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21 September 2001

Multilateral Development in the Health sector: where does the European Commission Stand?

Abstract: In the past decade, the European Commission has considerably increased its financial commitments to health development aid. The debate, however, cannot be confined to amounts involved. This paper examines why the European Commission's voice maintains limited influence in international debates despite its financial potential.

The paper uses the example of the Commission's Asian portfolio. It provides evidence of two major trends in the Commission's behaviour: a "follower strategy" in which the choice of interventions is guided by the international agenda, and an "innovator strategy" in which the Commission is able to propose different methodologies or approaches. Both strategies can be combined or can complement each other but the author's view is that the Commission tends to behave in a reactive way in relation to its management and institutional constraints, rather than in a prospective way. While there are advantages and drawbacks of each option, the Commission could develop a stronger donor identity by ensuring that the determinants of its choices are rooted in its own values, vision and experience.

The 1980s and 1990s saw a global shift in the international development policy agenda from economic development and food aid towards the social sector. Interventions in health have increased considerably, reflecting the recognition that health is fundamental to human development and represents an important political and economic tool for donors and recipients.[1-2] Although World Bank loans are thought to be the primary source of investment in health, the European countries, through both bilateral aid and the European Commission, in fact, constitute the largest grant contributors. The Commission alone is a major source of funding. Though its investment in health started late in comparison to other donors (i.e., at the end of the 80s), in the past decade its commitments have dramatically increased [3-4], reaching an annual average of 500 million Euro between 1995 and 2000 [5].

Apart from its role as a source of funds, how the Commission positions itself in the international scene remains unclear. In an attempt to identify the Commission's role, this paper explores the institutional context of the European Community (EC) and reviews some Commission programs, particularly those in Asia. These reviews highlight the Commission's two major patterns of involvement with international health development: the follower and the innovator strategies and point to factors limiting the Commission's work. They suggest that the Commission's influence in health development remains disproportionate to its financial capacities, in large part, because the context in which the Commission operates prevents the definition of a clear identity in the health debate. An identity can be built from a mandate, a thematic priority, a pattern of negotiation with recipients or specific capacities. The Commission has a little of each of these different dimensions but its assets are insufficiently promoted.

1. Institutional context

The European Union is governed by three institutions. The European Council and the European Parliament share the legislative and budgetary processes. The Commission constitutes the executive body and is answerable to both the European Council and the European Parliament. The Council, representing the Member States, and the Parliament, representing the citizens, constitute two driving forces of different political natures and, in development aid their agendas do not always coincide. The diverse influence of the two governing institutions has translated into an unequal balance between mandates and resources.

On the one hand, the European Parliament, sensitive to public opinion, gives much attention to social issues appealing to its electorate. It has significant power in the legislative and budgetary process to create or supplement aid instruments and sees this prerogative as an important tool for imprinting its vision on development. In health particularly, the Parliament has been very active in expanding budget opportunities and widening the Commission's responsibilities. While the Parliament has enlarged the scope of development aid, its power to increase the Commission's own operational resources is limited.

On the other hand, the Council, representing Member States' concerns, tends to contain the Commission's role. Politically, this reflects the fact that the Commission's development aid co-exists with Member States own programmes and with those of other multilateral organisations to which the European countries also belong. Member States consider it important to retain some control over the Commission's activities, to orchestrate its contribution to the international agenda and ensure that their interests are not ignored. Financially, they are eager to maintain the Commission's operational costs at the lowest possible level and avoid the development of an independent bureaucratic culture.

The institutional context has led to two main problems which limit the effectiveness of the Commission. First, multiple budget instruments fragment efforts and make co-ordination difficult. For health alone, aid can be delivered through twenty or so different budget lines: either country allocations or thematic instruments such as HIV/AIDS, population, refugees, rehabilitation, emergency aid and NGOs co-financing. Created over the years on a case-by-case basis, often upon Parliamentary initiatives, these budget lines have resulted in a multiplicity of parallel administrative rules and financial procedures, increasing the Commission's management burden.

Second, the operational budget is inadequate, in part because the budget for development aid and the Commission's operational budget come under different authorities and decision mechanisms. The increase in the aid budget has not been matched by adequate growth in operational resources. This is most notable with regard to human resources. In the past decade, only five medical or public health experts were available at headquarters to cover world-wide activities. Staffing is a common problem to many organisations that seek to do more with fewer resources in order to comply

with cost-efficiency models. For example, the World Bank has increased health loans by 272% since the 1980s but its human resources have grown by only 86%[6]. The lack of human resources limits planning, implementation and delivery and presents a particularly ambiguous message about European commitment to health for developing countries.

In the end, the Commission's health development aid operates in an environment characterised by the paradox of abundant financial resources, multiple budget instruments and scarce human resources. This ambiguity affects overall performance and causes concerns among many development actors. The UK Department for International Development stresses the EC's "lack of a coherent overall approach to the management of external assistance […] inappropriate skill mix and shortage of development expertise"[7]. The overall discrepancy between mandates and institutional capacities leaves the Commission "not sufficiently resourced to manage efficiently and effectively all the development co-operation programmes it is currently undertaking"[8]. Frequently the press condemns the cumbersome and slow process of aid or cites examples of political promises that did not materialise (Hurricane Mitch relief programme in Central America) and of incoherent investments (a Gaza hospital remaining empty because nor personnel or equipment provided. [9]-[10]

The ground for criticism may well lie in the gap between policy ambitions and implementation capacities. The constraints on the Commission are prone to affect its vision of development and hinder its capacity to play a complementary or distinctive role in the policy and strategic debate in relation to other donors.

2. The Commission's Role in Policy

In its 1998 review of Commission Development Aid, the Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development (OECD), stressed the overall splintered policy framework and lack of a coherent Commission-wide strategy[11]. A review of the major health policy papers issued by the Commission in the 90s (i.e., on Health,[12] Population,[13] and HIV/AIDS [14]) shows that, in comparison with World Bank or WHO frameworks, they reflect only broad principles with no major distinctive features. In terms of policy, the Commission has followed international thinking, endorsing each and every trend from primary health care to cost-

recovery and sector-wide approaches, from health sector reform to poverty reduction strategy programmes.

At the Commission level, the international agenda ought to have provided a common framework for addressing health issues. The translation of international trends into consistent operational strategies has, however, been less predictable than one could expect from a common agreement on objectives and methods. The delivery of external assistance is split between four directorates and practical strategic choices have often taken contradictory pathways. For instance, a disease-focused approach could be developed in Asia but rejected in Africa. Some directorates favoured channelling funds through the UN, while others were opposed to it. Sometimes funds have been pooled with large multilateral programmes but in others cases priority was given to targeted actions. The relentless effort to reconcile financial power and management capacities came at the expense of the Commission's policy and strategy development.[15] These circumstances create a situation in which choices are prone to be the result of individual convictions and circumstances rather than internal debate and co-ordination. As a result, priorities have been geared to the constraints of financial instruments rather than to beneficiary needs. The management process took over the coherence of policies and establishing the framework and management procedure of a budget line overcame its justification.

Given its management constraints, the Commission saw the logic of establishing consensus with other major donors but this also caused it problems. The evolution of EC's HIV/AIDS policy and strategy provides a practical example of its struggle to keep pace with international concerns in a context of heavy management constraints is. A special HIV/AIDS budget line, managed by an external AIDS Task Force, was created by the Parliament in the early 90s to address the issue. As envisioned, the HIV/AIDS special budget would serve as a trigger for larger investments from geographical budget instruments. But this never materialised. Instead, the AIDS Task Force functioned in isolation from the main Commission aid flows and had little leverage to integrate approaches. Recipient countries were reluctant to divert large amounts of European funding to the sector and, within the Commission itself, country officers were not sensitised to the issue and would not make interventions in the sector a priority or a pre-condition for other investments. Because of these problems, the management of the AIDS budget line was subsequently reintegrated in the Commission. Even in the first

approach, a thin budget was spread over multiple countries and projects; with reintegration, the human resources of the Task Force were lost, further limiting the capacity for analysis and design of interventions. The rule became to design few and large projects to lighten the management burden. This, however, allowed limited flexibility to adjust to a rapidly changing scientific environment and to country needs. For example, in the field of drug availability, the Commission's position reflected the lowest common denominator of consensus among actors and its principles have been partially outdated by the rapidly evolving international agenda. As a consequence of the problems outlined, the Commission's impact on HIV/AIDS during the 90s has remained marginal[16]. With few success stories to celebrate, the 1998 policy paper on Increased Solidarity to Confront HIV/AIDS [17] and the 2000 paper on Accelerated Action for Communicable Diseases [18] remained broad political exercises and did not provide a practical framework for operational strategies or ensure adequate means for implementation. Despite its financial capacities, the Commission has been unable to respond to the HIV/AIDS epidemic with important investments and rapid intervention matching affected countries' demands.

In its policy decisions, the Commission tends to act more in a reactive way shaped by its institutional constraints rather than in a prospective way. But few donors indeed can claim to provide distinctive inputs. For all donors policy design results from a combination of political factors and economic considerations that build into a momentum without clear evidence of who sets the agenda or who plays the more decisive role at a given point. Of greater concern in the case of the Commission is that endorsing international trends has not resulted in a consistent strategy framework nor has it led to choices enhancing a particular "savoir faire". As a consequence, the way the Commission behaves tends to reflect an unruly melange of the innovator and follower strategies, a mix of multiple priorities that do not contribute to a clearly defined role.

3. Patterns of Decision-making

The Asia portfolio illustrates the diversity of interventions the Commission may support in the health sector. In the past decade, investments in Asia have totalled approximately 500 million Euro (table 1). None of them have been initiated in isolation from other donors. As with any major multilateral agency, the trigger for intervention is often a

conducive political environment that attracts many donors at a given time. For its Asia portfolio in the 90s, the Commission seldom took the innovative path. Most of the programmes were designed in the larger framework of multi-donors' efforts although various modalities and degrees of interaction can be identified:

- The financial mode in which the Commission pools funds with other donors or responds to an international pledge. The 1998 Pakistan and 1999 Bangladesh health reform programmes were both developed within a donor consortium under World Bank strategic leadership. In Indonesia, the Commission was one of the donors that reacted in concert to the financial crisis threatening the availability of contraceptive supplies. In both types of programmes the Commission joined a global effort and its role in shaping the programme was limited.

- The financial-strategic mix in which programmes are elaborated within a global donor consortium plan. The Commission chooses components that best fit its instruments or overall policy, which emphasises rural development and primary health care with the involvement of civil society [19-20]. The 1991 Bangladesh and 1995 Philippines programmes reflect these priorities. In both cases a strong participatory approach was promoted in which community-based interventions could feed into the consortium policy design. This mode of collaboration offers a broader opportunity for the Commission to provide inputs in the overall programme.

- The common policy mode in which programmes are initiated by the Commission within a platform of common understanding among donors. Elaborated in the 90s, in line with international trends, these programmes were geared towards health systems development and health sector reform. Programmes in Vietnam and India were designed in consultation with other donors but implemented independently on the basis of parallel funding. The Commission role in such efforts is seen as complementary to those of other donors.

As shown above, some original approaches can be found in the follower pattern, but only two programmes in Asia can be considered truly innovative in their decision-making pattern and methodology. These are the 1995 Malaria Control Programme (Cambodia, Laos and Vietnam) and the 1996 Asia Initiative for Reproductive Health. In both cases, the Commission proposed strategies distinct from other donors, which combined regional integration in planning and extended diversified partnerships. In both

cases, the Member States' Committee, which must approve all programs, did so with reticence and granted the authorisation to move forward only after some guarantee that positive returns could be expected for their own bilateral aid.

4. The Programme Actor

The question remains whether, in programme experience, the choice of either the follower or innovator strategy has contributed to the definition of the Commission's role and place or enriched the knowledge and experience of the international community. The following analysis examines four programmes displaying follower and innovator features (table 2). It looks at the extent to which they have contributed to shaping the international agenda or provided new tools in addressing health issues; it explains their strengths and weaknesses and the consequences for defining the Commission's place in the sector.

1. In the 1991 Bangladesh programme, the EC component called "The Functional Improvement Programme" was an original system of specialised teams of local experts. The teams toured all districts involved to mobilise people and health care providers in order to find local solutions for improving service delivery and management. It represented a form of decentralisation carried out from the bottom up in order to ensure that the change in responsibilities was endorsed at the lower levels of the system. Throughout its implementation, the project was praised by the donor consortium as a genuine form of local empowerment, promoting practical solutions tailored to the local context. To some extent, the experience fed into the next consortium intervention "Health and Population Sector Programme" committed in 1999. The impact on the consortium agenda was, however, less than expected. Because of complicated internal procedures and cumbersome rules for tendering, the Commission missed the opportunity to carry out a thorough evaluation of the impact and the lessons learned. In the end, the experience was lost both as a pilot model of intervention and as a source of operational expertise, which could feed into the Commission's institutional memory and into the experience of the whole consortium.

2. The India Family Welfare Sector Support, which addressed the issue of fund allocation for the health sector, is an instance of the Commission exercising a valuable role among other donors. As an important financial actor and as the

representative of Member States, the Commission could negotiate issues related to sector financing that Member States could not address on their own. Traditionally the India Ministry of Health presented its annual global budget under a single financial envelope including both domestic and external aid budgets. With no clear separation between resources from each source, external aid budgets appeared to cover domestic expenses. In practice, most of the aid budget was earmarked and the domestic budget remained under-funded and. Subsequently, the states did not receive the federal budgetary provision for recurrent expenses such as personnel and supplies. The situation resulted in poor implementation of domestic programmes and low disbursement of the international aid programmes that relied on these basic domestic investments. The programme main achievement was a major modification of the sector funding approved by the Indian Parliament. The result included a regular annual increase in the federal budget and a clear separation of accounting for external aid to ensure a more transparent assessment of the complementarity of domestic and international funds. Whether such a move can be sustained in an unstable political context remains uncertain, but the programme is presently running smoothly and represents an example of an added value of the Commission in its capacity to negotiate conditions that could benefit Member States and other donors' programmes.

3. For the Malaria Control Programme in Cambodia, Laos and Vietnam, the originality of the design resided in the regional approach. The programme gathered similarly affected countries, with the aim of sharing technical and scientific experience and implementing a single strategy to fight the common transmission pattern, particularly in the border areas of the three countries. The programme achieved its goal of creating constant dialogue between the three countries and their neighbours, including governments, universities and other institutions. It enhanced the regional capacities for malaria control and dissemination of local experiences and it supported each of the countries in the implementation of its national plan. The programme, however, faced considerable problems. The standard Commission procedures were unable to secure the human resources required for such a complex programme. Permanent personnel were too few, short-term expertise irregular, and monitoring and evaluation scarce. In this context, co-ordination with other programmes in the region was poorly implemented, in part because the

Commission's funds were seen as a threat to existing activities. Implementation has remained uneven and the approach too experimental to reach a measurable impact. One of the dangers of insufficient implementation capacities resides in the impossibility to validate a method and disregard the approach rather than improving its feasibility.

4. The Asia Initiative for Reproductive Health is the best example of an innovative approach that has yielded significant impact both in providing country results and in testing a new model for intervention. While endorsing the Cairo Programme of Action, the Commission like other donors faced the difficulty of programme design in the context of complex inter-related issues (health, gender, education, culture, human rights). Intervention design was complicated by the need to avoid being too specific and failing to meet the Cairo agenda, or too broad to show significant impact. The Commission decided to focus on a single theme: sexual and reproductive health (SRH). It proposed an original model of partnership based on a regional approach for coherence, an operational partnership with UNFPA to build from the extensive resources of country offices, and an extensive network of NGO and non-profit institutions to ensure multi-sector dimensions. The programme also proposed a model for decision-making based on a three-dimensional analysis of a country situation (Figure 1).

   The first dimension included the major components of SRH, reflecting potential needs. The second dimension included the type of activities that could be used, listing the available tools. The third dimension included a stratification of the population, reflecting possible targets. For each country, choice of interventions could be based upon different combinations of components, activities and targets in order to ensure a mix that would fit the local context. Implementation was carried out by different partners (NGOs, non-profit institutions, local civil and government actors) who retained their specific identity and skills and agreed to work in synergy for the common objective and with common indicators for evaluation.

   The mid-term review carried out in 2001[21] revealed some problems, such as the difficulty harmonising both UNFPA and Commission administrative procedures. It also showed that the stratification of the population in targeted groups did not always coincide with local perception of vulnerable groups. In addition geographic

coverage proved uneven and the gender and education dimensions were not fully integrated. Despite these weaknesses, all partners consider the Asia Initiative a successful partnership. Although not perfect, the model demonstrates that country-based consensual decision-making is possible. It also shows that a regional approach and diversified partnerships increase awareness of reproductive health issues and disseminate experience across countries.

The above review shows that successes and failures can be encountered in both the follower and the innovator strategies. It also implies, however, that the quality of the outcomes might be related more to the difficulties the Commission encounters in sustaining its efforts than to the design of the programmes. Institutions are usually poor at learning from themselves and learning from the others.[22] The Commission's weaknesses lie in its own complexities which prevent the institution from capitalising on its own experience to justify its strategic choices.

5. The Choice of a Strategy and Its Impact

In the overall context of limited technical and management capacities, the follower strategy has prevailed in the 90s. There are limited indications that the Commission's choice of the follower strategy was grounded in the respective weight of advantages and drawbacks in programme design and implementation (Table 3). The Commission's choices are seldom based on extensive sector reviews. In Asia, apart from the India programme, the Commission's operational budget did not allow for the country analysis or feasibility studies that other multilateral agencies usually provide to ground their interventions in facts.

Essentially, the rationale for the follower strategy was based on the convenience to join multi-donors' programmes when limited technical and financial resources are available for programme preparation. In-country European Delegations seldom had technical health capacities and the decision-making needed to rely upon other donors' experience and occasional short-term expertise, which was further limited by strenuous rules for consultant hiring. As a result the design of an intervention was carried out over time by different teams, without much coherence and continuity in the analysis and recommendations.

As a follower, the decision-process did not require extensive internal technical (if not political) debates on the relevance of the actions. This minimised the risks of errors that

could be ascribed to the institution. Co-operation in the international agenda became, by itself, a justification for intervention. Finally, channelling Commission funds through other institutions or pooling money together with other donors felt less threatening to other players in the international scene.

The limited operational capacities also prevented the Commission from participating on equal terms in sector reviews, common monitoring and even donors' co-ordination groups. At the end of the day, the Commission has to bear the constraints of the follower role without taking much advantage of the opportunities. Its role is confined to an "associate financier" with limited contribution to the debate. Its heavy and cumbersome financial procedures further weaken the institution and place it in the uncomfortable position of the unreliable partner lagging behind.

Innovation per se might not be an ultimate goal but it represents an essential dynamic for meaningful contributions into the health development agenda. The major limitations of the innovator role include the uncertain outcome and the risks of fragmentation. But innovation can create new synergies and experiences enriching the international debate. Innovative approaches, often of small scale, can provide flexible processes in evolving situations and validate alternative solutions, favouring local initiatives or adjusting global policies to local context. As shown in the Asian experience, innovative approaches have isolated the Commission rather than helped it to capitalise on the experience or contribute to a better definition of its role. The constraints of innovation have outweighed the opportunities (table 4). Innovation costs are high, in human and technical investments and the Commission has seldom been in a position to sustain such a role. Successful innovation implies appropriate follow-up of the lessons learned to reinforce the institutional culture of development.

6. Future Steps: Using Its Advantages

While responsible for many of the limitations encountered in the delivery of aid, the institutional context in which the Commission operates also has its assets offering unique opportunities to use innovative pathways on the grounds of its institutional difference that could help to reinforce its identity.

First, the Commission is in a privileged position to play the crucial role of consolidating the aid experience of its fifteen Member States. It can serve as the common denominator, integrating the variety of lessons learned into strategic guidelines and

bringing together diversified European partnerships. The example of the Asia Initiative programme, implementation of which is based on a network of European expertise, proves that the Commission can develop added value out of the process. The Commission could also expand or duplicate bilateral success stories, finance additional research if needed, or support the dissemination of experience.

Further, the wide scope of the Commission's mandate in implementing the European Union Treaties, from agriculture to social agenda, trade and common external relations policy, provides a unique opportunity for a comprehensive approach to aid issues. The Commission can consider, for instance, the question of drug availability in poor countries in both development and trade perspectives. More broadly, the European Union has taken strong positions on social and human issues within Europe that could inspire its development aid policies. For instance, the values developed in the Charter of Social Rights [23]could underlie its development health policies. The Commission is represented in international conferences in its multiple capacities giving the institution a distinctive role to play among development agencies and an added weight to shape aid strategies according to European values.

Lastly, the fact that the Commission is accountable to both the European Council and European Parliament gives the institution more legitimacy than any other development agency. While the World Bank system gives pre-eminence in policy design to the largest contributors [24] and the mechanisms by which members contribute to the WHO also tends to favour the influence of major industrialised countries,[25] the Commission offers greater political accountability. The fact that both the Council and the Parliament share the legislative and budget power and the fact that both the Council and the Parliament control the Commission's activities guarantee a more democratic process than in any other institutional donor. It allows public opinion perspectives, which tend globally to enhance the humanitarian values of aid, to be reflected in the development agenda and thereby balancing the political and economic constraints governments have to face in negotiating in an international context.

Conclusion

In the 90s, the Commission's follower or innovator choices have remained largely dictated by the institutional context in which the Commission operates rather than by a development vision. The managerial aspects are being addressed within the on-going reform of external aid, which aims to increase resources, rationalise the procedures, concentrate the expertise and devolve responsibilities and resources at the country level [26]. While improving the Commission's organisation is essential for its credibility in the short-term, it may not change the perception of its role and place unless the Commission invests in a development vision.

Being a follower is well justified when proposed approaches are considered appropriate; institutional constraints are a poor reason to engage in this role. The overall impact of European development aid politics would be weakened if the Commission were to accept being a financier denied the capacity to invest in independent analysis and thinking. Innovation is also poorly justified when grounded in hypothetical analysis and insufficient investment in knowledge and expertise. Innovation rooted in a problem-solving approach, building on institutional assets, and investing in research and human resources offers a potential for a European voice in development to make a meaningful contribution to international debates.

Follower and innovator strategies are not mutually exclusive and the ultimate issue is not whether the Commission performs better in one or the other, but in which values the Commission's development aid is rooted. It might, however, prove difficult for the Commission to defend a European identity unless a clear message is forwarded from the Council and the Parliament emphasising that solidarity towards the developing world is embedded in the Treaties and is crucial to European values.

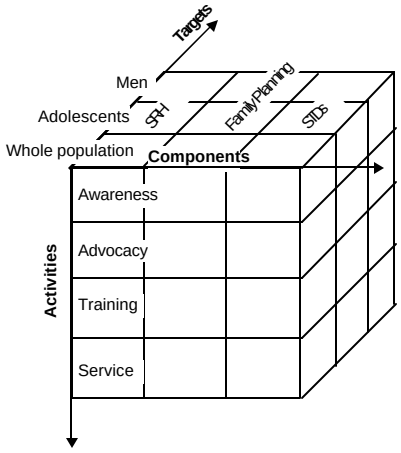
Table 1 : ***Asia Portfolio under bilateral agreements***			
Year	**Country**	**Amount**	**Main Features**
1991	Bangladesh	40 mEuro	Primary Health Care, Contraceptives
1995	Philippines	17 mEuro	Women's Health and Safe Motherhood
1995	Cambodia. Laos, Vietnam	29 mEuro	Regional Malaria Control
1996	India	200 mEuro	Health and Family Welfare Sector Support
1997	Asia Initiative	30 mEuro	Reproductive Health
1998	Vietnam	25 mEuro	Health Systems Development
1998	Pakistan	41 mEuro	Social Action Programme-Health
1999	Indonesia	10 mEuro	Social Safety Net, Contraceptive supplies
1999	Bangladesh	70 mEuro	Health and Population Sector Programme
	TOTAL	462 mEuro	

Table 2: ***Original or innovative approaches in the Asia Portfolio***				
Project	**Origin**	**Funds**	**Main Features**	**Co-ordination**
Within a follower strategy				
Bangladesh	WB	Co-finance	Only horizontal component addressing quality of care and local management at district level.	Consortium
India	EC	EC	A state-federal mechanism addressing under-funding, including planning and decentralisation of managerial and financial flows	Member States
Within an innovator strategy				
Malaria Control	EC	EC	Regional approach to address the main factors of transmission (border malaria)	WHO
Asia Initiative	EC	EC	Regional. Consensus at country level for priority definition Pooling the diverse expertise of NGOs while retaining common goals and indicators.	Member States

Table 3: The Follower Strategy		
	Opportunities	**Constraints**
Policy definition	Policy/strategy platform of understanding among recipient and donors	Uniformity of thinking. Global and not tailored approach. Donor driven
Co-ordination	Common priorities. Management facilities	Procedures and requirements for implementation different
Implementation	Uniformity of interventions. Simplified evaluation process.	Top-down approach. Conflicting agenda. Difficult ownership
Financing	Rationalisation of instruments for recipient tasks repartition	Little empowerment and ownership for the recipient.
Efficiency	Economy of scale	Adjustment to local context limited
Effectiveness	Common objectives and added resources can better achieve what is expected	One model of implementation. Difficult adjustment to what is intended according to context
Efficacy	Higher impact of beneficial results	Slow disbursements linked to the scale of interventions.
Benefit for donor	Contributing to the debate	Influence linked to scope of funding

Table 4: The Innovative Strategy		
	Opportunities	**Constraints**
Policy definition	Alternative Policy/strategy, tailored to country/objective	Dispersion, multiplication of priorities
Co-ordination	Synergy of experiences. Broaden the debate	Risk of loss of coherence and consistency. Competition
Implementation	Selection of areas of added value	Complex management
Financing	Synergy and complementarity	Additional burden for recipient
Efficiency	Experience driven	Risk of fragmented activities. High costs of piloting
Effectiveness	Small scale and better focus on what is intended	Often experimental, not always replicable
Efficacy	Problem solving models. Knowledge and research driven	Time needed for validating the process
Benefit for donor	Influencing the debate	Isolation in the debate

Figure 1


Targets
Men
Adolescents
Whole population
SRH
Family Planning
STDs
Components
Activities
Awareness
Advocacy
Training
Service

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