, control of malaria, tuberculosis and neglected tropical diseases, and access to HIV treatment. This has happened in some of the poorest countries, demonstrating that the MDGs are indeed achievable with the right policies, adequate levels of investment, and international support. Considering their historical experience, some poor countries and whole regions have made remarkable progress. For example, sub-Saharan Africa has made huge improvements in child health and in primary school enrolment over the last two decades. Between 1999 and 2004, sub-Saharan Africa achieved one of the largest reductions in measles deaths worldwide ever.

However, progress has been uneven, and – unless additional efforts are made – several of the MDGs are likely to be missed in many countries, particularly MDG5, which is the most off-track. The challenges are most severe in the least developed countries (LDCs), land-locked developing countries (LLDCs), some small island developing states (SIDS) and those vulnerable to natural hazards. Countries in or emerging from conflict are more likely to be poor and face greater constraints, as basic infrastructure, institutions and adequate human resources are often absent, while lack of security hampers economic development.

PROGRESS ON HEALTH-RELATED MDGS

Key Facts And Figures ⁽¹⁾

- Deaths among children under five have been reduced from 12,5 million per year in 1990 to 8,8 million in 2008 ⁽²⁾
- The number of people in low- and middle-income countries receiving antiretroviral therapy for HIV increased ten-fold in five years (2003–2008) ⁽³⁾
- There has been significant progress in reducing measles deaths and providing interventions to control TB and malaria. More than 500 million people are now treated annually for one or more neglected tropical diseases
- The proportion of under-nourished children under five years of age declined from 27% in 1990 to 20% in 2005
- Some 27% fewer children died before their fifth birthday in 2007 than in 1990
- Some significant progress was made to reduce maternal mortality in some countries. Maternal deaths dropped from 526 300 in 1980 to 342 900 in 2008 ⁽⁴⁾
- One-third of the 9,7 million people in developing countries who needed treatment for HIV/AIDS were receiving it in 2007
- The MDG target for reducing the incidence of tuberculosis was met globally in 2004. Tuberculosis is now falling in most parts of the world
- 27 countries reported a reduction of up to 50% in the number of malaria cases between 1990 and 2006
- The number of people with access to safe drinking water rose from 4,1 billion in 1990 to 5,7 billion in 2006. About 1,1 billion people in developing regions gained access to improved sanitation in the same period
- 200 million children have been immunised in 72 countries thanks to the GAVI Alliance

⁽¹⁾ WHO Fact sheet N°290 on Millennium Development Goals, May 2009, available on the WHO website: www.who.int/mediacentre/factsheets/fs290/en/index.html

⁽²⁾ www.childinfo.org

⁽³⁾ UNAIDS, AIDS Epidemic Update 2009

⁽⁴⁾ Hogan et al (2010) Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. *Lancet*, 12 April 2010, www.thelancet.com

EU Development Aid Overview

A. ABOUT THE EU INSTITUTIONS ⁽¹⁾ AND DECISION-MAKING PROCESS

The EU's institutional set-up is essentially based on its three main bodies (see Fig. 11): European Parliament (EP), Council and European Commission (EC). With the adoption of the Treaty of Lisbon, there are now seven EU institutions: the European Parliament, the European Council, the European Commission, the Council of the EU, the European Court of Justice, the European Central Bank and the European Court of Auditors. The Lisbon Treaty introduces a number of new elements to make these bodies more effective, consistent and transparent, all in the cause of better serving the people of Europe.

With the entry into force of the Lisbon Treaty, greater powers are conferred to the European Parliament in lawmaking, budgetary affairs and international agreements. The 'co-decision procedure' (renamed 'ordinary legislative procedure') has been extended to several new fields. This means that Parliament now has the same degree of lawmaking power as the Council. The Parliament now has a role to play in almost all lawmaking. The new treaty confirms the established practice of working with a multiannual financial framework, which

Parliament must approve. It also abolishes the former distinction between 'compulsory' expenditure (like direct income support to farmers) and 'non-compulsory' expenditure, with the result that Parliament and the Council determine all expenditure together. This innovation creates a new balance between the two institutions when approving the EU's budget. Under the Treaty of Lisbon, the European Parliament's assent is required for all international agreements in fields governed by the ordinary legislative procedure.

With the entry into force of the Lisbon Treaty, there is a greater role for national parliaments. The treaty gives the national parliaments greater scope to participate alongside the European institutions in the work of the Union. A new clause clearly sets out the rights and duties of the national parliaments within the EU. It deals with their right to information, the way they monitor subsidiarity, mechanisms for evaluating policy in the field of freedom, security and justice, procedures for reforming the treaties, and so on.

⁽¹⁾ European Commission, www.europa.eu/lisbon_treaty/glance/institutions/index_en.htm

Fig. 11: EU Main Bodies



In brief, the EC has the general power to initiate proposals for legislation while the EP and the Council share lawmaking and budgetary powers.

EU Development Aid Overview

Fig. 12: EU Decision Making Process



B. ABOUT EUROPE'S AID ARCHITECTURE

The European Union is the largest donor in the world, providing nearly EUR 100 per citizen in ODA⁽²⁾ every year. In 2009, the European Commission and Europe's 27 Member States donated a total of EUR 49 billion in ODA. Europe's aid architecture can be defined as "all the players, instruments and strategic or political frameworks governing aid development and implementation destined for developing countries⁽³⁾". Aid architecture across the world has become considerably more complex over the past few decades.

Europe has a particularly complicated system as development policy and funding is shared between Member States and the European Commission. There are therefore parallel levels and systems between the EU and its Member States, including community and bilateral policies respectively, which all have their own players, agencies, administrations and institutions. In addition, there has been a proliferation in the the number of NGOs, civil society organisations (CSOs) as well as non-state actors in development amounting over 230 international organisations, funds and programmes – more instruments than the number of developing countries they were created to assist⁽⁴⁾. Finally, there has been an explosion of so-called vertical funds – international initiatives that deliver funds focused on thematic objectives. There are now more than 1 000 international trust funds that act as donors⁽⁵⁾.

⁽²⁾ OECD

⁽³⁾ Corre, Gwénaëlle (ed), 'Current dilemmas in aid architecture; Actors & instruments, aid orphans and climate change', ECDPM Policy Management Report 16 (December 2008) Summary

⁽⁴⁾ International Development Association Resource Mobilization (FRM), Aid Architecture: An Overview of the Main Trends in Official Development Assistance Flows (February 2007) Executive Summary



EUROPEAN UNION OFFICIAL DEVELOPMENT AID (ODA)

1. EU remains the world's biggest donor in 2009 with ~ 64% of DAC ODA (~ EUR 49 billion)
2. European aid fell by EUR 1 billion in 2009. However, the EU ODA as a share of GNI increased from 0,40% to 0,42% as a result of the contraction of the European economies during the financial crisis.
3. Split between Member States and European Commission:
 - At Member states (MS) level
 - ~ 80% of EU ODA
 - Challenge: major differences among them (heterogeneity of contributions)
 - At European Commission (EC) level
 - ~ 20% of EU ODA
 - EC took-up role of monitoring MS ODA growth



C. ABOUT EU PERFORMANCE: DOING MORE, BETTER, FASTER? ⁽⁶⁾

Since 2003, the European Commission (EC) has been tracking Europe's performance on its aid commitments highlighted in its 2009 annual report on financing for development, also called Monterrey report⁽⁷⁾. Europe is the biggest provider of development aid in the world. Aid levels increased by more than 30% from 2004 to 2005, and the target of 0,39% GNI in 2006 was exceeded with a record EUR 47,7 billion in ODA (0,41% GNI). After a decline in 2007 (EUR 45,7 billion; 0,37% of GNI) EU aid increased again to EUR 49,5 billion in 2008 (0,40%), but aid figures for 2009, released by the OECD, show that the financial crisis has slowed aid flows. Worldwide development aid by DAC Members has increased by less than 1% in real terms by comparison with 2008. The EU donors in the DAC showed a slight decrease in their aid to developing countries.

Reaching promised aid levels – collective (EU) and individual (Member States) will be a major challenge and require determined action of EU Member States in order to meet the MDGs. The EU and the Member States committed to reach the 0,7% of GNI by 2015, setting interim goals for 2010: Collectively, the EU must reach 0,56% of GNI devoted to development aid by 2010. However, the burden is different for traditional donors (EU-15), countries that are full members of OECD DAC, and for new Member States (EU-12). The EU-15 must reach by 2010 0,56% of GNI while the EU-12 must reach 0,17%. Given the current outlook, the EC es-

timates that the EU will fall around EUR 18 billion short in 2010. Three out of the 5 largest donors worldwide in absolute terms are EU members – France, Germany and the United Kingdom. Four of the five countries exceeding the UN target of 0,7% of GNI being devoted to development aid – Denmark, Luxembourg, the Netherlands, Norway and Sweden – are also EU members, and Belgium is set to join this group in 2010.

As the world's largest donor of ODA, in recent years the EU has been strongly committed to improving aid effectiveness. The adoption of an ambitious Paris Declaration on Aid Effectiveness in 2005 was due to the strong input provided by the EU. Policy Coherence for Development plays a central role in reinforcing the EU contribution to developing countries' progress towards the MDGs. Its aim is to correct any incoherences that may exist between development policy and other policy areas such as trade, agriculture or immigration.

⁽⁵⁾ EC, 'The EU - a global partner for development. Speeding up progress towards the MDGs', Commission Staff Working Paper 435 (9 April 2008) p.9

⁽⁶⁾ CDG Development, EC, www.ec.europa.eu/development/how/monterrey_en.cfm

⁽⁷⁾ EC, 'Annual progress report 2009 on financing for development', Commission Staff Working Paper SEC(2009) 444 (8 April 2009). www.ec.europa.eu/development/icenter/repository/comm_native_sec_2009_0444_4_en_autre_document_travail_service-where-does-the-eu-go-from-doha.pdf

MEMBER STATES AID: EU COMMITMENTS

1. Aim to reach 0,70% ODA/GNI by 2015
2. After Monterrey (2002): intermediate targets for 2006:
 - Individually: 0,33% ODA/GNI + those at 0,7% to maintain
 - Collectively: 0,39% ODA/GNI
3. New commitments (2005) intermediate targets for 2010
 - Individually: 0,51% ODA/GNI for EU-15 + those at 0,7% to maintain. 0,17% ODA/GNI for 12 New Member States and 0,33% for 2015
 - Collectively: 0,56% ODA/GNI

EU Development Aid Overview

D. ABOUT EU DEVELOPMENT POLICIES ⁽⁸⁾

Development is at the heart of the EU's external action, along with its foreign, security and trade policies. The primary and overarching objective of EU development policy is the eradication of poverty in accordance with the principle of sustainable development, including the achievement of the MDGs.

EU action in the field of development is based on the European Consensus on Development ⁽⁹⁾, signed on 20 December 2005, whereby EU Member States, the Council, the European Parliament and the Commission agreed - for the first time in fifty years of cooperation - to a common EU vision of development which defines the framework of common principles within which the EU and its Member States will each implement their development policies in a spirit of complementarity.

On 31 March 2010, the EC released a Communication to enhance the EU's role in global health ⁽¹⁰⁾. Its objective is to make Europe's contribution more effective so as to better assist developing countries in getting back on track towards achieving health-related MDGs. In this communication the EC presents four approaches to improving global health: a) establishing a more democratic and coordinated global governance; b) pushing for a collective effort to promote universal coverage and access to health services to all; c) ensuring better coherence between EU policies relating to health; d) improving coordination of EU research on global health and boosting access in developing countries to new knowledge and treatments.

EU partnerships and dialogue with developing countries promote respect for human rights, fundamental freedoms, peace, democracy,

good governance, and gender equality, the rule of law, solidarity and justice. The European Union's contribution focuses on nine areas of intervention ⁽¹¹⁾, responding to the needs of partner countries.



E. ABOUT THE EC EXTERNAL COOPERATION PROGRAMMES ⁽¹²⁾

For the 2007 to 2013 financial perspective, the EU has adopted a package of six new instruments for the implementation of external assistance. The most important and relevant ones are the European Development Fund (EDF) and the Development Co-operation Instrument (DCI).

1. European Development Fund (EDF)

Based on the Cotonou agreement, which provides the bedrock of EU co-operation with African, Caribbean and Pacific (ACP) countries, the EDF supports assistance to the Union's 78 ACP partner countries and the overseas countries and territories of Member States. The EDF is not an instrument funded by the EC budget, but an intergovernmental fund set up by the EU Member States. For the period 2008-2013 an amount of EUR 22 682 billion has been agreed upon for the 10th EDF. The key areas for cooperation are economic development, social and human development, regional cooperation and integration. The European Parliament, the Commission and civil society organisations have repeatedly asked for its inclusion in the EU budget to increase public control of this aid, transparency and effectiveness.

EU Development Aid Overview

2. Development Cooperation Instrument (DCI)

The budget allocated under the DCI for the period 2007-2013 is EUR 16,9 billion⁽¹³⁾. The DCI covers three main components:

- Geographic programmes supporting cooperation with 47 developing countries in Latin America, Asia and Central Asia, the Gulf region (Iran, Iraq and Yemen) and South Africa.
- Five thematic programmes benefiting all developing countries (including those covered by the ENPI and the EDF): investing in people; environment and sustainable management of natural resources including energy; non-state actors and local authorities in development; food security; as well as migration and asylum.
- A programme of accompanying measures for the 18 ACP Sugar Protocol countries, in order to help them adjust following the reform of the EU sugar regime.

3. European Neighbourhood And Partnership Instrument (ENPI)

ENPI provides EU assistance to 17 countries⁽¹⁴⁾ from around the Mediterranean and Eastern Europe. Bringing about geographical cooperation with countries bordering the European Union Member States, the ENPI has a financial envelope of EUR 11,2 billion for the period 2007-2013.

4. European Instrument For Democracy & Human Rights (EIDHR)

EIDHR contributes to the development of democracy, the rule of law, respect for human rights and fundamental freedoms. It has been designed to complement the various other tools for implementing EU policies in this area,

which range from political dialogue and diplomatic actions to various financial and technical co-operation instruments, including both geographic and thematic programmes. It also complements the more crisis-related interventions of the new Stability instrument.

5. Instrument For Stability (IfS)

The IfS aims to contribute to stability in countries in crisis by providing an effective response to help preserve, establish or re-establish the conditions essential to the proper implementation of the EU's development and co-operation policies (the 'Crisis response and preparedness' component).

6. Nuclear Safety Co-operation Instrument (NSCI)

NSCI finances measures to support a higher level of nuclear safety, radiation protection and the application of efficient and effective safeguards of nuclear materials in third countries.

⁽⁸⁾ DDG Development, European Commission, www.ec.europa.eu/development/policies/gen_en.cfm

⁽⁹⁾ DG Development, European Commission www.ec.europa.eu/development/icenter/repository/european_consensus_2005_en.pdf

⁽¹⁰⁾ www.ec.europa.eu/development/icenter/repository/COMM_PDF_COM_2010_0128_EN.PDF

⁽¹¹⁾ Trade and regional integration; the environment and the sustainable management of natural resources; infrastructure, communications and transport; water; energy; rural development, territorial planning, agriculture and food security; governance, democracy, human rights and support for economic and institutional reforms; conflict prevention and fragile states; human development; social cohesion and employment.

⁽¹²⁾ EC, Europaid, www.ec.europa.eu/europeaid/what/delivering-aid/funding-instruments/index_en.htm

⁽¹³⁾ EUR 10,06 billion for the geographic programmes (60% of the total); EUR 5,6 billion for the thematic programmes (33% of the total); EUR 1,24 billion for the ACP Sugar Protocol countries (7% of the total)

⁽¹⁴⁾ Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Israel, Jordan, Lebanon, Libya, Moldova, Morocco, the Palestinian Authority, Russia, Syria, Tunisia and Ukraine.

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THE MONTERREY CONFERENCE ON FINANCING FOR DEVELOPMENT (2002)

The International Conference on Financing for Development, held at Monterrey, Mexico in March 2002, produced the Monterrey Consensus, in which more than 100 participating countries committed themselves to a basic compact of mutual accountability and partnership between developed and developing countries within the context of the global economy. Commitments involve mobilising domestic resources, attracting international financial flows, promoting international trade, increasing international financial and technical co-operation, sustainable debt financing and external debt relief, and enhancing the coherence and consistency of the international monetary, financial and trading systems.

THE DOCUMENT EMBRACES SIX AREAS OF FINANCING FOR DEVELOPMENT:

1. Mobilising domestic financial resources for development
2. Mobilising international resources for development: foreign direct investment and other private flows
3. International Trade as an engine for development
4. Increasing international financial and technical cooperation for development
5. External Debt
6. Addressing systemic issues: enhancing the coherence and consistency of the international monetary, financial and trading systems in support of development

Development aid may be channeled in a variety of ways by a donor country. The main 'traditional' ODA channels used by donor countries are bilateral aid and multilateral aid (given by the donor country to an international organisation which then distributes it among the developing countries). Over the past few years, the proliferation of aid channels for health has led to a new global aid architecture which has become increasingly characterised by diversity, complexity and innovation. New institutions, new ways of raising money and new approaches to delivering assistance have emerged. This section seeks to provide an insight into the minimum consensus on development that has been internationally agreed upon, as well as a comprehensive overview of the various channels and initiatives that are in line with the new global health architecture.

A. MINIMUM INTERNATIONAL CONSENSUS ON DEVELOPMENT

1. Financing For Development:

The Monterrey Consensus

The International Conference on Financing for Development was held from 18-22 March 2002 in Monterrey, Mexico. It was the first UN-hosted conference to address key financial and development⁽¹⁾ issues. This international Conference attracted 50 Heads of State or Government, over 200 ministers as well as leaders from the private sector, civil society and the major intergovernmental financial, trade, economic, and monetary organisations. As a key outcome, the Conference participants adopted the Monterrey Consensus, in which developed, developing and transition economy countries pledged to undertake important actions in domestic, international and systemic policy matters. Since its adoption the Monterrey Consensus has become the major reference point for international development cooperation.

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A Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus was held in Doha, Qatar, from 29 November until 2 December 2008. Officials from more than 160 countries, including nearly 40 Heads of State or Government attended this conference which resulted in the adoption by consensus of the Doha Declaration on Financing for Development⁽²⁾. The Doha Declaration reaffirmed the Monterrey Consensus and called for a United Nations conference at the highest level on the world financial and economic crisis and its impact on development. The UN General Assembly will consider the need to hold a follow-up financing for development conference by 2013.

2. Aid Effectiveness & Paris Declaration: High-Level Forums On Aid effectiveness

Development aid is not only about quantity – but also about quality. In uncertain economic times, better and predictable aid as well as lasting development results, are essential to encouraging increased financing for development.

Over the past 6 years, the OECD has organised 3 High Level Forums on Aid Effectiveness. At these Forums, a growing group of key stakeholders – including the international donor community, developing countries and civil society organisations – met to agree on the most effective ways to manage the aid process. The first Forum was held in Rome in 2003, followed by Paris in 2005 and Accra in 2008. The next Forum will take place in Seoul in 2011⁽³⁾.

The Paris Declaration on Aid Effectiveness, adopted in 2005, contains an unprecedented set of commitments to monitorable actions to increase aid effectiveness. The signatory countries developed action plans setting out how they intended to make progress on the Paris Declaration. They

agreed to a set of 12 targets (or indicators) to be measured nationally and monitored internationally, which would indicate their progress. The first progress review took place at the High Level Meeting on Aid Effectiveness held in 2008 in Accra, Ghana, where the Accra Agenda for Action (AAA) was drawn up, building on the commitments agreed in the Paris Declaration.

• The Rome High Level Forum On Harmonisation (2003)

In February 2003 major donors, multilateral organisations and countries receiving aid gathered in Rome for the first High Level Forum on Harmonisation. They broke ground by agreeing on a common set of principles to improve the management and effectiveness of aid: the Rome Declaration. This Declaration differs from the Paris Declaration, in that it contains commitments solely on the donor side. It focuses on the harmonisation of donor procedures and practices so as to reduce transaction costs for partner countries.

• The Paris High Level Forum On Aid Effectiveness (2005)

The Paris Declaration on Aid Effectiveness, endorsed on 2 March 2005, is an international agreement adhered to by over 100 Ministers, Heads of Agencies and other Senior Officials. By adhering, they committed their countries and organisations to continuing to increase their efforts in harmonisation, alignment and managing aid for results with a set of principles to improve aid effectiveness, monitorable actions and indicators, enabling them to reach specific targets by 2010. This is the highest-level existing statement of international norms regarding aid delivery, with 56 partnership commitments and 12 indicators of progress⁽⁴⁾.

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• The Accra High Level Forum On Aid Effectiveness (2008)

The Accra Agenda for Action was agreed in September 2008 at the Third High Level Forum on Aid Effectiveness. It contains a series of commitments to strengthening and accelerating the implementation of the Paris Declaration. While it does not replace the Paris Declaration and does not contain any additional monitoring arrangements, it elaborates on and sharpens the Paris commitments in important ways.

• The Seoul High Level Forum On Aid Effectiveness (2011)

Preparations are already underway for the next High Level Forum, to be held in Seoul, South Korea, in 2011. For this event, which will take stock of progress toward the targets set out in the Paris Declaration, a final round of monitoring, together with a full evaluation of the impact of the Paris Declaration, will be carried out. Based on these analyses and the discussions at the Seoul High Level Forum, participants will decide on the way forward.

The progress in implementing the Declaration appeared to be too slow. According to the OECD, without further reform and faster action most of the 2010 commitments for improving the quality of aid will not be met, and reaching the MDG targets by 2015 will be compromised. According to the 2008 Survey on Monitoring the Paris Declaration⁽⁶⁾, it appeared that donors should step-up efforts to use and strengthen recipient country systems, strengthen accountability over development resources, and improve cost-effective aid management. Another essential criterion for success is donors' complementarity and more effective division of labour so that no countries in need are left without aid, or overloaded with excessive

5 PARIS DECLARATION - 5 KEY PRINCIPLES FOR EFFECTIVE AID⁽⁵⁾:

1. **Ownership** - Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
2. **Alignment** - Donor countries align behind these objectives and use local systems.
3. **Harmonisation** - Donor countries coordinate, simplify procedures and share information to avoid duplication.
4. **Results** - Developing countries and donors shift focus to development results and results get measured.
5. **Mutual Accountability** - Donors and partners are accountable for development results.

THE ACCRA AGENDA FOR ACTION (AAA): AN AGENDA TO ACCELERATE PROGRESS

Predictability – donors will provide 3-5 year forward information on their planned aid to partner countries.

Country systems – partner country systems will be used to deliver aid as the first option, rather than donor systems.

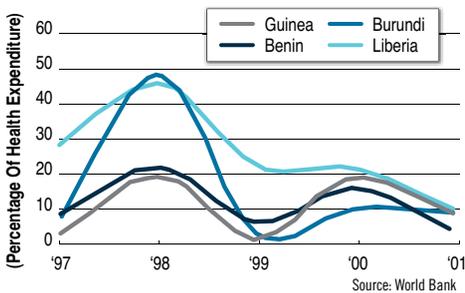
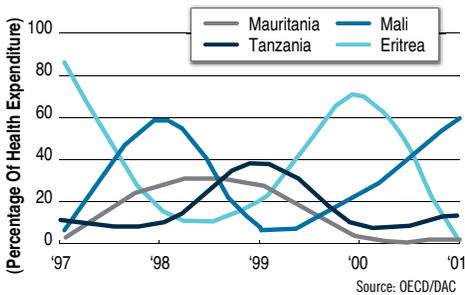
Conditionality – donors will switch from reliance on prescriptive conditions about how and when aid money is spent to conditions based on the developing country's own development objectives.

Untying – donors will relax restrictions that prevent developing countries from buying the goods and services they need from whomever and wherever they can get the best quality at the lowest price.



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Fig. 13: Donors Commitments For Health As Percentage Of Health Expenditure



bureaucracy and donors' reporting. Figures 13 and 14 illustrate that the lack of country coordination, division of labour and excessive fragmentation of aid at global, country or sector level impairs aid effectiveness.

Evolution in approaches to aid effectiveness has been driven by dramatic changes in the health aid environment. Aid for health has risen rapidly, new types of health donors have emerged and new channels for delivering assistance have been established, bringing new challenges for aid harmonisation and alignment to country priorities. The global aid architecture has become increasingly complex, with the growing importance of non-DAC and other "emerging" donors as well as with a high degree of aid proliferation and ODA fragmentation. This next section aims to present the traditional and new health aid channels. Aid for health has risen rapidly, new types of health donors have emerged and new channels for delivering assistance have been established, bringing new challenges for aid harmonisation and alignment to country priorities. The global aid architecture has become increasingly complex, with the growing importance of non-DAC and other "emerging" donors as well as with a high degree of aid proliferation⁽⁷⁾ and ODA fragmentation⁽⁸⁾. This next section aims to present the traditional and new health aid channels.



(1) Financing for Development Office, New York, www.un.org/esa/ffd

(2) www.un.org/esa/ffd/doha/documents/Doha_Declaration_FFD.pdf

(3) www.aideffectiveness.org/Events-Processes-Rome-Paris-Accra-Korea.html#Seoul

(4) www.oecd.org/dataoecd/57/60/36080258.pdf

(5) www.oecd.org/document/18/0,3343,en_2649_3236398_35401554_1_1_1_1,00.html

(6) www.siteresources.worldbank.org/ACCRAEXT/Resources/ExSummary-Monitoring-English.pdf

(7) "Proliferation" should be understood as the number of donor channels providing ODA to a given recipient country

(8) "Fragmentation" should be understood as the number of donor-funded activities as well as their average value

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COUNTRIES, TERRITORIES AND ORGANISATIONS ADHERING TO THE PARIS DECLARATION AND AAA ⁽⁹⁾

Afghanistan	Comoros	Greece	Luxembourg	Guinea	Sri Lanka
Albania	Congo, Rep. of	Guatemala	Madagascar	Paraguay	Sudan
Argentina	Congo D. R.	Guinea	Malawi	Peru	Swaziland
Armenia, Rep. of	Cook Islands	Guyana	Malaysia	Philippines	Sweden
Australia	Cyprus, Rep. of	Haiti	Mali	Poland	Switzerland
Austria	Czech Republic	Honduras	Mauritania	Portugal	Syria
Bangladesh	Denmark	Hungary	Mexico	Romania	Tajikistan
Belgium	Djibouti	Iceland	Moldova	Russian Federation	Tanzania
Benin	Dominican Republic	India	Mongolia	Rwanda	Thailand
Bolivia	Ecuador	Indonesia	Morocco	Samoa	Timor-Leste
Bosnia and Herzegovina	Egypt	Iraq	Mozambique	Sao Tomé & Príncipe	Togo
Botswana	El Salvador	Ireland	Namibia	Saudi Arabia	Tonga
Brazil ⁽¹⁰⁾	Estonia	Israel	Nepal	Senegal	Tunisia
Burkina Faso	Ethiopia	Italy	Netherlands, The	Serbia and Montenegro	Turkey
Burundi	European Commission	Ivory Coast	New Zealand	Sierra Leone	Uganda
Cambodia	Fiji	Jamaica	Nicaragua	Slovak Republic	Ukraine
Cameroon	Finland	Japan	Niger	Slovenia	United Kingdom
Canada	France	Jordan	Nigeria	Solomon Islands	United States of America
Cape Verde	Gabon	Korea	Norway	South Africa	Vanuatu
Central African Republic	Gambia, The	Kuwait	Pakistan	Spain	Vietnam
Chad	Germany	Kyrgyz Republic	Palestinian territories		Yemen
China	Ghana	Lao PDR	Panama		Zambia
Colombia		Lesotho	Papua New		

⁽⁹⁾ OECD, www.oecd.org/document/22/0,3343,en_2649_3236398_36074966_1_1_1_1,100.html

⁽¹⁰⁾ To be confirmed

INTERNATIONAL ORGANISATIONS ADHERING TO THE PARIS DECLARATION AND AAA

- African Development Bank
- Arab Bank for Economic Development in Africa
- Asian Development Bank
- Commonwealth Secretariat
- Consultative Group to Assist the Poorest
- Council of Europe Development Bank
- Economic Commission for Africa
- Education for All Fast Track Initiative
- European Investment Bank
- European Bank for Reconstruction and Development
- GAVI Alliance
- Global Fund to Fight Aids, Tuberculosis and Malaria
- G24
- Inter-American Development Bank
- International Fund for Agricultural Development
- International Monetary Fund
- International Organisation of the Francophonie
- Islamic Development Bank
- Millennium Campaign
- New Partnership for Africa's Development
- Nordic Development Fund
- Organization of American States
- Organisation for Economic Cooperation and Development
- Organization of Eastern Caribbean States
- OPEC Fund for International Development
- Pacific Islands Forum Secretariat
- UN Development Group
- World Bank

How To Channel Health ODA

B. BILATERAL AID

Bilateral aid is the assistance given from one country directly to another via a donor government agency. Bilateral aid can be divided into three categories: classic bilateral aid, multi-bilateral aid and budget support.

1. Classic Bilateral

According to the OECD DAC glossary, bilateral aid is defined as “bilateral flows provided directly by a donor country to an aid recipient country”. It is the aid channel that is generally preferred by donor countries, with about 70% of ODA being bilateral and the remaining 30% being multilateral.

Data analysis shows that there has been a growing number of bilateral donors and international organisations, funds and programmes over the last half century. The number of bilateral donors grew from a handful in the mid 1940s to at least 56 today. There has also been a dramatic increase in the number of international organisations, new funds and programmes specialised in the health sector⁽¹⁾.

2. Multi-bilateral

“Multi-bilateral” is defined as bilateral contributions channeled through multilateral channels. Half of the bilateral contributions channeled through multilateral channels in 2005 went through some degree of earmarking by sector or theme. Besides complicating budgetary management, earmarking may lead to a misalignment between donors’ and recipient countries’ priorities. By constraining recipients’ flexibility in allocating resources, earmarking may contribute to under-funding of other investments which are equally important for economic growth and poverty reduction, such as the health sector.



3. Budget Support

Budget support refers to the infusion of financial resources by a donor government to the National Treasury of a partner country under a set of agreed conditions for payment. In the context of the EU, there are two forms of budget support (BS): a) General Budget Support (GBS) which aims to support national development or reform policy/strategy and b) Sector Budget Support (SBS) which pertains to the support of a particular national sector programme policy and strategy.

a. General Budget Support

GBS has become more prominent since the late 1990s, as part of a wider quest to improve the effectiveness of aid. Funds provided through general budget support are disbursed through the recipient government’s own financial management system and are not earmarked for specific uses. However, they are accompanied by various understandings and agreements about the government’s development strategy. Instead of focusing narrowly on the use of the aid funds, government and donors together monitor implementation of the agreed strategy as a whole.

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b. Sector Budget Support

SBS is budget support that is earmarked for use in a specific sector or budget line (e.g. *health or education*). The sector-wide approach (SWAP), which became popular in the donor community in the mid 1990s, was a response to the fragmentation, and perceived limited effectiveness of aid. The sector-wide approach has helped countries to strengthen the public services they offer to their citizens, with the poorest ones being a particular focus. SWAPs have increased health sector funding in some countries increasing the aid flow through government channels, rather than through donor projects' channels.

According to an OECD-DAC evaluation⁽¹²⁾, budget support is seen as a means to ensure predictability of aid and results in higher allocations to health and education by partner governments, higher budget execution rates, and improved access to services. On the other hand, due to the nature of the instrument, one cannot directly attribute budget support to results in development. The European Commission is increasing its use of general and sectoral budget support in line with the European Consensus and the Paris Declaration commitments.

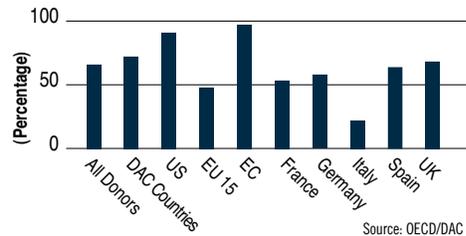
c. MULTILATERAL AID

Multilateral aid refers to the assistance given by the donor country to an international organisation which then distributes it among the developing countries. According to the DAC's Glossary, multilateral operational agencies are international institutions with governmental membership which conduct all or a significant part of their activities in favour of development and aid recipient countries. They include multilateral development banks (e.g. *World Bank, regional development banks*), United Nations agencies, and regional groupings (e.g. *certain European Union and Arab agencies*). A contri-

2009 ODA - NET DISBURSEMENTS (IN MILLIONS USD)⁽¹³⁾

	Bilateral	Multilateral
All Donors	98 863,27	37 241,35
DAC Countries	83 345,06	36 228,01
US	25 111,78	3 553,55
EU 15, Total	40 864,98	26 269,55
EC	14 615,56	406,76
France	6 854,47	5 576,44
Germany	6 999,18	4 983,25
Italy	854,39	2 459,48
Spain	4 299,37	2 271,47
UK	7 769,42	3 735,47

Fig. 14: Portion Of Bilateral Of The Main Donors



tribution by a DAC Member to such an agency is deemed to be multilateral if it is pooled with other contributions and disbursed at the discretion of the agency.

The growing importance of sector/thematic international organisations and private donors further increased the complexity of the aid architecture. The problem is particularly pronounced in the health sector, where the effectiveness of increased ODA will rest on finding an appropriate balance between providing resources for disease- and intervention-specific health programmes and strengthening health systems.

(11) World Bank, www.siteresources.worldbank.org/IDA/Resources/Aidarchitecture-3.pdf

(12) Evaluation of General Budget Support: Synthesis Report, May 2006

(13) Data extracted on 3 August 2010 13:59 UTC (GMT) from OECD.Stat

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D. INNOVATIVE FUNDING MECHANISMS

Current donor funding is neither sufficiently predictable nor large enough to enable us to reach the health MDGs. Even if efforts to improve the effectiveness of current aid for health are successful, a sharp increase in resources is required.

1. Innovative Financing Mechanisms For Health

Traditional forms of financing for development are under threat. Economies are contracting. ODA faces increased budgetary pressure. Commodity prices, private investment and remittances are down. Innovative financing focuses on new sources and new instruments for raising revenues. Innovative financing must help to bridge the gap between what is available and what is needed to reach the MDGs.

At the international level, donors have acknowledged the need to create and support innovative financial mechanisms as additional resources to help close the financial gap on the MDGs. This section will present two key examples of innovative sources of finance for development, namely UNITAID and MASSIVE GOOD, and provide an overview of recent international donor coordination mechanisms.

Other sources of innovative financing mechanisms for health are currently under discussion such as an international levy on financial transactions which would provide an additional source of finance for development. The Currency Transaction Levy (CTL) is a potential mechanism to raise additional resources needed to achieve all health-related MDGs (above ODA and Abuja commitments). The CTL would be a levy of just 0,005% (5 euro-cents

on EUR1 000) on the major currencies (US dollar, Yen, Euro and British Pound), painless for the foreign exchange market and able to fill much of the funding gap needed to achieve the health MDGs by 2015, including reducing child mortality, improving maternal health and combating AIDS, TB and malaria. This tax could provide an additional, predictable and sustainable source for funding for health and yield as much as EUR35 billion per year.

2. Donor Coordination Mechanisms

In line with the international agreement on aid effectiveness, donor coordination systems are needed to ensure aid harmonisation and alignment of funds with established priorities. Donor coordination is also needed to streamline funding channels and to increase the use of new funding modalities with a view to achieving increased development efficiency. In particular, donor coordination is required to meet the important concern of donors about aid effectiveness, which implies a well functioning government-donor architecture and partnership, based on mutual trust and open dialogue focused on policy and harmonisation issues. Three major donor coordination mechanisms are presented below: the International Health Partnership and related initiatives (IHP +), the 'Health 4' Partnership (H4), and the 'Health 8' agencies (H8).

• International Health Partnership And Related Initiatives (IHP +)⁽¹⁴⁾

The International Health Partnership and Related Initiatives⁽¹⁵⁾ (IHP+) seeks to achieve better health results by mobilising donor countries and other development partners around a single country-led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action. Launched in September 2007,

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the IHP+ aims to better harmonise donor funding commitments, and improve the way international agencies, donors and developing countries work together to develop and implement national health plans. Currently IHP+ has 46 members.

A Taskforce on Innovative International Financing for Health Systems was launched in September 2008 to help strengthen health systems in the 49 poorest countries in the world. The creation of a new high-level Taskforce on Innovative International Financing for Health Systems at the UN MDG Summit in 2008 was welcome by the international donor community as these efforts focus on increasing coordination, predictability, flexibility and aid volumes.

• The 'Health 4' Partnership (H4)

The H4 partnership represents an intensified joint effort by four international agencies, WHO, UNFPA, UNICEF and the World Bank, to

support countries in improving maternal and newborn health and saving the lives of mothers and babies – in other words, supporting countries to achieve MDG4 and 5. Improving maternal health and reducing newborn deaths involves strengthening health systems, scaling up programmes to reach remote rural areas and marginalised populations, and ensuring that appropriate resources are allocated.

During the coming years, the four agencies announced they will enhance their support to the countries with the highest maternal mortality, starting with six (Afghanistan, Bangladesh, Democratic Republic of Congo, Ethiopia, India and Nigeria), scaling up to 25 more and later covering 60 countries. They will focus on helping countries to strengthen their health systems so that they can reduce the maternal mortality ratio by 75 per cent and achieve universal access to reproductive health, as called for by the MDG 5⁽¹⁶⁾.

Fig. 15: IHP+ Framework



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• The 'Health 8' Agencies (H8)

The H8 refers to leaders of the eight global international health agencies: World Health Organization (WHO), Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Alliance for Vaccines and Immunisation (GAVI Alliance); the UN Population Fund (UNFPA); the World Bank's Human Development Network; Joint United Nations Programme on HIV/AIDS (UNAIDS); United Nations Children's Fund (UNICEF); and the Global Health Programme at the Bill & Melinda Gates Foundation. Created in 2007, this informal group meets on an biannual basis to discuss challenges to scaling up health services and improving health-related MDG outcomes, particularly for the poor. The H8 stimulates a global sense of urgency for reaching the health-related MDGs and focuses on better ways of working, particularly within institutions. It has a remit to ensure systematic and robust knowledge management and learning around the MDGs, and to seize opportunities presented by renewed interest in health systems.

The first informal H8 Agency Meeting was held in July 2007 in New York. At the meeting leaders from the H8 agencies agreed to⁽¹⁷⁾:

- **Stimulate** a global collective sense of urgency for reaching the health related MDGs
- **Modify** institutional ways of doing business (coordination and teamwork)
- **Foster** a more systematic and robust approach to knowledge management and learning
- **Recognise** the important opportunity presented by the renewed interest in health systems
- **Recognise** that the role of civil society and the private sector will be critical for success.

The Second informal H8 Agency Meeting was held on in January 2008 in Geneva. At the meeting leaders from the H8 agencies agreed to:

- **Focus** on results and keep health related MDGs high on agenda
- **Collaborate** on key events
- **Ensure** that country compacts are truly owned by countries and fully inclusive of stakeholders
- **Place** importance on M&E in the context of the results focus
- **Promote** linkages (between MDGs, between strategies for Africa, south-south cooperation, etc.).

⁽¹⁴⁾ www.internationalhealthpartnership.net/en/home

⁽¹⁵⁾ "Related Initiatives" relates to other initiatives which were established at around the same time as the IHP, and all of which aim to accelerate the achievement of the health related MDGs in line with the Paris Declaration. These include: Providing for Health (P4H), Harmonization for Health in Africa (HHA), Innovative Results-Based Financing (RBF), Deliver Now for Women and Children, Health Metrics Network (HMN), Global Health Workforce Alliance (GHWA)

⁽¹⁶⁾ www.unfpa.org/public/site/global/lang/en/pid/3918
www.who.int/pmnch/media/news/2008/20080925_jointstatement/en/print.html

⁽¹⁷⁾ www.internationalhealthpartnership.net/ihp_plus_about_agencies.html



(Left-right) World Bank Health, Nutrition and Population Vice President **Joy Phumaphi**; Bill & Melinda Gates Foundation Global Health President **Tadataka Yamada**; UNFPA Executive Director **Thoraya Obaid**; The Global Fund to Fight AIDS, TB and Malaria Executive Director **Michel Kazatchkine**; UNICEF Executive Director **Ann M. Veneman**; GAVI Alliance Executive Secretary **Julian Lob-Levyt**; WHO Director-General **Margaret Chan**; and UNAIDS Deputy Executive Director **Michel Sidibe** attend the first Informal Meeting of Global Health Leaders, at UNICEF House, in July 2007, in New York.



UNAIDS

*Leveraging the AIDS response, **The United Nations Joint Programme on HIV/AIDS (UNAIDS)** works to build political action and to promote the rights of all people for better results for global health and development. Globally, it sets policy and is the source of HIV-related data. In countries, UNAIDS brings together the resources of the UNAIDS Secretariat and 10 UN system organizations for coordinated and accountable efforts to unite the world against AIDS.*

WHAT NEEDS TO BE DONE?

At the end of 2008 it was estimated that 33,4 million people were living with HIV in the world. In low- and middle-income countries, more than 5 million of the estimated 9,5 million people in need of antiretroviral therapy were still without access to treatment. Accordingly, we need to ensure sustainable and predictable financing for universal access to HIV prevention, treatment, care and support in 2010 and beyond; strengthen the political will to tackle barriers preventing access for people living with HIV and vulnerable groups; mobilize for a prevention revolution.

FACTS & FIGURES

Annual Budget for 2009

For the period 2010–2011 UNAIDS require a budget of US\$484,8. This amount is shared among UN system organizations for a joint UN response to AIDS.

Percentage of budget devoted to Global Health

100% of resources devoted to Global Health.



"The European Union has a key role in the global AIDS response. I call upon the Members of the European Parliament to ensure that Europe's weight and significance as a progressive force in development is fully leveraged to promote the rights

of all people for better results in global health and development."

Michel Sidibé,
Executive Director of UNAIDS,
Under Secretary-General of the United Nations

SUCCESS STORIES

Antiretroviral therapy now reaches more than four million people. The number of new HIV infections has dropped by 17% worldwide in the past eight years. The most progress has been seen in sub-Saharan Africa, where there were 400 000 fewer new infections in 2008 than in 2001.

ROLE OF MEPS?

Advocate for AIDS to be in the international political agenda, including strong support for the Global Fund to Fight AIDS, Tuberculosis and Malaria and the UN response to AIDS

Advocate for a unified EU voice addressing barriers to universal access; strengthen country ownership through dialogue with partner country parliamentarians and support for civil society engagement.

POLICY REQUESTS FOR/TO M(E)PS

In the context of the new emphasis on global health and health system strengthening, step up policy dialogue at all levels to ensure delivery of health services and results for people living with HIV and key populations, such as injecting drug users, men who have sex with men and sex workers.

FUNDING REQUESTS FOR/TO M(E)PS

The investments required in 2010 for universal access to HIV prevention, treatment, care and support are estimated at US\$ 26,8 billion. In 2008 investments available for AIDS from domestic, multilateral and bilateral donors and the philanthropic sector amounted to a total of US\$ 13,8 billion.

UNAIDS - Brussels Office

Rue Montoyer 14, 1000 Brussels, Belgium - (t) +32 2 290 25 83/84 - www.unaids.org



The United Nations Development Programme (UNDP) is the UN's global development network, an organization advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. We are on the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity they draw on the people of UNDP and our wide range of partners.

WHAT NEEDS TO BE DONE?

A priority must be the achievement of the Millennium Development Goals related to health, including maternal health, reducing child mortality rates and combating HIV/AIDS, Malaria and other diseases. As we reach 2010 our focus should be on accelerating progress toward the achievement of the MDGs and hence the emphasis on Parliamentarians identifying the bottlenecks that are impeding its achievement. Furthermore, they have the power to hold all stakeholders accountable, publically, for the attainment of the MDGs through open and public debates in Parliament.

FACTS & FIGURES

Annual Budget for 2009
N/C

Percentage of budget devoted to Global Health
N/C

WHAT'S KEY?

UNDP's role is to create an enabling environment, reaching Parliamentarians by virtue of their "oversight role." They should hold the government/administration accountable to improve the levels of service delivery within a Country in all spheres of government.

Parliamentarians/legislators also have the authority to mobilize society at large around issues such as maternal mortality, in order to generate public debates/national debates on issues that are of grave concern to the country or society as a whole. In doing so the impact of saving lives and preventing deaths etc would be measured differently from the service providers/care givers in the sector.

ROLE OF MEPS?

Use the tools they have at their disposal (drafting laws, amendments of laws to create an enabling environment to achieve the MDGs, committee/public hearings and ensuring that there are parliamentary debates to highlight the MDGs, in this instance specific to health) **to advocate** for key global health goals.

POLICY REQUESTS FOR/TO M(E)PS

Parliamentarians should look at the prevailing policy and regulatory environment in their countries – as the contexts will differ between countries, within regions and between regions - and ensure that it is conducive for the achievement of the MDGs, and particularly those that are related to health.

To achieve the health MDGs it is necessary to ensure that their national public health system functions correctly, with the requisite staffing/human resources in place for it to remain effective. In this instance, parliamentarians should hold the administration in the country receiving the aid accountable, through their Executive, for a well functioning public health system at all levels of government.

FUNDING REQUESTS FOR/TO M(E)PS

Parliamentarians have the rare opportunity and ability to challenge powerful interest groups and industries, such as the Pharmaceutical Industry, to ensure that they are able to provide pharmaceutical products at affordable rates.

The influence of Parliamentarians/legislators is enormous, yet not always sufficiently tapped by their constituents, as in instances the 'loudest voices' tend to be that of lobbyists and powerful interest groups.

The United Nations Population Fund (UNFPA) is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

WHAT NEEDS TO BE DONE?

It is necessary to ensure that donor and recipient governments honour their pledges of aid to developing countries. In doing so we must advocate for increased protection of investments in the social sector, strengthening the capacity of national health systems. In addition to this it is necessary to ensure universal access to RH and RRs, to invest in South-South cooperation, and to support international health partnerships (H4, H8, IHP+, PMNCH, SPF-I, HHA, High Level Taskforce for Innovative Financing, etc).

FACTS & FIGURES

Annual Budget for 2009

In 2009, UNFPA incurred expenditures totaling \$800,1 million, made up of \$467,3 million under regular resources and \$332,8 million under other (earmarked) resources.

Percentage of budget devoted to Global Health

Cannot be quantified

SUCCESS STORIES

In 2008, modern contraceptive use prevented 188 million unintended pregnancies, 1,2 million newborn deaths, and 230,000 maternal deaths and other negative health outcomes that would have occurred in the absence of the use of any modern contraceptive method.

ROLE OF MEPS?

Advocate for further implementation of the principles for aid effectiveness as reflected in the AAA.

Advocate for increased resources and donor commitments for MDGs 4, 5 and 6, strengthening health systems, support of national health strategies,

Promote IHP+ and other health partnerships to reduce aid fragmentation and transaction costs, improve transparency and strengthen health systems.

POLICY REQUESTS FOR/TO M(E)PS

Parliamentarians should **harmonize** international assistance through established mechanisms such as IHP+ and PMNCH. The current economic climate warrants a focus on priority areas such as MDGs 4, 5 and 6 strengthening health systems, and harmonizing aid initiatives.

FUNDING REQUESTS FOR/TO M(E)PS

The IMF has stated that ODA will shrink. Therefore focus on priority areas is necessary.

MDG 5 is lagging behind the other MDGs, and therefore requires additional funding.

Strengthening health systems contributes to all the MDGs and requires additional investments.



The World Health Organisation (WHO) is the directing and coordinating authority on global health work within the United Nations' system. WHO supports countries' efforts to achieve the MDGs by developing guidelines and standards towards the achievement of all health targets as well as supporting national health authorities to develop coherent and well-costed national health strategies. In countries with many donors, the WHO office has a key role in assisting governments in their efforts to coordinate development partners and to ensure alignment between external assistance domestic priorities.

WHAT NEEDS TO BE DONE?

The EU and Member States should stick to their existing commitments to increase ODA including substantial allocations to health. Most importantly, the EU should ensure that all health allocations are spent optimally by allocating existing and additional funds in partner countries efficiently, filling gaps in costed and agreed national health strategies that are country owned

FACTS & FIGURES

Annual Budget for 2009

The total budget for the biennium 2008-2009 is US\$ 4227 million and broken down according to source as follows: total assessed contributions from Member States (2008-2009)US\$ 950 million; total voluntary contributions from Member States and partners (2008-2009)US \$3268 million.

Percentage of budget devoted to Global Health

WHO efforts are directed at supporting Member States to better formulate evidence-based policies to address global health challenges as well as accompany them throughout the process of implementation for improved health outcomes in countries.

SUCCESS STORIES

WHO is working to improve surveillance and treatment and is supporting 114 countries in assessing their cases of drug-resistant TB. More than 70 countries now have effective multi-drug-resistant TB management programmes and provide discounted drugs to an estimated 70 000 people. WHO and other members of the Stop TB Partnership have delivered 16 million TB treatments

ROLE OF MEPS?

Ensure EU pledges are met and channeled in ways that better support partners' strategies and priorities to minimize duplication and gaps.

Advocate for a substantial increase of resources focusing on health in accordance with the 20% benchmark for social sectors and the European Court of Auditors report on health sector assistance of 2008.

POLICY REQUESTS FOR/TO M(E)PS

Strengthen strategic policy dialogue with partner countries for a greater role for health in macroeconomic policies and decision-making. Build well functioning health systems to ensure that interventions are combined to provide efficient and equitable health services, universal social health protection and reduced out-of-pocket expenditures on health. Implement coherent whole-of-the-Union and comprehensive policies to address all causes of ill-health as well as improve effectiveness of aid in the health sector.

FUNDING REQUESTS FOR/TO M(E)PS

According to the Task Force on Innovative Financing for Health Systems, spending on health in low-income countries needs to be raised from an estimated US\$31 billion to US\$67-76 billion per year by 2015.

In order to plug the gap, innovative financing mechanisms would have to raise an additional US\$10 billion per year together with existing donor commitments to address critical health needs in poor countries.



World Bank

The World Bank is an international development institution that provides financial and technical assistance to developing countries to reduce poverty. The Bank—which includes the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA)—provides low-interest loans, interest-free credits, and grants for investments in education, health, public administration, infrastructure, private sector development, as well as other investments. To date, 186 member countries own the Bank.

WHAT NEEDS TO BE DONE?

More money is needed from domestic and external resources for health; MDGs would cost, by 2015, an additional \$36-\$45 billion (\$24-\$29 per capita) per annum, on top of the estimated \$31 billion spent in 2009 in low-income countries (from the Taskforce on Innovative International Financing for Health Systems, 2009). This money should be used more effectively and efficiently.

FACTS & FIGURES

Annual Budget for 2009

In financial year 2009, the Bank committed US\$46,9 billion in IBRD/IDA loans/ credits/ grants.

Percentage of budget devoted to Global Health

In the financial year 2009, US\$2,9 billion or 6,1 percent of US\$46,9 billion was for the health sector.

SUCCESS STORIES

www.go.worldbank.org/YXWJLYRF10
(IDA - Health, see Project Profiles)

www.go.worldbank.org/82WLVAK710
(IDA - HIV/AIDS, see Project Profiles)

www.worldbank.org/lachealth (under Highlights, see "Results in World Bank Health Programs in Latin America")

ROLE OF MEPS?

Advocate for increased health funding.

Advocate for increasing the effectiveness of aid to health through supporting inclusive donor recipient country partnerships, such as the International Health Partnership, and place a greater focus on results-oriented health system support.

Raise awareness of the need to better target health-related MDGs in development programs.

POLICY REQUESTS FOR/TO M(E)PS

Advocate for and support an EU aid-for-health program that provides: long-term predictable and adequate funding; results-focused plans and programs; enhanced coordination and efficiency at country, regional, and global levels and mutual accountability and monitoring of performance



The Global Fund is dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria. This global public/private partnership between governments, Parliamentarians, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organisations to supplement existing efforts dealing with the three diseases and has become the main source of financing the efforts, with funding of US\$ 19,3 billion for more than 572 programs in 144 countries. Global Fund financing enables countries to strengthen health systems by, for example, making improvements to infrastructure and providing training to those who deliver services.

WHAT NEEDS TO BE DONE?

While the EC and its Member States are the largest contributors to the resources of the Global Fund (providing over 50%), these contributions must be scaled up significantly if we are to meet the health-related MDGs and the goal of universal access to HIV/AIDS treatment, care and support.

FACTS & FIGURES

Annual Budget for 2009

The Global Fund has funding rounds each year. In the most recent Round 9 support was given for projects totaling over US\$2,4 billion for the coming two year period. This followed the largest ever Round in 2008 at US\$2,75 billion. All of the administrative costs of the Fund have been covered by interest on fund donations.

Percentage of budget devoted to Global Health

100% Global Health. 1/3 of funding supports strengthened health systems. The Fund also has a strong Gender Strategy and Sexual Orientation and Gender Identity strategy, and is working to increase links between SRHR and HIV programmes.

ROLE OF MEPS?

Play a key role in working to ensure that their governments increase their pledges to the Global Fund in this key replenishment year, to ensure adequate resources for the coming three years. Those from non-contributing countries can **support new contributions.**

POLICY REQUESTS FOR/TO M(E)PS

Play a very important role in key policy areas to help meet the MDG Goals 4, 5 and 6. They can be strong advocates in ensuring a human rights-centred, evidence-based approach to the three pandemics, working to ensure access to affordable medications, and supporting innovative financing mechanisms such as the CTL and FTT.

FUNDING REQUESTS FOR/TO M(E)PS

In the current replenishment period, 2007-2010, US\$10 billion was pledged. For the coming three years 2011-2014, critical for the 2015 MDG targets, at least US\$17 billion is needed just to maintain current progress, US\$20 billion to scale up to meet MDGs. So this means a 50-75% increase in current contribution levels as well as support for new sources of funding.



"We greatly value the strong leadership of civil society in the operation of the Global Fund, and we also encourage a much more vigorous engagement with Parliamentarians. You can play a key role in advocating for increased resources, speaking out on policies such as access to affordable medications, human rights issues such as criminalization of AIDS transmission or homosexuality, gender equality and enhanced harmonization and alignment of donors at the country level. The Global Fund values and respects the essential role of Parliamentarians, and looks forward to a stronger partnership in the future. I thank the EPF and Action for Global Health for the opportunity to join you in widely sharing the important results of the Global Fund with your dedicated members, and look forward to working with you in the future."

Prof. M. Kazatchkine,
Executive Director of the Global Fund

SUCCESS STORIES

The Global Fund programmes have contributed to saving some 4,9 million lives. They support over 2,5 million people on AIDS treatment, 6 million people on anti-TB treatment, and have distributed over 104 million anti-malaria bed nets. Global Fund programmes support thousands of women receiving PMTCT as well as orphans and vulnerable children, and target resources at prevention programmes including education and condom distribution.

GAVI Alliance

The GAVI Alliance is a public-private global health partnership committed to saving children's lives and protecting people's health by increasing access to immunisation in poor countries. The Alliance brings together developing countries and donor governments, the World Health Organization, UNICEF, the World Bank, the vaccine industry in industrialised and developing countries, research and technical agencies, civil society organisations, the Bill & Melinda Gates Foundation and other private philanthropists.

WHAT NEEDS TO BE DONE?

Address the overall funding challenge of US\$ 4,3 billion between 2010-and 2015 in long term predictable funding to meet the demand for the world's poor countries for life-saving vaccines.

FACTS & FIGURES

Annual Budget for 2009

Total of US\$ 852 million with: Programmes (vaccines & cash support for health services) – 86%
Programme implementation – 9%
Admin expenditure – 5%

Percentage of budget devoted to Global Health

100% of resources devoted to Global Health.



"Parliamentarians have a vital role to play in ensuring that aid funds target cost-effective, evidence-based interventions. New vaccines against severe pneumonia and diarrhoea can help to tackle the leading child-killing diseases. Together, you have the power to make a significant contribution to achieving the MDGs."

Julian Lob-Levyt,

Chief Executive Officer, GAVI Alliance

SUCCESS STORIES

Since 2000, the support of GAVI and its partners has prevented 5,4 million future deaths, and more than 257 million children have been immunised. If the funding challenge of US\$ 4,3 billion from 2010 to 2015 is met, GAVI-funded programmes can save an additional 4,2 million lives by 2015.

1 ROLE OF MEPS?

Advocate for increased resources for health ODA and importance of joint progress for health-related MDGs.

Highlight cost-effectiveness of immunisation in attaining MDG 4 and GAVI's potential to greatly accelerate reductions of child mortality and morbidity over the next 5 years, with the benefits that accrue across all MDGs.

2 POLICY REQUESTS FOR/TO M(E)PS

Ensure more effective and efficient use of EC funding through recognition of GAVI Alliance as an international organisation by the European Commission.

3 FUNDING REQUESTS FOR/TO M(E)PS

Of the total US\$ 4,3 billion required, predictable long-term funding of US\$ 1,1 billion cash inflows are needed in 2010-2012 and US\$3,2 billion in 2013-2015. A particular opportunity at the EU level is the next financial perspective 2013 – 2020.

UNITAID was created in 2006 as an innovative financing for health to inject extra finances into efforts to achieve the United Nations health-related Millennium Development Goals. Since then, UNITAID has helped increase access to treatment for people living with HIV/AIDS, malaria and tuberculosis in developing countries, impacting public health and medicines markets in developing countries. UNITAID's success is based on two strategies, raising funds from long-term sustainable and predictable sources, principally through a tax on airline tickets. These funds are then disbursed to international partners working in global health and health commodities procurement, such as the William J. Clinton HIV/AIDS Initiative and UNICEF, to name just two.

WHAT NEEDS TO BE DONE?

We need to ensure current pledges of ODA are met. We should also encourage more European countries to join this successful, vital initiative through the air tax.

FACTS & FIGURES

Annual Budget for 2009

2009 UNITAID Approved Budget - US\$565,2 million

Percentage of budget devoted to Global Health

100% of resources devoted to Global Health.

SUCCESS STORIES

UNITAID uses its purchasing power to encourage the development of new drugs better adapted to patients' needs, including paediatric formulations and fixed-dose combinations that combine several ingredients. These enable patients to take only one pill a day instead of several. By financing sustained high-volume purchases for quality-assured drugs and diagnostics, UNITAID is able to leverage economies of scale to drive prices down. This enables UNITAID and its partners to provide more drugs and treatments with the same outlay. Thus the 60% price reductions obtained for key paediatric AIDS medicines since November 2006 have enabled three times as many HIV-positive children to be treated for the same amount of money. As of today, UNITAID has collected US\$ 1,3 billion and disbursed about one billion to provide over 21 million treatments in 93 countries. UNITAID provides medicines for three out of four children treated for AIDS globally.

1 ROLE OF MEPS?

Ensure that European members continue to support the initiative.

Advocate for other European countries to join UNITAID by applying the air tax.

2 POLICY REQUESTS FOR/TO M(E)PS

Push for innovative financing for health - and use UNITAID as a successful example of that - to be included in the G8 and G20 Agendas.

3 FUNDING REQUESTS FOR/TO M(E)PS

The more countries join, the more people UNITAID will be able to treat.

MASSIVE GOOD

Powered by the Millennium Foundation, **MASSIVEGOOD** is a global movement and worldwide campaign aimed at saving lives through voluntary micro-contributions. **MASSIVEGOOD** gives travellers the choice to make a micro-contribution of 2 \$/€/£ to help fight HIV/AIDS, tuberculosis and malaria, and to help improve the health of mothers and children in developing countries, all through a simple click when they make their travel reservations.

WHAT NEEDS TO BE DONE?

A sharp increase in resources is required. To achieve this, the Millennium Foundation aims to inspire and empower citizens to join a movement to help the world's most vulnerable populations. The organization hopes to achieve this by making it easy for everyone who travels to make a 2 \$/€/£ micro-contribution through a simple click.

FACTS & FIGURES

Annual Budget for 2009

N/A – The project has just been launched in March 2010 in the USA.

Percentage of budget devoted to Global Health

100% of resources devoted to Global Health. Micro-contributions through MASSIVEGOOD will go to UNITAID.

SUCCESS STORIES

Innovative Financing mechanisms have already raised US\$2 billion over the past 3 years.

Using market-based solutions to guarantee a steady supply of affordable medicines for poor countries, UNITAID has achieved remarkable results in its short existence by reducing prices of quality medicines and increasing their availability.

1 ROLE OF MEPS?

Advocate for the roll-out of existing innovative financing mechanisms.

Support publicly and **advocate** for MASSIVEGOOD: join the Movement and invite citizens to do so.

2 POLICY REQUESTS FOR/TO M(E)PS

Diffuse the message that Innovative financing initiatives are critical to bridge the financing gap.

3 FUNDING REQUESTS FOR/TO M(E)PS

Ensure that innovative financing mechanisms remain additional. Keep the commitments made by Member States.

What Can Parliamentarians Do?

This section provides examples and ideas of initiatives that can be undertaken by APPGs, parliaments and parliamentarians in order to foster greater awareness and resource mobilisation for global health-related issues. This section also presents success stories and best practices through a selection of EPF's "recipes" for organising successful events.

1. BE ACCOUNTABLE

- Report back on your experience to your All-Party Parliamentary Group and the group's secretariat
- Report back to the NGOs working on Global Health in your country
- Report back to your political party and relevant Parliamentary Committees

2. SPEAK ABOUT YOUR EXPERIENCES

- At meetings of Parliamentarians
- In Committee/Plenary debates
- To the hierarchy in Parliament and your political party
- To relevant Ministers
- To representatives of the media

3. TAKE ACTION

- Forward recommendations based on what you have learned to relevant Ministers
- Pose Parliamentary questions
- Introduce Parliamentary resolutions
- Organise an event in Parliament
- Take action not only in your national Parliament but also in other Parliamentary assemblies to which you belong (e.g. the Parliamentary Assembly of the Council of Europe, IPU, APF)

4. CREATE VISIBILITY

- Write a press release and organise a press conference (upon your return from study tours, conferences)
- Write articles based on your study tour/conference experiences and what you have learned for newspapers, parliament media, political party media and your constituencies

5. DEMONSTRATE YOUR COMMITMENT

- Write and talk about participating in EPF study tour/conferences in your CV, on your blog, website and the websites of your party.

Successful Recipes For Parliamentary Action

RECIPE FOR A SUCCESSFUL AWARENESS-RAISING EVENT ON A HEALTH RELATED THEMATIC ISSUE IN PARLIAMENT

1

YOU NEED:

- > 1 MP with good standing, commitment and understanding of the issue to host the event
- > 1-4 speakers, including representatives of expert NGOs, International Organisations, Researchers, high-level personality, a partner from Southern
- > 1 draft motion for resolution on theme
- > At least 1 journalist

PREPARATION:

- > Make sure to book a convenient venue (in the Parliament)
- > Order catering (if working lunch or breakfast briefing)
- > Send invitation letters to convene your colleagues to the event (hearing/working lunch/breakfast meeting, etc)
- > Make sure to anticipate visa needs
- > Prepare and disseminate promotional material: posters/ flyers
- > Secure interpretation (if needed)

DURING THE EVENT:

- > Secure speaking slots for your speakers and time for Q&A
- > Present the draft text at the end of your event

AFTER THE EVENT:

- > Approach your colleagues and disseminate the motion widely over a period of 3 weeks
- > Approach or question your Government to request increased support
- > Give interviews or organise a press conference
- > Share the motion with other Parliamentary fora you are a member of (e.g. *Parliamentary Assembly of the Council of Europe*), and in international settings (*Euro-pean Congress of your Political Party*)

RECIPE FOR A SUCCESSFUL PARLIAMENTARY REGIONAL COOPERATION ON BEST PRACTICES EXCHANGE ON SRHR/HEALTH

2

YOU NEED:

- > 1 MP or APPG who is a regional champion on the issue of Health
- > Interested MPs from neighboring countries/regions interested in advancing on the issue
- > Speakers (MPs, other stakeholders, experts) presenting best practices, case studies, including on culturally sensitive issues
- > 1 draft declaration or action plan
- > At least 1 journalist

PREPARATION:

- > Make sure to book a venue in Parliament
- > Send invitation letters to convene participants to the event
- > Make sure to anticipate visa needs
- > Secure interpretation (if needed)

DURING THE EVENT:

- > Secure speaking slots for your speakers and time for Q&A
- > Organise country/thematic working groups, followed by wrap-up plenary session
- > Present the draft declaration or action plan

AFTER THE EVENT:

- > Follow up progress on the implementation of the Action Plan with all stakeholders

Successful Recipes For Parliamentary Action

3

RECIPE FOR A SUCCESSFUL “GLOBAL HEALTH WORKFORCE” EVENT ⁽¹⁾

YOU NEED:

- > 3-5 MPs from different political parties to organise the event
- > A theme (e.g. *Health systems in Sub-Saharan Africa; Health workforce in partner countries*)
- > A film to display on the theme
- > Prominent government officials, Ambassadors, artists, NGO and civil society representatives
- > Catchy action (e.g. *Stunt at which MPs raise their hands for health workers and Merlin’s Hands Up Campaign www.handsupforhealthworkers.org/*)
- > At least 1 journalist and 1 photographer

PREPARATION:

- > You need to secure a place inside or outside the Parliament on World Health Day (April 7th)
- > Invite your colleagues to join this symbolic event and show commitment for Global Health
- > Audio-visual equipment, banners, thermos with coffee

AFTER THE EVENT:

- > Give interviews and generate media visibility (TV, radio, write articles on your blogs, etc.)
- > Circulate information leaflet on global health workforce crisis
- > Invite your government to join the Global Health Workforce Alliance

RECIPE FOR A SUCCESSFUL LAUNCH OF A FLAGSHIP REPORT

4

YOU NEED:

- > 3-5 MPs (or more) from different political parties
- > An author organisation representative to present the report
- > Other relevant speakers, including governmental officials, civil society organisations, etc.
- > At least 1 journalist to secure media coverage

PREPARATION:

- > You need to secure a room in Parliament
- > Convene your colleagues to the event (hearing/working lunch/breakfast meeting, journalist briefing, etc.)
- > Ensure interpretation (if needed)

DURING THE EVENT:

- > Secure speaking slots for your speakers and time for Q&A
- > Approach your colleagues and disseminate the Report widely in Parliament

AFTER THE EVENT:

- > Organise a cocktail/reception
- > Approach or question your Government to request increased support on the basis of the report findings

⁽¹⁾ www.who.int/workforcealliance/en/

EPF Taskforce On Global Health

As a Parliamentary network that serves as a platform for cooperation and coordination for its All Party Parliamentary Groups throughout Europe focused on population, development and health issues, EPF is working with Parliamentarians to increase support and awareness on global health related-issues as an essential factor in achieving the Millennium Development Goals.

About EPF Taskforce on Global Health

Building upon the success of the existing EPF Taskforce on Malaria, EPF launched its new Parliamentary Taskforce on Global Health on 1st March 2010 in the European Parliament. Aiming to improve the political, policy and funding environment for Global Health, the EPF Taskforce on Global Health provides invaluable insight and leadership to fellow European Parliamentarians interested in supporting global health efforts. The Taskforce membership is strictly reserved to Parliamentarians, particularly from European donor countries.

THE AIM OF THE TASKFORCE IS TO:

- **Develop** a cohesive partnership and raise awareness, knowledge and support amongst Parliamentarians in Europe aiming to generate and promote increased support for global health related issues
- **Foster** political dialogue on malaria and scaling up political support
- **Build** cross-party consensus on the issue of global health
- **Mobilise** resources for global health
- **Strengthen** parliamentary oversight
- **Encourage** peer-to-peer exchanges
- **Support** developing countries' accountability

- **Provide** leadership and visibility for global health
- **Promote** the exchange of knowledge, information, good practices, share lessons and coordinate the work of Parliamentarians around specific events.

THE MAIN ACTIVITIES INCLUDE:

- Inter-Parliamentary visits
- Parliamentary Hearings on global health-related issues
- Parliamentary Study Tours to developing countries in order to be made aware of the need to prioritise global health-related issues in development cooperation efforts
- Parliamentary reports and questions on global health
- Joint/coordinated media events



To join or receive additional information about the EPF Taskforce on Global health, please contact EPF Secretariat: secretariat@iepfpd.org or +32 (0) 2 500 86 50

Recommendations⁽¹⁾

This section aims to provide parliamentarians with a set of ten concrete and detailed recommendations on Global Health, classified by theme. For the EU and the Member States to speed up the achievement of real and tangible health improvements in developing countries, parliamentarians have a key role to play for holding their governments accountable to their international commitment.

1. Take rapid action on the global health crisis
2. Fulfil obligations and guarantee the universal right to health
3. Make gender equality a reality
4. Ensure people have a say in aid
5. Divide labour and produce real results
6. Avoid parallel structures, align with country systems
7. Deliver long-term predictable aid for health
8. Be accountable and focus on health improvements
9. Keep your promises, meet aid commitments
10. Use new mechanisms to find additional money

1. TAKE RAPID ACTION ON THE GLOBAL HEALTH CRISIS

In responding to the global economic crisis prioritise and accelerate the response to the global health crisis. Meet aid commitments and improve aid effectiveness, focusing on pro-poor health outcomes that will make a concrete difference to the health MDGs.

This can be achieved through:

- **Meeting** the long-standing aid targets reiterated in the Accra Agenda for Action (2008), EU Agenda for Action on the MDGs (2008) and Doha Declaration on Financing for Development, 2008. *[See recommendation 9].*
- **Ensuring** that the allocation and delivery of aid is designed to achieve universal access to health and to benefit the poorest and most marginalised populations - through strengthening primary healthcare systems and addressing the social determinants of health.
- **Demonstrating** leadership at the global level within debates, processes and decisions relating to aid effectiveness and aid financing that affects health.

2. FULFIL OBLIGATIONS AND GUARANTEE THE UNIVERSAL RIGHT TO HEALTH

Guarantee the universal right to health and the role of the state as the primary duty-bearer, as a priority for countries that both give and receive aid for health.

This can be achieved through:

- **Meeting** the long-standing aid targets reiterated in the Accra Agenda for Action (2008), EU Agenda for Action on the MDGs (2008) and Doha Declaration on Financing for Development, 2008. *[See recommendation 9].*
- **Systematically** ensuring a rights-based approach within all policies and procedures relating to aid effectiveness and aid financing, especially in areas relating to health.
- **Investing** aid in primary healthcare - including sexual and reproductive health, rights and services - for all and addressing the social determinants of health.
- **Promoting** equality, equity and non-discrimination - especially for women, girls and marginalised communities - within decision-making and the allocation of aid for health.

Recommendations



4

4. ENSURE PEOPLE HAVE A SAY IN AID

Prioritise the principle of the democratic ownership of aid. Implement it through the meaningful involvement of all key stakeholders from local to global level, including civil society and parliaments, to ensure the scrutiny, transparency and effectiveness of health policies and budgets.

3

3. MAKE GENDER EQUALITY A REALITY

Ensure gender equality forms an essential component of decision-making to deliver effective provision of aid, sustained poverty reduction and the achievement of the health MDGs.

This can be achieved through:

- **Actively involving** gender equality advocates and women's Ministries in all stages of relevant decision-making about national development and aid delivery, including matters relating to health.
- **Implementing** accountability mechanisms for processes relating to aid for health that emphasise gender equality and women's empowerment.
- **Promoting** gender-responsive financing, budgeting, programming, monitoring and evaluation to ensure allocation of resources for women's priorities.

This can be achieved through:

- **Ensuring** the meaningful involvement of civil society - especially representatives of poor communities, marginalised groups and women's organisations - at all levels and stages of decision-making about aid effectiveness and aid financing, particularly in areas relating to health.
- **Investing** in increasing the knowledge, skills and capacity of civil society to enable the sector to fully engage in all stages of relevant decision-making processes.
- **Enabling** and promoting the full scrutiny of relevant health strategies, budgets and aid effectiveness and financing mechanisms by parliaments.



Recommendations

5. DIVIDE LABOUR AND PRODUCE REAL RESULTS

Implement a results-focused division of labour that contributes to strong health systems, including through adequate allocation of resources to health across all partner countries and meaningful involvement of civil society.

This can be achieved through:

- **Ensuring** a strong lead donor on health in every EU partner country – avoiding the risk of ‘orphan countries’ or ‘orphan sectors’.
- **Strengthening** health systems through better harmonisation of donors’ aid to health.
- **Ensuring** that this process does not lead to a decrease in financing for health.
- **Involving** all stakeholders, including civil society, in the division of tasks at the country level.

6. AVOID PARALLEL STRUCTURES, ALIGN WITH EXISTING NATIONAL SYSTEMS

Use an appropriate mix of financing mechanisms, including sector budget support for health and general budget support with all aid modalities properly aligned to country systems and contributing to better health outcomes.

This can be achieved through:

- **Enabling** partner countries to choose between a range of aid modalities, including budget support and sector-wide programmes, which are strongly aligned to country systems and demonstrate concrete improvements in health outcomes for all.
- **Ensuring** general budget support leads to health systems strengthening and achieving the right to health, including by using health-specific and gender-sensitive qualitative indicators.

7. DELIVER LONG-TERM PREDICTABLE AID FOR HEALTH

Enhance the predictability of aid for health to contribute to improving more sustainable health outcomes.

This can be achieved through:

- **Providing** long-term and predictable financing for a minimum of five years to support the achievement of the health MDGs.
- **Ensuring** commitment from all EU donors for the development of pro-poor and gender-sensitive mechanisms that increase predictability of aid and contribute to improved and more sustainable health outcomes.



Recommendations

8. BE ACCOUNTABLE AND FOCUS ON HEALTH IMPROVEMENTS

Ensure genuine mutual accountability for health results by linking aid to clear results frameworks that focus on progress towards the health MDGs, for which donors and recipient governments can be held to account.

This can be achieved through:

- **Ensuring** a strong and complementary focus on both mutual accountability and managing for development results.
- **Strengthening** mutual accountability from donor to recipient government, from recipient government to donor, and from donor and recipient government to civil society. Carrying this out within the development of clear results frameworks that link aid to progress towards the health MDGs and against which all stakeholders can be held to account for delivery.

9. KEEP YOUR PROMISES, MEET AID COMMITMENTS

Urgently meet longstanding aid commitments, including spending 0,7% GNI on ODA, as reiterated in the Doha Declaration on Financing for Development, 2008, and prioritise health spending.

This can be achieved through:

- **Providing** 0,51% of GNI to ODA by 2010 and 0,7% by 2015. This includes 0,15-0,2% of GNI to ODA to least developed countries and more than doubling ODA to Africa in real terms.

- **Spending** 0,1% of GNI on health, with a focus on increasing access to essential health interventions and strengthening primary health systems; supporting the European Parliament recommendation that 20% of all European development policy spending, including EDF, should be allocated to education and basic health in 2009.

- **Increasing** aid for health by €8 billion by 2010 to fulfil the EU's share of the estimated health financing gap.

10. USE NEW MECHANISMS TO FIND ADDITIONAL MONEY

Implement best practice in innovative financing to ensure that mechanisms leverage genuinely new money and to explore options for providing long-term and predictable financing to strengthen health systems.

This can be achieved through:

- **Ensuring** that innovative financing mechanisms leverage genuinely new money that is additional to current ODA and does not undermine future ODA. Ensuring that innovative financing mechanisms are in line with the principles of the Paris Declaration and promotes democratic ownership.
- **Broadening** the use of innovative financing to include the strengthening of health systems that are accessible to all

⁽¹⁾ AfGH Report Three, "Health in Crisis", March 2009, section five "Recommendations for Action", p.36. www.actionforglobalhealth.eu/uploads/media/AFGH__Health_in_Crisis__Report2009_.pdf

Additional Resources

EPF (European Parliamentary Forum on Population and Development): www.epfweb.org

Action For Global Health: www.actionforglobalhealth.eu

Other resources:

ActionAid: www.actionaid.org

AIDOS: www.aidos.it

CESTAS: www.cestas.org

DSW Brussels (German Foundation for World Population): www.dsw-online.de

European Public Health Alliance (EPHA): www.epha.org

Federación de Planificación Familiar Estatal (FPFE): www.fpfe.org

Global Health Advocates (GHA): www.ghadvocates.org

Interact Worldwide: www.interactworldwide.org

International HIV/AIDS Alliance: www.aidsalliance.org

Médecins du Monde (MdM): www.medecinsdumonde.org

Médicos del Mundo: www.medicosdelmundo.org

Plan International: www.plan-international.org

Stop AIDS Alliance (SAA): www.stopaidsalliance.org

TB Alert: www.tbalert.org

Terre des Hommes Germany: www.tdh.de

Welthungerhilfe: www.welthungerhilfe.de

All the pictures in this publication have been taken during the EPF Parliamentary Study Tours.



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