

HEALTH IN DEVELOPMENT COOPERATION AND HUMANITARIAN ACTION

2020 REPORT

HIGHLIGHTS




medicusmundi



The report “Health in Development Cooperation and Humanitarian Action” is a joint initiative of medicusmundi and Médicos del Mundo which, since 2002, has been providing a critical analysis of international, state and decentralised Official Development Assistance on health and humanitarian assistance.

The report also incorporates the most relevant policies and factors which affect health at a global level and that set the international agenda, together with detailed analyses of the reality of health in specific countries or regions.

All this information is available in the online tool CooperasSalud:

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INTRODUCTION

On 11 March 2020, concerned by the spread of COVID-19, its severity, and general inactivity, the World Health Organisation (WHO) declared a pandemic. We looked on aghast at an unprecedented situation of such magnitude and with such unpredictable consequences. The pandemic, with a death toll of 1.42 million people to date, could regress social progress to reduce poverty and hunger, accentuate humanitarian crises and inequalities, and cause human rights and democratic governability to go backwards.

This crisis has only exacerbated existing health problems. The impact on people suffering from HIV and AIDS, tuberculosis and malaria translates into a higher death rate, while care for non-communicable diseases has been either partially or completely interrupted in no fewer than 60 countries. There is an urgent need to advance in Sustainable Development Goal 3, related to health and well-being, and to attain Universal Health Coverage (UHC) and strengthen systems of social protection and public services.

Two months before WHO declared the pandemic, Spain’s first coalition government since the transition to democracy was formed. Led by Pedro Sánchez, who has committed to bolstering Cooperation policy — allocating 0.5% of the country’s Gross National Income (GNI) by the end of his term of office — aligning it with the United Nations’ (UN) 2030 Agenda and backing Cooperation that is transformative, feminist and responsive to climate challenges, as well as backing the recovery of Spain’s international role. The balance, however, is bittersweet: Cooperation has recovered its corresponding institutional level, but not the narrative or the political and budgetary level of official discourse.

Spain’s Official Development Assistance (ODA) remains scant and is still at the tail-end of the European queue — the wait for Spanish ODA goes on. Its ODA has increased by 7.15%, remaining at 0.21%, below the average of other donor countries from the Development Assistance Committee (DAC, 0.30%), donor countries in Europe (0.47%), and below the promise of and commitment to 0.7% agreed 50 years ago within the UN. Of note is the effort of Spain’s Autonomous Communities and municipalities, which continue on the path to recovery with growth of 10.2%.

In relation to health, the allocated 63.6 million euros represented 2.39% of the gross total of ODA, far below the average of DAC donors (12.91%) and insufficient for reducing health-related problems. Maternal death or the avoidable deaths of newborns and children under five, communicable diseases (AIDS, malaria, tuberculosis) and non-communicable diseases (cardiovascular, diabetes, mental health), which have a greater impact on more vulnerable populations, remain a challenge. Tools to combat this, such as UHC — guaranteeing access to sexual and reproductive health services;

obtaining protection against financial risks; access to quality essential services; and access to safe, effective, affordable and quality medicines and vaccines — are still not advancing and there is still a risk, increased by COVID-19, of not meeting the health targets for 2030.

Furthermore, the COVID-19 crisis must not distract us from other factors that are detrimental to health, for instance climate change, which in a few years will cause 250,000 additional deaths per year. To improve health there must be a strong global commitment with sound policies that create healthy environments.

Finally, mention must be made of the drift occurring in Humanitarian Aid, at its lowest ebb despite the slight increase in funding of 62 million euros annually, 2.35% of the ODA total, a far cry from the commitment of 10% and not enough to ease humanitarian needs.

HEALTH IN THE WORLD

The COVID-19 pandemic poses a threat to advances made in the 2030 Agenda and jeopardises the Sustainable Development Goals (SDGs) and the objective of “leaving no-one behind”.

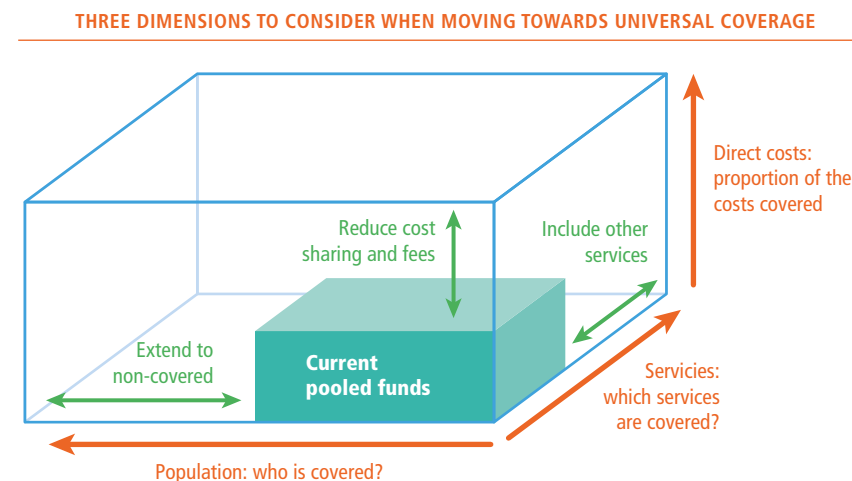
In 2020, COVID-19 is the biggest threat to world health; a health emergency affecting every country around the world, regardless of income or development, and negatively affecting practically all SDGs: in addition to impacting health, it has reduced the possibility of ending extreme poverty, increasing hunger and food insecurity, impacting teaching, augmenting the risk of gender-based violence for many women, and gravely damaging the world economy.

Governments have to put people and the planet ahead of other interests, and there must be a deeper commitment by all countries to the 2030 Agenda, a frame of reference for the much-desired “new normal” and an integral and equitable response to global problems such those related to the COVID-19 pandemic.

Globally, advances in SDG 3 on health and well-being fall short of being able to achieve Universal Health Coverage (UHC). Only between a third and half of the world’s population have had their essential health services covered, and the number of people having to incur significant direct health care expenses has increased. If the situation continues in the same direction, the WHO estimates that 5 billion people will not have access to health care by 2030.

Inequality in health care continues to be our biggest global problem and the planet’s most impoverished and vulnerable societies and people are the ones with the worse health — 12.7% of the world population spent over 10% of their household budget on health care. The highest rate of infant mortality and deaths from infectious diseases are located in Sub-Saharan Africa, a region which, along with South Asia, has the worst rates of maternal deaths, the majority of which are avoidable because we already have a solution for them. Non-communicable diseases (NCDs), accounting for 71% of global deaths, are not only related to poor access to health systems. They also have to do with other risk factors that include a poor diet, tobacco and alcohol consumption, and physical inactivity.

To obtain UHC and improve people’s lives, we must commit to strengthening public health systems and to providing Primary Health Care through an additional annual investment, in low- and medium-income countries, of 2 billion dollars. Investment that would save 60 million lives between now and 2030.



Source: World Health Organization

COVID-19, possibly the main cause of infectious disease-related deaths in 2020, has spread across the whole planet, and does not distinguish between countries’ incomes, negatively impacting all Targets from SDG 3, collapsing the operations of health systems and affecting other health-related problems — proof is interrupted programmes that fight against diseases such as HIV/AIDS, tuberculosis and malaria in over 70 countries.

No health care system, not even the most developed, has been enough to stop the pandemic on its own. There has been, and still is, a patent lack of preparation to deal with global health emergencies. Cutbacks in health care due to economy-based budgetary adjustment measures, along with a lack of genuine commitment by governments to invest in health and make it an equitable right, have played a part in this pandemic having a greater and more serious infection rate among the most vulnerable groups (the elderly, the poorest people, women affected by gender-based violence...), without forgetting the effects it is having on the wide range of people affected by other diseases around the world, people who have seen their access to the health system limited by COVID-19 because of the fear of infection and the logical diversion of resources to fight against the pandemic.

The strengthening of health systems and increased equality are key strategies for fighting against poverty and promoting development. Having a strong public health system is crucial in dealing with the coronavirus pandemic and others that could occur in the future. Therefore, there is a need to invest in human resources, information, supplies, transport, communications, and provide good treatments and services that respond to the needs of the population and are fair, financially speaking.

Despite previous warnings, the world was caught unawares by the COVID-19 pandemic. The fragmentation and weakness of global governance, combined with information overload and the lack of an integrated multilateral approach, have limited the capacity for an equitable global response.

The lack of strong global governance in health has hindered the ability to lead a joint response to the pandemic, a role that must be undertaken by the World Health Organisation. That said, many for-profit and not-for-profit actors, emerging countries, etc. are joining the governance of global health, questioning the current status quo and factoring in the multi-actor component to a multilateral institution in which States were solely responsible for making decisions. This new multi-actor landscape makes not only decision-making difficult, but also the obligation for transparency and accountability.

In civil society, we must be watchful of these and other issues, such global health governance's limitations concerning health security-related aspects, a neglect of the other global problems affecting populations, for instance the world's economic system, environmental degradation, gender inequality or the lack of social protection for every country's most vulnerable.

New global health governance demands an independent, professional and participatory WHO that is able to foster a common and multisector response to the pandemic based on independent evaluation that seeks potential im-

provements to be implemented and puts equal access to solutions and the right to health before other interests.

The coronavirus crisis is a constant reminder of the importance of defending the human right to public health and vaccines should be considered a global public asset.

Certain initiatives have been set up for the most impoverished countries to have access to the vaccine. The WHO and two coalitions, the CEPI (the Coalition for Epidemic Preparedness Innovations) and GAVI (the World Alliance for Vaccines and Immunisation), are promoting the COVID-19 Vaccine Global Access Facility (COVAX), a worldwide initiative intended to work with vaccine manufacturers in such a way that every country around the world has equitable access to safe and effective vaccines. COVAX is the benchmark of the ACT Accelerator (Access to COVID-19 Tools) vaccination, which aims to streamline development, production and equitable access to COVID-19 tests, treatment and vaccines.

The research, production and distribution of vaccines must be one-hundred-percent transparent and the vaccine price must be accessible for everyone who needs it. In an interconnected world, if people from low- or medium-income countries are excluded from vaccination, the virus will continue to kill and the global recovery will be delayed.

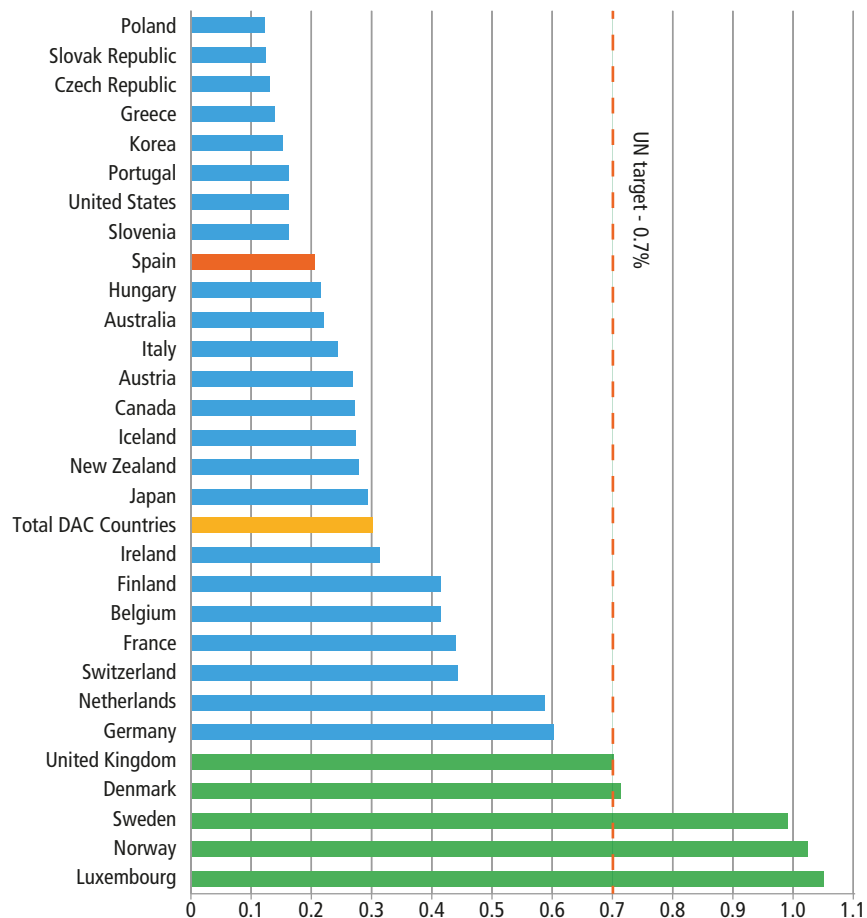
INTERNATIONAL PERSPECTIVE

In 2019, the total Official Development Assistance (ODA) of countries from the Development Assistance Committee (DAC) stood at around 1.53 billion dollars, representing an increase of 1.4% with respect to 2018, and 0.30% of Gross National Income (GNI). Only five DAC countries —Denmark, Luxemburg, Norway, the UK and Sweden — met the 0.7% objective.

The total ODA of DAC members represents 0.30% of the Gross National Income (GNI), some distance from the 0.7% commitment. The European Union (EU) and its Member States are, as a whole, the main donors worldwide. In 2019, their Cooperation represented 55.2% of DAC's total ODA — in excess of 84 billion euros — with the EU's joint aid and that of its Member States representing 0.46% of the EU's GNI. Five countries — the United States, Germany, the UK, France and Japan — contributed 68.2% of all ODA from the DAC group, although only the UK fulfilled its commitment to 0.7%. Spain remains in position 13 with regard to absolute figures and drops to 21 out of 29 in terms of the GNI percentage.

The route towards 0.7% requires a realistic process of partial and credible increases, and current trends are not travelling down the same path. It would be advisable for the 24 countries yet to reach it to make a political decision, just as the United Kingdom did in decreeing the 0.7% for Cooperation by law.

DAC COUNTRIES' ODA AS PERCENTAGE OF GNI, 2019



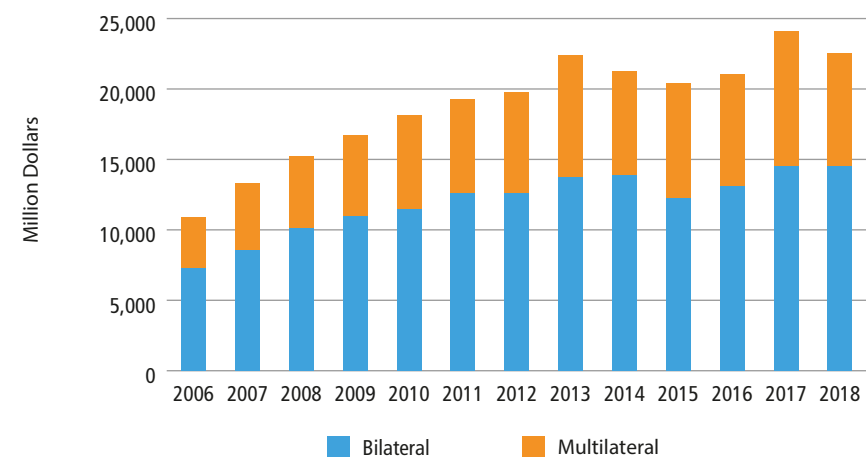
Source: OECD

ODA assigned to the health sector by the group of DAC countries stood at 22.5 billion dollars, dropping by 6.5% in comparison to the previous year. This reduction meant that the importance of health stood at 12.91%, almost one percentage point lower than the previous year.

The reduction in health-related ODA has primarily occurred in multilateral aid, given that bilateral aid has barely dropped from 15 million dollars. In terms of distributable aid (that which countries can choose where to send), health represents 18.24%, a percentage point lower than in 2017 and, although there is a demonstration of the importance of this sector to donor countries, the absolute numbers are not enough to help meet SDG 3. European institutions, encompassing the European Commission and the European Council's General Secretariat, allocated 542 million dollars to health, the lowest figure since 2010 and once again a demonstration of these institutions' limited interest in the sector.

The pandemic has brought to light the importance of international health Cooperation in the fight against the pandemic and the need to speed up the attainment of 0.7% and increased ODA allocated to health. We must be better prepared for emergencies, investing in health systems that fully respond to people's needs throughout their lives.

GROSS ODA DISBURSEMENT BY DAC COUNTRIES TO THE HEALTH SECTOR (SECTOR 120 AND 130) BY CHANNEL (IN CURRENT DOLLARS)

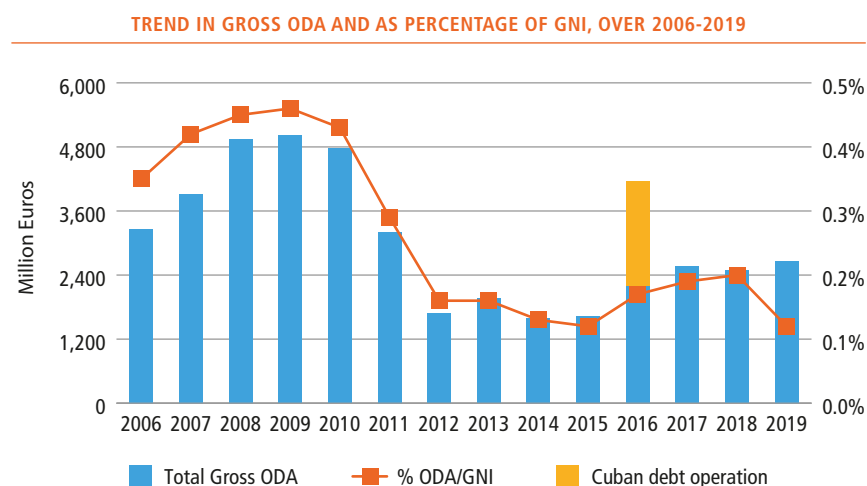


Source: Own elaboration from data published by OECD-CRS

HEALTH IN SPANISH COOPERATION

In 2019, Spanish ODA increased to 177 million euros, reaching 0.21% of the GNI, a percentage which is some distance from the 0.30% average of DAC donor countries, from the 0.47% average of EU countries and the 0.7% commitment agreed on 50 years ago within the UN.

The ODA paid by Spain in 2019 reached 2.66 billion euros, representing 0.21% of the GNI. If we take into account Spanish Cooperation's starting point, after a decade of cutbacks, clearly we face a highly insufficient increase which, once again, distances us from the path of the international commitment to 0.7% and that promised by the Spanish Government to allocate, after its term of office, 0.5% of the GNI to Cooperation.



Source: Own elaboration from ODA data published by DGPOLDES SECIPIC

To fulfil the global commitments and development challenges, Spanish Cooperation must be remodelled, ensuring enough funding through a law that makes 0.7% obligatory and equips the Spanish Agency for International Development Cooperation (AECID) with resources as the main institution executing Technical Cooperation. This must be joined by a participatory Cooperation strategy, where civil society and Decentralised Cooperation have a say in decision-making.

The COVID-19 pandemic has affected Spain in a unique way and opened up the cracks in its health care system — in other words, precariousness for health care staff and the health system, hospitals, intensive care units (ICUs) being overrun.

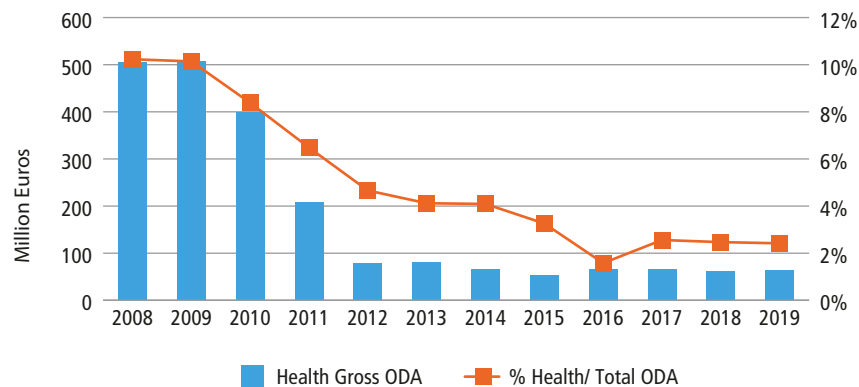
At the start of the crisis, Primary Health Care did everything possible to identify infections and contacts, manage the treatment of non-serious cases of infected people in their homes, avoid a collapse in the availability of hospital beds, severely cut back by different governments, treat other medical conditions and resolve people's doubts and fears by phone. The precarious situation many Primary Health Care professionals have found themselves in has not impeded them, at the height of the pandemic, from taking on a large part of managing COVID-19, tracing cases and possible contacts and working with different social sectors to control its effects.

We must end the precarious situation of professionals in Primary Health Care, improve their working and wage conditions and their social recognition, particularly where the situation is worse, for instance in isolated rural areas, neighbourhoods with a greater level of vulnerability, etc. Moreover, we must advocate the necessity of ongoing care and make it more appealing to new generations of health professionals.

Spanish Cooperation has allocated 63.6 million euros, representing a meagre 2.39% of the ODA total, a percentage which is way below the average of the group of DAC donor countries, which is at 12.91%.

This is not an occasional problem but a structural one. In 2008, that which was allocated to health by Spanish Cooperation exceeded 10% of the ODA; in 2010 it was 8%, and in recent years it has barely risen above 2%. If it had allocated the average percentage of DAC countries to health, this figure would have reached 340 million euros, 81% more than that allocated in 2019.

TREND IN HEALTH GROSS ODA AND AS PERCENTAGE OF TOTAL ODA, 2008-2019



Source: Own elaboration from ODA data published by DGPOLDES SECIPIIC

Increasing expenditure on health care is now unavoidable given that it is expenditure that provides equal opportunities and has a significant equalising factor for low-income and emerging countries, where access to basic health services is normally limited. Health must be a real priority for Cooperation that demands a substantial and sustained increase in resources.

Decentralised Cooperation rose to 320.3 million euros, increasing by 10.2% with respect to 2018. Health-related allocations have been 28.1 million euros, denoting 8.79% of the total paid out by Spain's regional governments and Local Bodies (EE.LL in its Spanish acronym)

Cooperation originating from Spain's Autonomous Communities (CC.AA. in its Spanish acronym) has grown — 4.8% — as has Cooperation stemming from its Local Bodies (22.1%). In health, the total assigned by Spanish Cooperation, 63.6 million, 44.1%, comes from Decentralised Cooperation, while Autonomous Communities have paid out 24.8 million euros, 88% of health-related ODA from Decentralised Cooperation. The importance of health-related ODA in Autonomous Community ODA is 11.44%, a much higher number than State Cooperation and very close to that which is allocated by the group of donors.

Decentralised Cooperation must be kept as a unique element and beneficially differential with respect to the Cooperation implemented by Spain's General State Administration (AGE in its Spanish acronym) and other donor countries.

Moreover, its advantages have not always managed to gain value, such as its flexibility to take on board the population's basic needs, health, or citizens' proximity to different realities that co-exist in the world.

TOTAL DECENTRALISED HEALTH ODA, 2017-2019

CCAA+EELL	Health ODA 2017	Health ODA 2018	Health ODA 2019
Andalucía	2,895,000	4,148,621	8,328,935
Aragón	540,910	911,630	663,338
Asturias	649,761	67,743	426,231
Baleares	704,091	612,093	824,607
C. Valenciana	1,188,569	3,750,008	2,325,832
Canarias		439,520	225,925
Cantabria	60,000	320,639	153,796
Castilla y León	536,112	783,637	567,207
Castilla-La Mancha	401,953	377,632	659,579
Cataluña	5,363,773	9,576,623	6,603,509
Extremadura	1,891,586	1,266,381	491,831
Galicia	503,458	732,712	1,061,898
La Rioja	177,201	174,624	280,897
Madrid	565,243	1,027,047	1,022,862
Murcia	122,361	87,632	20,000
Navarra	2,175,552	2,684,548	2,705,500
País Vasco	3,358,706	2,499,596	1,812,515
TOTAL	21,134,276 €	29,460,687 €	28,174,464 €

Source: Own elaboration from ODA data published by DGPOLDES SECIPIIC

HUMANITARIAN ACTION

In the face of a new rise in humanitarian needs around the world, the international community's response has been to reduce the funds intended for International Humanitarian Action (IHA) by 600 million euros, reported through the UN system, which will once again leave 40% of humanitarian needs uncovered.

Over the last decade, the number and complex nature of conflicts have grown significantly, doubling the number of those displaced, arriving at a figure of 70 million people. Nevertheless, funds going to Humanitarian Action were reduced by 600 million in 2019, standing at 24.7 million dollars.

These increased needs, which will no doubt continue to grow in the coming years, demand a greater economic commitment in the medium and long term by the international community in order to adequately respond to the new humanitarian reality.

Therefore, donors must assume their responsibilities and international commitments and substantially increased funds intended for humanitarian actions so as to reduce the funding gap from 40% to 25% between funds requested and funds received.

The COVID-19 pandemic response must not be carried out at the expense of leaving millions of people affected by humanitarian crises in a state of neglect. Instead, it must be done with additional funds.

In 2020, the COVID-19 pandemic has overlapped the fragile situation of many countries affected by violence, conflicts and climatic emergencies. All humanitarian needs remain, at the very least, as urgent as they were before COVID-19 and they cannot and must not be ignored.

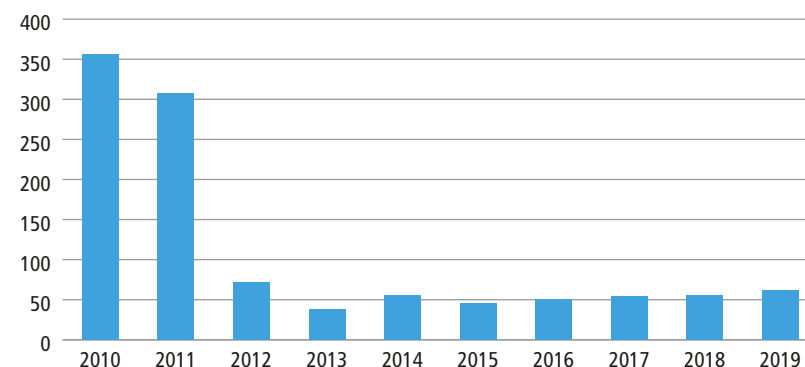
Until the end of October, the COVID-19 Global Humanitarian Response Plan launched by the UN had only received 3.39 billion dollars from the 9.49 billion requested — the equivalent to 35.7%.

The international community must assign the necessary funds to cover 100% of the COVID-19 Global Humanitarian Response Plan and these funds should be additional and not funds from other humanitarian budget items. The funding of this Global Plan cannot be carried out at the expense of funds allocated to other humanitarian crises.

Spanish Cooperation's Humanitarian Action remains at a bare minimum, despite the slight increase positioning it at 62 million euros, representing 2.35% of the ODA total and clearly not enough to fulfil its commitments.

In 2019, Spanish Cooperation's Humanitarian Action as a whole (the AGE, Autonomous Communities, Local Bodies and universities) kept up a tendency for growth, although they are still modest increases which do not allow for a suitable response to the humanitarian crises the world faces.

TREND IN SPANISH ODA TO HUMANITARIAN ACTION



Source: Own elaboration from ODA data published by DGPOLDES SECIPIC

The arrival of the COVID-19 pandemic and the response from Spanish Cooperation has to be through additional funds, without taking away from the scant funds designated to Humanitarian Action. We cannot neglect some needs to cover other ones.

Given the weakness of Humanitarian Action in Spanish Cooperation, the new humanitarian challenges the international community faces and the systematic non-compliance to the 10% commitment, Spanish Cooperation must establish a specific and credible schedule to reach the goal of allocating 10% of its ODA in Humanitarian Action in 2022 and to ensure that the response to the COVID-19 crisis involves additional funds.

The significant increase in Decentralised Cooperation intended for Humanitarian Action, which stands at just above 20 million euros, representing 6% of the ODA total.

The biggest growth has occurred in Decentralised Cooperation, which has grown by 30%, moving from 14.7 million euros in 2018 to 20.5 million in 2019. The main rise has occurred in Local Organisations, which have gone from assigning 1.5 million euros to allocating 5.7 million, while among Spain's Autonomous Communities there has been a jump from 13.2 million to 14.7 million.

DECENTRALISED HUMANITARIAN ACTION, CC. AA., 2018-2019

CC. AA.	2018	%	2019	%
Andalucía	3,848,848	28.99	5,885,286	39.77
Aragón			117,891	0.80
Asturias	1,183,000	8.91		
Baleares	546,749	4.12	440,000	2.97
Canarias				
Cantabria	50,000	0.38	50,000	0.34
Cataluña	796,889	6.00	726,330	4.91
Castilla-La Mancha	190,400	1.43	60,000	0.41
Castilla y León			81,000	0.55
Comunidad Valenciana	1,695,600	12.77	2,581,650	17.45
Extremadura	1,094,949	8.25	913,300	6.17
Galicia	229,675	1.73	110,108	0.74
La Rioja	130,000	0.98	90,076	0.61
Madrid	405,999	3.06	624,229	4.22
Murcia	32,500	0.24		
Navarra	418,000	3.15	240,000	1.62
País Vasco	2,652,419	19.98	2,878,777	19.45
TOTAL	13,275,029 €	100%	14,798,647 €	100%

Source: Own elaboration from ODA data published by DGPOLDES SECIPIC

The main Autonomous Communities according to financing volume are Andalusia, the Valencia Community and the Basque Country, which have expanded their Humanitarian Action funds and, between them, contribute 76.6% of funds for such purposes.

With regard to Local Bodies' financing, the major increase in funding is concentrated in seven Autonomous Communities: Andalusia, Asturias, Castilla-La Mancha, the Canary Islands, Catalonia, Madrid and the Basque Country, with the last four accumulating the biggest growth.

DECENTRALISED HUMANITARIAN ACTION, EE. LL., 2017-2019

EE. LL.	2017	2018	2019
Andalucía	16,045	135,000	574,184
Aragón		371,954	10,000
Asturias	25,000		128,000
Baleares	6,632	76,632	6,632
Canarias		24,000	850,000
Cantabria			
Cataluña	200,410	25,181	938,546
Castilla-La Mancha	26,320	14,000	23,000
Castilla y León	43,798	144,077	101,149
Comunidad Valenciana	23,757	172,546	10,700
Extremadura			
Galicia	11,252	25,240	11,376
La Rioja			
Madrid	2,113,350	37,000	1,499,526
Murcia	14,100	66,000	
Navarra	84,000	99,500	92,814
País Vasco	86,860	334,170	1,507,089
TOTAL	2,651,524 €	1,525,300 €	5,753,016 €

Source: Own elaboration from ODA data published by DGPOLDES SECIPIC

Although we are talking about significant increases, an historical analysis demonstrates serious peaks and troughs, making an adequate response to increasingly more complex and protracted humanitarian crises more difficult as they require more medium-term support. This can only be obtained by stable and multiannual funding.

Decentralised Cooperation must consolidate increases in its financing allocated to Humanitarian Action and must continue to grow until it reaches the goal of 10% allocation in all ODA for such ends.





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