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COMMISSION STAFF WORKING DOCUMENT

Contributing to universal coverage of health services through development policy

Accompanying document to the

COMMUNICATION FROM THE COMMISSION TO THE COUNCIL, THE EUROPEAN PARLIAMENT, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

The EU Role in Global Health

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COMMISSION STAFF WORKING DOCUMENT

Contributing to universal coverage of health services through development policy

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COMMISSION STAFF WORKING DOCUMENT

Contributing to universal coverage of health services through development policy

This staff working document complements the Communication *'The EU Role in Global Health'*. It elaborates on specific objectives, within the present legal, regulatory and financial framework.

Health is central to *poverty reduction* and sustainable development and ill-health is a barrier to social and economic progress. The EU is committed to protecting and promoting health as a human right for all[1]. The *European social model* includes certain common features aimed at guaranteeing healthcare for all EU citizens. The EU has agreed common values of *solidarity* with a view to *equitable and universal coverage by quality care*[2] *in health systems*.

1. LATEST TRENDS

During the last decade millions of children's deaths per year have been averted. The under-five mortality rate declined 28% between 1990 and 2008. The decade has seen unprecedented mobilisation to combat HIV/AIDS, malaria and tuberculosis. HIV/AIDS treatment reached over 4 million people (over 40% of those in need) in developing countries, compared with virtually none at the beginning of the decade, pushing back AIDS mortality.

Three of the eight millennium development goals (MDGs) are directly related to health: reducing child mortality (MDG 4), reducing maternal mortality (MDG 5) and the fight against AIDS, malaria and other poverty-related diseases (MDG 6). They are closely interconnected with all the other MDGs, as nutrition (MDG 1), education (MDG 2), gender equality (MDG 3) and water/sanitation (MDG 7) tie in with the main risk factors behind ill-health. Unfortunately, these health-related goals are the MDGs least likely to be achieved in many parts of the developing world – especially in Africa.

However positive these particular outcomes are, overall progress towards the health MDGs has been slow, with over 50 developing countries off-track, especially in sub-Saharan Africa. Progress towards MDG 5[3] has been particularly disappointing. This

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1 In 2000 the United Nations Committee on Economic, Social and Cultural Rights published General Comment 14, which defines in detail states' obligations, patients' health entitlements, and their ethical implementation using human rights principles. Child health is specifically protected by the Convention on the Rights of the Child, reproductive and maternal health by the Cairo Action Plan and the Resolution on Preventable Maternal Mortality and Morbidity at the United Nations' Human Rights Council; and rights of persons with disabilities as outlined in the Convention of the Rights of People with Disabilities..

2 Council Conclusions on Common values and principles in European Union Health Systems (2006/C 146/01).

3 'The Millennium Development Goals Report 2009': http://www.undp.org/mdg/basics_ontrack.shtmlhttp://www.undp.org/mdg/basics_ontrack.shtml.

lack of progress on the health MDGs reflects the heavy burden of disease globally[4], especially in developing countries. Over 60 million die prematurely every year, most due to social and environmental factors and lack of adequate healthcare[5]. Nine million of them are children under the age of five[6].

The *difference in life expectancy* across the world has been widening, with the richer top billion enjoying an average life expectancy close to 80 years, twice that of the poorer bottom billion[7]. Worldwide, exposure to health risks and inadequate access to healthcare are to blame for a loss of 20% of *potential healthy life*. The average loss is 10% in the EU but close to 50% for the world's poorest billion.

This staff working document is a contribution to the communication on the *EU role in global health*. It elaborates on the policy commitments in relation to the specific objective of '*Progress towards universal coverage by basic quality healthcare'*. Consistent with the attention already given to health equity within the EU, this document focuses on *how the EU's external action can contribute to reducing health inequalities worldwide* and to progress towards *universal coverage by health services in partner countries.*

1.1. Health inequities

In the poorest parts of the world human suffering from ill-health remains extremely high. There are *also very large differences in state of health* between and within countries and regions. According to the report by the Commission on Social Determinants of Health[8], differences in health indicators within countries are closely linked to degrees of social disadvantage, the circumstances in which people live and work and the systems put in place to protect health and deal with illness. The report concludes that '*The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health'*.

Amongst the countries of the EU itself, there is a five-fold difference in deaths of babies under one year of age and an 11-year gap in life expectancy at birth. Mortality rates are much higher in the least developed countries than in the EU: more than 100 times higher for maternal mortality and 15 times for infant mortality, with close to a 40-year difference in life expectancy. In sub-Saharan Africa, the region with the lowest health indicators, the lifetime risk of dying during pregnancy is one in 20, the risk of dying during childhood is one in six and the risk of dying during economically active life (between the ages of 15 and 60) is almost one in two.

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4 Burden of disease is measured by Disability Life Adjusted years, i.e. the healthy years lost to premature deaths and to various degrees of disability during disease.

5 'The global burden of disease: 2004 update', WHO.

6 'The State of the World's Children 2009', UNICEF.

7 WHO statistical information system: http://www.who.int/whosis/en/.

8 CSDH (2008): 'Closing the gap in a generation: health equity through action on the social determinants of health', Final report by the Commission on Social Determinants of Health, Geneva, World Health Organisation.

1.2. Insufficient and uneven progress towards the health MDGs

As mentioned in section 1, *progress towards the health MDGs* has been slow and uneven. However, there are good examples where a combination of political stability, adequate domestic funding for health, strong international support and a genuine policy dialogue has led to sustained progress on reducing child and maternal mortality[9].

Over the last decade progress was made towards *MDG 4* (child mortality). The under-five mortality rate declined by 28% between 1990 and 2008 (down to 65 per 1000 live births). Most of this reduction was attributable to progress in Asia, mainly India and China. Almost 30 countries made no progress on reducing childhood deaths[10]. Sub-Saharan Africa, with only 10% of the world's population, accounts for about half the deaths of children under five in the developing world. Although coverage by measles vaccination has improved, many other risks to child health (mainly unsafe water, sanitation and inadequate nutrition) remain high and access for children to basic health services remains low[11].

As regards *MDG 5*, maternal mortality remains extremely high across much of the developing world. Over 500000 women die every year during pregnancy or childbirth, 99% of them in developing countries with sub-Saharan Africa and Southern Asia accounting for 86%. This reflects the low rate of safe deliveries, but also gender inequities, lack of access to sexual and reproductive health and rights and high fertility rates, compounded by the burden of HIV/AIDS and malaria in sub-Saharan Africa.

In the case of *MDG 6*, the decade has seen broad mobilisation to combat HIV/AIDS, malaria and tuberculosis. HIV/AIDS treatment reached over 4 million people (over 40% of those in need) in developing countries, compared with virtually none at the beginning of the decade, pushing back AIDS mortality. The number of new infections decreased only slightly ─ by just 10% ─ largely because prevention is still weak in many countries. As regards malaria, rapid increases in the availability of insecticide-treated bed nets (from close to nil in 2000 to one in three of the population at risk today) and effective treatment have resulted in a 50% reduction of under-five mortality due to malaria in Asia and in Africa. Progress on tuberculosis has been slower and during the decade the number of emerging diseases has increased.

MDG 7, in particular access to basic sanitation which is directly related to health as it offers a means of preventing waterborne diseases, is also off-track globally and,

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9 One good example could be Zambia where, despite many weaknesses, there are acceptable levels of compliance with the Abuja targets (15% national budget allocation to health), international aligned and predictable support (mainly basket fund and budget support, with the exception of PEPFAR and the Global Fund) leading to overall public on-budget funding above €20 per capita, SWAP set up with participation of CSOs, reforms in human resources for health and in abolition of user fees for basic services in rural areas, increased uptake and completion rates for basic education with progress on gender equity, sustained economic growth and improved household economies during one decade and demographic health surveys with ample statistical significance showing progress on MDGs and lower infant and maternal mortality.

10 See UNDP MDG Monitor: http://www.mdgmonitor.org/map.cfm.

11 'State of the World's Children', UNICEF, 2009.

especially, in Sub-Saharan Africa, where, at the current rate, the sanitation target will be missed by more than two generations.

1.3. Weak health systems

In the 50 developing countries which are off-track to meet the health MDGs, access to comprehensive healthcare remains low. Coverage by many of the essential health services is low and has not expanded for the last decade in the least developed countries: one third of all pregnant women have no access to antenatal care and half of them lack safe care during delivery; only half of the women who wish to avoid a pregnancy have access to contraceptives and fewer than half of children are adequately treated against diarrhoea, respiratory infections or malaria. Although coverage by vaccination and basic services against HIV/AIDS, malaria and tuberculosis have been increased by targeted programmes, prevention and treatment of other diseases are lagging behind: for example, under a third of hypertensive or diabetic patients are diagnosed in developing countries and only a minority have access to adequate treatment.

1.3.1. The main features of health systems

The 1978 Alma-Ata[12] declaration put forward a set of values, principles and approaches with the aim of raising the level of health in deprived populations. Alma-Ata's holistic view of health, looking beyond a narrow medical model, and its participatory approach has become the basis for modern health systems.

Thirty years later the Alma-Ata principles have been adapted to the global context today. Effective health systems should be based on the *principles* set out in WHA Resolution 62.12[13] on Primary Health Care, including Health System Strengthening. The first principle ─ *a rights approach with inclusive leadership* ─ requires active community participation together with clear institutional leadership. Few health systems allow meaningful community participation, although this is difficult to measure. A second principle is that health systems must include the *health-in-all* approach relating health services to the sources of the main risks (nutrition, water and basic sanitation, education, transport, governance and gender equity). The health system must also deliver *people-centred services* which respond to needs at the level of care required for the final principle of *universal coverage*.

Identifying the priority services with the aim of universal coverage requires access to and analysis of a comprehensive range of data gleaned from regular monitoring and population health surveys. This information is essential in order to define the *package of priority health services* and to deliver it rationally across the different levels of care. At present, less than a third of all countries have timely demographic and health surveys (DHS/MIPS) and only a third of national health systems in developing countries have up-to-date data on national health accounts. Very few of them conduct performance analysis and monitoring.

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12 Alma-Ata Declaration, International Conference on Primary Healthcare, Alma-Ata, USSR, 6-12 September 1978.

13 WHA 2009, Resolution 62.12 on Primary Healthcare, including Health System Strengthening.

Once the services to be delivered have been defined and the components of the system (see below) identified, the health strategy would ideally provide input for a *national health budget* and a mid-term expenditure framework. A *health information and management system* would monitor inputs, processes and outcomes, provide input for policy decisions and steer research towards health priorities.

Effective health systems need to respond in a balanced way to the four main health challenges: *sexual and reproductive health, child health, communicable diseases and non-communicable diseases*. Each of these areas will require an integrated approach combining specific training, protocols by levels of services, indicators and applied research. At present, many national strategies in developing countries are able to cover only some of the diseases or services essential to their population.

There are a number of essential components or 'health pillars' which health systems require in order to provide universal coverage of the services agreed: *human resources*, *access to essential medicines, infrastructure and logistics* allowing access and timely referrals between levels of care and *fair financing schemes ensuring equitable access for all*. Each of these pillars requires a strategy and a budget. Together, they should provide an integrated response to the goal of universal coverage. In some developing countries these pillars suffer from serious structural weaknesses: a shortage of human resources, low availability and unaffordability of essential medicines, inadequate infrastructure and referral capacity (one clear example is in obstetric emergencies) and financing schemes which, in most countries, still require direct payments at the point of delivery.

1.3.2. Health financing

Global health expenditure totals €4 trillion. Sixty percent of it is collected via taxes or social insurance schemes. Low GDP per capita, limited fiscal revenue and weak macroeconomic frameworks leave many of the poorest countries with *levels of public per capita financing of health* 100 times lower than in the richest. Low public expenditure places significant constraints on the availability of health professionals and their capacity to deliver quality services. In some countries inefficiency compounds the problem.

Under resolutions adopted in 2005 (WHA 58.33) and 2009 (62.12), all countries are committed to fair financing of essential health services, ensuring universal coverage. However, little progress has been made in this direction, except on specific diseases in the global spotlight, such as HIV/AIDS. In most developing countries, user fees are a barrier to access to basic services for the poor. Direct payments for health services drive some 100 million under the poverty line every year. Extending the EU principles of solidarity to global level with a view to universal coverage would require a major shift in the distribution of health financing worldwide. Ill-health should be mitigated by a wider set of policies, including protection during sickness (paid sick leave), occupational health and safety and adequate working conditions. Basic social protection schemes can be set up, even in poor countries, with some financial support. Social protection for health should therefore be part of each country's wider social protection net covering basic needs.

2. THE GLOBAL RESPONSE

2.1. Complex global health governance

In theory, global health governance stems from the debates and resolutions at the World Health Assembly and the guidance from the WHO. In practice, however, many of the resulting resolutions remain non-binding. Many decisions which influence health strategies originate in the G8 context. International financial institutions also influence the health policy choices of national governments. On the other hand, private and philanthropic entities provide a significant share of health services, reflecting their own sensitivities or interests. This complex set-up generates strong and dynamic interactions and draws on multiple sources of funding, but it also calls for clearer global leadership.

2.2. Fragmented health aid architecture

The aid architecture for health is complex and has gone through numerous changes over the last decade, in terms of levels of aid, donor profile and focus.

Because health is critical to achieving the millennium development goals, it has attracted a high level of political attention and increased international funding. In 2007, DAC countries' bilateral aid to health amounted to € 8,1 billion (53% from the EU) and multilateral agencies' aid to € 3,45 billion. Average annual growth over the period 1980-2007 was 10% but this accelerated over the most recent years (17% annually from 2000 to 2007)[14].

The patterns of aid funding for health have also changed. The share contributed by the UN and the World Bank has decreased from one third to one sixth and has gradually been targeted on specific activities. For example, less than 20% of WHO funding is un-earmarked. In parallel, global health initiatives and NGOs have gradually stepped up their shares of public health aid, and the contributions by private philanthropy and corporations have also increased. This *'privatisation of health aid'* has sharpened the focus of aid on projects and disease-targeted activities, leading to *'fragmentation of health financing.'*

Aid is not being used to support comprehensive national health plans. Instead, it is becoming increasingly fragmented, with the bulk of health aid now outside government accounts and, for the most part, neither recorded by countries' planning authorities nor connected to national health plans. At Accra, signatories reasserted the Paris Declaration commitment to disburse 66% of aid by means of Programme Based Approaches (PBAs) by 2010. However, overall progress with making a greater use of PBAs is slow and remains at around 40%[15].

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14 November 2009, OECD-DAC, www.oecd.org/dac/stats/health

15 2008 Monitoring Survey Appendix table A9. Note:

2.3. Growing attention to strengthening health systems

Aware of the central role of health systems in improving health and making effective and sustainable progress towards the health MDGs, the international community has been paying growing attention to strengthening health systems. One essential for robust health systems is the availability of adequate national funding, supplemented by aligned and predictable external support.

In September 2007, the *International Health Partnership* (IHP) was established to apply aid effectiveness principles to the health sector. In 2009 the global debate on health development aid (HDA) has focused on 'health systems'. Whether in Accra, in Doha, in New York (UNGA) or at the *World Health Assembly,* the international community has reiterated the need to support health systems to enable countries to make progress towards the MDGs and to strengthen the synergies between vertical programmes and country systems.

The *High-Level Task Force on financing for health* concluded a cycle of studies and consultations with an analysis of the public funding gap to be bridged to support health systems, plus a menu of innovative financing initiatives to top up ODA commitments. At the same time, the IHP has been developing a tool for *'joint assessment of national strategies'* whereby donors and global health initiatives can join in country compacts and fund comprehensive national health strategies. Likewise, the main global health initiatives ─ the Global Fund for Aids, TB and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI) ─ have expanded their scope to include support for health system components in disease-specific programmes or to fund 'horizontal' health system components. In this context, the Washington seminar (2008) agreed on the idea of a joint World Bank-GFATM-GAVI *platform to strengthen health systems*. – The provision of supporting national policies through single joint mechanisms of performance assessment and dialogue ("Sector-wide approaches" – SWAps) have been implemented in a number of countries, for some already a decade (e.g. Ghana, Mozambique, Tanzania, Zambia), and stocktaking and assessment of these processes can provide valuable insights for future work and become a basis for partnerships and Division of Labour in health sector monitoring and policy dialogue at country level.

3. MAKING BETTER USE OF GLOBAL AID FOR HEALTH

Given the landscape described above, it is essential to make better use of global aid for health, in order to boost progress towards health MDGs. The main challenges are to improve the distribution of health aid and country ownership and to sharpen the focus of health strategies on poverty.

3.1.1. Distributing health aid better across countries and health services

a) The distribution of health aid per capita across countries varies greatly. A recent analysis confirmed a positive correlation between health aid per capita and the burden of disease. This correlation has increased during the last decade, influenced by higher levels of aid to countries with high HIV prevalence and where malaria is endemic (mainly by the US President's Emergency Plan for AIDS Relief PEPFAR and the

Global Fund). By contrast, the correlation between health aid and GDP is weak. In 2008, the Commission introduced the concept of 'potential public financing gap for health.' This contrasts the public finance that would be available for health if the country complied with the Abuja target (15% of national budget) with the minimum threshold of spending per capita (as estimated by the Commission on Macroeconomics and Health in 2001 and maintained at €20 by the IHP). The distribution of health aid between countries does not appear to correlate with these potential financing gaps, with some countries in critical need receiving far less health aid per capita than others whose public financing capacity is above the minimum threshold.

b) The distribution of health aid by diseases also reveals wide disparities. Despite its limitations, the sub-sectoral breakdown of health aid by of OECD Development Assistance Committee (DAC) sub-codes indicates that 40% of health aid targets HIV/AIDS, close to 20% malaria and tuberculosis, 16% 'basic health care' (with a large proportion for vaccination programmes by GAVI), 13% reproductive health and the remaining 14% going to 'health in general' where investment in health facilities, training, research and untargeted support for health would be included. HIV/AIDS, which causes 10% of the burden of disease in developing countries (and 20% in Southern Africa), receives 40% of health aid. By contrast, other diseases which also cause a heavy burden, such as acute respiratory infections, diarrhoea or malnutrition, receive little direct support and depend on the limited aid for 'health in general'.

3.1.2. Increasing country ownership

At country level, health aid is excessively fragmented between partners, each of whom has its own reporting requirements and preferred areas of activity. This fragmentation undermines the leadership of national governments. Poorly resourced and ill-equipped health ministries in developing countries find it difficult to negotiate the contributions from so many partners and to coordinate them under an agreed plan. Health support for countries should gradually shift to on-budget and predictable funding. This shift requires greater trust in the capacity of national governments sustained by policy dialogue and mutual accountability mechanisms. In this area, the EU could benefit from making more systematic use of its experiences with single joint monitoring and dialogue mechanisms in the health sector, and build partnerships for health sector monitoring and dialogue on established country level mechanisms.

Beyond government ownership, democratic governance in health requires the involvement of national parliaments in policy-making and budget scrutiny. Active participation by civil society can improve equity, pertinence and accountability. However, in many countries civil society is not able to contribute effectively to the national planning, implementation and monitoring and, in some cases, is not entirely representative.

3.1.3. Addressing the link between poverty and health

Within each country, health indicators are correlated with social determinants of health. Poverty decreases access to safe water and sanitation and increases the risks of malnutrition, low-quality living conditions, unhealthy working environments and lower levels of education. The poor have lower access to health services and, when they do use them, are exposed to longer delays, lower quality and higher case-fatality

rates. Poverty has a similar adverse effect on under-five mortality, maternal mortality and adult survival rates.

The poor have lower access to health services and spend a higher proportion of their income on paying for them, mainly in the form of direct payments at the point of delivery. If health systems are to reach out to the poor, the arrangements for financing them should therefore also be reformed, by greater pooling of contributions based on the ability to pay in advance and moving towards gradual abolition of user fees. This should be part of wider social protection nets that protect the poor from disease and other risks.

Health is central to *poverty reduction* and sustainable development and ill-health is a barrier to social and economic progress. The EU is committed to protecting and promoting health as a human right for all[16]. The *European social model* includes certain common features aimed at guaranteeing healthcare for all EU citizens. The EU has agreed common values of *solidarity* with a view to *equitable and universal coverage by quality care in health systems*[17].

4. THE EU STRATEGY FOR MOVING TOWARDS UNIVERSAL COVERAGE BY HEALTH SERVICES IN DEVELOPING COUNTRIES

(1) This section gives fuller details of the proposals made in the Communication.

a. Where?

- To ensure that health ODA goes to countries in critical need, Commission services will organise collective EU analysis and a list of priority countries will be defined on the basis of health financing gaps identified in country compacts of the International Health Partnership. The Commission will seek support of the WHO in this exercise.

- Commission services will *monitor programmed and forecast direct EU health aid by recipient country and by global channels,* in order to facilitate compliance with the EU Code of Conduct on Division of Labour[18] and improve the distribution of aid across partner countries. This will require regular updates and annual meetings to identify opportunities to increase support for countries in greater need.

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16 The Treaty of the European Union stipulates that a high-level of health protection shall be ensured in the definition and implementation of all Union policies and activities. The Charter of Fundamental Rights of the EU further stipulates that everyone has the right of access to preventive healthcare

17 Council Conclusions on Common **values** and principles in European Union Health Systems (2006/C 146/01).

18 See, for example, the 'EU Code of Conduct on Division of Labour in Development Policy', Communication from the Commission to the Council and the European Parliament, COM(2007) 72, Brussels, 28 February 2007.

b. What?

- Where health is a focal sector and/or there is general budget support, Commission services will ensure that its financial support is linked with adequate dialogue on strengthening health systems, taking into account the main components described in section 2.3.

- The Commission services will contribute to joint assessment of national strategies (JANS) under the International Health Partnership and using the results of the JANS to align its funding behind national strategies.

- In order to increase the collective EU capacity in the health sector dialogue and global health issues, the following activities will be carried out by Commission's services:

a) Organise a stocktaking exercise of established single joint mechanisms of performance monitoring and policy dialogue in the health sector, particularly in countries with experience over longer periods (e.g. SWAps in Ghana, Mali, Mozambique, Tanzania, Zambia and other countries). These processes will be assessed and lessons learnt will be used for a common EU concept for performance monitoring and policy dialogue in the health sector at country level; opportunities for partnerships and division of labour will be explored.

b) Mapping every two years the health expertise capacity available at country level and match it against the needs for health sector assessment and policy dialogue in partner countries, especially where health is a focal sector and where the Commission provides general budget support and MDG contracts. The resulting analysis of needs will provide input for the Commission, the Member States concerned for allocating human resources in the relevant EU delegations. It will also facilitate practical arrangements for in-country division of labour in the health sector.

c) Development with Member States of joint health sector guidelines covering assessment of the health situation and trends, analysis of the health sector, choice of forms of aid, monitoring of system performance and of the impact of aid and the relation to global commitments and aid architecture.

d) Explore with the WHO, other relevant UN agencies and the World Bank, opportunities for closer collaboration on health assessments and policy dialogue in the context of the IHP and JANS technical assistance in the field of health. In collaboration with the UN agencies, Commission services will comply with the Accra commitments and maximise use and development of local expertise.

e) Contribute, in collaboration with EU Member States, to quality assessment and dialogue in global health fora such as the WHO Executive Board, the World Health Assembly and the relevant UN summits. Commission services will also engage in a dialogue on health and development matters with other major partners such as USAID, the African Union Commission and the health policy agencies of Brazil, China and India.

f) Commission services will contribute, from the resources of the thematic programme 'Investing in People', to development of a *workforce of excellence in global health analysis and policy dialogue* based on the existing EU public health networks.

g) In health emergencies, opportunities to build national capacity from the start of EU humanitarian actions will be analysed for linking humanitarian aid to longer-term reconstruction and development of the health sector. The Linking Relief Rehabilitation and Development (LRRD) analysis of health needs should provide input for the annual meetings on division of labour for health referred to above.

c. How?

1. To comply with aid effectiveness commitments:

a) In line with the Paris and Accra commitments in aid effectiveness and the proposed target in the Communication, the Commission will allocate, by 2015, at least 80% of its health aid using country systems (public finance and procurement) and 66% through programme based assistance.

b) In countries where the IHP JANS and country compacts are not in place or where there is insufficient assurance of the quality of health strategies and public financing and notably in fragile contexts, opportunities for "shadow alignment processes" and enhanced capacity-building will be explored so as to prepare the ground for aligned and predictable health aid.

c) Commission services will organise information sessions with the IHP Secretariat for EU Member States to inform them and encourage them to consider joining the IHP principles and its country compact commitments.

d) Commission services will call for joint EU positions on the boards of global health initiatives (the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation) encouraging them to comply with IHP commitments. This will imply gradually expanding the scope of their activities and the predictability of their grants to adapt to national expenditure frameworks and to country strategies and using the JANS process as a basis for their funding.

2. To support developing countries' efforts:

a) In relation with the Council conclusions of November 2008, Commission services will convene joint EU dialogues with partner countries to facilitate progress towards their commitments on allocation of domestic revenue to

health[19]. This dialogue will be closely linked to public expenditure reviews and to regular monitoring of budget support and MDG contracts.

b) In compliance with the Council conclusions of November 2008, Commission services will support development of social protection frameworks aimed at improving access to quality health services and mitigating the economic impact of ill-health, giving priority to action in the most disadvantaged communities.

- Commission services, in collaboration with the WHO, ILO and initiatives such as 'Providing for Health' or the International Centre of Progressive Financing, will develop specific guidelines on assessment and dialogue at country level on health financing schemes and strategies to improve their contribution to universal coverage.

- Commission services will facilitate exchanges of experience between the EU and other regions on different models of health financing schemes based on the common principles of solidarity, equity, universality and quality of care and adapted to local contexts.

- Commission services will monitor, in collaboration with the WHO and WHO-Afro, the progress towards the target set in the EU-Africa Strategy on progressive abolition of user fees for basic healthcare, its impact and the lessons learned from those processes. Based on the experience gained from this, Commission services will adjust its sector policy guidelines.

3. To address the multi-sectoral nature of health:

Commission services will stress, in EU coordination and in the dialogue with partner countries, the multi-sectoral dimension of health, particularly the links to gender equality and access to education (MDGs 2 and 3), nutrition (MDG 1) and water and sanitation (MDG 7).

a) Commission services, in collaboration with the WHO, UNFPA and UNIFEM, will assess progress and promote policy dialogue at country level on the gender dimensions of national health strategies, ensuring universal access to reproductive health and a better gender balance in human resources for health. It will focus on the EU efforts in this area, such as the EU Action Plan on Gender Equality and Women's Empowerment, and promote greater collection and use of data on health giving a breakdown by gender.

b) Commission services will continue to explore, with the UN, diverse leads

[19] Africa Union in Abuja target, other ACP countries in Brussels declaration: both calling for 15% national budget allocations to health.

on food security and nutrition, ways to support stronger UN leadership and a global multi-sectoral action plan on nutrition, as agreed by the WHO Executive Board in 2010. At country level, Commission services will continue to address nutrition in the policy areas of food security, food assistance, social protection and health and to support development of national nutrition plans which are multi-sectoral with clear leads, mandates, services and targets. Commission services will ensure that health strategies include basic nutrition services and links with the key sectors on food security and social protection. The wider relations between health and nutrition and access to adequate food will need to consider the important concept of the *right to food,* making use of tools such as the FAO Right to Food Methodological Toolbox.

c) Commission services will continue to collaborate with UN organisations and other partners to speed up the contribution made by water and sanitation services to improving health. Commission services itself, and whenever calling for joint EU action, will promote aid effectiveness and the link between comprehensive and multi-sectoral national health strategies and availability, access and rational use of safe water and hygienic sanitation with the aid of links with the sectors and/or ministries responsible at country level. The link between health strategies and water includes considering the national legal definition of the human *right to water* and sanitation and its relationship to other civil, cultural, economic, political and social rights. At operational level, attention will be paid to measuring water- and sanitation-related indicators in the health and other related sectors (mainly, the incidence of water-borne diseases and endemic parasitic infections which, together, are responsible for a large share of the burden of disease in developing countries).