

# Overall Recommendations for MDGs 4, 5 and 6:

## The Health Related MDGs

Of all of the MDGs, the health-related MDGs are some of the most seriously off track. Although some progress has been made, it is uneven and there much more remains to be done. The statistics speak for themselves: in 2008, 8.8 million young children died from largely preventable or treatable causes (MDG 4); in 2005, there were 450 maternal deaths per 100,000 live births in developing countries compared to just nine in the developed world (MDG 5); and in 2008, an estimated 2.7 million new HIV infections occurred and an estimated 2 million people died due to AIDS-related illnesses worldwide around 1.77 million deaths from tuberculosis and approximately 1 million deaths from malaria (MDG 6).

**The health MDGs are closely interrelated and require a joint and comprehensive approach.**

Success in meeting the health MDGs will only be realised if they are addressed as a coherent package, and not in isolation from each other.

In order to make progress in MDG 4, 5 and 6, a comprehensive approach to improve health is essential. Therefore, CONCORD recommends the EU and its member states to take up strong overall actions on health funding, health systems and access to quality health services, next to additional actions required for each of the MDGs 4, 5 and 6.

### The EU should:

- Implement their **health ODA commitments**, including the EU Agenda for Action on the MDGs to ensure sufficient, long-term and predictable health aid.
- Establish **0.1% of GNI** to health as a benchmark performance target for its ODA, in accordance with the recommendation of the WHO's Commission on Macroeconomics and Health. WHO estimated in 2001 that in order to achieve the health MDGs by 2015, donors need to allocate at least 0.1% of its GNI (equivalent to 15% of the 0.7% GNI donors have committed to provide to ODA).
- Urgently supporting, in addition to ODA, the **development and implementation of innovative sources of finances**, in particular financial transaction taxes including a currency transaction levy.

### Support strengthening of health systems and capacities which take into account the following:

- The health MDGs can only be achieved if **both health systems strengthening and disease-specific responses are equally addressed**. The EU as a whole needs to adopt and implement a strong and coherent joint approach to support countries achieving universal access to a basic health care package, which includes universal access to HIV prevention, treatment, care and support, universal access to sexual and reproductive health services, and malaria universal coverage.
- The EU should push for greater aid effectiveness by closely **coordinating and harmonising its aid with other donors** at the country level, including through the International Health Partnership and related initiatives (IHP+) and **meaningfully engage civil society** in health systems strengthening efforts.
- In addition, the support provided for the strengthening of health systems should include built-in financial resources and capacity building for the training, remuneration and retention of a **skilled health workforce**. Without the coverage of these significant recurrent costs, health systems will remain too weak to deliver the necessary universal coverage.

### Ensure fair access to health services:

- The EU needs to provide the support necessary to allow the abolition of user fees and the provision of public basic health care services (including access to medicines, supplies, vaccines) so that these are provided free at the point of use in developing countries. This strategy should also include how the EU and its member states act within the decision making of the IMF and World Bank to allow such policies to be promoted.
- The EU should strongly promote **gender equality** and the development of **social protection mechanisms** at the country level so as to ensure access for the poorest and most marginalised.
- The EU should commit to providing political and financial support to enable civil society to play its critical role in holding donor and national governments accountable for delivering healthcare services and strengthening communities' capacities to deliver healthcare services
- Rural areas must receive appropriate proportions of funding and health systems strengthening. Effective community based solutions must be re-emphasised, fully implementing the Alma Alta accords.

**Target:** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate from 95 to 31 per 1,000 live births by 2015.

**Indicators:** 4.1 Under-five mortality rate; 4.2 Infant mortality rate; 4.3 Proportion of 1 year-old children immunised against measles.

## 1. Introduction

A staggering 8,8 million children die each year – around 26,000 a day, or nearly one child every three seconds – before they are five years old<sup>37</sup>. The six causes of 90% of under-five child mortality – acute respiratory infections, diarrhea, measles, malaria, HIV/AIDS and neonatal conditions – are easily preventable.

The large majority of these deaths could easily be avoided if developing countries had well-functioning health systems that prioritised child health and respected commitments made when ratifying international conventions. Article 6 of the United Nations Convention on the Rights of the Child, for example, states that every child has the inherent right to life and that States Parties have to ensure to the maximum extent possible the survival and development of the child, while Article 24 ensures that States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health and take appropriate measures to diminish infant and child mortality.

## 2. Tracking progress

Overall, MDG 4 is one of the MDGs most unlikely to be achieved by 2015, despite the availability of simple, low-cost and effective interventions<sup>38</sup>.

The under-five mortality rate fell worldwide from 95 per 1,000 live births in 1990 to 65 in 2008<sup>39</sup>. However, at the current rate of progress, child mortality rate will only be reduced by a quarter instead of the planned two-thirds by 2015. Asia, home to one-third of the world's children, is on track to reach the goal<sup>40</sup> as is Latin America<sup>41</sup>. However, only one country in sub-Saharan Africa is on track to meet this target<sup>42</sup> and this region accounts for half of all under-5 deaths<sup>43</sup>. The situation in fragile states, where the MDGs are most off-track, is of particular concern, with only two of 35 fragile states on track to meet this MDG<sup>44</sup>.

Nonetheless, even when a country is on-track, deep inequalities still persist, with the poorest communities continuing to experience far less progress than the richest.<sup>45</sup> Mortality rates for disabled children under five can be as high as 80%, even in countries where overall under-five mortality is below 20%<sup>46</sup>.

New-born deaths account for 40% of deaths in children under the age of five each year. Progress in decreasing infant mortality has been poor. More than two-thirds of all newborn deaths occur in just 10 countries: India, China, Pakistan, Nigeria, Bangladesh, Ethiopia, DRC, Indonesia, Afghanistan and Tanzania. Severe infections, asphyxia and premature birth cause 86% of newborn deaths. However, with better pre and post-natal care and skilled attendants at childbirth, many of these deaths could be avoided.

Significant progress has been made on reducing child mortality from measles. Between 2000 and 2008 the number of deaths attributable to measles worldwide fell by 78% to 164,000<sup>47</sup>. This was in large part due to the ever-expanding coverage of measles vaccinations with, in 2008, 83% of children being given at least one dose by their first birthday, up from 72% in 2000<sup>48</sup>.

## 3. Barriers to achieving MDG 4

There are a number of key barriers that have been identified as contributing to the insufficient progress on MDG 4. These include:

- **Lack of funding:** if countries are to be able to strengthen their health systems, funding must be adequate, long-term and predictable. In 2001, the Commission on Macroeconomics and Health (CMH) estimated that an additional US\$94 billion (approx €70 billion) was needed by 2015 in order to reach the health MDGs. More recently, in 2009, the High Level Taskforce on International Innovative Financing for Health estimated that, now, an additional US\$36-45 billion is required<sup>49</sup>. Developing countries have committed to dedicate 15% of their national budget to health but despite this, owing to a lack of domestic resources, it is clear that a large part of the necessary funding will need to come from donors. For their part, donors have committed to provide 0.7% of their Gross National Income (GNI) to Official Development Assistance (ODA). However, owing to the financial crisis, the amount of funding provided risks being considerably lower than foreseen (and necessary).
- **Weak, poor-functioning health systems** – at a minimum, health systems should be equipped, staffed and organised to deliver proven interventions, effectively and equitably, to those mothers, newborn babies and children who need them. These systems need to operate across what is called the 'continuum of care'. Yet in many poor countries and communities, such systems are simply non-existent. Two aspects of weak systems to which attention should be drawn are:
  - Shortage of health workers, including skilled attendants at birth.
  - Shortage, or unavailability, of medicines, or vaccines, especially preventative and curative treatment for pneumonia, diarrhea and malaria.
- **Barriers to accessing health-care** – there are several factors which make accessing health difficult or impossible and therefore contribute to high rates of child mortality. These include:
  - User fees or informal payments – a number of studies have shown that when user fees are introduced, poor people's demand for primary health services falls, and when they are abolished, it increases dramatically.<sup>50</sup>
  - Distance to health care facilities, and a general lack of adequate funding and attention to rural areas<sup>51</sup>.
  - Discrimination on the grounds of gender, caste, ethnicity, religion or disability.

- **Under-nutrition** – A child is almost ten times more likely to die if they are severely underweight than if they are of average weight for their age. This could be prevented through initiatives promoting breastfeeding, complementary feeding, micronutrient supplements, social protection mechanisms.
- **Shortage of clean water and lack of safe sanitation** can cause or worsen disease such as diarrhea.

#### 4. The role of the EU

The role of the EU in achieving MDG 4 is not only a crucial one, but also multi-faceted.

##### Policy commitments

There has been much recent action within the EU to address global health issues. In addition to an upcoming communication on the EU's role in global health, the EU has produced policies based around what it considers to be the two key elements involved: health systems strengthening and human resources for health<sup>52</sup>. Furthermore, the Council of the European Union has set itself ambitious targets for 2010 to "save four million more children's lives each year, two million of which in Africa; and to have 35 million more births attended by skilled health personnel each year"<sup>53</sup>.

The Africa-EU Strategic Partnership on the Millennium Development Goals (2007) calls for "joint actions to strengthen district and national health systems, including... the elimination of fees for basic health care" yet no further policy commitment has been made and no clear ideas have been laid out as to how this will be achieved<sup>54</sup>.

##### Budget Allocations

The European Commission's funding for the health sector has not increased as a proportion of its total development assistance since 2000<sup>55</sup>. The assistance committed directly to the health sector in sub-Saharan Africa, for example, represented 3.5% of the total tenth European Development Fund (EDF commitments €793.8 million), well below their 15% target and down from 5.5% of EDF commitments in the ninth EDF.

##### Implementation of Policy

The EU, in its policy commitments, shows willingness to take a rights-based, holistic approach. Yet, in practice it focuses on specific issues or diseases. It does not therefore take a health systems strengthening approach which is widely agreed to be necessary. This is further undermined by a lack of coherence between policy areas in the EU. Just to cite one example, the European Commission promised to "provide increased support to country-level efforts to strengthen national health systems, supporting the development of comprehensive and inclusive national strategies to increase the capacity and performance of the health workforce"<sup>56</sup>. However, the development of a 'Blue Card' which will allow highly-skilled migrants fast-track admission to the EU<sup>57</sup> is likely to impede its stated commitment to tackling the 'brain drain' of health workers in developing countries, and on the contrary encourage such workers to come to Europe.

#### 5. Recommendations to the EU

We call on the EU and its member states to scale up urgently their response to MDG 4. The EU should:

- Commit to contribute to the **milestones outlined in the EU Agenda for Action on the MDGs**. This includes: a) saving four million more children's lives each year, of which two million in Africa; b) having 35 million more births attended by skilled personnel each year, of which 13 million in Africa; and c) increasing coverage of Integrated Management of Childhood Illness programs.
- Ensure a **rights-based approach to children's health** which, among other things, should tackle discrimination, target poor and marginalised groups, and address birth registration to facilitate access to basic services.
- Avoid treating the MDGs as silos and build on the obvious links between education and health, water and sanitation and health, nutrition and health.
- Recognise that gender is a barrier to accessing health care for girls, as well as women, and provide support to reduce these barriers with particular attention to the rights of adolescent girls
- Promote direct nutrition interventions such as breast-feeding counselling, weaning practices, micronutrient supplements, nutrition education and growth monitoring.
- Strongly support the overall recommendations calling for an integrated approach to the health MDGs (see page 15) and ensure children are at the heart of their response with:
  - **Full funding** of commitments to address the main causes of child mortality, ensuring that the specific EU policy commitments on MDG 4 are reflected in EU funding for developing countries, **focusing on those countries most off-track**.
  - A child-friendly approach to **health system strengthening** that includes support to community-based service delivery, child-friendly sexual and reproductive health services, training of health workers on child health.
  - Measures targeted specifically at children to ensure **fair access** to essential health services such as promoting **social protection schemes for children** and ensure that they include marginalised and vulnerable groups (such as exploited or abused children, those with disabilities, who suffer social exclusion, orphans, children affected by HIV/AIDS).

**Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio**

**5.1 Maternal mortality ratio**

**5.2 Proportion of births attended by skilled health personnel**

**Target 5.B: Achieve, by 2015, universal access to reproductive health**

**5.3 Contraceptive prevalence rate**

**5.4 Adolescent birth rate**

**5.5 Antenatal care coverage (at least one visit and at least four visits)**

**5.6 Unmet need for family planning**

## 1. The global context and tracking progress

In 1994 at the **International Conference on Population and Development (ICPD)**, 179 countries (among which the EU Member States) committed to an ambitious Programme of Action (PoA) for improving sexual and reproductive health and rights (SRHR) over the world, taking a strong human-right's based approach. The PoA included the goals to reduce maternal mortality and to ensure universal access to reproductive health care by 2015. MDG5 includes targets deriving from the ICPD PoA and should be considered in the context of that comprehensive package of SRHR recommendations.

**MDG 5 is the most off track of all MDGs**, especially in fragile states. No significant progress has been made since 1990. Despite dramatic statistics and the current needs that have grown drastically over the last decade, financial commitments and political will are strongly lagging behind. The interventions needed to achieve MDG 5 are available, but are not being delivered to the mothers (and children) who need them.

**Target 5.A:** 15 years after the ICPD PoA, **maternal mortality is still the most dramatic indicator of global health inequity**. Every minute, a woman dies from a pregnancy or childbirth-related cause<sup>59</sup>. It represents 536,000 of women and girls deaths every year as well as 1 million children left motherless. These children are 10 times more likely to die within two years of their mothers' death. 70.000 of these maternal deaths are due to unsafe abortions, one of the leading causes of maternal mortality<sup>60</sup>, 99% all of these deaths occur in developing countries, with half of them in sub-Saharan Africa and another third in South Asia. For every death, at least another 20 women suffer illness or injuries related to childbirth or pregnancy<sup>61</sup>. Although maternal mortality ratios are declining globally, **the decline is very limited, slow and unequal** between countries and regions. Maternal mortality rates decreased by less than 1% per year from 1990 to 2007, far below the 5.5% annual decline required to achieve MDG 5<sup>62</sup>. In sub-Saharan Africa, where maternal mortality is highest, the annual decline has been only 0.1%.

A major bottleneck is weak health systems with unavailable, inaccessible, unaffordable, or poor quality delivery services. four out of five maternal deaths are the direct result of obstetric complications, most of which could be averted through delivery with a **skilled birth attendant (SBA)** and access to **emergency obstetric care**<sup>63</sup>. Whereas globally there is an increase of care provided during pregnancy and delivery, the proportion of deliveries assisted by SBAs remains far below the required level of 90% of all births. Only

46% of births in Africa and 65% in Asia are attended by SBAs in contrast to 99.5% coverage in North America and Europe<sup>64</sup>. Moreover the **quality** of the services remains poor with a general lack of attention given to maternal, newborn and basic SRH services.

Poor maternal health also reflects the **violations of women's rights** in societies and the broader failure of States to respect, protect and fulfill women's full range of human rights. Early marriages, recurrent childbearing, gender-based violence, including female genital mutilation<sup>65</sup>, are among the indirect factors of maternal ill-health. Exposure to infections having dramatic consequences on pregnant women such as malaria or HIV and AIDS also play a significant role. The provision of **comprehensive sexuality education and services** for women, men and young people is therefore crucial for improving knowledge, dispelling myths surrounding family planning and maternal health and reducing sexual risk behaviors.

**Target 5.B:** This target was incorporated within the MDG monitoring framework based on recommendations of the world leaders at the 2005 World Summit.

One in four women who want to avoid or space a pregnancy are not using an effective method of contraception<sup>66</sup>. With an estimated 215 million women having an **unmet need for family planning**, the proportion remains unacceptably high. It represents up to 24% of women aged 15-49 in sub-Saharan Africa. It is however recognised that ensuring universal access to family planning is efficient for reducing maternal and child mortality<sup>67</sup> and is a cost-effective way to help achieving MDG 5<sup>68</sup> as well as other MDGs.

Overall **contraceptive prevalence rate** remain low despite increases in contraceptive use in most developing regions, generally accompanied by reductions in fertility. The major exception is sub-Saharan Africa, where contraceptive use, though nearly doubling between 1990 and 2005, was still only 22% in 2005 (with some countries facing a prevalence rate still below 10%). Contraceptive needs are however predicted to increase by 40% by 2015 as the world's one billion young people enter their reproductive years.

**Antenatal care** is a crucial service for healthy motherhood and childbirth by monitoring the well-being of both the woman and her baby. However the recommended norm of four antenatal visits is still not accessible to many pregnant women worldwide with the lowest proportion in sub-Saharan Africa (55% of women have no access).

**Pregnancy in adolescence** also contributes to the cycle of maternal deaths and indicates limited access to reproductive health services especially for young people. Pregnancy and deliveries are the leading causes of death for young women under 19 in developing countries. But adolescent fertility remained stagnant or increased marginally between 2000 and 2005.

Among the **main barriers** to the advancement of MDG 5 are:

- **Lack of political will and leadership in matters related to MDG 5.** Both donors and recipient governments neglect women's health and rights as well as SRHR in their policies and budgets and are insufficiently addressing gender discriminations and barriers to quality services access.

- **Lack of funding** for maternal health and SRHR, both from domestic and external sources. Current levels are insufficient to cover the needs<sup>69</sup>. Striking is the decline since 1995 of donor funding for family planning, even as progress in maternal health stalls. It has shrunk from 55% of the resource flows for population activities to only 5% from 1995 to 2006. (A decrease of 34% since 2000)<sup>70</sup>.
- **Lack of prioritisation of SRH services (incl. maternal health) in health system strengthening** as well as lack of linkages between related services such as HIV and AIDS, newborn, malaria and TB, insufficient trained health workers and access to reproductive supplies and equipment.

## 2. The role of the EU:

The EC and the member states have made strong political and funding commitments for universal access to SRH as set out at the 1994 ICPD PoA<sup>71</sup> and for MDG5 specifically<sup>72</sup>. The November 2004 Council Conclusions called for significantly more financial resources and support for SRHR and in June 2008, the Council adopted the EU Agenda for Action on MDGs which includes a set of specific milestones and timelines to put back on track MDG 5. However, despite strong policy commitments, evidence shows that more needs to be done to ensure their implementation.

In practice, health, especially maternal health and SRHR are not sufficiently prioritised in the Country Strategic Papers (CSPs). None of the CSPs under the 10th EDF has chosen SRHR as a focal sector and only a handful of CSP had chosen Health<sup>73</sup>. Moreover, it was shown that in sub-Saharan Africa where maternal health is the worst<sup>74</sup>, the EC financial support to health remains low. Allocations to the health and maternal health sector have not increased since 2000 as a proportion of total ODA despite the EC's commitments to the MDGs. Moreover, whereas the EC has a thematic budget line on SRHR under "Investing in People", the average funding level per year decreased from the period 2003-2006 when it was €18 million/year to the period 2007-2013 when it became €12 million.

## 3. Recommendations to the EU

### **Internationally (and specifically at the UN Summit on MDG+10), the EU and its Members States should:**

- Show strong **political will** and play a **leadership role** in prioritising MDG 5 with a particular focus on prevention, human rights and gender equality.
- **Call for improvement and enforcement of gender and SRHR laws and policies** with specific focus to legislating against traditional harmful practices (early marriage, female genital mutilation (FGM)) and gender-based violence as well as eliminating discriminations against women in the field of access to health care.
- Take leadership in **accelerating investments** in SRHR, with a focus on sexuality education, family planning as well as quality delivery services and training of skilled birth attendants.
- Encourage international health initiatives (Global Fund, GAVI, UNITAID, IHP) to expand funding for SRH (including maternal health) as well as reproductive health supplies in their activities so as to place MDG 5 at the centre of global health initiatives and funding mechanisms.

### **The EU and its member states should work towards the following objectives between 2010 and 2015:**

#### **Reversing the trend in declining assistance to MDG 5, the EU should:**

- Fulfil the **health ODA financial targets** set out in the EU Agenda for Action on the MDGs (€8 billion by 2010) by allocating adequate, long term and predictable funding for SRHR in the EU budget, the EDF and national development budgets.
- Commit to further contribute to the 2010 Milestones of the **EU Agenda for Action on the MDGs** which call for: 1) urgent support for attainment of universal access to RH; 2) have 35 million more births attended by skilled personnel each year, 13 million of which in Africa and 3) provide 50 million more women in Africa with modern contraceptives and access to family planning.
- Ensure that SRHR programmes are funded **through a mix of funding** mechanisms including general as well as sector budget support earmarked funding as well as partnerships with civil society, UN agencies and private sector<sup>75</sup>. Guarantee inclusion of monitoring and evaluation tools.

#### **Prioritising MDG 5 at EU policy level as well as in policy and political dialogue with partner countries.**

- Promote a clear political and financial commitment towards achieving MDG 5 through supporting the development of **national action plans on gender and SRHR**, including maternal health services.
- Ensure that the EU policy commitments on MDG 5 are **reflected in financial agreements** with developing countries by including systematically gender and SRHR-related performance indicators.
- Support policy dialogue at country level with partner countries on the importance of gender and SRHR for poverty reduction. The dialogue should include the following areas:
  - Commit to **effective health systems** that ensure the delivery of a **quality package** of SRH and maternal health services (including skilled health workers) and guarantee **accessible and affordable services to all people**, including marginalised and vulnerable groups.
  - Support the **strengthening of the linkages** between SRHR and related services such as prevention, treatment and care of STIs (including HIV), child health, malaria and tuberculosis.
  - Give special attention to the SRH needs of **young people**, by involving them in the design, formulation and implementation of relevant health policies and programmes and by ensuring access to youth-friendly health services as well as comprehensive sexuality information and education.
  - Promote the **empowerment of women** by encouraging policies and support programmes aimed at enhanced social position of women in societies and recognition of their rights.
  - Support **gender-sensitive approaches** which also meaningfully include boys and men.

## MDG 6 Combating HIV/AIDS, Malaria and Other Diseases

**Target 6a: Halt and begin to reverse the spread of HIV/AIDS**

**Target 6b: Achieve, by 2010, universal access to prevention, treatment, care, including greater transparency and support for HIV/AIDS**

**Target 6c: Halt and begin to reverse the incidence of malaria, tuberculosis and other major diseases**

### 1. The global context and tracking progress

An estimated 33.2 million people worldwide are currently living with HIV. While HIV epidemics have reported stabilisation in some regions, HIV prevalence remains alarmingly high in sub-Saharan Africa, particularly in Southern Africa. Eastern Europe and Central Asia are also presenting disturbing figures, with rising prevalence among key populations in countries in these regions, particularly among injecting drug users, sex workers and men who have sex with men, who have limited access to HIV prevention, treatment, care and support services. AIDS-related illness is the leading cause of death and disease among women of reproductive age globally.<sup>76</sup>

Furthermore, in 2008, AIDS-related deaths were the principal cause of under-five mortality in a number of sub-Saharan African countries, and millions of children have lost one or both parents to AIDS. Therefore there is a clear need for not only halting and reversing the spread of HIV/AIDS, but also to mitigate the devastating impact that this disease has on the lives of those living with and affected by HIV through the provision of social protection mechanisms. Additionally, gender inequality continues to drive the epidemic, especially in sub-Saharan Africa where women and girls account for nearly 60% of those infected – a result of their entrenched social and economic inequality within sexual relationships and marriage.

Global coverage of antiretroviral therapy (ART), the life-saving treatment for people living with HIV, has risen from 7% for those in need in 2003 to 42% in 2008. Despite this, more than two million AIDS-related deaths occurred in 2008, many of which could have been prevented through provision of ART. There is an urgent need for stronger and sustained investments to ensure lifelong treatment for all in need. However there are worrying signs of declining international support to combat HIV/AIDS, including a funding deficit that will need to be resolved in order to provide ART to 80% of people living with AIDS who still do not have access to treatment by the end of 2010.



Malaria is a disease which nearly half the world's population (3.3 billion) is at risk of contracting. Prevention of malaria is achieved through providing long lasting insecticide nets and treatment, which are highly effective interventions at limited cost. Such interventions have resulted in a 50% decrease in malaria cases and deaths in certain countries. However, progress is still lagging behind in many countries due to lack of sustainable funding and support.

Similarly, while global incidence of tuberculosis (TB) has declined, the number of cases continues to increase in areas particularly affected by drug-resistant TB and HIV, such as Eastern Europe and Africa. Alarmingly, less than 1% of the estimated Multi Drug Resistant and extensively drug resistant TB (M/XDR-TB) were treated according to set guidelines and drugs in 2007. The re-emergence of the disease, particularly in co-infection with HIV, requires renewed efforts to ensure adequate treatment.

The EU should continue to support initiatives on other major diseases as noted in target 6c, as part of a general support to health systems. For example, the neglected tropical diseases (NTDs) are a group of 13 parasitic and bacterial infections that affect over 1.4 billion people, most of whom live on less than US\$1.25 per day. NTDs cause physical impairment, reduce economic productivity and prevent individuals from being able to care for themselves or their families—all of which promote poverty. For some of these diseases, the goal of elimination is now within reach.

### 2. The role of the EU

**The European Programme for Action to Confront HIV/AIDS, Malaria and TB through External Action (2007-2011)** is the first commitment to collective action by the EU on these three areas. The 2009 Council Conclusions<sup>77</sup> on progress on the Programme for Action call for stronger, more effective and more concerted efforts of the EU at all levels, including through the creation of collective EU Action Teams. In addition, the Commission is requested to initiate the preparation of a new Programme for Action to ensure continued action to confront the three diseases beyond 2011.

**The EU-US Summit declaration of November 2009** renews and intensifies the transatlantic dialogue on development cooperation and the MDGs, in the running up to the UN High Level Meeting on the MDGs this September. In the context of the ongoing discussions on the new Communication on the EU role in global health and the new Global Health Initiative of the US Government, there is a vital opportunity for the EU and the US to develop synergies and harmonise between the different US and EU's aid modalities at the country level to ensure that universal access to HIV prevention, treatment, care and support, universal access to sexual and reproductive health and rights, and universal coverage of malaria interventions is achieved.

**The Global Fund to fight HIV/AIDS, Tuberculosis and Malaria** has achieved incredible results in tackling the three diseases since its existence as a results-based, innovative and country-owned financing mechanism with strong involvement of civil society. However, it has been unable to obtain sufficient donor commitment to meet the estimated financing need of US\$17-20 billion for the coming years, which directly affects the ability to respond to the three diseases by implementing countries.

### 3. Recommendations to the EU

We urge the EU to:

#### Scale up political and financial commitment for sustainable impact on these diseases by:

- Ensuring EU member states realise their 0.7% ODA contribution with 0.1% earmarked for health and initiate policy discussions with partner countries to motivate increased budget allocations for health (15% of national budgets according to the Abuja declaration).
- Ensuring a targeted response to the three diseases to achieve universal access to services, including by fully funding the Global Fund to Fight AIDS, Malaria and TB through increased contributions by the European Commission and EU member states.
- Supporting the achievement of the nine priority actions in UNAIDS 'Outcome Framework', in strong collaboration with UNAIDS and international community.
- Strengthening political and financial support for research and development for new preventive technologies, such as vaccines and microbicides for HIV and malaria prevention, and ensuring that they are accessible and affordable for all.

#### Promote effective country responses to AIDS, Malaria, and TB as well as NTDs by:

- Working in partnership with partner countries to develop and support implementation of country-led strategies to confront the three diseases with meaningful engagement of civil society.
- Supporting the strengthening of health and social protection systems and solving the crisis of human resources for health through contributing to better alignment of financing mechanisms with other donors and by promoting adequate fiscal space for social sectors.
- Involvement of people living with, most at risk for, and affected by the three diseases – including those providing home and community based care – in the design, implementation and monitoring of programmes and services in order to ensure that these are evidence-based and lead to concrete outcomes.
- Ensuring that HIV/AIDS, TB and malaria issues are effectively mainstreamed across all poverty development priorities and programmes.
- Increasing support to NTD elimination, to permanently remove an obstacle to poverty eradication. The burden of these diseases in terms of Disability-Adjusted Life Years is comparable to TB and malaria and there are tested, effective and safe treatments available.
- Ensuring the response to NTDs includes health systems strengthening, particularly training and equipping at the primary health care level, as this is where much of the effort of treatment and control is made.

- Ensuring that while support to pharmaceutical treatment continues, the other elements required for NTD control, particularly provision of safe water, sanitation and hygiene promotion, are also available and links are made with EU support in these areas under MDG 7.

#### Develop effective division of labour and partnerships to confront the diseases through:

- Emphasis on managing for results and mutual accountability in the division of labour between donors and making optimal use of available health expertise within European member states and EU delegations.
- Greater mobilisation and engagement of EU member states in the effective operationalisation of the EU Action Teams as outlined in the Progress Review of the Programme for Action 2009<sup>78</sup>.
- Supporting and facilitating dialogue between partner country governments and civil society at the country level on the development and implementation of comprehensive and evidence-based national health strategies, which promote gender equality, human rights and the needs of vulnerable and marginalised populations.
- Playing an important role as a global advocate to address sensitive priority interventions such as combating stigma and criminalisation, addressing the needs of sexual minorities, harm reduction, condom programming and integration of HIV and sexual and reproductive health and rights programmes.

**HIV/AIDS, TB, malaria and NTDs are devastating diseases in developing countries, with major impacts on the social and economic growth of those countries. We therefore urge the EU to scale up and live up to their commitments in order to achieve universal access to HIV prevention, treatment, care and support, universal access to sexual and reproductive health and rights, universal coverage of malaria interventions, universal timely treatment and diagnosis of TB and support for NTD elimination – all of which will contribute to the achievement of MDG 6.**

