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REPORT

on the Commission communication on Health and Poverty Reduction in Developing Countries
(COM(2002) 129 – C5-0334/2002 – 2002/2178(COS))

Committee on Development and Cooperation

Rapporteur: John Bowis

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PROCEDURAL PAGE

By letter of 22 March 2002, the Commission forwarded to Parliament a communication on Health and Poverty Reduction in Developing Countries (COM(2002) 129 – 2002/2178(COS)).

At the sitting of 2 September 2002 the President of Parliament announced that he had referred the communication to the Committee on Development and Cooperation as the committee responsible and the Committee on Women's Rights and Equal Opportunities for its opinion (C5-0334/2002).

The Committee on Development and Cooperation had appointed John Bowis rapporteur at its meeting of 20 June 2002.

It considered the Commission communication and the draft report at its meetings of 12 November 2002, 23 April and 11 June 2003.

At the latter it adopted the motion for a resolution unanimously.

The following were present for the vote:Joaquim Miranda chairman; Margrietus J. van den Berg , vice-chairman; John Bowis, rapporteur; Jean-Pierre Bebear, Yasmine Boudjenah, John Alexander Corrie, Michael Gahler (for Luigi Cesaro), Vitaliano Gemelli, Richard Howitt (for Linda McAvan), Karin Junker, Karsten Knolle, Nelly Maes (for Paul A.A.J.G. Lannoye), Miguel Angel Martínez Martínez, Hans Modrow, Didier Rod, Ulla Margrethe Sandbæk, Francisca Sauquillo Pérez del Arco, Agnes Schierhuber (for Nirj Deva) and Maj Britt Theorin.

The opinion of the Committee on Women's Rights and Equal Opportunities is attached.

The report was tabled on 13 June 2003.

MOTION FOR A RESOLUTION

European Parliament resolution on the Commission communication on Health and Poverty Reduction in Developing Countries (COM(2002) 129 – C5-0334/2002 – 2002/2178(COS))

The European Parliament,

– having regard to the Commission communication (COM(2002) 129 – C5-0334/2002[1]),

- having regard to Article 152 and Articles 177 to 181 of the Consolidated Treaty establishing the European Community,

- having regard to the ACP-EU Partnership Agreement signed in Cotonou (23 June 2000),

- having regard to the Policy Statement on the EC Development Cooperation (April 2000),

- having regard to its resolution of 1 March 2001 on the European Community's Development Policy[2],

- having regard to its resolution of 15 March 2001 on access to drugs for HIV/AIDS victims in the Third World[3],

- having regard to its resolution of 4 October 2001 on accelerated action targeted at major communicable diseases within the context of poverty reduction[4],

- having regard to the resolution adopted by the ACP-EU Joint Parliamentary Assembly on 21 March 2002 (Cape Town) on health issues, young people, the elderly and people living with disabilities[5],

- having regard to its resolution of 30 January 2003 on the proposal for a regulation on aid for poverty diseases (HIV/AIDS, malaria and tuberculosis) in developing countries[6],

- having regard to the Rome Declaration on Hunger adopted by the World Food Day Colloquium (October 1982),

- having regard to the United Nations Convention on the Rights of the Child,

- having regard to the Rio Declaration on Environment and Development adopted by the United Nations Conference on Environment and Development (14 June 1992),

- having regard to the Protocol on Water and Health to the 1992 UNECE Convention on the

[1] Not yet published in OJ.
[2] OJ C 277, 1.10.2001, p. 130.
[3] OJ C 343, 5.12.2001, p. 211.
[4] OJ C 87, 11.4.2002, p. 159
[5] OJ C 231, 27.9.2002, p. 55.
[6] P5_TA-PROV(2003)0031 .

Protection and Use of Transboundary Watercourses and International Lakes (Water Convention),

- having regard to the Millennium Development Goals (MDG) adopted at the Millennium Summit of the United Nations (6-8 September 2000),

- having regard to the Monterrey Consensus of the UN Financing for Development Conference (22 March 2002),

- having regard to the Johannesburg Declaration on Sustainable Development adopted by the United Nations World Summit on Sustainable Development (4 September 2002),

- having regard to the resolution of the Council and Representatives of the Governments of the Member States on Health and Poverty of 3 May 2002,

- having regard to Rule 47(1) of its Rules of Procedure,

- having regard to the report of the Committee on Development and Cooperation and the opinion of the Committee on Women's Rights and Equal Opportunities (A5-0217/2003),

A. whereas health is a basic human right recognised in Article 25(1) of the Universal Declaration of Human Rights,

B. whereas there can be no sustainable economic and social development without good health; and in developing countries, disease, disorder and disability continue to limit individual and collective human development,

C. whereas health and the need to improve health outcomes for the poor feature prominently in the Millennium Development Goals (MDG),

D. whereas the achievement of the ICPD Programme of Action is vital in realising the MDGs,

E. whereas the European Community (EC) is committed to greater support for improved health under the new ACP-EU Partnership Agreement and in its Policy Statement on Development Policy,

F. whereas the resolution on the general budget for 2003 emphasised the need to increase EU interventions in basic health, building on the agreement to ensure a minimum 35% allocation to social spending,

Health and poverty

1. Welcomes the Commission's Communication setting out a framework policy for health aid in developing countries;

2. Believes that the focus on reducing poverty is correct, but that the focus on three diseases is too limited and that there is a need to extend attention and support to other areas of healthcare such as action to combat diarrhoeal diseases, which in particular kill hundreds

of thousands of children, and also to the problems linked to areas such as mental and physical disorder;

3. Given that 3 million people die every year from water-borne diseases, calls on the Commission and Member States to raise their contributions towards meeting the MDG target 10 to halve by 2015 the proportion of people without sustainable access to safe drinking water;

4. Emphasises that there are a number of other debilitating diseases and calls on the Commission and Member States to make an impact in such areas as dysentery, cholera, river blindness, meningitis, epilepsy, diabetes, asthma, typhoid, hepatitis, polio, lymphatic filariasis, diphtheria, pertussis, measles, mumps, tetanus, haemophilus influenzae, pneumococcus, rotavirus and yellow fever;

5. Believes that the strategy for effective health investment is as important as the total spending available and notes the dramatic improvements that have taken place where national programmes on immunisation have focused on comprehensive local implementation, and believes that extensive vaccination campaigns against common popular diseases are therefore vital;

6. Underlines that better basic health and education can lead to better individual and family health, more effective use of health services and improved family planning and reduction in sexually transmitted diseases, which means that poverty reduction must be given pride of place among all development policy measures;

7. Stresses that the fight against poverty involves access to education, training and the new information technologies, as well as access to property and saving and credit mechanisms, and calls on the European Community to develop specific measures directed at women in these areas, particularly as part of its cooperation and development policy; calls on the Commission to take positive action against trade and trafficking in human organs;

8. Asks the Commission to foster the involvement of local populations, and in particular the involvement of women, in order to bring about substantial changes in the field of health, with a view to establishing fora that are open to everyone regardless of their race, religion or gender, thereby enabling an indigenous health system to be developed without imposing the model used in developed countries. Certain cultural traditions, or ones relating to religious beliefs, exclude women from access to sexual and reproductive health services;

9. Asks the Commission to support the initiatives aimed at reinforcing the role of primary health care, which is the only means of extending complete health to the very poor. There is also a need to ensure universal access to health care and to guarantee access to adequate sexual and reproductive health services and the access of local populations to medicines, and to support the strengthening of public health systems, the development of healthcare skills and the promotion of research;

10. Notes that HIV/AIDS affects exactly the population able to work, and calls for an improvement of the Global Fund to fight AIDS Tuberculosis and Malaria (GFATM);

11. Stresses that it is urgent to promote access to medicines for all and recognises that there is a need to encourage pharmaceutical producers to make available pharmaceutical products at afordable prices in increased volumes by ensuring that these products remain on these markets;

12. Believes that palliative care has received inadequate attention in areas where HIV/AIDS is rampant; and urges that, in its community non-hospice form, it should be enabled to play its low-cost part in caring for those with life-limiting diseases, such as HIV/AIDS, Tuberculosis and Cancer, and that treatment should also be authorised, under medical supervision, with painkillers,such as morphine, which are otherwise considered as narcotics and whose use is legally restricted;

13. Notes that mental disorders such as depression are accelerating significantly, but that mental health services in developing countries are often poor or non-existent; and that, for individuals, the burden of the disorder is often compounded by stigmatisation by their local society; and calls on the Commission and Member States to place greater emphasis on mental health;

14. Notes the inadequate access to services for and discrimination against many people living with disabilities and calls on the EC and Member States to help ensure good health and social care, including access to medical devices and rehabilitation services for people with disabilities, and to encourage education and training programmes that combat discrimination;

15. Notes the high rate of maternal and infant mortality; stresses the importance of universal access to reproductive health care services such as family planning, safe motherhood services, prevention, detection and treatment of sexually transmitted infections, including HIV/AIDS, and to infant health services including childhood vaccination; also notes the totally inadequate quality of sex education, particularly for young people, and that in particular it fails to convey to boys and young men a change in cultural attitudes which would lead them to dispense with behaviour detrimental to the health and dignity of women;

16. Draws the Commission's attention to the desirability of highlighting the importance of women as the main promoters of health and the consequent need to incorporate the gender perspective in health policies, statistics and studies on this subject; points out that, at present, 20% of the world population is of reproductive age and it is therefore crucial that information on sexual and reproductive health and sexual and reproductive health services should be available to help this section of the population protect themselves against unwanted pregnancy, clandestine abortion and sexually transmitted diseases, including HIV/AIDS;

17. Believes that *bona fide* traditional medicine and treatments can play a beneficial role in addressing health needs in developing countries when traditional healers and Western medicine practitioners work in cooperation;

18. Notes that more than one third of all pregnancies are unwanted or ill-timed, due to lack of access to contraceptives and contraceptive failure: notes that millions of unsafe abortions are administered every year, killing nearly 80 000 women and causing hundreds of

thousands of disabilities, which could, however, be prevented via reproductive health care programmes;

19. Notes the large number of households relying on biomass fuels for cooking and heating without proper ventilation, exposing people to high levels of indoor air pollution, and calls for support for a shift from biofuels in the long term and improved cooking stoves equipped with flues or hoods in the interim, and believes that measures to raise awareness of environmental protection are vital in order to curb the damaging use of wood and the deforestation this entails, and to encourage people to use solar power;

20. Notes the need to combat pollution, deforestation, desertification and industrial development given that they have a detrimental impact on health, especially through the impact on water supply and untreated waste and sewage;

Investing in health

21. Notes the Monterrey commitments fall short of the funds needed to meet the MDG of reducing world poverty, of which women and children are particular victims, by 50% by 2015; and that according to the Commission on Macroeconomics and Health an additional $31 billion of aid financing to the health sector is required;

22. Welcomes the African Governments' initiative (Abuja 2001) to commit 15% of national budgets to health; while noting that the governments of developing countries spend on average less than 15% of their national budgets on basic social services while many poor or heavily indebted countries spend over 20% of their annual budgets servicing debt;

23. Draws attention to the unspent €10 billion of the European Development Fund and calls on the Commission to ensure that it is spent on the purposes for which it was budgeted, including health support;

24. Believes there is a special need for investing in the health of displaced persons, refugees and victims of war and disaster to ensure they have access to proper care and that this does not become an impossible burden on the health services of the receiving country;

25. Stresses the need for more effective and increased global investment in the development of new products, particularly vaccines, vector control products and drugs, and stresses the need for global collective action, coordination and financing to produce and develop - in sufficient supply - specific global public goods, in particular, those commodities, resources and services related to eradicating deadly communicable diseases, the benefits of which accrue to all people across borders, and whose beneficiary effect by an individual does not detract from others' benefit;

26. Believes that there is a need for pharmaceutical companies to produce high quality compounds, for pharmacies to prescribe medicines responsibly and for individuals to adhere correctly to prescriptions; and for drugs and vaccines already in production to be made more accessible, notably by increasing international cooperation, and stresses the need for the EU to show responsibility and solidarity by giving strong support to existing initiatives such as the national multi-year immunisation plans funded and supervised by GAVI and the Vaccine Fund;

Improving effectiveness

27. Agrees with the Commission that there is a need for additional selective and targeted approaches to complement ongoing Community support to strengthen health systems to deliver services that benefit the poor;

28. Notes that donor driven projects can absorb scarce human and financial resources, can have limited coverage and set standards that cannot be sustained, and that heavy reliance on foreign technical assistance can hinder the development of local capacity;

29. Stresses the importance of expanding the range of expertise in the field; and of stemming the drain of skills, especially medical skills, from the developing world to the developed world;

30. Stresses the need for further coordination within the EU, between missions in the respective developing countries and between the EU and other donors, both globally and locally, and welcomes moves by the European Commission to strengthen cooperation with Member States and with NGOs, including WHO, UNAIDS, UNFPA, UNICEF, World Bank, GFATM, Global Alliance for Vaccines and Immunisation, STOP TB, Roll Back Malaria, and International AIDS Vaccine Initiative;

31. Highlights the positive role that civil society, including faith-based organisations, can play in public-private partnerships;

32. Emphasises the desirability of involving international and local NGOs and communities in the health sector, and in particular the provision of primary care and peripatetic services;

33. Calls on the Commission to ensure that health is not included within the scope of the General Agreement on Trade in Services (GATS) as a 'service' subject to free market sources and productivity criteria;

34. Points out to Commission that it would be appropriate to highlight the importance of women as primary health promoters and that a gender perspective therefore needs to be introduced into health policies, and the statistics and research relating to them and into education, environment, international trade, agriculture and immigration policies. 20% of the world's population are currently of child-bearing age, making it crucial for information to be provided on sexual and reproductive health and for sexual and reproductive health services to be available to enable this population group to guard against unwanted pregnancies and against sexually transmitted diseases such as HIV/AIDS;

35. Calls on the Commission to pursue an active policy to combat trade and trafficking in counterfeit, adulterated or out-of-date medicines and their transit through the territory of the European Union;

36. Asks the Commission to introduce the concept of food sovereignty[7] alongside that of food

[7] According to the World Forum on Food Sovereignty held in Havana in September 2001, this is the means to

security, with food sovereignty meaning the right of peoples to frame their own sustainable policies and strategies for the production, distribution and consumption of food;

Monitoring

37. Highlights the need for effective target setting and outcome measurements for individual projects and programmes;

38. Urges the use of specific indicators to assess the impact of EC assistance in terms of the various types of contribution;

39. Underlines the need to ensure that Country Strategy Papers (CSPs) reflect the basic principles of EC support for health in developing countries;

40. Considers that monitoring national budget allocations and health outcomes should be part of the Poverty Reduction Strategy Paper process;

41. Instructs its President to forward this resolution to the Council, the Commission, the World Health Organisation (WHO) and the ACP-EU Joint Parliamentary Assembly.

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eradicate hunger and malnutrition and guarantee lasting and sustainable food security for all of the peoples of the world.

EXPLANATORY STATEMENT

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

-- Benjamin Disraeli

European competence and experience

The European Union, collectively and through its individual Member States, has given itself a competence and a duty to provide support for the low-income countries of the developing world. Such support involves money, personnel, training and know-how. It sometimes means emergency humanitarian aid to respond to disasters, but most of the time it means development aid, to enable our partners in the developing world to overcome the obstacles to their achievement of the economic and social progress, that our Western world has come to expect, after centuries of uneven effort and momentum.

Over two centuries, we in Western Europe have been coping with disease, hunger, wars and population movement. Within living memory many of our citizens faced poverty and hardship. Where there were dramatic improvements, these were often consequent upon advances in medical science and social theory. Our pattern of progress has not been uniform and we continue to be in development mode, but we learn from each other and we have resources and experience, which may be helpful to others.

The lesson that health and wealth are interdependent is an old one and a current one. Even within our own countries, with the single exception of breast cancer, there is evidence of a disproportionate number of cases of disease, disorder and disability among people on low incomes. How much more is that the case when one compares rich and poor countries. Wealth means, on average, better health; poverty, on average, means ill health; and ill health means poverty for nations, families and individuals.

The challenges

In developing countries, 28,000 children under five die every day from diseases easily preventable by currently available medicines. Diarrhoreal diseases kill over 1.5 million children a year. African women face a 1 in 13 risk of dying during pregnancy and childbirth. By 2020 non-communicable diseases (cardiovascular, cancer, respiratory, diabetes) will account for 80% of the global burden of disease, with mental health disorders the fastest growing. 1.1 billion people are without access to clean water and 2.4 billion lack hygienic sanitation. 3 million die every year of water-borne diseases (typhoid, dysentery, cholera, hepatitis, malaria, trachoma, fluorosis and Japanese encephalitis). Tuberculosis kills 2 million a year and is estimated to cost poor countries over $12 billion a year (WHO). 1 million die of malaria and 300 million suffer from acute malarial illnesses. If malaria in Africa had been tackled 30 years ago, when effective control measure became available, Africa would, it is estimated, have been $100 billion better off (WHO). The impact of HIV/AIDS is well documented; in Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe one in five adults live with it; and seven million agricultural workers across 25 African countries have died since 1985. Ninety-five per cent of the five million new cases every year are in

low-income countries in the South. There are 25 million people living with AIDS in Africa and 6 million in the new growth area in South, Southeast and Central Asia in particular.

HIV/AIDS

Where AIDS is concerned, we face a vicious cycle of infection, incapacity and poverty, alongside the 16 million deaths. We see two million deaths a year in Africa: a quarter of all Africa's deaths. Ten per cent of people between fifteen and fifty years of age are living with AIDS. There are 10 million AIDS orphans. The people, who expected to be looked after by their families in their old age, are now unable to have that care and support, because their children are dead. The elderly are going back to work to scrape a living to provide for their orphaned grandchildren. That is the scene confronting us.

When *The Economist* went to Zambia, it saw two-thirds of the patients in one hospital dying of AIDS. People's limbs, they reported, looked like broken broomsticks. They were desperate, not for retroviral drugs but food. They were too poor to afford either. Poverty hastens death; and death accelerates the survivors' descent into poverty. Zambia's Department of Health estimates half the population will die of AIDS. In some countries teachers are recruited for training at a rate 25% above need, because that will be the wastage through AIDS during training.

Range of diseases

A child in a developing country is ten times more likely to die of a vaccine-preventable disease than a child in Europe.

Lifestyles contribute to ill health. Indoor air pollution, caused by burning unprocessed solid fuels, particularly biomass (crop residues, wood and dung), in people's homes, can cause acute respiratory infections, tuberculosis, chronic obstructive pulmonary disease, and lung cancer as well as asthma, cataract and blindness, anaemia and adverse pregnancy outcomes.

40 million people in developing countries live with epilepsy and 32 million receive no treatment, when for tiny amounts of money and medication some 80% could lead seizure-free lives. Without them they are excluded from economic and social activity.

Mental health disorders are rampant in developing countries, as in Europe. Often they march with, and at the same pace as, diseases such as HIV/AIDS. Mental disorders need more medical and social supervision than most physical disorders and yet doctors, hospitals, clinics and community services are rare or non-existent in many developing countries. Medication and therapies are scarce while stigma adds to the suffering of the disorder. One in four of the population in all parts of the world lives with mental, behavioural and neurological disorders or mental retardation. Most are treatable; many are preventable or curable; all are manageable. One of the tragedies of the developing world is the low priority given to this fundamental area of human health and its impact on and from poverty.

These are the stark and challenging facts about ill health and its link to and from poverty. Without health there can be no wealth. That is the global challenge, which the European Union is rightly determined to play its part in meeting.

Achievability

The good news is that it need not cost enormous sums to make a difference and that, very often, improved delivery of healthcare can lead to substantial improvements in quality of life. Small sums of money can prevent needless deaths from treatable health problems. Infant deaths from diarrhoea could be significantly reduced - the cost of 125 doses of oral rehydration salts is €7. For €4 Oxfam provides specially designed lidded water containers that keep water safe and clean, reducing the risk of exposure to disease.

Changes in the application of resources are equally important. For example, the National Programme on Immunisation shows a continuing and dramatic decline in the incidence of fatal childhood diseases in Nigeria, including tetanus, poliomyelitis, diptheria, measles, tuberculosis, yellow fever, and cerebrospinal meningitis, which have been responsible for high infant mortality in the country. The key to the decline was a change in public perception about routine immunisation. The programme adopted a house to house strategy, in which each immunisation team was permanently stationed in a community for the duration of the immunisation exercise. In earlier exercises the vaccination teams had been continually on the move.

The Communication

Broadly the Commission's Communication is to be very much welcomed. It rightly links policy to the Millennium Development Goals (MDGs). MDG 4, 5 and 6 are, however, seen as the "health goals", while the importance of Goal 8 of MDG is often forgotten. Goal 8 includes Indicator 33, to measure the proportion of Official Development Assistance (ODA) allocated to basic social services, including primary health care, nutrition, safe water and sanitation. It also includes Target 17 and Indicator 46 which are concerned with cooperation with pharmaceutical companies to provide access to essential drugs in developing countries and Target 10 which relates to access to safe drinking water.

The main reservation, on an otherwise very welcome Communication, is the limited scope of the proposal. HIV/AIDS, TB and Malaria are among the most important health challenges. It is right to give them special attention, but they are by no means the only health threats. The Communication largely ignores non-communicable and other diseases. Many people in many developing countries are vulnerable to asthma, upper respiratory infections and neuropsychiatric disorders. South Africa has 2 million diabetes mellatus cases. Nor does the Communication mention other diseases, such as chages, soil-transmitted helminths, schistosomiasis, lymphatic filariasis, guinea worm / dracuncoliasis, trypanosomiasis and dengue. Many of these have low levels of mortality but high levels of morbidity and disability. As has been said, the great extermination campaigns saved millions of children from an early death but left them to face diminished lives because of the neglect of the diseases that weaken rather than kill.

Lymphatic filariasis, for example, affects over 80 countries in Africa, Asia, the Americas and the Western Pacific with 1.1 billion people at risk. Investment in these diseases can pay dividends and Chinese economists have estimated that every $1 invested in the elimination of lymphatic filariasis brings a return of $15.

Too often Country Strategy Papers (CSPs) and Sector Wide Approaches (SWAps) have

tended to be high on rhetoric but low on proposals specific to health and education. To date out of the 61 CSPs published, only 9 have chosen health as a focal area for cooperation representing just 4.3% of programmable resources.

It is also important that policy should be sufficiently flexible to respond to regional variations in the pattern of diseases, for example, between the Caribbean and Africa. We also need to emphasise that poverty and health is not just a medical and care issue; it is linked to the wider programme of nutrition, safe water, sanitation, housing, education and the environment and rehabilitation, re-training and employment.

Hunger

Hunger is important to the health and poverty equation. The public's perception of hunger is very often the televisual one of famine. The major problem is, however, malnutrition. One aspect of this is poor water, which leads to disease, disability and death and a less productive workforce. That, in turn, leads to low-incomes, which leads to malnutrition, and so on - the cycle of deprivation, that needs to be broken.

It is exacerbated when humanitarian aid undermines local farmers and local economies. We give our food surpluses to low-income countries, not realising that the harm it can do to the farming economy in those countries. It is exacerbated again, when we close our European doors to their food exports. Protectionism against developing countries takes some $100 billion from them - much more than the total volume of development aid. If they could increase their exports to us by just 5%, this would generate $350 billion.

It is a quarter of a century since targets were set. In 1996 we aimed to halve the 800 million undernourished people by 2015, at the rate of 22 million a year. The numbers are falling by only 6 million a year. The target will not be reached until 2030. And per capita food production has not increased in the high-debt, low-income countries, especially in sub-Saharan Africa. Yet the United Nations Development Programme estimates that it would take just $13 billion a year to solve this problem - the same amount that Europe and America spends on cosmetics.

In the last 50 years almost 400 million world-wide have died from hunger and poor sanitation. That is three times the number of people killed in all the wars fought in the entire 20th century. Every year some nine million people die from hunger. That is 24,000 deaths a day.

Action and cost

World Bank estimates suggest the central goal of halving poverty by 2015 would require a rapid doubling of ODA flows. According to the report of the Commission on Macroeconomics and Health (December 2001), $31 billion of additional aid financing to the health sector from this date to 2015 will be required to meet the MDGs in this sector.

The EU development budget has been criticised for its lack focus on poverty. The present Commission's communication goes some way in addressing this but we will have to wait and see whether there can be real progress on the ground. There needs to be significant shift of resources to social sectors, particularly basic health and education.

According to the Commission, in 2001 it disbursed just 3.4% (€201,62 million) of the combined general budget of the Commission and European Development Fund on health. If macro-economic support is going to take a greater slice of the development aid budget, one must question how the health sector will be served and how this will be measured. The European Parliament has consistently called for 35% of development aid to be allocated to health and education, and for appropriations for Least Developed Countries (LDCs) not to be diverted to non-LDC countries.

Health systems in many developing countries are starved of resources. The countries themselves will need to mobilise increased investment for better health outcomes and initiatives such as that of African Governments (Abuja 2001) to commit 15% of national budgets to health are welcome. Yet in most low-income countries the international community will need to complement country level public and private investments with long term financial support; many countries will require technical support and capacity building rather than major financial transfers.

Developing countries have inadequate access to affordable services and drugs. The reasons are complex and include the effects of international and national pricing policies, tariffs, taxation and the implementation of intellectual property rights agreements. Options to further improve access and affordability include the exploration of the use of differential pricing (tiered pricing), voluntary licensing agreements, parallel trading, technology transfer, increase in local capacity for production, and the use of generic and patented products.

Summary

We need to see an upgraded EC Development commitment to support in the health field. Increased financial inputs to the social sectors by themselves do not necessarily result in improved outcomes in health. More efficiently targeted investment is the key. Performance of health systems and the support given to health has to be measured better; trends have to be monitored in a co-ordinated manner and capacities developed to do so. One thing is certain, Europe must stop draining developing countries of medical skills; currently, according to the WHO, developing countries lose 63,000 doctors annually and receive back on 1,300. Overall we need to see a programme of more action and not just fine words.

31 January 2003

OPINION OF THE COMMITTEE ON WOMEN'S RIGHTS AND EQUAL OPPORTUNITIES

for the Committee on Development and Cooperation

on health and poverty reduction in developing countries
(COM(2002) 129 – C5-0334/2002 – 2002/2178 (COS))

Draftsperson: Elena Valenciano Martínez-Orozco

PROCEDURE

The Committee on Women's Rights and Equal Opportunities appointed Elena Valenciano Martínez-Orozco draftsperson at its meeting of 10 July 2002.

The committee considered the draft opinion at its meetings of 25 November 2002 and 23 January 2003.

At the latter meeting it adopted the following conclusions unanimously.

The following were present for the vote: Anna Karamanou, chairperson; Elena Valenciano Martínez-Orozco, draftsperson; María Antonia Avilés Perea, Regina Bastos, Lone Dybkjær, Geneviève Fraisse, Fiorella Ghilardotti, Lissy Gröner, Jutta D. Haug (for Christa Prets), Hans Karlsson, Rodi Kratsa-Tsagaropoulou, Astrid Lulling, Thomas Mann, Olle Schmidt (for Marieke Sanders-ten Holte), Patsy Sörensen, Feleknas Uca, Sabine Zissener.

CONCLUSIONS

The Committee on Women's Rights and Equal Opportunities calls on the Committee on Development and Cooperation, as the committee responsible, to incorporate the following points in its motion for a resolution:

1. Calls on the Commission to support the first of the United Nations Millennium Development Goals, which is to halve the number of people living in extreme poverty, of which women and children are the main victims, by 2015;

2. Calls on the Commission to ensure that health is not included within the scope of the General Agreement on Trade in Services (GATS) as a 'service' subject to free market sources and productivity criteria;

3. Calls on the Commission to ensure that development policies and other policies are consistent and establish measures involving women, who are particularly affected by poverty and at the same time are essential players in the development and social cohesion of their countries. Education, health, the environment, international trade, agriculture and immigration are important policy aspects which have a very direct impact on developing countries and which could and should serve as instruments to combat poverty by eliminating the inequalities that make women in developing countries all the more vulnerable;

4. Stresses that the fight against poverty involves access to education, training and the new information technologies, as well as access to property and saving and credit mechanisms, and calls on the European Community to develop specific measures directed at women in these areas, particularly as part of its cooperation and development policy; calls on the Commission to take positive action against trade and trafficking in human organs;

5. Asks the Commission to foster the involvement of local populations, and in particular the involvement of women, in order to bring about substantial changes in the field of health, with a view to establishing fora that are open to everyone regardless of their race, religion or gender, thereby enabling an indigenous health system to be developed without imposing the model used in developed countries. Certain cultural traditions, or ones relating to religious beliefs, exclude women from access to sexual and reproductive health services;

6. Calls on the Commission to pursue an active policy to combat trade and trafficking in counterfeit, adulterated or out-of-date medicines and their transit through the territory of the European Union;

7. Asks the Commission to support the initiatives aimed at reinforcing the role of primary health care, which is the only means of extending complete health to the very poor. There is also a need to ensure universal access to health care and to guarantee access to adequate sexual and reproductive health services and the access of local populations to medicines, and to support the strengthening of public health systems, the development of healthcare skills and the promotion of research;

8. Points out to Commission that it would be appropriate to highlight the importance of women as primary health promoters and that a gender perspective therefore needs to be introduced into health policies, and the statistics and research relating to them. 20% of the world's

population are currently of child-bearing age, making it crucial for information to be provided on sexual and reproductive health and for sexual and reproductive health services to be available to enable this population group to guard against unwanted pregnancies and against sexually transmitted diseases such as HIV/AIDS;

9. Asks the Commission to introduce the concept of food sovereignty[8] alongside that of food security, with food sovereignty meaning the right of peoples to frame their own sustainable policies and strategies for the production, distribution and consumption of food which guarantee the entire population's right to food, and which are based on small and medium-scale production and respect local culture and the diversity of types of farming and fishing and the indigenous systems of agricultural production, marketing and the management of rural areas, in which women play a fundamental role;

10. Stresses that health is also promoted by educating people, particularly women, in the elementary rules of health and hygiene and by providing access to, and education in, sustainable management of water, air and energy in order lastingly to improve people's standard of living and level of health.

[8] According to the World Forum on Food Sovereignty held in Havana in September 2001, this is the means to eradicate hunger and malnutrition and guarantee lasting and sustainable food security for all of the peoples of the world.