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Title

A Case Study on the European Commission's Contribution to Development Assistance and Health (DAH)

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ABBREVIATIONS

ACP	Africa, Caribbean and Pacific
AIDCO	EuropeAid Co-operation Office
ALA	Asia and Latin America
COM	Communication of the Commission
CSP	Country Strategy Paper
CSS	Country Support Strategy
DAH	Development Assistance and Health
DG	Directorate General
EC	European Commission
ECHO	European Community Humanitarian Office
ECTP	European Clinical Trials Platform
EDF	European Development Fund
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisations
HAP	Health, AIDS and Population
ICPD	International Conference on Population and Development
INCO-DEV	International Co-operation in Research for Development
iQSG	Inter-service Quality Support Group
MEDA II	Euro-Mediterranean Agreement II
MS	Member States
SWAp	Sector Wide Approach
SCR	Common Service for External Relations
PRSP	Poverty Reduction Strategy Paper
UNGASS	United Nations General Assembly Special Session

SUMMARY

This short case study demonstrates that over the last decade the European Commission has become a major donor in development assistance and health working through a wide variety of financing instruments. The paper concludes that while there are reforms on-going there is still much work to be done to improve efficiency and effectiveness of this support . It also concludes that while difficult to quantify at this time substantial support to DAH will continue over the coming 5-10 years.

- The European Commission is increasingly recognised as a major contributor to development assistance for health. It supports work in development and humanitarian settings in 150 countries and is a major source of research funding.
- The EC has increased its contribution to DAH more or less year on year over the last decade. In the region of Euro 4.2 billion has been committed through a wide variety of financial instruments between 1990 and 1999 by the EC for DAH.
- Prospects are good for continuing high levels of DAH (Euro 800 million in the year 2000). Through the Programme of Action that has been recently endorsed there will be an increased focus on funding HIV/AIDS, Malaria and Tuberculosis.
- The EC's record on Aid efficiency and effectiveness has often been criticised. Very little information is available about the effectiveness of EC DAH. Progress in this area is slow although there are some indications that the EC requirements for clear objective setting and systematic monitoring is growing. New policies emerging from the EC now speak more consistently of results oriented planning and the need for more rigorous tracking of progress.
- Co-ordination on DAH within EU is still an area where improvements could yield considerable results. The positive experiences with EU co-ordination at international conferences demonstrates the potential for influencing agendas by the EU when it works together. Country level co-ordination between EU bilaterals and the EC even in countries where SWAps are now in operation is an area that needs more attention.
- The EC is an agency that recognises the important influences of other sectors and activities on health. An appreciation of this is build into the new development policy. In particular the relationships between development assistance and trade has been frequently highlighted in the last year. The EC is playing an important role in linking aid and trade in areas such as affordable pharmaceuticals.
- A new development policy has been adopted which puts poverty reduction at the heart of EU development policy.
- There is a new ACP Agreement (Cotonou) which makes substantial new funds available. This is supplemented by major resources from previously unallocated EDF funds. The new Agreement highlights the principles of

country led programming, respect for human rights and the importance of partnership with civil society. The move away from project funding means that the majority of support to social sectors under EDF 9 will be through budget support. However health sector programmes and projects will continue for some years through EDF 8 programming that is just coming into effect.

- There appears to be poor linkage and transfer of knowledge between research and programming. This should be viewed as a missed opportunity and more efforts made to ensure that this exchange takes place more effectively. The research funds linked to DAH under INCO-DEV do however stress the importance of genuine partnership between European and developing country researchers. Under the 6th Framework (2002-2006) research on DAH will be provided through a poverty related diseases work programme and focus on development of drugs and vaccines for diseases such as HIV, malaria and TB.
- A reform process is on-going at the European Commission and this is intended to tackle obstacles to EC aid effectiveness exist - the large volume and scope of aid; numerous financing instruments; lengthy procedures with too many steps; limited human resources and concentration in Brussels are all issues that are being considered. The EC has created a new EuropeAid Co-operation Office for management of external assistance (sometimes referred to as AIDCO). This office will manage the largest international assistance budget in the world operating in over 150 countries. The new arrangements also include de-concentration of management responsibility from Brussels to Delegation offices overseas. This will need to be supported by increasing staffing levels to provide the needed capacity.

INTRODUCTION

This case study aims to provide an input to the debate on "how much and what forms of development assistance are needed to improve health outcomes for the poor?". This paper gives a brief outline of the contribution to development assistance in health (DAH) from the European Commission (EC) over the past decade. The paper explores the concerns about management procedures and the effectiveness of EC assistance and some of the ways that these are being addressed. It also examines recent developments that will affect both the volume and effectiveness of future aid from the EC and some of the influences that have helped to shape policy and decision-making.

Information for the case study was collected from existing documents and reports, articles and press releases> In addition a set of interviews was conducted during July 2001 with selected European Commission officials and individuals with knowledge of the institution. Interviews were held with people in policy, management, programming and health advisory positions to obtain a broad range of opinion.

THE EC - A KEY INSTITUTION OF THE EUROPEAN UNION

The European Commission is a complex and often poorly understood institution in terms of its role as one of the key institutions of the European Union. For this reason it is worth including some basic information on the EC's complex mandate and relations with Member States governments, the European Council and the European Parliament.

Within the European Union there are three principle institutions. Representatives of national governments of Member States form the Council of Ministers and directly elected individuals form the European Parliament. These two institutions share the legislative power within the Union. The third is the European Commission and this is the executive arm of the Union. It has the role of initiating the legislative process with proposals to the Council and Parliament and of ensuring the legislative decisions are implemented.

The Union functions in different ways depending on the issue at stake and the role of the European Institutions compared with national governments varies considerably. Development Co-operation is known as a "Common Policy" where there is no exclusive competence and the role of the EU institutions is subsidiary to the national policies. This in effect means that EC policies coexists with national policies of the Member States. The implications of this co-existence is discussed again later. In terms of the budget, the Council decides on the obligatory contributions related to the Treaties whereas the Parliament has considerable influence over how the budget is spent.

To set the scene it should be noted that the European Commission is providing in the region of 10% of worldwide official development assistance. In 2000, new funding amounted to about Euro 7.6 billion.

A NEW EC DEVELOPMENT POLICY

With the establishment of the new Commission there was a push to redefine the development policy of the Commission. This work was conducted in 1999 and culminated in agreement on a new Communication on Development Policy (COM(00)212). One of the key new elements is the clear priority given to addressing the issue of poverty that is confronting such a high proportion of developing country populations.

A list of six areas have been identified that are important: the link between trade and development; support for regional integration and co-operation; support for macro-economic policies; transport; institutional capacity-building. Social sectors (health and education) are emphasised particularly with a view to ensuring equitable access. This support will take the form of sectoral programmes developed with country partners. In view of the limited human resources at the Commission there is also a need to concentrate support in each country to a limited number of areas.

KEY EC HEALTH, AIDS AND POPULATION RELATED LEGAL AND POLICY FRAMEWORK DOCUMENTS (1992-2000)

The health, AIDS and population policy of the Commission is spread over a number of Communications and Regulations. The 1994 Communication was important as it set out a basic health policy that shifted the focus from projects to sector support, from infrastructure to systems strengthening and institutional development and towards greater integration of cross-sectoral themes. One of the priorities of the policy was to ensure that the health dimension was taken more fully into account in development policies, particularly in structural adjustment programmes. The EC has also been aware of the need to place special attention on some important health issues and this is particularly evident for HIV/AIDS and, more recently, other major communicable diseases. The recent Communication of Communicable diseases has been an important contribution to the international discussions, particularly in the area of affordability of key pharmaceuticals, and has enabled the EC to actively engage in the discussions.

Health, AIDS and Population	
Health	Commission Communication of 03/94 Council Resolution of 05/94
HIV/AIDS	Commission Communication of 07/98 Council Regulation of 03/97 Commission Communication of 01/94 Council Resolution of 05/94
Population	Council Regulation of 07/97
Family Planning	Commission Communication of 11/92 Council Resolution of 11/92
Communicable Diseases	Commission Communication of 9/2000

When considering health policies it is also important to recognise the influence of several other key Commission Communications. These relate to issues such as human and social development, poverty alleviation, coordination and structural adjustment.

General Development	
New ACP-EU Partnership (Cotonou Ageement)	08/02/2000
Development Policy	Commission Communication of 05/2000 Commission Communication of 05/92 Council Declaration of 11/92
Gender Issues	Council Conclusions of 05/98 Commission Communication of 09/95 Council Resolution of 12/95
Human & Social Development	EC Working Papers of 10/96 Council Resolution of 11/96
Structural Adjustment	Council Resolution of 06/95
Fight Against Poverty	Council Conclusions of 05/98 Commission Communication of 11/93 Council Resolution of 12/93
Coordination	Commission Communication of 05/93 (procedures) Council Resolution of 12/93 (procedures) Commission Communication of 03/93 (priorities) Council Conclusions of 05/93 (priorities)

THE EVOLUTION AND INFLUENCES ON THE EC'S HEALTH AIDS AND POPULATION (HAP) POLICY

Member States' policies

A major influence on EC HAP policies has been the national development priorities of the Member States (MS). When differences in MS policies and strategies exist it can be easily seen that this makes developing acceptable EC proposals on HAP policy and strategy difficult and very time consuming. Where differences exist EC proposals need to seek a compromise or way around these differences. Community HIV/AIDS policies are a good example where differences have existed in the past and where considerable work was needed during Member States' Expert meetings to develop a policy framework that was acceptable to all Member States.

Wide geographic and thematic range

The fact that the EC is dealing with a huge range of issues of European and International interest means that maintaining co-ordinated and coherent policies is difficult. This is made all the more difficult by the fact that the EC works in almost all countries around the world. Great effort is put into ensuring that the various communications and regulations of the EC are compatible. There are many small budget lines each focusing on a specific issue and each one needs a legal framework in the form of a Regulation. Each of the major budget sources such as the new Cotonou Agreement also has a framework which spells out the policy priorities. For these reasons EC policy is spread over many documents.

International Conferences and agreed priorities

The agreed outcomes of the International Conferences in the 1990s have provided important inputs to shaping EC policies on HAP. The ICPD in Cairo (1994), the Women's Conference in Beijing (1995), and the Copenhagen Conference of 1996 have all been important. The focus on poverty alleviation that has grown during the last decade is also reflected strongly in new EC documents as has the priority being given to Human Rights and the importance of partnerships.

Tackling Communicable diseases

Several emerging priorities in the field of health that have led to new international initiatives such as GAVI, Roll Back Malaria and Stop TB have all led to high level dialogue between the EC and other partners and political backing and announcements by senior EC officials that these are emerging priorities that will be provided with additional funds. The EC has been increasingly involved in these international debates over the past few years and has hosted several International Roundtable meetings in Brussels.

A new focus on Communicable Diseases as outlined in the EC Communication (COM (2000)585) has now been adopted. The EC has been at the centre of discussions and may in the future play a major role in supporting the financing of the Global Fund for AIDS and Health. Strategic Priorities outlined in the EC Communication are:

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

Increasing partnership with the UN

Increasing partnership with UN agencies WHO, UNAIDS are also evident with more instances of collaborative work. The recent agreement between the EC and UN will open the way for greater collaboration. This increasing partnership is particularly true on HIV/AIDS issues over the last 5 years and is increasingly the case with the communicable diseases agenda being led by WHO and UNAIDS.

MAJOR EC FINANCING INSTRUMENTS USED IN SUPPORT OF HEALTH, AIDS AND POPULATION

The European Commission has a large number of different financing instruments for DAH. This has the positive effect of allowing funds to be channelled to many important, and sometimes neglected, issues but comes at a price in terms of the heavy administrative burden associated with managing large numbers of projects. In fact there are over 20 budget lines when all small lines are taken into account. The main ones are presented below. The volumes of assistance going through the different instruments is presented later.

European Development Fund (EDF)

- The mainstay of EC Cooperation to the the 71 ACP countries is provided through the European Development Fund (EDF), the legal basis of which can be found in Part IV of the Treaty of Rome. This overview accounts for the period corresponding to the two five-yearly financing protocols, EDF 7 (1990-1995) and EDF 8 (1995-2000) covered by Lome IV. The 9th EDF was established at the Cotonou Agreement in February 2000, covering ongoing commitments for the period through to 2005.

Co-operation with the Mediterranean under the MEDA programme

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

HIV/AIDS and Population Special Budget Lines

- To complement the principal financial and technical co-operation instruments, special Community thematic budget lines have been used to support key policy and strategy development work in HIV/AIDS and population. These funds are designed to support the testing-out of innovative methodologies and strategies as well as the generation of knowledge in gaps of understanding.

NGO Co-Financing

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

Humanitarian Aid

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

Research

- The EC supports research geared towards the health problems of developing countries within its regular budget that is managed by DG Research. Funding is currently provided in the framework of the INCO-DEV programme[1] that emphasises active collaboration in research between scientists from both developing country and European institutions on the basis of equal partnerships. The collaborative nature of this work enables EU researchers to understand global health issues better and developing country scientists to gain access to high-level research of particular relevance to their countries' most pressing problems. It covers the ACP, Asian and Latin American countries.

[1] The INCO-DEV programme covers the ongoing period 1998 to 2002. Previous programmes were INCO-DC (1994-1998) and STD 3 (1990-1994).

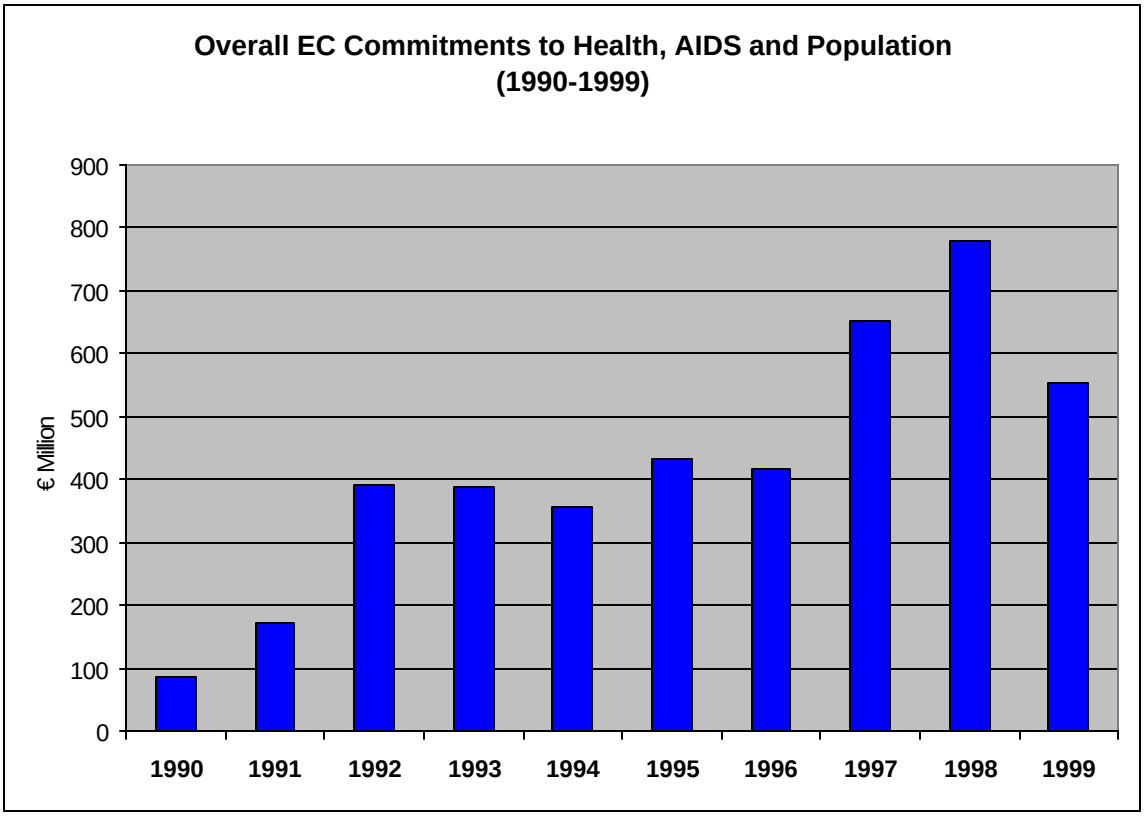
AN OVERVIEW OF THE EC'S CONTRIBUTION TO DEVELOPMENT ASSISTANCE TO HEALTH (DAH) IN DEVELOPING COUNTRIES

Global Overview

The current best estimate for the total level of European Commission support to health, AIDS and population interventions in developing countries over the 1990-1999 period is € 4.2 billion. This makes the EC a major international donor in the health sector and when added to the significant Member States' bilateral contributions the EU is second only to the World Bank in supporting the sector.

The graph below illustrates how this level of commitments has evolved over time, starting from around € 60 million in 1990 and reaching a peak of well over € 700 million by 1998 before dropping somewhat in 1999. Although the increase over this period has been very substantial, it has not been continuous. The initial peak in 1992, followed by a trough and a second peak in 1998 is partly explained by the cyclical nature of funding through the EDF and structural adjustment facilities to the ACP countries. The first peak coincides after a one to two year time lag with the onset of the 7th EDF while the second peak coincides with the onset of the 8th EDF. In addition, the approval in 1994 of the first set of official health policy guidelines provided an important part of the impetus for the subsequent steep rise in HAP commitments from 1995 onwards shown by this graph.

It should be emphasised that this is commitment and not disbursement information. The later is currently very difficult to obtain in any aggregated form but is known to be well below commitment levels with a lengthy lag period. The performance of the EC in terms of disbursements is a major concern for the current administration.



Note:

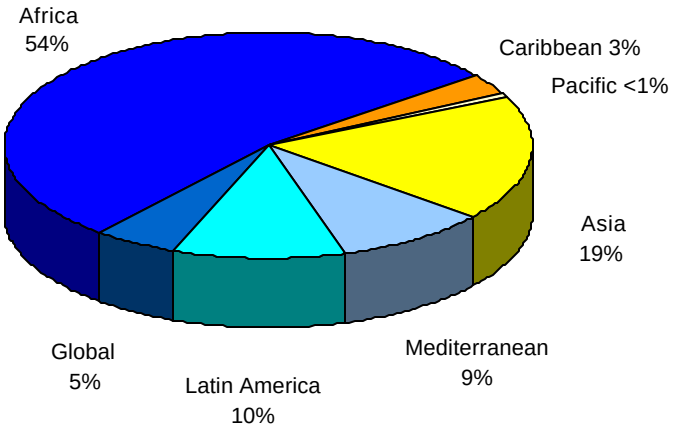
This chart and all others produced in the overview includes information from the EDF, ALAMED financial & technical protocols, special budget lines and the Comission's research budget as well as informed estimates from structural adjustment, ECHO managed aid and NGO Co-financing. However, these figures should correctly be viewed as underestimates since relatively 'small' projects (ie.below € 200,000) have not been included nor have interventions under other headings often classified as being health- related such as water and sanitation, drugs rehabilitation or nutrition.

Regional Breakdown

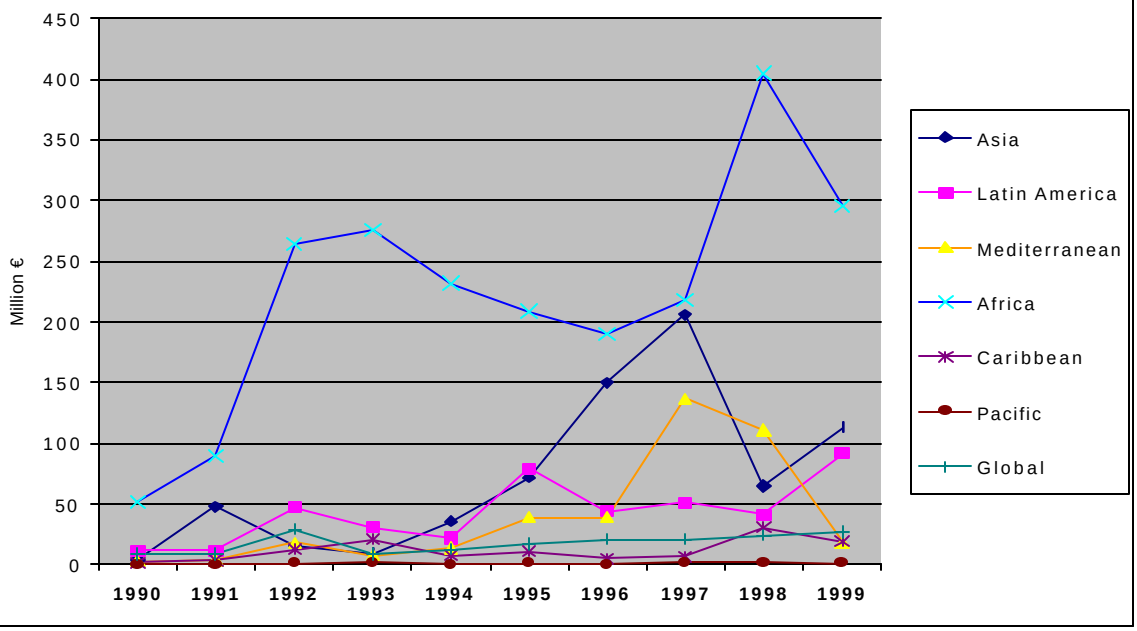
The EC has a long history of co-operation in development with the African, Caribbean and Pacific countries and given the region's population and the depth of its health problems, it is to be expected that Sub-Saharan Africa has received the lion's share of HAP support over the past decade with 54% of all commitments. In recent years, the EC has formalised and given greater structure to its co-operation agreements with both the Asian region (on a country-by-country basis) and Latin America and both these regions have taken a substantial share of HAP support (at 19% and 10% respectively). As the Mediterranean has become much more important as a partner in EC development co-operation, it has also received a significant proportion of support (9% of the total), with the Caribbean and Pacific some way behind with 3% and less than 1% of the total respectively. The trend in commitments over time shows that while the cyclical nature of EDF 'project aid' and structural adjustment has been pronounced, HAP commitments to Sub-Saharan Africa have continued to expand significantly. Health investments to the Mediterranean have also

grown strongly as have investments to Asia although there was a particularly high peak in 1997 followed by a trough in 1998. Commitments in HAP to Latin America, the Caribbean and the Pacific have shown a more gradual increase during the 1990s.

Overall EC Commitments to Health, AIDS and Population by region (1990-1999)

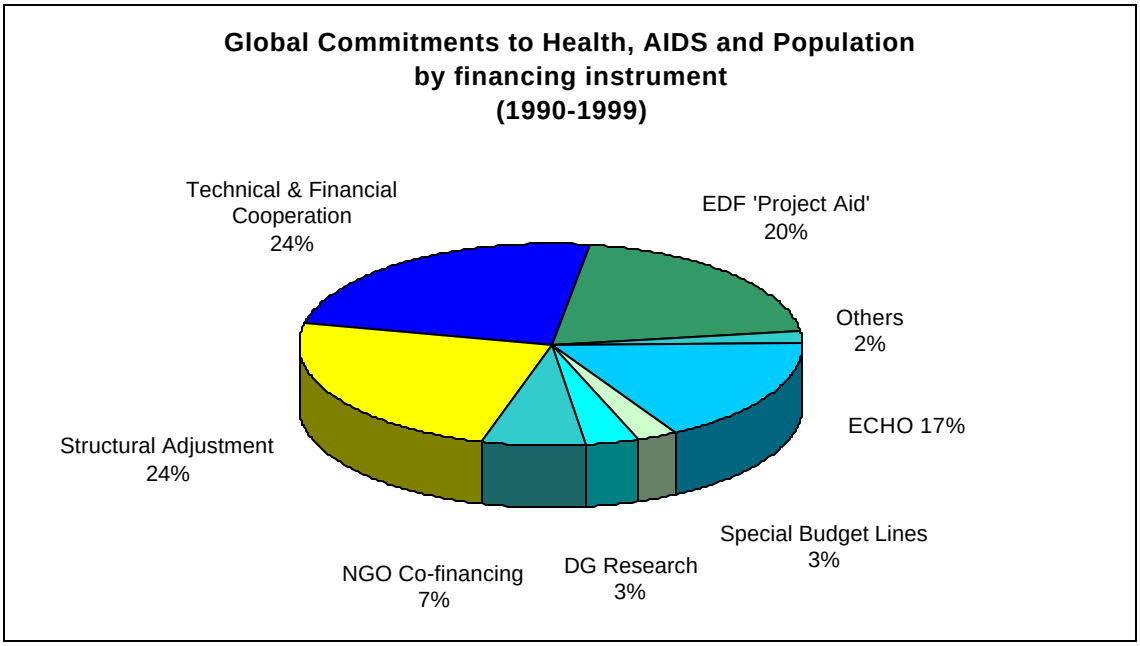


Evolution of Commitments to Health, AIDS and Population by region (1990-1999)



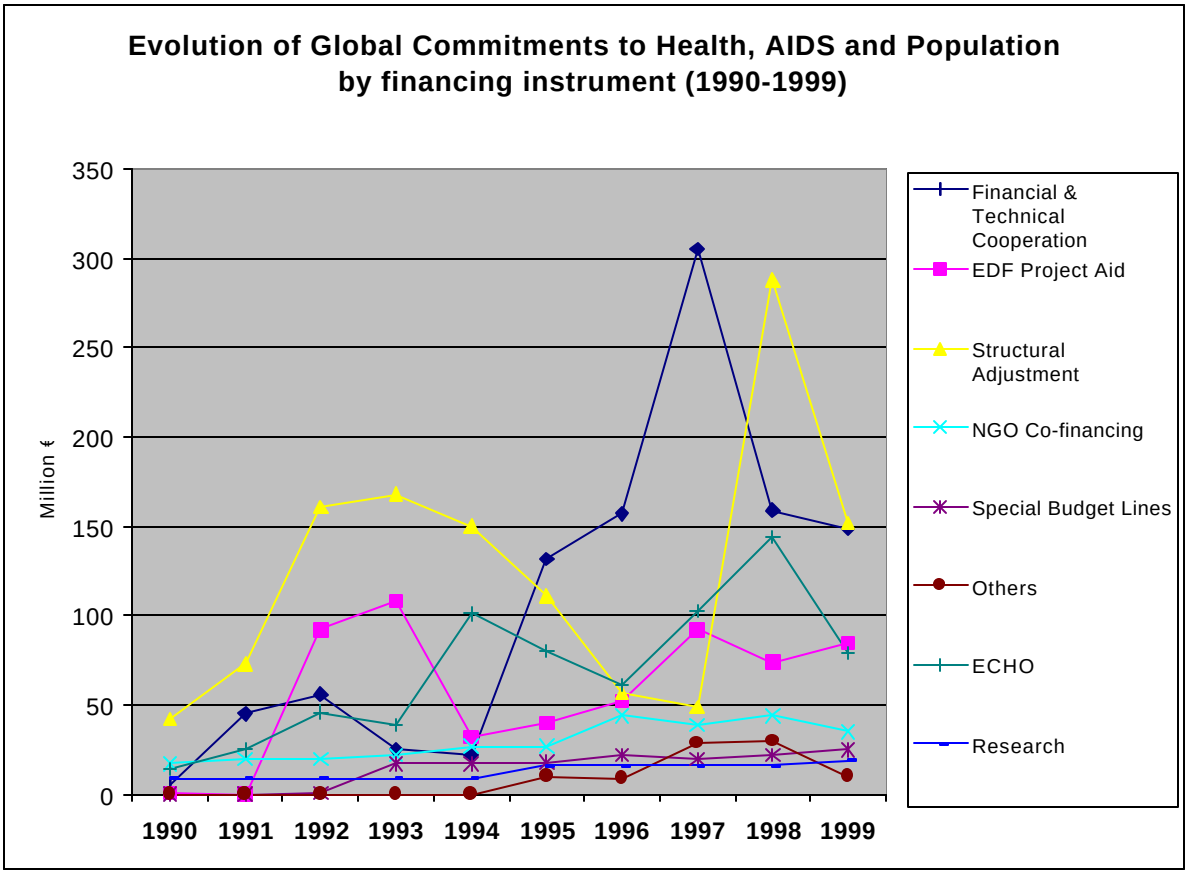
Financial Instruments

As can be seen from pie chart below, it is clear that for the period 1990-1999, three instruments were responsible for by far the largest share of all HAP funding, namely structural adjustment (24%), the technical and financial co-operation protocols (for Asia, Latin America and the Mediterranean) at 24% and EDF project aid (for the ACP countries) at 20% of the total. Humanitarian Aid managed by ECHO has also been an important source of health related support (at 17%) followed by the NGO Co-financing instrument (7%) the special HIV/AIDS and population budget lines and the EC research budget (both at 3% of the total).



In addition, while funding for the special budget lines for HIV/AIDS and population and for health activities under the NGO Co-financing budget line has increased steadily over the review period, the growth in HAP funding from the three main instruments has been significantly stronger.

The chart below further illustrates how the bulk of the substantial increase in overall EC funding of health activities in developing countries over the past decade can be attributed to the growth of structural adjustment, EDF and financial and technical co-operation. In the case of Technical and Financial Co-operation, these graphs clearly show how the year 1994 can be regarded as an important watershed for the priority attached to health investments in developing countries. While health related commitments had shown a relatively gradual increase up to this point, the growth in volume of commitments was markedly stronger from 1994 onwards coinciding with the adoption that year of formal EC policy guidelines for health in developing countries. Commitments to HAP related activities generated from the EC's structural adjustment programme to the ACP countries show a slightly different pattern.



While the graph shows how these have also tended to increase during the 1990s, they have followed a more markedly cyclical pattern with the first peak occurring in 1992 when the Structural Adjustment Facility became operational and the second following the onset of the 8th EDF.

Thematic Breakdown

The EC Portfolio is presented below according to a number of programme categories. While there is overlap between these categories and accurate allocation of commitments is difficult without a considerably more in-depth analysis of individual programmes, the data presented does provide a useful insight into the principle types of intervention being used. This rather crude categorisation also demonstrates that the EC has not invested substantial funds during the 1990s in tertiary facilities or infrastructure, reflecting a trend towards development assistance that focuses more attention on the primary care level. What is perhaps more surprising is the rather low investment in tackling communicable diseases especially given the alarming rise in HIV and AIDS in Africa and other parts of the developing world over the past decade. The lack of disaggregated programme data perhaps masks the real volume of funds committed to communicable diseases by the EC. Recent attention given to tackling the major communicable disease killers such as malaria, tuberculosis and AIDS is likely to result in considerably greater investment for these areas over the next few years.

The largest share of all HAP related funding (35%) has been provided via the EC's Structural Adjustment Programme in the form of health targeted budgetary aid which has been earmarked in agreement with the national authority of the recipient (ACP) country (see charts below). Although always within the framework of stated national health priorities, the Commission has stipulated that a significant proportion of these funds should be directed towards certain key areas, notably recurrent expenditures and technical assistance towards the strengthening of government capacity in the area of budgeting and planning as well as the rational procurement, management and supply of essential drugs and medicines.

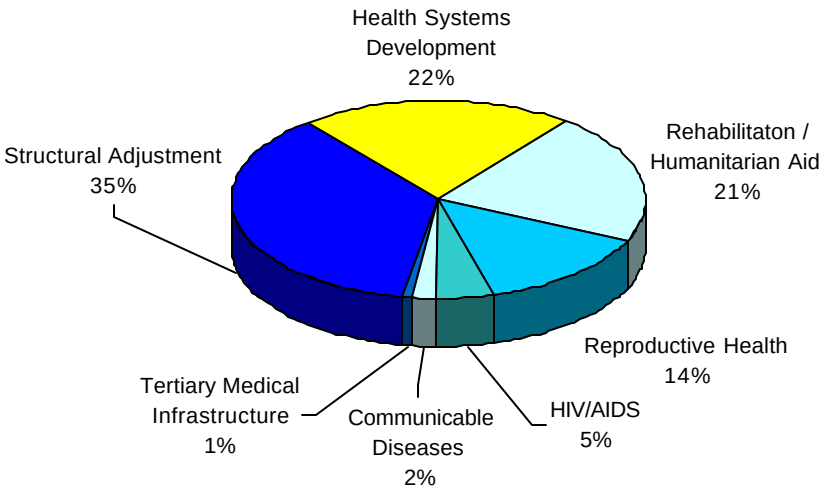
The second most important type of programme in terms of overall volume of support has been to health systems development (at 22% of the total) principally through EDF 'project aid' as well as financial and technical co-operation in the ALA/Med countries. This has also been the area which has shown the steepest increase in funding during the 1990s particularly as the EC has placed increasing emphasis on supporting health sector reform efforts from the middle of the decade and more recently on sector-wide approaches (SWAPs) and basket funding where appropriate.

Health focused humanitarian aid and support to health systems rehabilitation (21% of the total) has also received a relatively large proportion of funding which peaked in 1994 and 1995 partly in response to the crisis in Rwanda.

Support to reproductive health and HIV/AIDS activities also forms an important share of the total HAP commitments at 16% and 5% respectively with the 1994 Cairo + 5 process being a key stimulus. Interventions targeted at communicable diseases have received around 2% of funds but it should be noted that the EC has up to now mainly tackled these issues through its broader health systems

development programmes. Finally, support directed towards tertiary medical infrastructure forms a small (around 1%) and shrinking share of total HAP commitments.

Overall EC Commitments to Health, AIDS and Population by intervention type (1990-1999)



MANAGEMENT OF EC'S DEVELOPMENT ASSISTANCE

The European Commission has a mixed record for delivery of development assistance and reports of frustrated partners are quite common. In particular there have been concerns about the rate of disbursement of EC funds and in some cases the content of EC support is also questioned. This is a major cause for concern both within the EC itself and for Member States development Ministers. There are a number of factors that have contributed to the current situation confronting the EC in implementing its development assistance work. Firstly, the scale and scope of development assistance is far greater than that undertaken by individual Member States in their own bilateral programmes. Secondly, the organisational structure of the European Commission and its management system are very complex and for those who have little direct contact with the institution they are often a source of great confusion. Thirdly, staffing levels are low and the pressures on EC staff are high due to the often complex and bureaucratic procedures that are in place. This human resources situation linked to a rather hierarchical culture with limited delegation of authority to country offices has created serious bottlenecks to the disbursement of aid.

The problem of timely and relevant disbursement of Commission funds is recognised by the current Commissioners and there are on-going efforts to streamline procedures and increase delegation down the system and out to country offices. Making progress in the short term in improving the management situation is itself compounded by the fact that over the last four years the Commission has been undergoing a more or less constant process of reforming the organisational arrangements including the basic structure and roles and responsibilities. This on-going reform process has at times resulted in uncertainty even within the various Directorate Generals about who is responsible for what and has, to some extent, been a constraint in itself .

Management portfolio

When considering the EC's performance in management of external assistance it is important to have an idea about the scale of work involved. Figures[2] provided by EuropeAid (see below) indicate that the scope of support encompasses the European Development Fund (for ACP countries), 70 budget headings and work in 150 countries, territories or organisations. In 2000, new funding amounted to about Euro 7.6 billion. In 1999, aid management involved 2,715 new financing decisions, 34,180 payments, and more than 3,000 tender procedures and over 8,000 contracts. One of the key problems has been the proliferation of budget lines aimed at tackling specific issues and supported strongly by interest groups and the European Parliament. This has tended to lead to large numbers of relatively small projects being supported which in turn have a high management demand. This is particularly problematic in the EC due to the low staff to budget ratio (when compared with bilateral donors).

[2] Data provided on EuropeAid website.

Commission Reform - improving external aid management

The constraints facing the EC services in management of external aid led to serious backlogs and delayed payments. The EC began the process of reform to tackle these mounting difficulties by creating the "Common Service for External Relations" (SCR) in 1998 with the purpose of unifying the services managing aid and improving performance. This was to be done by having all the key players under one roof with a mandate to simplify contract and grant awarding procedures, make payment procedures easier and to improve information systems.

The establishment of the SCR was very much a first step and did not have a great effect on the efficiency of aid management. In recognition that there was still much to be done if the EC's performance was to radically improve the decision was to set up the EuropeAid Co-operation Office on 1 January 2001. This is a more ambitious programme of change and one which will have to demonstrate tangible improvements in aid management if the Commission is to avert further criticism of its ability to handle the substantial volumes of aid under its responsibility.

With shifting responsibilities going hand in hand with the establishment of the new EuropeAid Office there have been substantial changes in the way assistance is managed. The new Office is responsible for all phases of the project cycle (identification and appraisal, preparation of financing decisions, implementation and monitoring and evaluation). DG-Development and DG-External Relations are now more focused on country level negotiations and policy and strategy development with retention of responsibilities for pluri-annual programming. This includes ensuring that external assistance work are in line with EU priorities[3]. They will also be responsible for the devolution of responsibilities to EC Delegations. The separation of the former from policy and strategy development is potentially problematic and is still the subject of some debate particularly concerning the way lessons are to fed into policy and strategy development. These areas will need to be sorted out in the near future. The main programming is agreed during country negotiations and set out in the form of a Country Indicative Programme (ACP - under EDF) or Joint Agreements for other regions[4]. As mentioned above there are specific agreements for some regions that provide an overall framework for national negotiations such as the Barcelona Agreement covering Euro-Mediterranean partnership and the Cotonou Agreement covering ACP countries.

[3] Specific programmes will be handled by Commission services established e.g. DG Enlargement for Pre-adhesion programmes; ECHO for Humanaitarian Aid; DG ECFIN for Macro-financial assistance.
[4] Perin, I. unpublished paper on EC development aid and the health sector

De-concentration Policy for the external service

At this time the EuropeAid office (sometimes referred to as AIDCO) is still being established and staff being recruited to some of the key posts. In July 2001 the Commission adopted a Communication outlining the overhaul of the External Service with a view to strengthening its contribution to representing European interests in trade negotiations, development cooperation and other key areas of Community activity. Chris Patten stated that this was "another step forward in our efforts to reform and modernise the Commission" and that it would "help the Commission play its part in the growing international role of the EU".

De-concentration of the management of external assistance to Delegations is one of the key components of the reform decided on the 16th May 2001 and this includes a commitment to the associated transfer of responsibilities by the end of 2003. The EC's delegations play a key role in development assistance and their role will now expand greatly as a consequence of the de-concentration policy that starts this year and will now have to manage projects and programmes directly in the field. In view of the severe budgetary constraints that exist the Commission has to weigh up priorities and resources. A Development Plan has been developed that aims to make optimal use of available resources to strengthen Delegations to be able to undertake this expanded role.

EC PERFORMANCE MONITORING AND AID EFFECTIVENESS

A consultation exercise in DG Development, DG External Relations and the then "Common Service" (SCR) was carried out in September 2000 to gauge opinions on existing systems and approaches for monitoring performance of the HAP portfolio. The focus for interviews was on Unit level managers with responsibility for tracking progress of projects and programmes in a given region. Data quality and access to data were clearly identified as problems by nearly all those consulted. Information on achievements of the portfolio is scattered and not organised around a corporate information system.

Work on improving basic financial and management information systems is in progress and should improve access to project listings, commitments and disbursements data. However at present there is little qualitative information on progress and impact available and what there is cannot be readily accessed. Work in progress through the EuropeAid evaluation unit should result in more monitoring and evaluation work across the different sectors and provide a new source of information.

It is currently very difficult for EC policy advisers on HAP to access good quality information on effectiveness of different approaches or to produce synthesis reports on thematic issues. This in effect means that feeding lessons learned on what works and does not work - from the huge portfolio of activities - into policy and strategy decisions is difficult.

The consultation exercise highlighted the fact that the different services use a number of different management information systems and that these are often not effectively linked nor entirely compatible. Information systems are mainly focused on financial management and contain only basic information on project and programme content which is not sufficient to effectively measure performance. The MIS systems are under review and work is underway to further develop these in a way that will effectively link up the various systems in operation. At present access to information is not universal and data quality is cited regularly by Commission staff as a major problem with missing and duplicate entries making analysis difficult.

The people consulted all agreed that a system that would allow better access to qualitative information on projects and programmes would be useful, especially if it provided information on objectives, outcomes and contract partners. Initiatives are presently being undertaken by different groups within EuropeAid aimed at improving basic financial and management information. This is clearly seen as a priority to improve the ability of the Commission to effectively manage the portfolio. At the same time the Evaluation Department is engaged in developing a project monitoring approach which is beginning to provide information on progress for a number of projects across the different sectors.

The major constraint to progress in developing performance monitoring systems is competing demands for time of senior management officials. The priority is still to strengthen financial management systems and ensure timely and full disbursement of funds that have been committed. Having said this the criticism of EC performance by Member States and other groups working as partners is a major concern for the Commission and is driving the debate on aid effectiveness. The new EuropeAid Office is charged with the responsibility to improve programming systems, to establish comprehensive evaluation programmes and to develop mechanisms for feeding back evaluation results. This is likely to take time before comprehensive systems are in place to judge the performance of EC portfolios.

RECENT DEVELOPMENTS

There have been a number of important developments over the last year or so that have major consequences on the nature and scope of the EC's development assistance for health over the next five to ten years. These are a mixture of factors that will affect both the volume of aid, the channels used and its effectiveness.

Research

INCO-DEV, part of the Fifth Framework Agreement on Research

DG-Research has been supporting research in the field of health and development since 1983. At present funding is provided under the International

Co-operation in Research for Development (INCO-DEV) covering the period 1998-2002 with a budget of around Euro 202 million[5] which is a part of the EU's 5th Framework Programme. Health is one of the priorities under INCO-DEV and Africa has been the focus although increasingly work is being supported in Asia and Latin America. The basis of research funding is the active collaboration and equal partnership between scientists from developing countries and Europe. Substantial support will be flowing to developing country research institutions through this mechanisms. One of the key issues now is to ensure a link up between the research findings and policy and programme development which has been poor up to now.

The 6th Framework Programme (2002-2006) has highlighted eight priority areas and has a budget of Euro 17 billion. Biotechnology and health is one of these priorities with a global budget of Euro 2 billion. Within this priority there will be Poverty related diseases Work Programme with a budget of between Euro 350 - 700 million. A set of integrated projects each covering one disease is proposed. This will support work on drugs and vaccines for diseases such as HIV, malaria and TB. In addition support is proposed for a European Clinical Trials Platform (ECTP) for existing and new candidates.

AID and Trade links

One example of how the EC is bringing together trade and development issues is the call by the Commissioner for development co-operation to obtain the commitment of industry to a global tiered pricing system where the cost of drugs would be related to ability to pay. The Commission is in a good position to debate the links between development assistance and trade interests. This promises to become an important area of work over the next few years as the demand for cheaper drugs in developing countries for the major diseases intensifies.

Cotonou Agreement - ACP countries

A new partnership agreement was signed by the European Community and its Member States and African, Caribbean and Pacific states in Cotonou, Benin, in June 2000. This was the culmination of one and half years of negotiations. This agreement replaces the Lomé Convention. This new Agreement focuses more on the need for political dialogue in shaping the nature and objectives of assistance provided under EDF. The Agreement focuses on principles of respect for human rights, democracy, the rule of law and good governance. It also emphasises the need for partnerships with civil society, the private sector and trade unions.

In order to address concerns expressed about the performance under previous EDFs in the new Agreement there has been considerable reform of management procedures and this should result in a more rapid implementation of projects.

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[5] Ref: Draft EC report on health related research (2001) - unpublished

Under the Agreement the EC is committed to making available new resources of Euro 13.5 billion over the next seven years. In addition the Euro 9.9 billion of previously uncommitted EDF resources will be included. This makes a total fund available to ACP countries of Euro 23.4 billion.

The new Agreement combines politics, trade and development and is based on five pillars: a comprehensive political dimension; participatory approaches; a strengthened focus on poverty reduction; a new framework for economic and trade co-operation; and, a reform of financial co-operation.

The Cotonou Agreement includes reforms to programming procedures in a bid to improve performance. It will be more result-oriented with a single Country Support Strategy (CSS) for each country. Sharing of this CSS with the recipient country is a departure from the previous situation where the EC formulated its support strategies on its own. This strategy will focus on a limited number of sectors where the Community is seen to have a comparative advantage and there will be an operational Indicative Programme which will be the basis of annual operational reviews.

European Commission participation in HIPC

The European Commission has contributed Euro 1 billion to the HIPC initiative making it one of the biggest contributors. This process was started two years ago and has been in operation for the last one and a half years. This is an example of the EC participating into a larger process and of EC funds going to budget support but with targeting to the social sectors. This input has also triggered greater thinking in the EC about how to track sector performance and a greater emphasis on monitoring progress against a selected number of indicators. Funds appear to be from unspent balance of EDF funds. Progress to date is good with one third already disbursed and the remaining two thirds committed.

Programme for Action on Communicable diseases

A comprehensive programme for action has recently been adopted by the Commission and endorsed by the General Affairs Council. This programme focuses on HIV/AIDS, malaria and TB and calls on global partners to develop new approaches to deliver additional resources. The Global Fund (see below) is one such option. The EC plans to work within an expanded partnership involving the UN, World Bank NGOs, G8 members and EU Member States.

The main elements of the plan have been defined as:

- Increase the money allocated to health, HIV/AIDS and population programmes as delivery capacity improves. For 2000, Euro 800 million is available, representing 8% of total development co-operation programme.
- New objectives: setting up in developing countries of pharmaceutical policies better adapted to their needs, support for investment in the development of local production capacity.
- A commitment in favour of tiered pricing where developing countries pay the lowest possible price for medicines.
- An acknowledgement of the possibility to explore the best use of compulsory licensing systems.
- A commitment by the Commission to launch a debate in the WTO on reconciling the TRIPS agreements with the objectives of health protection in developing countries.
- In the area of research, launching of a major initiative concerning clinical trials.

Global Fund for AIDS and Health

As is well known there have been many recent developments in international efforts to establish a global health fund. There is great interest in this issue being shown by several of the Member States mostly those actively engaged in DAH at present. There is also an interest to discuss this within an EU context.

Member States representatives all stressed that the Commission has played an important role as a facilitator for discussion and information sharing, such as through the EC Roundtable in Brussels and through the new Communication on communicable diseases.

The EC's position also appears to be that the Fund should complement ongoing efforts; resources should be additional and complementary to ongoing funds/commitments to strengthen health systems; developing countries must lead and own the process. In other words not creating parallel programmes and not replacing either donor or government funds through the regular budget.

Most Member States have called for the EC to support in principle the Global Health and HIV/AIDS and Fund. This is also evidenced by the support for the Communication from Member States. This entails complementarity with ongoing efforts to improve existing instruments and impact of HAP programmes; continued emphasis and support to the principle of tiered pricing; and support for R&D for new global public goods. Most Member States called for a clear political statement or signal from the EC, indicating its support or non-support to a Global Health Fund.

Through its established relationships with developing countries the EU has a crucial role in furthering consultation with its developing country partners, both on the establishment of a global fund and the evaluation of its benefits at a later stage. The EC is currently still in negotiations about supporting the Fund.

The EC is also hosting the latest meeting (Brussels 12-13 July) on the transitional arrangements for the fund with a view to the fund becoming operational at the end of 2001.

Institutional Reforms - De-concentration Policy

One of the keys to improving efficiency should be the de-concentration of management responsibility from Brussels to the EC delegations overseas. For this to work it will need to be accompanied by a shift in personnel to strengthen the capacity in these offices which is dependent on the Budget Authority releasing the necessary funds. This remains to be seen. However there are some encouraging signs such as the reduction in the number of tendering procedures, publishing of procurement operations and creation of a single procedures manual and standard contract models. In addition the EC reports that the pace of payment executions is also steadily increasing.

FUTURE PERSPECTIVES ON THE EC'S DAH

EU Coordination on DAH

One major issue that needs to be examined is the way the EC and Member States work together. Is this making full use of the large contribution that is being made by the European Union as a block? Too often Member States put their own bilateral aid priorities before a common position by the EU Member States as a whole and in so doing reduce their potential influence. The lack of a joint position also increases the burden of donor demands on the recipient. There is potential to change the way the EU uses its combined development assistance and create a more coherent approach to supporting governments in developing countries, however national interests (e.g trade links) and political priorities complicate this. There are examples where the EU has worked successfully and with great effect as a coherent block. One is during the negotiations preceding the international conferences of 1994 and 1995. The European Union group worked on a common position at the preparatory conferences of the International Conference on Population and Development (ICPD) and its five year follow up. It is widely recognised that this common position was one of the biggest influences on the final outcome of the conference in 1994 and of the UNGASS in 1999.

In some instances the Sector wide approaches are providing an opportunity for a more coherent and co-ordinated approach from the EC and Member States however even here Member State bilaterals are still tending to follow their own national health development policy priorities on a more or less unilateral basis. Another mechanism that is being used to increase consensus is Member States Health Advisory Meetings held on an annual or biannual basis. These tend to focus on international or thematic issues.

Health as a priority sector?

In the APS (Annual Programme Strategy) 2002 for the Commission six priority areas are identified, one of which includes health and education. This implies that an increased spend on these will be forthcoming. However at the same time there is also the move to concentration of EC development cooperation to one or two focal sectors per country. One of the sectors that is receiving most attention in the preparation of Country Strategy Papers is transport due to the perceived expertise in this sector and the lack of involvement of many Member States. At present - based on available draft CSPs - health is not appearing as a major focal sector for the EC in many countries and the percentage of funds under 9th EDF allocated to specific sectors is less than 5%. However this may not give a good representation of the situation that is likely to unfold over the next 3-5 years. Much of the 9th EDF (under Cotonou) will be used for macro-economic support to countries with the intention of reducing poverty and as such increased budgetary flows to the social sectors is expected - although what conditionalities will be introduced is not very clear as yet. One of the likely conditionality principle is likely to be a link to the PRSP process with improvements in key sectoral indicators being monitored. Again as for other donors the way that this will be done is not yet clear.

It should also be noted that while these discussions and negotiation on the CSPs and programming for the 9th EDF are now starting the programming for the previous 8th EDF is, in many cases, just beginning to materialise. In this previous round there was much more focus on projects and sector support programmes in health and less focus on budget support. What may now result in several ACP countries is that health programmes will begin to be implemented (under EDF 8) and negotiation on budget support commence that will also seek to ensure increased flows to the social sectors (under EDF 9).

One of the constraints currently emerging is the fact that while the policy development work has been progressing there has been less progress with detailed programming guidelines and this will need to be given emphasis especially in the context of the new de-concentration policy mentioned earlier. Without this there may be a tendency for a business as usual approach in the programming work.

Prospects for improved Aid Effectiveness?

While there can be some confidence that the volume of EC support to DAH should be maintained or even grow in the short term there is still the issue of timely disbursement of funds to be tackled by the newly created EuropeAid office. This will not happen overnight and while being given top priority by senior management the institutional reforms are progressing slowly and there is still a lack of confidence within parts of the institution itself that the corner has been turned. In addition slow progress is being made on addressing the issue of effectiveness and there are clearly grounds for some hesitation in thinking that

this will improve in the short term. The priority for the new EuropeAid office is to ensure improvement in management practices, performance monitoring and in transparency of activities.

On the issues of quality and aid effectiveness of development assistance all CSPs and programming for all budgets whether EDF, ALA or MEDAII now must go through the Inter-service Quality Support Group (iQSG) prior to consideration by the different development committees. This is a positive development and given the shift towards budget support will provide a forum for critical appraisal of important aspects such as selection of focal sectors and conditionality.

Scale and focus of EC's DAH

The stage is set for EC's contribution to DAH to continue at current levels or even increase although the mechanisms used are moving from projects and sector support programmes to budget support. However this will take some time. The focus on poverty reduction points in part to increasing support to the social sectors. The new policies on communicable diseases and the increasing international support for tackling the major diseases should also involve substantial contribution from the EC although the level of this is not yet clear. The cyclical nature of EDF commitments will continue to cause fluctuations between years particularly if the ACP countries are looked at separately. The large fund available under the 9th EDF and the unspent funds being brought forward provide an opportunity for a sector such as health to increase provided the mechanisms are available to allow commitments to be made with confidence that disbursement of funds will go ahead in a timely manner. With funds for health sector projects and programmes continuing to come through the programming pipeline under major budget lines such as the previous 8th EDF, ALA and MEDA I as well as new programming now in progress under 9th EDF, ALA and MEDA II, which will see greater emphasis on budget support together with a smaller number of sector programmes, the EC's contribution to DAH over the next 5-10 years will be substantial.