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for Economic Cooperation
and Development

STRATEGIES 187

Sector Strategy: German Development Policy in the Health Sector



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Abbreviations

AA	Federal Foreign Office
AIDS	Acquired Immune Deficiency Syndrome
BMG	Federal Ministry of Health
BMZ	Federal Ministry for Economic Cooperation and Development
CIM	Centre for International Migration and Development
D2H	Debt to Health
DED	German Development Service
EU	European Union
FC	Financial cooperation
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHWA	Global Health Workforce Alliance
GPEI	Global Polio Eradication Initiative
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HIV	Human Immunodeficiency Virus
IGWG	Intergovernmental Working Group on Public Health, Innovation and Intellectual Property
ILO	International Labour Organization
IMF	International Monetary Fund
Inwent	Capacity Building International, Germany
IPPF	International Planned Parenthood Federation
KfW	Kreditanstalt für Wiederaufbau
MDG	Millennium Development Goals
NGO	Non-governmental organisation
ODA	Official Development Assistance
P4H	Providing for Health
PHC	Primary Health Care
SRHR	Sexual and reproductive health and rights
TB	Tuberculosis
TC	Technical cooperation
TRIPS	Trade-Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

I. Summary

Access to adequate health care for poor population groups and protection from the financial, health and social risks associated with disease are a **core element of human development and poverty reduction**. The right to the highest attainable standard of health is a **basic human right** which is enshrined in various human rights conventions and is internationally recognised. Every country that has ratified the relevant covenants must respect, protect and guarantee the right to health. Against this background, German development policy in the health sector pursues a human rights-based approach.

Since the adoption of the **Millennium Declaration** in 2000, health spending worldwide has therefore increased substantially. Some health indicators reflect this – for example, child mortality around the world has fallen significantly in recent years. Nonetheless, the health situation in many regions remains critical, with massive health disparities remaining between affluent and poor countries.

The problems and challenges are numerous and diverse; they include **poverty, a lack of financial resources**, strong population growth, a severe shortfall in trained health workers, management deficits, and a lack of political prioritisation. In many developing countries, patients are expected to pay for health care out of their own pockets, often putting these services beyond the reach of poor population groups. Due to the rapid population growth in many developing countries, the pressure on health systems will greatly intensify over the next few years. Additional problems include the massive **inequalities** in access to health care in many developing countries: access is not only determined by a person's ability to pay, but often also depends on gender, ethnicity, age, education, place of residence and disabilities. Infectious diseases, especially HIV/AIDS and

tuberculosis (TB) but also the “neglected” tropical diseases, pose particular problems for developing countries. The continuing high rate of child mortality, primarily from infectious diseases, malnutrition and lack of access to clean water, is a persistent and avoidable problem. The same applies to the health risks and mortality affecting women during pregnancy and childbirth. Over the past few decades, chronic non-transmissible diseases (cardiovascular diseases, cancer and metabolic disorders) as well as accidents have also increased in significance in the developing countries.

For German development policy in the health sector, the universal human rights and internationally agreed targets form the key framework for action. The **Millennium Development Goals (MDGs)** adopted by the United Nations are of particular relevance. Three out of the eight Millennium Development Goals relate directly to health. Increasingly, measures to strengthen health systems on a comprehensive and sustainable basis, but also more effective and efficient alignment of aid with partner strategies, are at the forefront of the international community's policy objectives. **Germany's development policy commitment** to the health sector aims to contribute to the provision, in the partner countries, of effective, efficient, equitably funded health care that is accessible to everyone, encompasses prevention, treatment and rehabilitation and addresses people's main health problems in accordance with their needs. It supports the realisation of citizens' rights and assists states to fulfil their obligations. Both are derived from the goal of improving access to health care, health information and healthy living conditions for everyone, including poor and disadvantaged population groups. Removing the structural causes of deficits in health care provision and strengthening participatory approaches play a key role in the **priority areas of activity**. These are:

- strengthening health systems: in particular, contributing to the training and professional development of health workers, the development of solidarity-based health financing systems and social protection, and cross-sectoral approaches to health promotion;
- strengthening the prevention and treatment of HIV/AIDS and other infectious diseases, including supporting access to low-cost drugs;
- strengthening women's rights and choices in relation to contraception, pregnancy and birth.

The specific needs and constraints on the rights of the poor and on the health care access of disadvantaged groups, such as children, young people and women, but also ethnic minorities, sexual minorities, the disabled or people with HIV/AIDS are addressed on a targeted basis.

The Federal Ministry for Economic Cooperation and Development (BMZ) pursues these objectives within the framework of the EU and relevant multilateral institutions such as the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and other UN organisations, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank. It also deploys bilateral development instruments, i.e. financial and technical cooperation. Germany is also working within international processes and institutions such as G8, the International Health Partnership and the Providing for Health (P4H) Initiative to harmonise the wide range of instruments being applied by many different actors, with a view to increasing the effectiveness and sustainability of aid and identifying and deploying additional financial resources.

In the developing countries themselves, German development policy cooperates with governments but also with non-governmental organisations (NGOs) and the private sector.

II. General objectives and programmatic framework of German development policy; the role of sector and cross-sectoral strategies

German development policy contributes to reducing poverty worldwide, building peace and realising democracy, promoting equitable forms of globalisation and protecting the natural environment. In seeking to fulfil these responsibilities, BMZ is guided by the vision of sustainable global development, expressed as economic performance, political stability, social justice and environmental sustainability in equal measure.

BMZ actively supports the new global partnership between industrialised and developing countries. The United Nations Millennium Declaration and the Millennium Development Goals provide the programmatic framework for German development policy. Germany is also working to implement the German government's commitments to improving the quality and effectiveness of aid (Paris Declaration on Aid Effectiveness, 2005).

Sector and cross-sectoral strategies are just some of the development policy instruments deployed by Germany to achieve these goals. They contain key criteria of relevance to the shaping of, and decisions on, development policy, notably as regards:

- a) the identification, appraisal, design, implementation, management and evaluation of sector/thematic programmes and modules. The strategies contain binding requirements that the agencies tasked with implementing official development assistance (ODA) must adhere to. They also serve as a frame of reference for the work of non-governmental organisations and private sector actors;
- b) the development of regional strategy papers, country strategy papers and priority area strategy papers for bilateral development policy;
- c) the positioning of German development policy in the international debate and development of our contributions to multi-lateral/regional cooperation and European development cooperation;
- d) relations with the general public in Germany, and liaison with the German Bundestag and other federal government departments.

1. Health, Development and Human Rights

Worldwide, poor health and poverty go hand in hand. Ill health is both an effect and a cause of poverty. *It is an effect* because the conditions of life associated with poverty – such as a lack of education, poor nutrition and bad housing – have a negative impact on the health of the population group concerned. Furthermore, health care services are often located some distance away, are almost unaffordable, and are not geared towards the needs of the poor. *It is a cause* because poor health reduces people's capacities and performance and costs time, money and energy, making it a major risk factor for poverty. Access to adequate health care for poor population groups and protection from the financial, health and social risks associated with disease are therefore a **core element of human development and poverty reduction**. According to expert opinion, at least 35 per cent of the economic boom in Asia from 1965 to 1990 was due to factors relating to health and demography, especially measures to improve child and reproductive health.

The right to the highest attainable standard of health is a basic human right which is enshrined in various human rights conventions and is internationally recognised.¹ It comprises the right to the prevention, treatment and control of diseases, the right of access to health care and related goods, and the right to health education and information.

The key elements of a human rights-based health strategy are:

Availability of health care services, especially treatment and rehabilitation facilities and adequately trained medical staff, suitable equipment and essential drugs. Adequate remuneration plays a key role in the availability of health care; decent salaries are especially important.

Accessibility: This means *de jure* and *de facto* access to health care. This access must be affordable and within the reach of poor, disabled and other disadvantaged sectors of society as well.

Acceptability: All health facilities, goods and services must respect the principles of medical ethics and the cultural values of the community concerned, to the extent that these values do not violate human rights.

Quality: Health services must be medically appropriate and of good quality.

Every state that has ratified the International Covenant on Economic, Social and Cultural Rights² must respect, protect and guarantee the right to health. This gives rise to the following minimum commitments of states vis-à-vis their citizens, irrespective of the country's development status and whether or not some areas of health care are organised with private sector involvement:

¹ The Universal Declaration of Human Rights, adopted by the United Nations (UN) in 1948, states in Article 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services (...)" The most important reference norm in the international treaties is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). A binding interpretation of this Article can be found in General Comment No. 14 adopted by the United Nations Committee on Economic, Social and Cultural Rights in 2000 (<http://www2.ohchr.org/english/bodies/cescr/comments.htm>).

² As of June 2009, the International Covenant on Economic, Social and Cultural Rights had been ratified by 160 countries. For a current overview, see http://treaties.un.org/Pages/ViewDetails.aspx?src=UNTSO&tabid=1&mtdsg_no=IV-3&chapter=4&lang=en.

- The state must ensure that all health care services are non-discriminatory.
- The state must develop and implement a strategy for the progressive – but also the swiftest possible – realisation of the right to health for the population as a whole.
- The state must prevent the realisation of the right to health falling back to a level lower than that already achieved; this also applies during privatisations of health care.

2. Health in Developing Countries – Current Situation and Challenges

2.1. Health status

Since the adoption of the Millennium Declaration in 2000, health spending worldwide has increased substantially. The health share of ODA alone increased from USD 6.8 billion worldwide in 2000 to more than USD 17 billion in 2008. This is reflected in a number of health indicators. For example, child mortality around the world, despite substantial regional disparities, has decreased considerably in recent years, falling by 27 per cent between 1990 and 2007. In 2007, there were 9.2 million under-five deaths, compared with 13 million in 1990. Nonetheless, the health situation in many regions remains critical, especially in sub-Saharan Africa. The massive health disparities between individual developing countries cannot be ignored. These are a reflection of the social parameters, the state of public and private health services, and prevailing patterns of disease. Above all, however, there are massive health disparities between the world's affluent and poor countries. Although **life expectancy** in the developing countries has risen overall in recent decades, average life expectancy in the low-income countries was still only 55 years in 2007 – much less than the average life expectancy of 79

years in the affluent countries. Substantial disparities can also be observed in relation to **maternal mortality**: as a result of early and frequent pregnancies, unsafe abortions and complications arising during childbirth, there were 450 maternal deaths per 100,000 live births in the developing countries in 2005 – compared with just 8 maternal deaths per 100,000 live births in high-income countries. The **under-five mortality rate** in the world's poorest countries – 130 deaths per 1,000 live births in 2007 – also contrasts starkly with the situation in the high-income countries, where the figure is just 6 for every 1,000 live births. These disparities reflect the often limited access to health care in the developing countries. For example, in 2000 – 2007, only 32 per cent of births in the world's poorest countries were attended by a trained health worker; in the affluent countries, the figure was 99 per cent.

2.2. Structural challenges

Poverty and a lack of financial resources mean that many developing countries cannot provide even the most basic health care for citizens. This situation is exacerbated in many countries by a

poorly functioning public health system, inadequate infrastructure and under-resourcing (especially a severe shortage of trained health workers), poor management and a lack of transparency, inadequate regulation and monitoring of non-governmental (private, charitable, faith-based) actors, a lack of political prioritisation and poorly adapted political systems (centralist and lacking in transparency).

Most developing countries lack adequate **social protection systems to share the cost burden in the event of illness**. In many developing countries, patients are expected to pay for most health care themselves (out-of-pocket payments), often putting these services beyond the reach of poor population groups. Many people go into debt in order to obtain health care or simply do not access medical services at all. The World Health Organization (WHO) estimates that every year, 150 million people face catastrophic health expenditure and more than 100 million individuals are pushed into poverty by the need to pay for health services.

In many developing countries, there is a severe shortage of **trained health workers, especially in rural regions**, partly due to the lack of comprehensive financing systems. Often, poor pay, a lack of incentives and very difficult working conditions prompt well-qualified doctors and nursing staff in particular to migrate from their countries of origin to industrialised countries or to move to other employment sectors in their own countries (brain drain). The shortfall of workers in many developing countries is now so severe that it is putting the functionality of the health systems at risk.

Furthermore, adequate access to essential drugs is often undermined by a lack of **infrastructure** and by logistical deficits. The availability of effective medicines is also limited by regulations in the field of international patent law, which make drugs unaffordable for many people in develop-

ing countries, and by the lack of new and more advanced drugs to treat tropical diseases.

Globalisation poses both challenges and opportunities in the health sector. On the one hand, initially localised health problems (e.g. SARS, bird flu and new types of influenza) can quickly spread around the world due to increased mobility. This is reinforced by climate change, as a result of which certain tropical diseases such as malaria and dengue fever are likely to spread into the Northern hemisphere as well. On the other hand, the industrialised nations are paying greater attention to the developing countries' health problems, and health is increasingly being regarded as a global public good. Since August 2003, for example, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement) has provided the opportunity for issuing compulsory licences to manufacture essential drugs to treat life-threatening diseases, such as AIDS, for reasons of public interest. In May 2008, the WHO's World Health Assembly, within the framework of the IGWG process (Intergovernmental Working Group on Public Health, Innovation and Intellectual Property), adopted a global strategy to improve research and the provision of drugs in response to the needs of developing countries. International partnerships are also increasingly emerging, offering new financing opportunities for health system development and specific health programmes.

However, this **diversity** is also creating various challenges. In 2009, more than 40 bilateral donors and 90 global initiatives are actively engaged in health-related development policy, to say nothing of the numerous private and charitable initiatives also working in this field. Often, the programmes focus on specific aspects of health care – mainly certain diseases – rather than addressing the health system as a whole. This has resulted in strong fragmentation of cooperation and excessively high coordination costs, and has led to various other problems for the partners in the developing countries.

A structural challenge, but also an opportunity, is the **strong interaction between health policy and other policy areas**. This applies especially to poverty reduction, food, social protection, water and sanitation, education, equality, population growth, employment, housing, justice, the environment, energy, transport and research and technology.

2.3. Structural disadvantages

There are massive **inequalities** in access to health care in developing countries. Due to their often disadvantaged social status and economic dependencies, **women and young people**, for example, often have poorer access to health information and services. Power relations in the home, but also discrimination in terms of their political participation impact negatively on their access to health care.

Generally speaking, **rural communities** tend to be at a disadvantage compared with the urban population: in the often still strongly centralised health systems in developing countries, the urban population – provided that they are able to pay for these services – generally have access to high-quality health care, whereas rural communities are frequently excluded. Discrimination in access to health services may also mean that the health status of **ethnic, religious and other minorities** is lower than that of the majority population.

2.4. Main health problems

Besides the structural deficits affecting health systems and the general under-provision of health care in many developing countries, the following health problems give particular cause for concern:

On account of their geographical location, many developing countries are especially affected by **tropical diseases**. **Malaria**, for example, claims

between two and three million lives in Africa, Asia and Latin America every year. **Pregnant women and children** are particularly at risk. A number of other infectious tropical diseases such as bilharzia (schistosomiasis), river blindness (onchocerciasis) and dengue fever are endemic and common, are often caused by poverty and a lack of access to safe drinking water, and inflict a heavy disease burden on the populations of developing countries. Infectious tropical diseases which receive little investment in research and control measures are known as **neglected diseases**. These are often associated with poverty and cause a heavy disease burden and sometimes lifelong disability; leprosy is a good example.

HIV and AIDS pose a growing challenge to the health sector. 90 per cent of the 33 million people infected with HIV/AIDS worldwide live in developing countries. The causes and effects of the epidemic radiate far beyond the health sector: gender inequality, discrimination and criminalisation of certain types of behaviour that are associated with a high risk of HIV transmission, poverty, social transition processes and migration all contribute to the spread of HIV. As AIDS – unlike most other diseases – affects women and men in young adulthood and hence in the most productive years of life, generally causing death even if life-prolonging treatment is successful for a time, the epidemic has major social and economic consequences. Access to prevention and antiretroviral drugs is still inadequate in many developing countries. Furthermore, due to the rise in HIV infections, the number of people suffering from **tuberculosis** and other infectious diseases that were previously in decline is also increasing in developing countries.

Over the past few decades, chronic degenerative diseases (cardiovascular diseases, cancer and lifestyle diseases) as well as accidents have increased in significance in developing countries. This shift in the main causes of death away from infectious diseases to chronic, non-transmissible disorders

has accompanied the rise in life expectancy and is generally known as “epidemiological transition”. Nonetheless, in many developing countries, the burden of infectious diseases remains heavy and unchanged.

Safeguarding **sexual and reproductive health and rights (SRHR)** is one of the main challenges facing the health sector in developing countries and – besides social protection systems – is a key factor for the long-term reduction of population growth. A lack of information, a lack of opportunities to use contraception to prevent unwanted

pregnancy and sexually transmitted diseases, inadequate medical care, especially during pregnancy and birth, violence against women, the continued practice of female genital mutilation (FGM) and unsafe abortions all drive up the rate of maternal and child mortality in these countries.

Poverty-related problems, **especially lack of access to clean water and adequate food**, are the main causes of the continuing high rate of **child mortality**, especially in Africa. Water scarcity and contamination will occur more frequently as a result of climate change.

3. Objectives of Germany's Commitment to the Health Sector

3.1. International framework and goals

With its commitment to the **concept of primary health care (PHC)** at the International Conference in Alma-Ata in 1978, the international community recognised for the first time that improvements in health cannot be achieved through specific medical actions alone. Rather, a multisectoral, participatory approach which is geared primarily towards prevention and responds to the expressed health needs of the community is required. The World Health Organization's renewal of primary health care in 2008³ and the DAC Guidelines⁴ for this sector set the agenda for the international process and for BMZ's policies and action. In accordance with the WHO's objectives, the PHC concept is increasingly being enhanced with a comprehensive framework for action on **health systems**. This includes the promotion of good governance, participation, equity and sustainable systems of health financing.

The **Millennium Development Goals (MDGs)** are of particular relevance. Three out of the eight Millennium Development Goals relate directly to health. Goal 4, for example, aims to reduce the under-five mortality rate by two-thirds by 2015 against the 1990 baseline, while Goal 5 aims to reduce the maternal mortality ratio by three-quarters over the same period, and achieve, by 2015, universal access to reproductive health. Goal 6 aims to have halted by 2015 and begun to reverse the spread of HIV/AIDS and reduce the incidence of malaria and tuberculosis. In addition, Goal 8 defines the establishment of a fair trading system

and the provision of access to affordable essential drugs in developing countries as development objectives. Due to the close correlation between poor health and poverty, Goal 1 (reducing poverty by 2015) is also relevant.

The international community is engaged in various fora in which it is seeking to improve co-ordination and harmonization of measures in the health sector. It is also committed to providing the necessary financing, including via innovative financing mechanisms. During its dual presidency of the EU and the G8 in 2007, the German government initiated a number of important processes in this context and is involved in the relevant initiatives. At the G8 Summit in Heiligendamm, Germany, together with France, was the initiator of the Providing for Health (P4H) Initiative to establish social health protection mechanisms, and is also a member of the International Health Partnership (IHP+).

The G8 has undertaken numerous commitments since 2000 to improve the health situation, especially in Africa. Under the German presidency of the G8 in 2007, comprehensive measures to combat HIV/AIDS, tuberculosis and malaria and to strengthen health systems and social health protection mechanisms were agreed, with gender inequalities in access to health care also being a particular focus of attention. Specific commitments were made in a number of areas, including the eradication of polio, reducing the gaps in the area of maternal and child health care, and improving the provision of trained health workers.

3 WHO (2008): "Primary Health Care – Now More Than Ever". World Health Report 2008.

4 OECD/WHO (2003): "Poverty and Health". DAC Guidelines and Reference Series.

The **European Union (EU)**, in the Communication from the Commission on health and poverty reduction (2002), identified the need to gear development policy measures in the health sector towards poor population groups (pro-poor policies), support fair health financing mechanisms and promote research into poverty-related diseases. Council Conclusions on HIV/AIDS, malaria and tuberculosis, adopted under Germany's EU Council Presidency in 2007, emphasise the importance of strengthening health systems and underline the fact that women and young people are particularly at risk from these diseases.

In terms of content, the various donor commitments and EU and UN contributions are geared towards the relevant political declarations from the partner regions (in Africa, for example, these are the Abuja Declaration by the African Heads of State and Government, and the Maputo Declaration adopted by the African Union).

3.2. Specific targets of Germany's commitment to health care

Germany's development policy commitment to the health sector aims to contribute to the provision, in the partner countries, of effective, efficient, equitably funded health care that is accessible to everyone, encompasses prevention, treatment and rehabilitation and addresses people's main health problems in accordance with their needs. It supports the realisation of the individual's rights and assists states to fulfil their obligations, the aim being to improve access to health care, health information and healthy living conditions, especially for poor and disadvantaged population groups. Removing the structural deficits in health care provision, strengthening par-

ticipatory approaches, improving the opportunities to exert political influence (empowerment) and capacity development all play a key role.

For German development policy in the health sector, a key priority is **health system development**. Here, specific aims include increased provision of health professionals; adequate training and professional development for health workers; development of sustainable, solidarity-based funding systems (social health protection); improving the organisation, structure and management of health systems; and rehabilitation and expansion of infrastructure.

Some diseases such as malaria, tuberculosis and the "neglected" diseases are endemic in the developing countries and greatly increase the disease burden and loss of productivity. Efforts to control these diseases should take place primarily through the strengthening of health systems and cross-sectoral cooperation. Besides these integrated approaches, however, support is also provided for individual measures such as the provision of mosquito nets as part of malaria control. Measures to combat risk factors such as alcohol and tobacco consumption are becoming increasingly important in developing countries as well.

HIV/AIDS control occupies a special position in German development policy. Here, the focus of support is on preventing infection, combating the stigma attached to HIV/AIDS, and improving access to treatment. In this context, particular importance is attached to empowering and protecting women and girls in the context of the pandemic. HIV/AIDS is not only a health problem: the pandemic has evolved into a social crisis, so cooperation with all development sectors (mainstreaming) is an essential prerequisite for combating HIV/AIDS.⁵

5 More detailed information is provided in the Action Plan to implement the Strategy of the Federal Government to fight HIV/AIDS (<http://www.bmz.de/en/service/infotehk/buerger/AIDS.pdf>) and the BMZ policy paper on HIV/AIDS (www.bmz.de/en/service/infotehk/fach/spezial/spezial110_90.pdf).

Sexual and reproductive health and rights (SRHR) are a further thematic priority in German development policy, directly benefiting the attainment of MDG 4 and MDG 5 on improving child and maternal health. Services in this area contribute to social development as a whole and – alongside social protection systems – are a key factor for the long-term reduction of population growth. Promoting sexual and reproductive health and rights means helping to improve access to safe and effective family planning services, the provision of medical care from trained health workers before, during and after pregnancy, access to decent medical care for women undergoing abortions, and the prevention and treatment of sexually transmitted diseases.⁶ The prevention of sexual violence, treatment and care for victims, and efforts to combat female genital mutilation (FGM) and overcome its effects also fall into this area of work.

Linkage of health policy with other policy areas, in line with the concept of “health as the outcome of all policy measures”, is becoming increasingly important.

3.3. Experience

In the health sector in most developing countries, national programmes and established forms of cooperation between government and donors exist, e.g. in the form of sector-wide approaches (SWAs), to which German development policy contributes. **Bilateral** cooperation often plays an important role in this context. SWAs are complex processes which particularly benefit from the trust and confidence built up by bilateral cooperation at the lower levels.

Examples of successful measures include those undertaken in the field of capacity development,

the social marketing concept (e.g. condoms), and the development of social protection systems, including voucher schemes which facilitate poor peoples’ access to good-quality health care. In HIV control, measures to enhance the GFATM funding programmes are an increasing focus of attention. German development policy assists its partner countries to access the GFATM and optimise their utilisation of its funding mechanisms. German development policy is successfully engaged in efforts to link HIV/AIDS control, family planning and maternal health programmes to a greater extent with a view to utilising the synergies between them.⁷

In the SRHR sector, too, target-group-specific approaches, especially those aiming to strengthen women’s and young people’s rights and opportunities for participation (empowerment), have proved particularly useful. In the area of infrastructure, it has become apparent that investment in the primary and secondary level of care (health centres and district hospitals) is particularly effective in improving the health of disadvantaged social groups.

In light of the international goals outlined above and the experience gained in this field, German development policy in the health sector will continue to pursue human rights-based approaches, with a consistent focus on the needs of particularly vulnerable and disadvantaged groups in all its projects and programmes (mainstreaming).

In view of the activities of the **multilateral** organisations, which are gaining in relevance, especially in relation to infectious disease control, German development policy in the health sector is increasingly characterised by its support for and participation in international organisations and partnerships. Germany’s broad range of development policy experience is proving to be a valuable asset in linking multilateral and bilateral approaches.

⁶ See BMZ (2008): Policy Paper: “Sexual and Reproductive Health and Rights, and Population Dynamics”, BMZ Special 149 (German: 148, French: 159).

⁷ See BMZ/DED/GTZ/Inwent/KfW (2007): Policy Brief “Promoting Linkages and Synergies for Sexual and Reproductive Health and Rights and HIV/AIDS – Key Issues and Opportunities”.

4. Approaches and Desired Impacts

4.1. Desired sector-specific and cross-sectoral impacts

Due to the interaction between poverty and ill health, described above, health-sector measures can be expected to have positive impacts that radiate beyond the health sector itself, and in some cases are only measurable or attributable to specific projects and programmes to a limited extent. For example, improving the availability of contraceptives can have positive impacts on families' prosperity by reducing the birth rate. It can also facilitate access to education, improve families' nutritional status, and have positive environmental impacts. The direct effect of health programmes can be demonstrated using a monitoring and evaluation system which focusses on the verifiable outcomes achieved for specific population groups and, in particular, measures improvements in the health of poor and socially disadvantaged groups. The following key questions can provide information about the impact of relevance to poverty and human rights:

- To what extent has **health status** improved, particularly of poor and disadvantaged groups?
- To what extent has **access** to health care improved, particularly for poor and disadvantaged groups?
- To what extent has the **quality** of health care improved, in terms of both the quality of medical care and its socio-cultural appropriateness?
- To what extent has the **level of health-related information** improved, particularly for poor and disadvantaged groups, and to what extent have these groups de-

veloped an awareness of their rights in relation to health care?

- To what extent has the **participation** of poor and disadvantaged groups in the planning, implementation and monitoring of health-related measures been strengthened at institutional level?
- To what extent have the **capacities** of duty bearers (governments) been strengthened?
- To what extent have institutional mechanisms for **accountability and the handling of complaints** been strengthened?

Many developing countries still lack adequate epidemiological and demographic data required for comprehensive assessment of the impacts of health-sector measures. To facilitate impact assessment of a pro-poor, human rights-based health policy, support must be provided to the developing countries to enable them to collect the relevant data, broken down by age, marital status, income, gender, disability, ethnicity and region, taking due account of legal data protection standards.

According to current opinion, the most efficient and sustainable health outcomes are achieved with an approach that focusses primarily on strengthening health systems at the various levels, integrates target-group- and disease-specific measures to the maximum extent and delivers services in the form of comprehensive care in health centres. As well as maximising synergy and efficiency gains, this approach avoids gaps in health care provision (for example, patients' vaccine protection status can be reviewed as part of disease-specific treatment).⁸

⁸ See Report of Working Group 1 of the High Level Taskforce on Innovative International Financing for Health Systems, June 2009.

Mainstreaming of HIV/AIDS control measures and sector-specific approaches: Due to the negative impacts of HIV/AIDS on development processes, mainstreaming HIV/AIDS control as a cross-cutting issue in development policy is extremely important. This enables partners and development actors to overcome/mitigate the causes and effects of HIV/AIDS more effectively and sustainably in their work (e.g. projects and programmes) by adapting and improving their activities (core business) and workplaces in response to HIV/AIDS. Support is also being provided for workplace programmes for employees of the implementing organisations of German development policy and its partners. These measures are being planned, financed and implemented within the framework of current programmes.

There is a great deal of interaction with other policy areas. German development policy aims to achieve positive reinforcement of this interaction, notably in relation to education, water and sanitation, food, transport, housing, justice, the environment, energy, and science and technology, as well as to cross-cutting themes such as human rights, good governance, employment, participation, women's empowerment and social security.

4.2. Approaches: instruments and processes

4.2.1 Relevant international organisations and initiatives

It is primarily the **World Health Organization (WHO)** that is responsible for setting effective global health standards and developing relevant strategies, which are then agreed at the annual World Health Assembly. Germany will be represented on the Executive Board of the WHO for the next few years. In addition, numerous **other UN organisations** deal with health, such as the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS

(UNAIDS) and the United Nations Population Fund (UNFPA). The **World Bank** plays a key role in strengthening health systems, both in conceptual and financial terms. Besides the private global actors which have recently come on the scene, notably the Bill & Melinda Gates Foundation or Rotary International, which make a major financial contribution, initiatives such as the Global Alliance for Vaccines and Immunisation (GAVI) and the Global Polio Eradication Initiative (GPEI) have played an important role for many years. BMZ is one of GPEI's largest donors and has provided more than € 270 million for polio eradication under GPEI. The German government (BMZ, Federal Ministry of Health (BMG), Federal Foreign Office (AA) is actively engaged in the relevant bodies and has helped to set new priorities in various sectors in recent years (gender, strengthening of health systems, mainstreaming, social protection, sexual and reproductive rights, financing). In the field of sexual and reproductive health, the German government also supports the International Planned Parenthood Federation (**IPPF**), which is the leading global advocate of sexual and reproductive health and rights and the international umbrella body for the non-governmental organisations working in this field.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (**GFATM**) was established in 2002 to improve and enhance the effectiveness of cooperation between countries involved in the field of infectious disease control. The GFATM is a new type of financial mechanism, involving international cooperation by governments, civil society and the private sector. Today it is the principal financial instrument in the fight against HIV/AIDS, tuberculosis and malaria (GFATM provides around 25 per cent of international funding for HIV and AIDS for developing countries, and 60 per cent of international funding for malaria and tuberculosis programmes respectively for developing countries). As one of the largest donors to the GFATM, Germany (BMZ) has an influential position on the GFATM Board. In recent years, Ger-

many was able to make a substantial contribution to the development of a gender strategy, as well as promoting a greater focus on health systems in the GFATM's work and contributing to the development of a partnership-based approach. In view of the GFATM's key institutional role, this position will be maintained in the coming years and utilised, for example, in the forthcoming process of structural reforms in the GFATM and in achieving better linkage with the partner countries' own health strategies and other donors' projects and programmes.

Processes to improve **aid effectiveness** play a particularly important role for the health sector. This is due to the large number of actors and the need to "join up" disease-related and system-based approaches. BMZ provided financial support (via KfW) during preparations for the 3rd High Level Forum on Aid Effectiveness in **Accra** in 2008 ("Health as a tracer sector" project) and will continue to make an active contribution here. The international community is now working intensively on the **consolidation and coordination of the complex donor structure in the health sector**. An important role, in this context, is played by the **Global Campaign for the Health Millennium Development Goals**. This is the strategic framework for numerous stakeholders and initiatives to work towards more effective attainment of the Health Millennium Development Goals. The **International Health Partnership (IHP)** was launched in 2007 by German Chancellor Angela Merkel and the British Prime Minister Gordon Brown with the aim of improving cooperation between multilateral and bilateral donors in the health sector, based on national health plans and priorities. Participation in this initiative at global and especially at country level is likely to

characterise German development policy in the health sector in the coming years. The **Providing for Health (P4H) Initiative** was initiated and developed during Germany's G8 presidency in 2007. It is a **partnership of bilateral and multilateral organisations** (Germany, France, World Bank, WHO, ILO) which, together, provide support to partner countries to enable them to develop **social protection mechanisms** in the health sector and fund them on a sustainable basis. The Initiative aims to reduce individual **out-of-pocket payments for medical care** and thus make health care more accessible, especially for poorer population groups.⁹

In response to the critical shortage of trained health workers worldwide, the **Global Health Workforce Alliance (GHWA)** was established in 2006 under the aegis of the WHO. A unique alliance of national governments, civil society, international agencies, researchers and professional associations, it is a particularly appropriate partner for German development policy in the further development and establishment of strategic approaches to "human resources for health" at national, regional and global level. An important basis at EU level is the European Programme for Action to tackle the shortage of health workers in developing countries, which was developed under the German EU Presidency in 2007 on the basis of Conclusions from a General Affairs and External Relations Council meeting in 2006.

In the **SRHR** sector, the **Reproductive Health Supplies Coalition (RHSC)** was established in 2006.¹⁰ Germany has been a member of this global coalition, comprising more than 70 bilateral and multilateral donors, UNFPA and WHO, private foundations, civil society organisations, partner

⁹ For information on the development and expansion of social protection systems in general, see BMZ's Sector Strategy on Social Protection.

¹⁰ See BMZ (2008): Policy Paper: "Sexual and Reproductive Health and Rights, and Population Dynamics", BMZ Special 149 (German: 148, French: 159).

countries and the private sector, since 2006. The aim of the Coalition is to achieve sustained improvements in access to high-quality contraception, material, consumables and drugs for sexual and reproductive health in developing countries. To that end, it promotes transparency and harmonisation of licensing and regulatory processes, cooperation on the development and expansion of needs-based planning and procurement procedures, and efficient financing systems, as well as better information about needs, methods and strategies.

4.2.2 Measures for effective strengthening of partner structures; relevant levels of action

Health system development can start at policy level (sector reform) and at delivery level (improving health service performance). Structural improvements in the health service can be achieved through decentralisation of the health system, the development of sustainable and socially equitable systems of health financing, and improvements in planning and management capacities. At the delivery level, the focus is on the development of organisational structures for effective planning, implementation, monitoring and evaluation of health programmes. Starting points for German development policy are capacity development and capacity building in the logistics sector and personnel and resource management. Investment in infrastructure should generally be restricted to the primary and secondary level of health care (health centres and district hospitals). Infectious disease control, also in the context of SRHR, must be embedded in the health systems and should not operate in parallel to them.

To reduce the **shortage of trained health workers**, which is reaching critical levels in some areas, the following measures are beneficial: training and professional development, establishment of requisite legal frameworks and acceptable working conditions, human resources management

strategies, and international rules. The problem can only be solved by means of a cross-sectoral and international approach and the adoption of binding rules applicable to the national labour market and migration, and addressing the targeted recruitment of developing countries' health workers by other countries. Limited deployment of German health workers may also be helpful in bridging the chronic shortfall of trained health workers in some regions.

Solidarity-based health financing and social health protection: Socially equitable health financing is a key objective of German development policy in the health sector. The approaches being adopted here are diverse and are aligned to the priorities and conditions in the partner country concerned. Options include the funding of health services from taxation, social health insurance schemes, community-based health insurance and subsidising the demand for health services, e.g. via health vouchers. **Conditioned social transfers** may also be an effective, low-cost way of reaching extremely poor population groups in particular. These transfers are targeted directly at families living in extreme poverty and at specific groups such as babies, young children and pregnant women.

The human right to health: Prevention is key, also in terms of easing the burden on systems and strengthening structures. Prevention can take place through the following and other measures: screening; immunisation; provision of information about ways of preventing pregnancy and infectious diseases; know-how transfer in areas such as pregnancy, child health, and hygiene, and empowerment of civil society actors in these areas; and information about rights, also with a view to eradicating harmful traditional practices such as genital mutilation. The development of peer education schemes is also useful here.

Key elements of **SRHR** are the provision of advice on improvements to **legislation** and the utilisa-

tion and **strengthening of private sector distribution channels** and marketing strategies to promote sales of (generally subsidised) products that promote health (contraceptives, condoms, mosquito nets) via **social marketing**.

Important institution-building elements relating to **HIV/AIDS** are: empowerment and training for key health service actors involved in HIV/AIDS control, adaptation of health systems to HIV/AIDS-related needs, and development and promotion of HIV/AIDS workplace programmes at company level and in public institutions. The promotion of social science research and knowledge transfer between hospitals as part of the programme to promote hospital partnerships between universities in Germany and in developing countries launched by BMZ in 2007 is also relevant.

To improve access to **drugs** in sub-Saharan Africa, BMZ is providing support to enable its partners to fully **utilise existing flexibilities afforded by the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement)** in the health sector and expand the local **pharmaceutical industry** through institution-building approaches. Local production of drugs to treat poverty-related diseases is also being supported.

Over the next few years, in response to the specific problems being experienced by Africa in relation to the attainment of the Millennium Development Goals, the expansion of Germany's profile in health sector cooperation in **sub-Saharan Africa** will play a particularly important role.

4.2.3 Right holders, duty bearers and partners

Health sector programmes must be geared, on the one hand, towards poor or otherwise disadvantaged population groups (right holders). On the other hand, they also work with the decision-makers responsible for realising the human right to health. For these duty bearers, that means safeguarding the provision of good-quality health

care services, improving access to health care and, in particular, ensuring that disadvantaged groups do not suffer additional discrimination in this context.

Women's empowerment must be mainstreamed in all health sector programmes with a view to improving their health status, reducing their workload and promoting their political participation in decision-making processes. Due to social roles and relationships of dependency, it is essential, when seeking to improve the health status of women, to involve boys and men on a targeted basis as well. Particular account should also be taken of the needs of **adolescents** and young adults in health programmes, firstly because they are substantially affected by disease (especially sexually transmitted diseases) and also because there are many opportunities to improve their health behaviour. **Infants and children** are greatly at risk from poverty-related diseases, and so all programmes should take account of factors that are specific to child health. The interests of disadvantaged groups – whether these are ethnic or sexual minorities, the disabled or persons with HIV/AIDS – must also be considered. Health sector programmes should be based on **participatory** approaches.

German development policy in the health sector is actively involved at all levels of intervention. Its **partners** for health promotion measures are, firstly, government agencies and administrative bodies in the developing countries, which naturally includes the relevant ministries first and foremost. Secondly, it collaborates with other donors, multilateral institutions, UN organisations, international, national and local NGOs, self-help groups and the private sector.

4.2.4 Instruments and implementing organisations

Within the framework of **financial cooperation**, advice, support and funding are provided for

partner countries' programmes with the aim of increasing ownership and building capacities in line with their needs and development strategies. Besides contributing to programme-oriented joint financing (PJF) (basket funding, sectoral budget support), financial cooperation also provides funding for measures to improve health infrastructure and delivery as well as the provision of vaccines, contraceptives, pharmaceuticals and other materials. The concept of social marketing of socially desirable products, which is also supported through financial cooperation, has proved successful. Finally, financial cooperation supports voucher schemes which offer certain target groups (e.g. pregnant women) better access to relevant services (e.g. maternity care).

In the area of **technical cooperation** in the narrower sense (the main agency here being GTZ) and in the broader sense (CIM, DED, Inwent), capacity building for individuals, organisations and institutions is the main focus of activities. Capacity building and capacity development in the areas of programme and strategy development, programme implementation, promotion of sector coordination, and quality management are just some of the core competences in the field of technical cooperation. Typical instruments here are policy and organisational advice in the health sector, support for structural reforms, promotion of participatory decision-making processes, training for decision-makers and health workers, capacity development for institutions that provide training for health workers, and information for target groups. Cross-sectoral cooperation and south-south cooperation are also promoted. The targeted deployment of experts ensures that additional support is available in a range of areas (technical cooperation in the broader sense).

Overall, German development policy **focuses on achieving complementarity between technical cooperation and financial cooperation programmes**. In the health sector in particular, due to its specific characteristics – its substantial need

for advice, training and information, as well as for a high level of investment – close linkage between technical and financial cooperation is essential.

International and multilateral approaches are particularly relevant to development policy in the health sector. The use of **synergies and the development of complementary strategies** in the design and implementation of bilateral and multilateral approaches will pose a key challenge in the coming years. German development policy has developed innovative approaches (e.g. via the P4H Initiative outlined in Section 4.2.1 above, its bilateral contributions to the WHO, UNICEF and UNFPA, and TB control, polio eradication and family planning programmes supported by financial cooperation) which are now recognised by the international community. Furthermore, German development policy also assists applicants for GFATM funding to structure their applications and supports implementation, especially in the field of health system development and the reduction of gender inequalities through the German BACKUP Initiative.

Germany is involved in the development of **innovative financing instruments** for the health sector and has provided fresh impetus for health measures through Debt to Health (D2H), which promotes debt-to-development swaps in partner countries.

Since the late 1990s, **programme-based approaches** (PBAs; when applied to a single sector, they are known as *sector-wide approaches* (SWAs)) have gained in importance. PBAs can contribute to harmonisation of instruments and enhance the effectiveness of aid in the health sector on a sustainable basis. The coordination of bilateral instruments with the **IHP** (see Section 4.2.1.) will become increasingly relevant in numerous partner countries in the coming years, and it will be important, in this context, to capitalise on the potential afforded by existing mechanisms and structures at national level.

To ensure that there is positive mutual reinforcement between health and **other policy areas, intensive cooperation** is needed on health promotion in developing countries. Alongside strategic cooperation between the health sector and other fields of action (see Section 4.1.), this entails the targeted mainstreaming of health-related aspects in other programmes.

German development policy in the health sector has, for many years, cooperated not only with government institutions but with **non-governmental organisations** as well. The responsibility of the **private sector** for development policy has also grown in importance in recent years, resulting in a number of public-private partnerships (PPPs) as well as cooperation with the Working Group on Healthcare Infrastructure in Develop-

ing Countries and Emerging Markets, established under the aegis of the Federation of German Industries (BDI).

In the past, the German government has been the driving force behind key initiatives for global health promotion and the eradication of poverty-related diseases, not only within the United Nations framework but also via G8. In this context, BMZ works closely with other federal government departments, especially the German Federal Ministry of Health and the Federal Ministry of Education and Research. German development policy will continue to support these processes and make its contribution to ensuring that the right to the highest attainable standard of health enshrined in the Universal Declaration of Human Rights is guaranteed to the maximum possible extent.

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