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DEVELOPMENT

COOPERATION ACTIVITIES IN THE FIELD OF HEALTH IN THE ACP COUNTRIES

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Cover: Young girl and child (Sierra Leone) in good health. Prevention first.

CONTENTS

The progress made in improving health in the ACP countries is considerable, but too many children, women and men are continuing to suffer and to die of illnesses which could to a large extent be avoided. The inequalities in the face of sickness and death remain and in some cases are being exacerbated. It is impossible to regard the progress made as satisfactory or to accept the present situation.

We must continue and intensify our efforts.

Given the extent and rapid growth of requirements, the health resources which can be mobilised seem singularly limited. We all know that, in view of the multiplicity and complexity of the health problems facing our ACP partners, there is no simple answer or miracle solution. We must reflect upon and analyse the situation together; we need to adopt an overall approach to the problems, coordinate our action and call upon all the people who are willing to play a role.

For greater effect, we must reflect and discuss in depth and act together.

In recent years we have tried - successfully, in my view - to give new impetus to our cooperation on health with the ACP countries. We have been resolute in our approach and the results achieved should encourage us to continue.

That is the message which this brochure seeks to convey

Pr João de Deus Pinheiro
Member of the Commission

FOREWORD

1. Health is indisputably an area in which Europe has long shown considerable solidarity with the developing countries. Evidence of this is the fact that the European Community and its Member States today undertake almost half the international financial effort to improve the health of the developing countries' populations.

This solidarity takes a visible and familiar form in emergencies, in the event of natural disasters or armed conflict. It is also shown outside periods of crisis, indisputably less spectacularly and in a way which is less familiar to the general public, through sustained, longer-term efforts to help these countries to formulate and implement appropriate and effective health development policies.

Over and above motives of a humanitarian nature, this long-term aid for health is an essential investment, since it helps develop human resources and combat poverty. It also contributes to promoting social justice and strengthening social cohesion, which are vital for the beneficiary countries but also the world as a whole. It also helps stem evils which know no frontiers and so concern all of humanity.

2. In order for this solidarity to be fully expressed, the Member States of the European Community have over the years developed machinery for providing assistance that is comprehensive but at the same time relatively complex.

The European Commission helps define objectives and implement Community aid. This Community aid is aimed at all the developing countries, the countries of Eastern Europe and the Mediterranean region. For reasons related as much to geography and history as to the economy, because they are among the poorest and most disadvantaged countries, Europe maintains particularly close cooperation with the African, Caribbean and Pacific (ACP) countries. These relations are governed by a specific convention, namely the Lomé Convention, based on the partnership principle. Within the European Commission, it is the Directorate-General for Development (DG VIII) which implements this cooperation with the ACP countries.

3. In health as in many other areas, the situation of the ACP countries is still a great source of concern. Despite the very considerable progress made over the last decades, there is still a large gap between them and other developing countries and the more developed countries. The population still endures considerable suffering, which it knows could be avoided or alleviated. This state of affairs generates frustration and anger which has considerable social and political impact at local and international level.

Furthermore, since the eighties, most ACP countries have been experiencing great difficulty in maintaining their achievements and meeting even the most essential health needs of their people. This is due firstly to the general state of affairs, characterised by major political upheavals, economic standstill or even recession and far-reaching social changes. Countries are also faced with very rapid population growth, the need to meet diverse and large-

scale requirements, the emergence of new problems and the rapid spread of new diseases, at the forefront of which is AIDS.

4. In a context such as this, international aid remains absolutely essential, but it must be adapted more closely to the rapid change in societies and diversifying situations.

In the early nineties, with the aim of meeting the countries' and peoples' needs and expectations more closely and making its aid more relevant and efficient, the European Commission set out to give new impetus to its cooperation with the ACP States on health.

The Commission, adopting an overall, sectoral approach to problems and their solutions, undertook a detailed dialogue with its ACP partners. The nature of the Community's activities concerning health was radically changed, and at the same time the number of operations and the total volume of financial aid for health were greatly increased.

Reflecting the principles, guidelines and objectives laid down in the Council resolutions of 6 May 1994 on cooperation policy regarding health and HIV/AIDS, Community aid is intended to help the partner countries to formulate and implement health policies geared to meeting their peoples' most fundamental requirements on a sustainable basis.

5. For the last few years (from 1990 to 1996) and under the seventh EDF, the resources allocated to the ACP countries for health projects and programmes totalled ECU 413 million. On top of this a further ECU 573 million, mobilised from structural adjustment counterpart funds, was used to provide budget aid for priority public health expenditure.

Community aid, exclusively in the form of grants, may take very varied forms.

It is mobilised by means of a wide range of instruments, tried and tested procedures and improved technical facilities, and makes it possible to find appropriate solutions for very different problems.

Present efforts are aimed simultaneously at:

(i) improving further the relevance of aid by closer analysis of problems and their solutions;

(ii) mobilising all the Community instruments in a more cohesive way, in particular by drawing up, for each country involved, a general aid plan in the health sector;

(iii) dovetailing Community efforts more efficiently with the efforts made by the countries themselves and improving coordination with the efforts of other external partners and above all those of the Member States of the Union.

6. In the developing countries, as elsewhere, an improvement in health can be attributed just as much to better living conditions and hygiene and a higher standard of education (particularly for women) as to the development of medical care.

The answers to health problems of necessity require an overall approach. In this approach, described as "public health", health protection can no longer be summed up as treating sick people but must also extend to creating a favourable environment for health and taking more action to reduce health risks.

It is this overall approach which the European Community intends to promote and support in the African, Caribbean and Pacific countries.

It already does so through many operations covering very diverse areas. The link between these operations and health is often direct and evident. This applies, for example, to programmes for improving access to drinking water or developing sanitation networks, all training activities and support for education systems, and the Community food security and aid programme, etc. In some cases it is less direct, less immediate or less visible, but nevertheless just as important. This applies for instance when the Community helps to ensure that account is taken of matters involving health when economic or trade policies are formulated or in urban or rural development programmes, etc.

7. It was not part of the aims of this brochure to paint a picture, even an incomplete one, of the various Community programmes and activities helping to create a favourable environment for health. The fact that this brochure presents almost exclusively activities involving the development and reform of health systems does not mean that the Community fails to take account of, and take action on, other factors determining health.

This brochure sketches the broad outline of the problems of health development, the principles and guidelines of the cooperation policy for health and the procedures for implementing Community aid. The last part contains a few specific examples of the activities involved.

DESPITE UNDENIABLE PROGRESS, THE HEALTH SITUATION IS STILL OF GREAT CONCERN

Consultations are basic. A lack of equipment is one of the main weaknesses of Africa's healthcare system.

1. Considerable progress

For all the ACP countries, the progress made on health over the last decades is greater than that made for centuries before. Evidence of this is the fact that life expectancy at birth has been prolonged by over ten years and infant mortality has been reduced by half.

Many illnesses are no longer the social scourges they once were. Smallpox has been totally eradicated. Although still in existence, leprosy, plague, sleeping sickness, river blindness, dracunculosis (Guinea worm) now present much less of a threat. The development of vaccination has greatly reduced the danger from diseases such as measles, tetanus, whooping cough, diphtheria and poliomyelitis. More people can now freely exercise their choice as to the number of children they wish to have and the intervals between births.

Access to care has been greatly improved by setting up a large number of clinics, health centres and hospitals, and also by training many doctors, nurses and medical ancillaries.

The direct gains in terms of people's welfare and also the indirect - economic and social - gains from this progress are considerable.

2. Progress which is patchy, inadequate and precarious

Without denying these achievements, it must nevertheless be admitted that the progress made is very patchy, inadequate and precarious.

Firstly, it is impossible to overlook the continuation, even worsening, of very serious inequalities in the sickness and death rates. Overall, in the last 30 years, the gaps between the ACP countries and the richest countries have got wider. Similarly, without there being any easy explanation for them, very large discrepancies exist between countries within the same continent or the same region. Even within the same country, blatant inequalities exist between social groups; it is of course the poorest groups, in town and country alike, which are the most disadvantaged from the health point of view.

Secondly, there is the fact that the progress achieved is inadequate. Despite the efforts made, infant mortality remains very high, in particular in sub-Saharan Africa. One child in ten, on average (and in certain countries one child in five), does not reach the age of five. Over one woman in 100 (as opposed to one in 4 000 in Europe) still dies in childbirth or in the immediate aftermath.

Generally speaking, it is still infectious and parasitic diseases, which pose no real threat and are properly contained in other countries, which cause most problems. Measles, respiratory infections and diarrhoea, along with malaria, continue to be the main causes of infant mortality.

Many of the diseases and disabilities and much of the suffering could be avoided or considerably alleviated. For example, in the Sahel, nine out of ten people with cataract go blind for lack of proper treatment.

Lastly, the progress made appears very precarious.

Any slackening of effort, simply through lack of funds or because of crises, is quickly reflected in renewed epidemics (cholera, spinal meningitis, etc.) or the re-emergence of diseases "of the past" which had previously been brought under control.

3. New problems to complicate the picture

Only a few years after it started, the epidemic linked with HIV and the sharp rise in AIDS cases undermined many of the achievements. Sub-Saharan Africa alone had, in 1996, over 13 million adults living with HIV. Exacerbated by a very high incidence of sexually transmitted diseases, the extension of AIDS was also accompanied by a very sharp rise in tuberculosis. Affecting the young and active population, and orphaning thousands of children, AIDS has a considerable human, economic and social impact. A major public health problem, it now slows down development in many countries and is a very serious threat to others.

The campaign against infectious and parasitic diseases is at present hindered by the development of resistance to treatments which combined simplicity and low cost. The same is true of malaria with the development of resistance to chloroquine and of many other infectious diseases which are becoming resistant to inexpensive antibiotics.

At the same time, there is a significant rise in non-transmitted

diseases, cancers, cardio-vascular diseases, diabetes, accidents, mental illness and drug addiction owing to the changes in lifestyle and urbanisation.

A number of African countries have undergone or are undergoing very serious crises and armed conflict. The fighting, in itself very serious, also has severe direct, long-term effects on the population's health. Just by way of an example, very many civilians, particularly children, have been disabled for life as a result of the large-scale use of anti-personnel mines. Little is yet known about the psychological and psychiatric effects of the conflict and the massacres, but these effects are obviously serious and widespread and will not quickly be overcome.

The impact of the fighting on health systems and services is also very considerable (infrastructure and equipment have been destroyed or damaged, health staff have fled or become demotivated and the administration has been disrupted, etc.).

THREE MAJOR CONSTRAINTS AFFECTING THE IMPROVEMENT OF HEALTH IN THE ACP COUNTRIES

1. High population growth and major social changes

In most ACP countries population growth is still very high, at almost 3%. It is true that, in some countries, there has been a decline in fertility since the nineties. The movement is nevertheless too slow and too slight to prevent a probable doubling of the population over the next 20 years. At this rate, considerable efforts are required merely to maintain what has been achieved and to keep providing a minimum service and access to basic care.

The very rapid urbanisation process, like the development of major migratory movements, has very serious consequences for public health. Given the extent and speed of these processes, the investment capacity for improving living conditions (water, sanitation and housing) and the capacity for financing health services are quickly exhausted.

Lastly, the clear improvement in access to information and education makes the population more demanding as regards the availability and quality of health care services. The fact that these requirements are inadequately met gives rise to a feeling of frustration. The existence of major inequalities as reflected in the sharply differing sickness and death rates by population group brings with it frustrations which have serious consequences at local and international level.

2. Limited finances

The resources available to the ACP countries, in particular in sub-Saharan Africa, to cope with health problems bear no comparison with those mobilised in the European countries (which have up to 100 times more). How can the ACP countries deal with their problems when for each inhabitant for a year they have hardly more than the price of a packet of aspirin? How can the growing requirements be met when the resources which can be harnessed for health can barely be increased?

The economic difficulties which many ACP countries have experienced since the beginning of the eighties are considerable. That these difficulties have seriously impaired the previous impetus is easier to understand when we consider that in 1993, out of 43 sub-Saharan African countries, 35 had a per capita income lower than in the previous decades, and in some cases lower than in the sixties. The economic recession affects the Caribbean and Pacific countries to almost the same degree.

For a long time the main source of financing for the sector, the public budgets earmarked for health have hardly increased in real terms and in most cases were reduced throughout the eighties. First of all, the countries have been forced to cut back their investment in the sector very sharply, but they have also had to reduce certain essential expenditure on maintaining existing buildings and equipment, running the health services, obtaining sufficient supplies of medicines and other consumables, and the supervision and ongoing training of staff. These cuts have been only partially offset by external aid and the increasing contribution by patients to the cost of care.

"Cost recovery", in hospitals and the basic services, has been generally accepted by the population, even though it has often accentuated the inequalities and further limited access to health services for the very poor.

An increase in countries' health budgets is indeed possible, mainly

by means of intersectoral reallocation and a reduction in other forms of expenditure, particularly military expenditure. It can, however, be only limited unless economic growth is restored and unless the taxation systems provide a better return. Households already provide a large volume of direct financial contributions - proportionately much more than in the developed countries. This volume cannot be significantly increased when incomes are at a standstill or even declining and while people have great difficulty in meeting other requirements which are just as essential, such as food, housing, education for their children, etc.

A visit to the doctor is dreaded by most Africans because of the cost, or by fear of knowing the thruth about diseases.

It still seems possible to reduce the costs. Although it is not feasible to reduce the already low salaries and incomes of medical staff, the cost of medicines can be reduced very considerably. An improvement in supply procedures, the use of only essential medicines and generic medicines, an appropriate pricing policy and rationalisation of prescription practices can produce major savings without impairing the effectiveness and quality of the products distributed.

The training of management staff and new organisational and management methods are undoubtedly of help in making more efficient use of resources.

All the evidence suggests, however, that the financial constraint will impinge for a long time to come on the development of health systems and campaigns and that it is, and will continue to be, impossible for the countries to release sufficient resources speedily even to meet their population's most essential needs. External aid is vital and will remain so for a long time.

3. The need for far-reaching reform of health policies and care systems and the difficulties involved

The health policies adopted have for a long time placed the emphasis on the development of curative medicine. Major health networks have been set up as a result, their technical facilities have been significantly improved, and the number of faculties and training schools has been increased so that there are considerably more medical staff. At the same time, the countries have developed a number of specialised action programmes, with resources focused on extending vaccination cover, combating certain widespread conditions (diarrhoea, acute respiratory infections and vitamin deficiencies, etc.). This concentration of resources has had positive results even though these results have been fragile and/or short-lived.

These policies have been geared mainly to developing the public sector, managed direct and supervised by the central administrations. The private sector was very limited, catering only for a very small élite.

In countries affected by armed conflict, all these efforts have frequently been very quickly brought to nought. The systems did not withstand the absence of the state or the disruption of the administrations. Infrastructure and equipment were destroyed or deteriorated through lack of even the most rudimentary maintenance; many of those trained were forced into exile.

In the others, the financing crisis has revealed the limits of these policies. It has stopped progress in its tracks and made the inequalities sadly obvious. It has underlined the insufficient attention paid to prevention, the existence of major imbalances in the structure of the health systems and the relative inadequacy of the basic services and local medical care. It has revealed the limits of the strategies based on a plethora of specific initiatives and vertical programmes. It has led to the questioning of the way in which resources, both financial and human, are mobilised and managed in these systems and in particular the extreme centralisation of decision-making and management powers.

In view of this financing crisis, the recruitment of staff to the civil service has been blocked or considerably reduced and salaries have been frozen. This has led in some cases to de facto privatisation of certain public services. Since faculties and schools are training an increasing number of doctors, nurses and other paramedical staff, the private

sector has developed quickly. Formal or informal, profit-making or non-profit-making, it already occupies an important place and is continuing to spread without the introduction of any regulatory and supervisory mechanisms.

Problems of access, the poor quality of care provided in official facilities, difficulties in obtaining medicines and their excessive prices encourage patients to resort to the many forms of traditional medicine, which range from reliable, conscientious traditional practitioners to mere charlatans, and also to obtain unsupervised medicines from the market stalls.

In this context, health policies must be adapted. As elsewhere, it is a question of reconciling fairness, the need to meet health requirements and the objective of obtaining good-quality health care with the need to keep expenditure at a level accessible to government and individuals.

First of all greater attention must be paid to measures which will make it possible to create an "environment" (in physical, economic but also social terms) which is more conducive to good health, i.e. measures to reduce the risks for individual and collective health.

In order for further progress to be possible, a reform of the care system must be implemented. It must have three main objectives:

- to remedy structural imbalances;

- to mobilise resources more efficiently and more fairly;

- to share responsibilities and duties more effectively.

The change in the role of government and the public sector is undoubtedly at the forefront of the discussions on this adjustment of policies and these reforms. Government, once almost sole supplier and manager of services, now sees the growth of its duties in directing, regulating and supervising the development of the health system. The central administrations have to transfer certain powers and responsibilities to decentralised units, autonomous health institutions, local communities and the private sector.

This adjustment of policies and implementation of reform measures is no easy task. There is no single remedy, no universal model or plan. In the face of what are often very complex problems, there are no simple solutions. To a great extent, the solutions to be found are not solely of a technical nature but also lie within the remit of political leaders and civil society. Given what is at stake and, among other aspects, the sensitivity of the medical staff wherever their interests are involved, it is understandable that the political leaders remain cautious and are very mindful of the consequences of the choices they are called upon to make.

Some aspects of child healthcare in Cameroon's north-west province.

Consequently, the process of adjusting policy and reforming the systems must now be given very careful thought, with very wide-ranging consultation and active participation by the various people involved or responsible and actual and potential users. This exercise should provide the greater degree of democracy which is required and may help to implement solutions but it brings with it the need to "make haste slowly".

Implementation of a process of this kind is unlikely to progress at an even pace; it is bound to come up against restraints just as there are bound to be times when it suddenly makes rapid headway. It will also continue to be expensive, not just financially, but also socially and politically.

THE COMMUNITY'S COOPERATION POLICY IN THE 1990s.
THE NEED FOR A NEW APPROACH AND NEW IMPETUS

Improving people's state of health is one of the main aims and priorities of development aid because it is not simply an end in itself but also a means and a driving force of development. In ACP-EC cooperation, however, the role of health has remained fairly limited.

According to the spirit of the fourth Lomé Convention and its focus on improving human resources, the keynote of the 1990s should be an increase in health-related operations.

A shift from a project-based to a sectoral approach

For a long time the volume of Community funding for this sector was quite small and focused on developing health infrastructure, first hospitals and then smaller units, and on supplying equipment and/or pharmaceutical products as part of one-off, isolated or piecemeal projects. These operations served their purpose at the time but the limits of such an approach soon became increasingly clear. A multitude of investment projects does not constitute a viable and effective health development strategy.

A more comprehensive, sectoral approach was becoming vital. In 1990 the Commission began redirecting operations in the health field. Attempts to ensure greater pertinence and effectiveness led to more sustained health policy dialogue and a closer dovetailing of aid and national policies.

To make headway, it was necessary to identify the areas of intervention in which the Commission enjoyed comparative advantages, seek greater coherence in the use of instruments for consigning aid and draw up guidelines for action. Lastly, within the Commission itself, the requisite public health expertise needed to be found and a new technical support system developed.

Principles and guidelines of action

In 1993 the Commission presented two communications to the European Parliament and the Council on cooperation policy with the developing countries in the field of health and HIV/AIDS. These communications set out the broad thrust of the current health development situation in the developing countries and proposed guidelines for action.

Basing itself on the Commission's findings and proposals, the Council drew up the major principles, objectives and guidelines for ACP/EU cooperation in the field of health and HIV/AIDS. These principles, objectives and guidelines are set out in the Council resolutions adopted on 6 May 1994 on cooperation policy in the field of health and HIV/AIDS.

Another resolution was adopted in 1992 on cooperation on family planning. In response to the call for complementarity made in the Maastricht Treaty on European Union, the Council underlined in these resolutions the need to develop consultation and operational coordination between European partners.

An AIDS prevention centre in Ghana. Women are increasingly aware of the risks of Acquired Immune Deficiency Syndrome.

A GENERAL FRAMEWORK FOR COMMUNITY ACTION IN THE HEALTH FIELD

Three main principles:

- Cooperation must help to seek greater fairness and social justice and make it possible to express an individual and collective right to better health.

- Cooperation is not a substitute for national efforts, it is not meant to answer all problems and needs but is there to help countries satisfy the most fundamental needs, particularly those of the most vulnerable groups.

- There is no universal model for organising health systems or their constituent parts. National characteristics and requirements must be respected.

Two general objectives for Community aid

- to contribute to the creation of an environment more favourable to health;

- to help countries to formulate and implement health policies designed to meet their people's

Four strategic priorities:

- to ensure that the health dimension is taken more fully into account in development policies, particularly in the preparation and implementation of structural adjustment programmes.

- to help correct structural imbalances in health systems, by directing action towards supporting and strengthening basic services.

- to facilitate institutional reform by building up capacity at central level, supporting the decentralisation process, encouraging the sharing of responsibility among the various parties and especially between the public and private sectors.

- to help countries develop systems and measures to mobilise and manage available resources more efficiently, particularly by developing support for programming and budget management and measures to improve supply systems for medicines.

Ref: COM (94)77 final; Council Resolution of 6 May 1994.

PRINCIPLES AND STRATEGIES IN RESPECT OF HIV/AIDS

Four priority strategic objectives

- to reduce the spread of the epidemic while preventing discrimination and exclusion of people at risk of infection or living with HIV and AIDS.

- to enable the health sector to cope with the additional burden of HIV/AIDS.

- to lessen the impact of the epidemic on economic and social development.

- to increase scientific understanding and know-how.

Six guiding principles for action:

- adaptation to risk environments: measures to prevent the spread of the epidemic must be tailored not only to individual behaviour but also the social and structural factors which are at the basis of risk exposure.

- gender sensitivity: analyses and measures must take account of gender issues and special attention be given to women's problems.

- respect for human dignity: coercive measures should be avoided and all forms of discrimination against communities and individuals prevented.

- empowerment and responsibility: communities and individuals must be helped to assess their own risks and behaviour and make the appropriate choices.

- integration in a wider framework: measures focusing on HIV/AIDS must be incorporated in social policy for education and health and in other aspects of development policy.

- adaptation to the stage of the epidemic and rapid response: the response must be tailored to the real stage of the epidemic and must be as swift as possible.

Ref: COM(93) 479; Council Resolution of 6 May 1994

PRINCIPLES AND GUIDELINES FOR ACTION IN THE POPULATION AND FAMILY PLANNING FIELD

Basic principles for action

- Everyone has the right to decide freely the number of children he or she wants and when. Aid should not be granted to programmes of a coercive or discriminatory nature or which undermine people's fundamental rights.

- Family planning is a fundamental social service; men and women are entitled to the most complete and scientifically accurate information on reproduction, the spacing of births and contraception and free access to all ways and means of spacing or limiting births.

Priority objectives

- to allow women and men to exercise their right to choose freely and responsibly the number of their children and the spacing of births;

- to contribute to creating an environment more conducive to full exercise of this choice, in particular as a result of increased access to good quality family planning services;

- to reduce substantially risks to women and children's health by providing competent reproductive health services;

- to enable countries and local communities to respond to and influence population growth and movement.

Ref: SEC(92) 2002 of 4 November 1992; Council Resolution of 19 November 1992.

PRIORITY AREAS OF INTERVENTION AND APPROACHES OF COMMUNITY AID

1. Support for formulating health development policies and strategies

Collating and processing facts and information about a country's health situation, analysing the results, identifying possible solutions and assessing their technical feasibility and cost, pinpointing priorities for research and action are laborious and often expensive tasks but they are indispensable.

The Community lends its assistance by commissioning consultants and experts or relevant bodies to conduct research, studies and analyses. It also provides specialist technical assistance and contributes to strengthening the technical capacities of national administrations by organising training schemes and supplying equipment. It encourages pooling experiences and disseminating information and the results of work involving both developing and developed countries.

But health policies and strategies are not just a matter for technical experts. The Community also helps countries to organise open discussions about planned strategies and to seek a broad consensus among both national players and external partners. It assists countries in drawing up objectives, priorities and programmes and publicising them by promoting regular sectoral round tables, coordination meetings and dissemination of information.

In Africa, long waits to see the doctor are common.

The Community is involved in many other development fields, such as formulating macroeconomic policies and structural adjustment programmes and it tries to ensure that the health and HIV/AIDS dimensions are taken on board in general development policies.

2. Institutional capacity building and support for democratisation

In the current climate where the role of the state is progressively changing, supporting administrative and institutional capacity building in the health sector and encouraging the delicate process of decentralisation calls for action at several levels.

Community assistance is aimed primarily at the central administration, namely the Ministry of Health departments responsible for planning, finance and medicines policy. The main aim is to help develop proper decision-making tools in the health field.

Community support is also designed to boost the capacity of the Ministry's regional decentralised administrative units and health districts. Another objective is to define more clearly the share-out of tasks and responsibilities between central administration and local authorities and help the latter to take on roles for which they are still ill-prepared.

On the same lines, the Community assists in establishing a legal and regulatory framework and measures to direct and regulate private sector development. In addition, the Community encourages different forms of partnership between public and private sector (non-profit-making and profit-making) with a view to streamlining health cover.

3. Improving financing capacity and support for rationalising the use of financial resources

Helping to maintain a sufficient level of public health expenditure - for example during discussions on macroeconomic reforms or by providing budget aid - is essential but it is not enough. The Community endeavours to help countries to match up this expenditure with health policy objectives and to reform programming systems and budget allocation criteria.

In this case the Community contribution takes the form of active participation in public expenditure reviews, encouraging dialogue between the parties involved and providing the Finance and Health Ministries with technical assistance.

Families and patients already bear a substantial share of the costs of care. The Community wants to help draw up fairer systems for generating these contributions..

4. Strengthening and improving basic services

Community aid certainly does not ignore the hospital sector but it gives priority to developing and improving basic services, to which the general population has easiest access and which are best suited to combining curative treatment and preventive measures.

This support is designed to improve health cover and make services more accessible to the population. The aim is to improve the running and quality of the services provided and to develop functional relations between the different levels of service.

Both in rural and urban areas aid is always directed at complete services - systems comprising dispensaries, health centres and local hospitals. Following local development plans and programmes, operations combine construction and renovation of buildings, supply of essential equipment, technical assistance with the organisation of work and management of services and retraining of health personnel..

5. Promoting essential medicines

Improving the availability of effective and reliable medicines but at a lower cost is in many cases socially and economically vital.

The Community has undertaken to help countries focus their supplies on the most essential medicines, reduce purchase costs and avoid breakdowns in supply. Without encouraging monopoly situations, Community aid is used to reorganise and improve the management of public or parastatal supply centres. It supports the formulation and implementation of medicines price policies and legislative and regulatory frameworks for marketing authorisations for pharmaceutical products.

Direct, free supplies of medicines, which is not a viable form of aid, are now only countenanced in exceptional circumstances.

Assistance generally consists of a combination of specialist technical assistance, financing for vital equipment and start-up stocks.

Support is also given to improving the prescription of medicines and promoting the use of generic medicines among health staff and the general population.

6. Human resources: initial training and continuing education

For a long time the Commission has given its backing to training in the form of study awards and support for health faculties and schools. Continuing education schemes are also included in a large number of programmes. Even if there must now be some changes to this type of support, training and continuing education, which are vital for improving the quality of care, will go on receiving Community funding.

Staff costs still account for over half of public health spending. The distribution of health staff both nationally and within the different types of service is far from ideal. Staff "productivity" is generally low. In several countries there is a curb or even a freeze on civil service recruitment and yet the number of school leavers continues to rise. This situation calls for solutions which affect the organisation of the entire sector.

To date Community support in the human resources field has been fairly piecemeal. In the next few years it will be extending and intensifying this support, primarily by helping to formulate and implement planning and management policies for health staff, in both the public and private sectors.

7. Support for civil society initiatives

In the ACP States people do not sit by passively, expecting everything from the state. A type of "burgeoning" process is under way with all kinds of initiatives to set up small mutual benefit associations and professional associations, associations to create and manage health centres and service users' or patients' associations.

The Community plans to provide these initiatives either with direct aid or indirect aid - the latter by cofinancing measures carried out by European NGOs.

8. Support for coordination and regional integration

The problems which affect the ACP countries often straddle borders or are very similar from one country to another. An effective response therefore frequently requires consultation between countries and programme coordination. The Community plans to focus support on efforts to coordinate more closely measures to combat the principal health problems in a single region or subregion. It supports inter-state training and research initiatives, it contributes to financing for scientific studies, pooling of information and experiences, setting up networks of experts, researchers, patients and NGOs. It gives direct support to certain regional programmes or organisations.

9. HIV/AIDS and sexually transmitted diseases

Since 1987 the Community has devoted major financial and technical resources to helping countries to control the spread of the epidemic. These resources are used to improve the prevention and treatment of sexually transmitted diseases, increase the safety of blood transfusions and reinforce sex education and reproductive health education. Steps are being taken to ensure that this particular dimension is more fully integrated in development policies and to alleviate the economic, human and social impact of these diseases. Funding is also being used to seek the most effective strategies to prevent the spread of the epidemic.

As there is no effective vaccine and treatment at an affordable price for the population of the ACP countries, stepping up prevention, education and information activities is vital. A wide range of far-reaching and sustained measures are needed to ensure that such activities become an everyday concern and task of health staff and other involved parties. HIV and AIDS cause tremendous physical and mental suffering. It can be alleviated by treating opportunistic diseases, providing better care for patients, particularly at home, and ensuring that health staff and other members of society show greater care and understanding.

The Community backs measures to guarantee non-discrimination of people living with HIV and those at greatest risk and actively supports associations of AIDS sufferers.

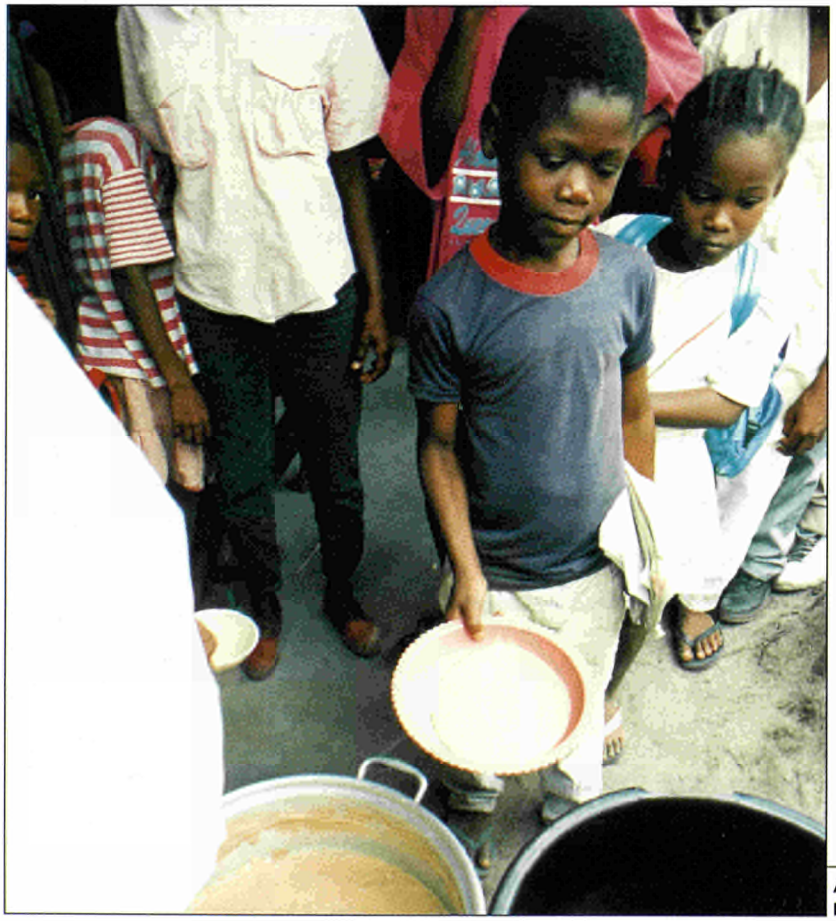
10. Family planning, health and reproduction

A prime objective is to allow women and men to exercise their right to choose freely and responsibly the number of their children and the spacing of births. In particular, the Community wishes to ensure increased access to information and family planning services and methods. It also wants to reduce the risks for women's health by developing the provision of sexual health and reproductive health services.

The Community wants to encourage these aspects to be taken into account in social policies, particularly those concerning the education and health sectors. It is working towards getting activities such as family planning, promoting safe sex and preventing reproductive risks included in the relevant services.

11. Midway between emergency and development: rehabilitation

The number and scale of conflicts or internal crises has considerably increased over the past few years. Besides the direct consequences on people's health there are the consequences on the health system. After the emergency itself there comes a transition and rehabilitation phase which should lead to the restoration of acceptable running conditions for health services and the basis for further developments to the system. The choices made in this phase have a major long-term impact. They must ensure sustainable development and prevent the re-emergence of imbalances and organisational problems which pre-dated the crisis. In highly unsettled political and economic circumstances the Community strives to provide the right sort of support.



A good diet means better health.

RESOURCES AND INSTRUMENTS FOR ACP-EU COOPERATION IN THE HEALTH FIELD

Financial means: two sources

Essentially Community aid to the ACP States comes from the European Development Fund (EDF) which is constituted each time the Lomé Convention is renewed or revised.

The Member States of the European Union pay direct contributions into this five-year fund. The programmable part is shared among national, regional and "all ACP" programmes.

For the national programmes, resources are shared out among countries according to criteria which include GNP and population size. But the proportion allocated to health in these various programmes is not fixed from the outset. It is the result of negotiations between the ACP States and the Commission and reflects the priority given to this sector when the indicative programmes, which define the major thrust and types of operation to be carried out, are negotiated. The programmes under way are financed from 7th EDF resources (1990-95). 8th EDF programming (1996-2000) is well in hand.

- Resources also come from specific budget headings of the "ordinary" Community budget voted each year by the Council and the European Parliament. These budget headings cover all developing countries, obviously including the ACP States. They can cover specific areas such as HIV/AIDS, specific countries or groups of countries beset by a particular problem such as rehabilitation or even the activities of certain groups and partners - for example cofinancing European NGOs.

A major increase in the financing allocated to health since the beginning of the 1990s

For a long time the volume of resources allocated to health was not enormous, amounting to about 3% of the total of all EDFs set up prior to Lomé IV. Since 1990 and 7th EDF programming more ACP States have included health in their indicative programmes as a priority sector for cooperation with the EC. As a result, under the 7th EDF the total volume of health allocations has more than doubled, reaching ECU 413 million in 1997.

At the same time, the "health" budget aid linked with the newly established structural adjustment facility has increased substantially, totalling close on ECU 573 million in 1997.

Health sector financing by EDF

EDF	Amount on health in ECU million	
	Projects (incl. HIV/AIDS)	Budget aid
5th	138,83	0,46
6th	183,81	43,55
7th	412,90	573,11

From these 7th EDF allocations, specific HIV/AIDS operations amounted to ECU 50 million (ECU 20 million from a regional programme for all the ACP States and ECU 30 million from national indicative programmes).

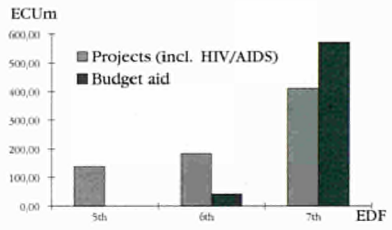
The budget resources that can be used for health have also increased considerably in the past few years.

This is particularly the case for cofinancing NGOs. Almost a third of this cofinancing is used for operations directly linked with health. Nearly ECU 50 million is thus added to aid for the health sector each year.

Similarly, more resources have also been allocated to HIV/AIDS initiatives and since 1996 they amount to ECU 15 million per year.

This is not the full range of the financing allocated to health. It does not include the very large amounts mobilised for the health sector as part of emergency humanitarian aid (via ECHO, the European Commission's special department).

Health sector financing by EDF



The ways in which aid is provided

Almost all Community aid consists of grants in order to ensure that it does not further add to the ACP countries' already high level of indebtedness.

In the case of projects financed from EDF resources in a particular country, the Community adopts a comprehensive approach to tackling problems, so that the whole of the health sector is covered by a coherent set of operations that combine various projects plus, in certain cases, budget support.

As a general rule, a number of different types of input are combined in community-funded projects: technical assistance, training schemes, purchasing capital goods and logistical equipment

on the local or international markets, building and upgrading infrastructure, and the like. Although projects are, in the main, geared towards investment, they may incorporate operational support and cover certain recurrent costs, in particular a share of the additional costs attaching to investments.

From 1990 onwards, there has been a very significant increase in the volume of budget aid. Since the conclusion of the fourth Lomé Convention, the Community has been involved in defining and implementing the structural adjustment programmes prescribed by the International Monetary Fund (IMF) and the World Bank. Alarmed by the social repercussions of macroeconomic reforms and adjustment programmes, the Community is paying special heed to the social sectors, in particular health. While the Structural Adjustment Facility (SAF) granted by the Community is directed primarily at macroeconomic objectives, in particular balance of payments equilibrium, it generates counterpart funds in local currency that are largely used (40%) to help recipient countries maintain the level of their public health expenditure.

Since 1991, structural adjustment support has played an increasingly important part in ACP/EC cooperation. While it aims to support macroeconomic restructuring policies, the Commission has sought to ensure that priority is also given to its deployment in the social welfare sectors, especially health.

As part of Community support for structural adjustment, hard currency is transferred under general or sectoral import programmes to pay for imports of an equivalent value from European Community or ACP countries. The local currency resulting from the conversion of the hard currency constitutes counterpart funds that are used by the government to fund expenditure stipulated in the adjustment programme and entered in the table of government financial transactions. In the case of Community support, these funds are "targeted", i.e. allocated to clearly identified expenditure. In accordance with Commission guidelines, 70% of the counterpart funds are targeted on the social welfare sectors, with 40% going to the health sector alone.

One of the main advantages of using this instrument is the possibility of entering into a dialogue with the government regarding its policies, the way the national budget is structured and public funds are allocated. The funds are released subject to compliance with certain conditions to ensure that progress is made with health sector reforms.

The various instruments must be used in a coherent manner

As in other sectors, the range of instruments devised by the Community to promote health care is very broad. However, having a variety of tools available is not enough. The best use needs to be made of them, they must complement one another and be deployed in a coherent fashion.

This complex task has been tackled by the Commission, which has ascribed to each instrument particular functions and objectives that tie in with the different strategies and priorities of cooperation policy.

Improved technical assistance

From the outset, the Commission has always been able, with the agreement of the authorities in the ACP countries, to provide short- or long-term specialised technical assistance for the projects and programmes it supports.

In 1990 the Directorate-General for Development (DG VIII) made a start on building up its provision of technical assistance and its own technical skills in order to further develop dialogue with the ACP countries on policy issues and to better prepare, monitor and administer programmes. It intended that the number and scale of programmes should also be stepped up.

This resulted in the setting-up, in May 1993, of a "Health, family planning and AIDS" unit comprising experts specialising in public health and also health economics and macroeconomics. This unit works closely with the "Social and human development" unit which is more specifically concerned with defining social policies and strategies.

The "Health, family planning and AIDS" unit works closely with the other Commission departments in Brussels and with the Commission's Delegations in the ACP countries. It is closely involved in policy formulation and provides technical support for the preparation, monitoring of implementation, management and evaluation of health projects and programmes. It plays a very active part in identifying priority strategies for Community support to the health sector in the ACP countries. It helps prepare the terms of reference for studies and technical assistance missions.

Lastly, it helps to monitor implementation of the various components of the programmes and to conduct mid-term reviews and evaluations. In this connection it participates, generally by means of invitations to tender, in the selection of outside experts working for consultancy bureaux or specialised agencies or teams from universities and public health schools in Europe and the ACP countries.

DETAILED ARRANGEMENTS GOVERNING THE PROVISION OF COMMUNITY AID

1. Ongoing in-depth dialogue is an essential prerequisite for any form of cooperation

This involves regular, sustained consultations and negotiations between representatives of the ACP countries concerned and the European Commission. This dialogue must, of course, be based on objective information and data which are frequently unavailable and have to be sought out. It must also draw on the experience gained in other fields and different points of view.

For such a dialogue to take place, a large number of studies, surveys and audits have to be carried out and there must be a constant pooling of information with other institutions, partners and interest groups.

2. Comprehensive negotiations, programmes that define the objectives and priorities for ACP/EC cooperation

The Lomé Convention and the European Development Fund Regulation stipulate that an indicative programme must be established for each country or region by negotiation between the Community and the partner countries.

These national indicative programmes (NIPs) or regional indicative programmes (RIPs) determine the overall framework for ACP/EC cooperation, indicate the priority sectors and fields for cooperation, state in broad terms the objectives of the programmes that are to qualify for Community financing and specify the measures that the governments propose to take in the sectors concerned.

3. Preparation and implementation of projects - five main stages

Where it emerges from the policy dialogue and the negotiations that operations in support of the health sector could be mounted, there are five main stages to the process of preparing and implementing Community action.

A pre-feasibility study is conducted, leading to the preparation of a general action plan giving the broad outlines of the measures proposed. Here, particular attention is devoted to ensuring that these are relevant to the problems affecting the sector, that they are in line with the priorities of national healthcare policy and that they dovetail with the measures taken by other external partners.

Preparation of the plan is based either on a thorough sectoral review or more cursory programming support missions, depending on the circumstances of each case. The sectoral review procedure is set in train where knowledge of the problems affecting the health sector is insufficient, where there has been a manifest change in the health situation, where the government's health policy needs to be rethought and/or where there is a significant change in the operating strategies of external partners. Otherwise, a programming support mission suffices.

In the course of carrying out reviews or missions, the different possible scenarios for the action to be taken are discussed at length and the interconnections between the various problems are studied carefully. The potential repercussions and the possible risks inherent in the action to be taken are weighed against one another. At this stage, only a rough estimate of the funds required is made.

A feasibility study then spells out in detail the action to be taken and the financial and human resources needed. It also describes the detailed arrangements for carrying out the measures in question.

A financing proposal, based on all these elements and the negotiations with the ACP partners, is then submitted to the EDF Committee for its opinion.

After the Commission's proposals have been considered and discussed, this Committee, made up of representatives of the fifteen Member States of the Union, adopts its position by qualified majority. No fewer than eight Member States, accounting for a total of 145 out of a possible 221 votes, have to be cast in favour of a project for it to be endorsed.

If it is endorsed, the Commission adopts the Financing Decision and a Financing Agreement is concluded confirming the agreement with the recipient country or countries.

Under the Lomé Convention, the recipient ACP State is responsible for implementing the financing arrangements and the measures to be taken. As a general rule, the Ministry of Health, as lead Ministry, takes on this responsibility but the Finance Minister or the Minister for Planning, acting as the EDF National Authorising Officer, is ultimately responsible for all expenditure incurred in implementing a project or budget aid.

Lastly, project evaluation is essential

To ensure that operations and resources are administered properly, projects are regularly monitored from the outset. This is to check that they are being implemented correctly, to assess the extent to which their objectives are being achieved and to make any adjustments needed.

Subsequently, the impact of a project is assessed through ongoing and ex-post evaluations. They may specify the conditions under which it may be extended and/or possibly replicated in other contexts.

INTENSIFIED DISCUSSIONS AND JOINT ACTION

In Haïti, health problems are discussed so that they can be better tackled.

As has been emphasised in this document on a number of occasions, the health care problems facing our ACP partners are far from simple. It is no easy task to identify the best solutions, determine the most appropriate and effective aid strategies to prevent wastage and secure the greatest impact. This is particularly so in that circumstances can easily change, sometimes very rapidly, and new problems pile up on top of the old ones. Ongoing discussion and analysis as well as striving to improve operational coordination between partners are indispensable.

1. Improving operations through intensified discussions

In the light of the guidelines for action and the changes in the problems that affect the health sector, the Commission departments concerned have decided to focus discussions in the years to come on five fundamental aspects.

- Decentralisation

Many countries have embarked on programmes aimed at bringing decision-makers and the general public closer together. As far as the decentralisation of government departments, the independent management of major hospitals and the further development of local authorities or the private sector are concerned, there is no universal or ready-made solution. Intensifying discussions and improving the action taken necessarily mean comparing experiences and results, pooling more information and weighing different points of view against one another.

- Human resources

Although all the ACP countries are suffering from a shortage of qualified healthcare workers, staffing costs account for half of health expenditure. The difficulties must not, however, be viewed solely in quantitative terms. Improved basic training and the further development of continuing education are becoming essential. In systems that are undergoing far-reaching reorganisation, with reallocation of duties and further development of the private sector, action must be taken to secure better management of human resources and put in place arrangements for regulating and monitoring activities.

- Health in urban areas

Towns are rapidly expanding and soon one in every two inhabitants in the ACP countries will be living in an urban environment. These rapid changes bring many problems in terms of public health. However, concentrations of population stimulate innovation. They give rise to new approaches to social issues, stimulate new attitudes to health and are focal points for determining the ways in which healthcare professionals will practise in the future. Better knowledge of these problems and improved analysis of the

changes that are taking place will make it possible to define more appropriate strategies and working methods than those adopted up to now.

- Rehabilitation

To respond to the increasing numbers of disasters and conflicts, international aid efforts have created institutions, mechanisms and means for taking emergency action. Once a crisis is over, emergency operations must give way to development programmes. Discussions are under way aimed at putting forward a set of principles and guidelines for rehabilitation operations in the health sector.

- Essential medicines and medicines policy

A comprehensive policy needs to be established and implemented to ensure that every individual can benefit from appropriate treatment and have access to safe and effective medicines at affordable cost. Numerous aspects of such a policy are currently being considered, the aim being to determine the most appropriate measures to ensure regular supplies and improved distribution (including the private sector) of the most essential products, provide better information and guidance for doctors and patients, secure stricter control of this special market and combat fraud.

2. Joint action

Exchanging information, project coordination and consultations between partners are effective ways of preventing wastage of precious resources and improving the impact of aid.

Major efforts have been made along these lines in recent years, aimed not only at more in-depth consultations regarding aid policies but also, on a practical level, at improving coordination on the ground.

Attention has, of course, been devoted, in the first instance, to stepping up consultations and improving coordination between European partners, and between the Commission and the various ministries and agencies responsible for cooperation in the EU Member States.

Three groups of European experts have been set up (to cover health and development, sexually transmitted diseases and HIV/AIDS, and population issues and family planning).

War devastated Angol has every nature of health problem.

They discuss the various problems together, exchange experiences and identify the most effective aid strategies.

Coordination is improving on the ground. There is more regular exchange of situation reports and information on operations that are under way or planned. Efforts are made to ensure that projects complement one another and that cooperation schemes are interlinked. Where feasible, common programmes are established with other partners. At the present time, consideration is being given to the possibility of taking joint action through sectoral support programmes.

The machinery for coordinating operations with the major cooperation agencies, whether working on a bilateral or multilateral level, and with the World Bank has also been improved.

As far as the Community is concerned, what is needed is to promote concerted action based on a policy and on sectoral priorities that are clearly defined and to assist the work of national government departments (particularly in terms of administration) so as to prevent support being fragmented.

A COMPREHENSIVE APPROACH TO HEALTH PROBLEMS: NEW IDEAS ILLUSTRATED BY COMMUNITY ACTION IN CÔTE D'IVOIRE

It had become difficult to obtain medical treatment in Côte d'Ivoire in 1990. To consult a doctor and obtain the medicine prescribed, people had to embark on a veritable marathon and spend a great deal of money whether they lived in towns or in the countryside.

Provision of health care was in a parlous state, infrastructure and equipment were poorly maintained and staff morale was low. The state medicine supply and distribution system was collapsing and the central pharmacy (the PSP) was close to bankruptcy. This stemmed from the crisis in public financing, partly caused by the economic difficulties that the country was experiencing. It was also the result of previous health development policies, in particular the medicines policy, which decreed that only expensive proprietary products could be used. Generic products were forbidden.

Up until that time, the Commission had not been greatly involved in the health sector. Accordingly, it entered into discussions with the government, at the same time preparing, together with the World Bank, a wide-ranging programme to optimise the use of human resources. On the basis of close cooperation with all the partners concerned, the problems affecting the sector were reviewed in their entirety, discussions were held on ways and means of bringing about reforms and support programmes were analysed.

The initial operations were put in hand rapidly. As far as the Commission was concerned, they represented a novel approach. The agreement reached on a structural adjustment programme meant that it could make use of the funds released by an import programme to quickly provide budget support targeted on medicinal products and implement a set of projects aimed at supporting reform of the medicines policy and relaunch the PSP.

In subsequent years, Community action in support of health continued, based on four successive general import programmes. Further budget aid was provided, targeted on health, enabling the essential medicines programme to be strengthened and extended and helping Côte d'Ivoire to bear the top priority health costs.

At the same time, a more "traditional" programme was embarked upon, closely linked to the structural adjustment support projects, to assist with reforms in the health sector, help formulate health policies, improve the skills of ministry staff, provide support for the decentralisation process and, in particular, improve the running of health services in two of the country's regions.

Preparation and implementation of the projects were always preceded by very detailed discussions involving not only senior government officials and Commission representatives but also all the external partners and many leading figures from the country's public and private sectors. An all-encompassing approach was adopted, viewing the sectors' problems and possible solutions as a whole.

The first results were quick to appear. For example, the PSP was able to recommence operations as a result of improvements in purchasing and management procedures, concentrating on supplies of the most essential products and making greater use of generic products. A system for the resale of medicinal products was set up in both hospitals and health centres. Prices fell sharply and are now a quarter of those charged by the private sector.

As a result of the discussions that took place in connection with the public expenditure reviews, greater efforts have been made to gear the budget towards priority needs, steer public expenditure towards the provision of basic health care and improve the management of public funds assigned to the health services. The latter have shown a marked improvement.

The Commission is carrying out studies and other projects to support the government's efforts aimed at a better analysis of the situation, a more accurate inventory of existing resources and preparations for the future by determining a health policy more in line with the country's circumstances. The National Health Development Programme 1996-2000, published in 1996, bears witness to the efforts the country has made and the turnaround that has been achieved.

Nevertheless, all the problems have not been resolved; far from it. The state of health of the citizens of Côte d'Ivoire is still a cause for concern. Access to health care, especially for the poorest sections of the population, and the quality of the care provided, are still well below an acceptable level for a country that is, after all, richer than some of its neighbours and which has benefited, since 1994, from the devaluation of the CFA franc. New problems are emerging, such as the increase in the number of AIDS cases, the still relatively unchecked expansion of an informal private sector and a decline in the take-up of public health services. Considerable further efforts need to be made.

Côte d'Ivoire has certain advantages which can be used to deal with this situation. It can also count on support from its external partners, in particular the Community. It will be possible to make further headway by maintaining a dialogue on all the problems affecting the sector and by taking concerted and well-coordinated action involving all the parties concerned.

SUPPORT FOR A CONCERTED POLICY ON MEDICINAL PRODUCTS IN THE COUNTRIES BELONGING TO THE FRANC AREA

In the countries belonging to the franc area, 90% of medicinal products are imported. The private sector takes the lion's share, distributing virtually nothing but proprietary medicinal products, which are generally more costly than generic ones. Although the size of the public sector is considerable, its share of the market in such products is limited (less than 20%). There was, accordingly, a danger that the decision taken in January 1994 by the fourteen Heads of State and Government to devalue the CFA franc by 50% would have serious repercussions on the pharmaceutical sector in the countries concerned, with the cost of products doubling so that inequality of access to medicines and health care would worsen still further.

A medical analysis laboratory in Cameroo

In view of this danger, the fourteen countries concerned agreed, on the basis of the Abidjan Declaration, signed by their Health Ministers in March 1994, to devise a strategy that would afford their citizens the best possible guaranteed access to high quality medicinal products. The assessment of the situation carried out in Abidjan focused on a number of crucial issues, in particular the considerable disparities in the prices charged by suppliers, the inadequacies of the state supply units and the need to step up consultations with the private sector. In addition to the emergency measures that needed to be adopted, the Abidjan Declaration called for a more determined comprehensive policy.

This strategy was immediately supported by their external partners, in particular the European Community which, by providing technical and financial support, helped to define and implement emergency measures that included support for a temporary price freeze by means of appropriate subsidies, the amendment of certain laws, simplification of the registration procedures for generic medicinal products, the provision of information and guidance to doctors and patients regarding the use of generic products, exemption from certain taxes, and the like. At the same time, of course, even greater efforts were devoted to developing longer-term action aimed at rethinking policies on medicinal products and improving the performance of the state purchasing units.

In March 1995, the Commission provided support for the organisation of a second meeting of Health Ministers. In addition to the fourteen countries that were involved initially, a further six expressed great interest in attending. The meeting resulted in contacts with many European and African figures from both the public and private sectors as well as bilateral and multilateral organisations. The general feeling was that the worst had been avoided. Devaluation had not resulted in a systematic increase in prices. It was clear that there had been a change in attitudes in the pharmaceutical sector, both public and private. However, the meeting concluded that much remained to be done.

The representatives of the governments and their external partners decided to take these moves further and to set up six working groups which would concentrate on the following priority issues: quality control, information on the market in medicinal products, the introduction of generic medicines into the private sector, amendment to the legislation governing pharmaceutical products, improvement of prescribing practices and promoting national manufacture of medicinal products. The work carried out by these groups has already borne fruit and is continuing.

In many respects, the support given to the political initiative launched by the franc area countries and the regional momentum that was thus created exemplifies an approach to cooperation that affords support to a comprehensive programme with wide-ranging consultation of all those involved. Such an approach should be given priority in the future.

COMMUNITY SUPPORT FOR VACCINE INDEPENDENCE IN THE SAHEL

Towards real independence.

Support for vaccination campaigns or programmes has long been one of the mainstays of international aid. In recent years foreign donors have helped, often substantially, to bring about a vast improvement in vaccine coverage and protect millions of children. During this period international aid has been responsible for the supply of vaccines and much of the investment made under EPIs (enhanced programmes of immunisation).

But the supply of aid is not infinite - the countries concerned cannot continue to be over-dependent on foreign aid and financing. However, they are unable from one day to the next to pay from their own resources for vaccines or immunisation operations. Tried and tested systems, such as for the purchase of vaccines on the international market, can be tampered with only at considerable risk. A transition phase is essential.

The Community has therefore devised and developed together with UNICEF an ECU 9.5 million regional project for vaccine independence covering 8 Sahelian countries.

The idea behind the project is that expenditure on the supply of vaccines should be treated as priority public spending and therefore entered in the state operating budget. The Community's role involves helping with the budget entry and, in the event of budget difficulties, securing the corresponding expenditure (primarily by means of structural adjustment aid or, if necessary, via the project).

Together with USAID and UNICEF, the Community has helped to maintain the UNICEF vaccine procurement system while at the same time developing it in such a way as to hand greater responsibility to national health ministries. The system guarantees the quality of vaccines and ensures their supply at minimum cost.

Lastly, a regional technical assistance team has been set up in the Muraz Centre at Bobo Dioulasso in Burkina Faso. Its role will be to provide backup to the countries during the transition phase and to help build national planning and management capacity in vaccination operations. It is responsible for regional coordination of training measures, studies and surveys and for exchanges of know-how so as to increase Sahelian expertise in this field.

The above project testifies to the Community's approach which is to provide states with encouragement and support but not take their place. It also demonstrates that, through close coordination, progress can be made by drawing on various foreign partners' expertise and comparative advantages.

CIVIL SOCIETY - FROM CRISIS TO DEVELOPMENT IN ZAIRE (FROM 1997, DEMOCRATIC REPUBLIC OF CONGO)

In the 1970s Zaire was considered one of the most advanced countries in the public health field - it had drawn up a primary health care charter, set up a "health zone" system and put health care contributions into general application. Its health system and experts were renowned worldwide.

Today the country's public image is in tatters: AIDS, ebola, the disintegration of public services, poverty, floods of refugees. But all is not lost. Despite the hostile conditions, non-governmental organisations, particularly those churches traditionally involved in health matters, have continued their work and tried to provide a service to the community.

Although formal relations with Zaire had been broken off, the Community saw it as its duty to help the NGOs meet the people's basic health needs. In August 1994 it embarked upon an ECU 24 million programme of temporary assistance to the health sector (PATS), the first phase of a programme to improve Zaire's health system.

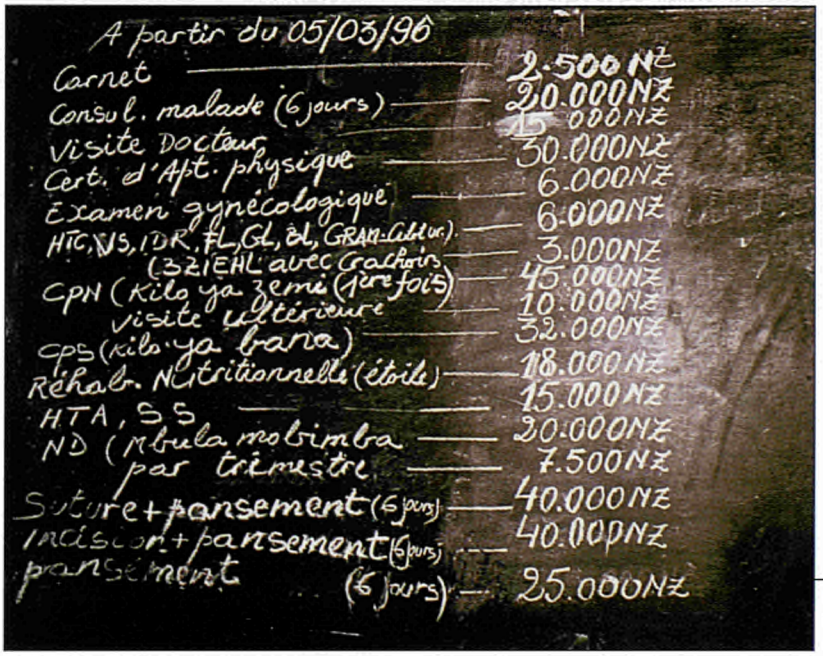
PATS has two main objectives: to meet basic health requirements and to safeguard the future. The programme grants aid to step up health services in rural areas, support urban community initiatives and set up projects to combat diseases such as AIDS, tuberculosis and sleeping sickness. The programme has three target zones: Kinshasa and the regions of Kasai and Kivu. More than 50 projects have been implemented in total.

One notable aspect of the programme is its reliance on Zairean civil society. Half of the projects are being carried out by Zairean NGOs with first-hand experience of working with the people, especially the poor, through the four main Church networks (Catholic, Protestant, Kimbanguist and the Salvation Army).

The European NGOs concerned, which are responsible for 25 different projects, use mainly local staff. Indeed some no longer have any permanent expatriate staff.

Another significant aspect of PATS is the emphasis on coordination. At the top level is the Community which organises regular consultations between all the foreign partners involved in Zaire. There is close coordination between the Community and its Member States who take an active role in PATS either by contributing to the financing of projects or supporting additional projects. Then there is coordination at the level of the regions concerned where technical assistance offices have been set up. With technical assistance at close hand, it is easier to identify the best partners, monitor and support projects and coordinate without losing sight of individual project needs.

The success of the first programme led in December 1996 to a new aid package - PATS II - being proposed for a total ECU 45 million. The aim of the new programme is to consolidate what has already been achieved and extend the coverage to first referral hospital facilities. All health zone activities are to be coordinated at regional level.



Paying for health care in the former Zaire (Congo/Kinshasa).

PATS has a dual role: (i) it is a coherent package of projects carried out by the partners in civil society themselves who thus help to build up its capacity; and (ii) it represents an opportunity to develop gradually a new approach to public health in a country where, after years of political upheaval, the social foundations of development need to be re-laid.

SAFE BLOOD TRANSFUSION: LEARNING FROM THE UGANDAN EXPERIENCE

Thanks to rigorous donor selection and strict screening, the risk of transmitting HIV during blood transfusion in industrialised countries is practically non-existent. In the developing world, however, this method of contamination is still responsible for many AIDS cases. Guaranteeing safe transfusions is a vital need. The Community's contribution to this has been to establish aid programmes in 27 countries with the aim of setting up or strengthening blood transfusion services.

Uganda provides a typical example of activities under the programme. In 1986 the country was emerging from a twelve-year civil war. With AIDS starting to take its toll, the blood bank in Kampala lay in ruins. It was still staffed, however.

The Community funded repairs to premises and provided essential equipment and technical assistance. A temporary laboratory was set up in Makerere University to cover needs while the work was in progress. Volunteer donors were then asked to come forward and "donor clubs" were formed, recruited primarily from population groups at low risk from HIV, e.g. religious orders.

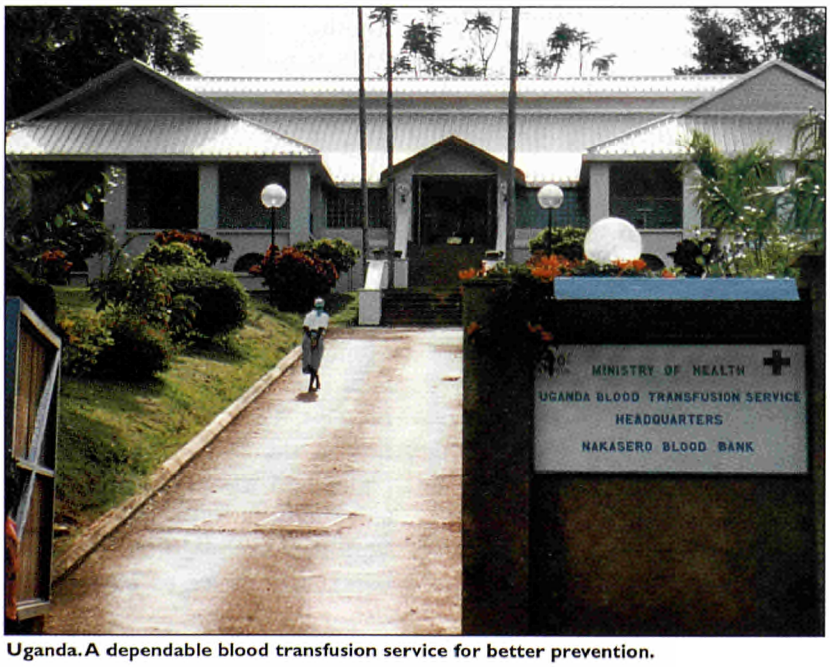
In the space of 20 months the blood bank was restocked and the 60 members of staff received appropriate training. The results were immediate. Kampala's hospitals alone now received 10 000 units of clean blood per year compared to only 2 000 units of untested blood for the whole country in 1986.

But this was not the end of the scheme. Encouraged to give blood regularly, though without payment to keep things above board, sufficient donors have now come forward. With the support it has received, the Uganda Blood Transfusion Service (UBTS) can now supply 88 hospitals throughout the country via four regional blood banks set up in 1991. The UBTS has practically reached its goal of 40 000 units of blood per year, enough to cover national requirements, and manages to pay its staff an appropriate wage. The safety of blood transfusions is now guaranteed. With increased capacity, the central laboratory can now offer screening services to thousands more, not just to blood donors.

Special attention has also been paid during this period to training all hospital medical staff and establishing clear guidelines for appropriate and less systematic use of blood and blood products. Many thousands, especially the young, have been made aware of the importance of donating blood.

The Community's involvement in Uganda has helped identify the measures required for a good blood transfusion policy which are appropriate to the situation in developing countries: select donors and encourage them to give blood regularly; ensure donation is on a voluntary basis; provide training to ensure that greater care is taken with the use of blood; extend screening to other infectious diseases (hepatitis, sexually transmitted diseases); give priority to professionally organised collection and supply rather than to sophisticated laboratory equipment.

The Uganda initiative has helped build considerable experience. The example it has set serves as a reference for other such schemes and training in many other countries. It also demonstrates the significant long-term impact of such schemes.



Uganda. A dependable blood transfusion service for better prevention.

MOZAMBIQUE: IMPROVING THE PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

Although sexually transmitted diseases pose a genuine public health problem, they are often paid inadequate attention by health services and their staff. The prevention and treatment of these diseases must be ensured by all health services. However, the problem should be addressed not just from the medical angle.

Mozambique has been ravaged by a long civil war during which more than 5 million people were displaced or sought refuge in neighbouring countries. Faced with poverty and violence, displaced and dispersed, families and social structures have been broken apart, encouraging sexual promiscuity and prostitution and thereby considerably increasing the risk of infection from sexually transmitted diseases (STD) and HIV.

The Community did not wait for the 1993 peace agreements to help Mozambique deal with the problem. It started providing aid to the Ministry of Health in 1988 with the aim of ensuring that STD prevention and patient care formed part of everyday health-service activities both in hospitals and at the level of grassroots services.

Specifically, the Community has contributed to:

- the definition of procedures, appropriate to the level of service, for the diagnosis and treatment of STD infections;

- health staff training: doctors, nurses and health workers.

The first phase of the project focused on the hospital in Maputo before being gradually extended to the whole of Maputo province, then to six other provinces. Priority was given to supporting activities in densely populated areas and returnee zones. The highest risk groups, in particular pregnant women and the young, received special attention.

The whole range of activities made a substantial contribution to improving the screening and treatment of sexually transmitted diseases by health services.

However, the problems posed by sexually transmitted diseases need to be tackled on more than just the medical front.

In Mozambique, the Community has supported schemes to improve information to the public and to change attitudes and behaviour. This has been achieved mainly through information campaigns in schools conducted by the Ministry of Education. But the Community has also provided support for tours by educational theatre companies in rural areas and for campaigns to raise awareness among truck drivers.

Mozambique is a good example of how the Community not only provides support to facilitate the incorporation of measures for the prevention of sexually transmitted diseases into everyday health service activities but goes beyond the medical approach to the problem too.

Mocuba, Mozambique. An EDF-funded training centre for healthworkers.

SOUTH AFRICA - SUPPORT FOR FAR-REACHING PUBLIC HEALTH REFORMS

In South Africa, as elsewhere in Africa, prevention against infectious diseases is linked to water quality.

During the apartheid years, the Community supported South Africa's health sector by means of pilot projects involving local and European NGOs and the local community aimed at improving access to health services for disadvantaged sections of society.

When the new government came to power in 1994, a substantial aid package of more than ECU 19 million was launched to provide large-scale support for the authorities' major national health system reforms.

The primary objective of the health service reorganisation was to bring together the 14 fragmented health departments and develop a national health system based on the district approach and a policy of primary health care.

Reorganisation of the system at national and provincial level was soon achieved but much work remains to be done before the health districts are on an operational footing.

The Community's support for the restructuring took the form of high-level technical assistance for planning and allocating the appropriate resources and aid to develop the district policy so as to serve the most deprived sections of the community.

In addition to the structural reform package, the Commission supported the development of policies to improve coverage of reproductive health and the HIV/AIDS epidemic, two areas in which the mortality and morbidity indicators are particularly disturbing.

Three initiatives supported by the Community have made a significant contribution to the process of reforming the South African health system:

- a health sector expenditure review;

- development of a national sickness insurance scheme;

- development of a hospital reform policy.

The review of expenditure in South Africa's health sector took place in conjunction with the United Kingdom, the World Bank and the NGOs and other bodies represented in South Africa. The review showed that South Africa had spent 30 billion rand on health services in the year 1992-93, an amount equivalent to about 8.5% of GNP, or in other words 740 rand (USD 247) per capita - a relatively high level compared to other developing countries. However, the study also showed that South Africa was not spending the resources allocated to the health service in the most efficient way.

The EC-funded technical assistance also enabled South Africa to develop a national sickness insurance system. The technical foundations of the future system have already been defined while the political debate to decide on its implementation continues.

Lastly, the hospitals study has helped develop a policy for the re-allocation of resources from level-3 and level-4 hospitals to basic health services without losing sight of the need to ensure the survival of the hospitals and introduce gradual reform.

Community support for the reform of the South African health system has enabled the rapid deployment of the European and local expertise essential to establishing conditions conducive to the necessary health care policy reforms.

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