GLOBAL HEALTH IN THE G7 AGENDA

THE PROPOSALS OF CIVIL SOCIETY

INTRODUCTION

The consequences of the economic crisis that has been afflicting the global population for more than a decade are aggravated by the often insufficient and ineffective responses adopted to date by the international community and the national governments: in this situation, the political responsibility of the leaders of the G7 countries is now greater than ever. In spite of the progress made in combating poverty, one in ten people in the world is still living in conditions of extreme poverty[1] and the growing gap between rich and poor indicates the economic inequality which is becoming increasingly evident in every country. The concentration of economic resources is paralleled by the concentration of political power, excluding the most vulnerable people, those most needful of change, from the possibility of making decisions and taking action to improve their condition. This accentuates tension and injustice, and promotes polarisation and conflicts, as well as increasing migratory flows and the pressure on national frontiers.

The governments of the G7 countries now have a unique opportunity to play a leading role in this process of change by interpreting the global need for a transition toward a more just and sustainable world.

As emphasised by the Italian cooperation, health is a key factor in human development which is also necessary for progress in other areas (such as education and employment). Health is a dramatic early indicator of the performance of other development indicators and equal access to healthcare demonstrates the quality and extent of the rights accorded to the individual members of a society. On one hand, the determining socio-economic factors (gender, education, income, employment, work and life environment and quality of social and health services) have a strong influence on the health of individuals and communities. On the other, if physical, mental and social wellbeing are not assured, participation in the socio-economic development of a community is seriously jeopardised, creating a vicious circle.

Global health has made considerable progress in the last twenty years, thanks to efforts by the international community to achieve the Millennium Development Goals, and to the economic growth of many countries, which has improved access to healthcare, prevention, treatment and care schemes and has contributed to the increase in life expectancy. Nevertheless, unacceptable differences remain and continue to worsen, not only between industrialised countries and so-called developing countries, but also within these (including many European countries). 400 million people in the world still don't receive the healthcare they need and have no access to basic medicines[2]. It is also estimated that having to pay unexpected healthcare expenses reduces a hundred million people to a state of poverty every year[3].

Within the framework of the Sustainable Development Agenda, governments have made important commitments to health-related issues[4]. The goals to be achieved by 2030 represent a starting point for the necessary process of change, but they must be transformed into tangible actions, financed with additional resources and monitored to ensure effectiveness and transparency.

This short report analyses the main challenges faced with regard to global health: the fight against epidemics, the improvement of public health systems, violence in general, protection of sexual and reproductive health, mother and child health and, lastly, malnutrition in all its forms. It also describes strategies that can contribute effectively to achieving adequate levels of global health, such as greater involvement of local authorities in view of their roles as institutional players closest to the community. At the same time, it highlights certain recent tendencies, such as health service privatisation, which could aggravate the overall situation instead of improving it.

Lastly, the report describes the Italian government's commitment to cooperate in the health sector, in the hope that there will be future increases in resources for this crucially important sector, less fragmentation in the distribution of aid and greater transparency.

For each of the areas analysed, the conclusions of the report offer the Italian government precise recommendations in order to ensure an improvement in the quantity and quality of public aid for development aimed at health cooperation programmes, actions to further extend access to care at global level, greater focus on action in gender-related health matters and also attention to the topic of nutrition, which is a prerequisite for adequate global health.

For the Italian government, the G7 Summit to be held in Taormina in May 2017 represents an important opportunity to focus the debate on the many global health challenges and to take tangible action. As the country hosting and presiding over the event, Italy can bring its experience in the "universal" health system to the attention of the other countries, consolidating that principle of equity found in the Constitution, while working on strengthening and increasing its commitment and that of other G7 governments.

LIST OF ABBREVIATIONS

AIDS Acquired Immune-Deficiency Syndrome
AMC Advanced Market Commitment
AMR Antimicrobial resistance
ARV Antiretroviral
CFS Committee on World Food Security
CRS Common Reporting Standards
DAC Development Assistance Committee
DGCS Direzione Generale Cooperazione allo Sviluppo (Directorate General for Development Cooperation)
EFSA European Food Security Agency
FAO Food and Agriculture Organisation
FEM Forced and Early Marriages
GAVI Global alliance for vaccine immunization
GNI Gross National Income
GPEI Global Polio Eradication Initiative
HIV Human Immunodeficiency Virus
IFAD International Fund for Agricultural Development
IFC International Finance Corporation
IFFIm International Finance Facility for Immunization
IOM International Organization for Migration
LGBTQ Lesbians, Gays, Bisexuals, Transgenders and Queers
MAECI Ministero degli Affari Esteri e della Cooperazione Internazionale (Ministry of Foreign Affairs and International Cooperation)
MDGs Millennium Development Goals
MFG Mutilation of Female Genitals
MPP Medicines Patent Pool
N4G Nutrition for Growth
NGO Non Governmental Organization
NTDs Neglected Tropical Diseases
ODA Official Development Assistance
OECD Organisation for Economic Cooperation and Development
PPP Public-private partnership
RMNCH Reproductive, Maternal, Neonatal and Child Health
SDGs Sustainable Development Goals
SRH Sexual and Reproductive Health
SUN Scaling Up Nutrition Movement
TB Tuberculosis
UHC Universal Health Coverage
UNAIDS Joint United Nations Programme on HIV/AIDS
UNFPA United Nations Population Fund
UNGA United Nations General Assembly
WHO World Health Organisation
WFP World Food Programme

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1. THE HEALTH AGENDA IN THE LAST G7 SUMMITS. AN OVERVIEW OF THE RESULTS ACHIEVED AND UNFULFILLED COMMITMENTS

	AT THE G7-G8 SUMMITS ON HEALTH					
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012	LOUGH ERNE 2013	BRUXELLES 2014
STRENGTHENING OF HEALTH SYSTEMS	Confirm the commitments already made, including the investment of 60 billion dollars to combat infectious diseases and strengthen health systems by 2012. Take action regarding the scarcity of specialised health workers in the so-called developing countries.	Increase the number of trained medical personnel and set up a network dedicated to health innovation. Foster the strengthening of health systems as an instrument to improve the health of mothers, children and newborns.				Respond to the Ebola emergency, supporting the Global Health Security Agenda, and cooperate with countries so that they meet the International Health Requirements (IHR) of the WHO. Work on the prevention, identification and monitoring of any epidemy breeding grounds.

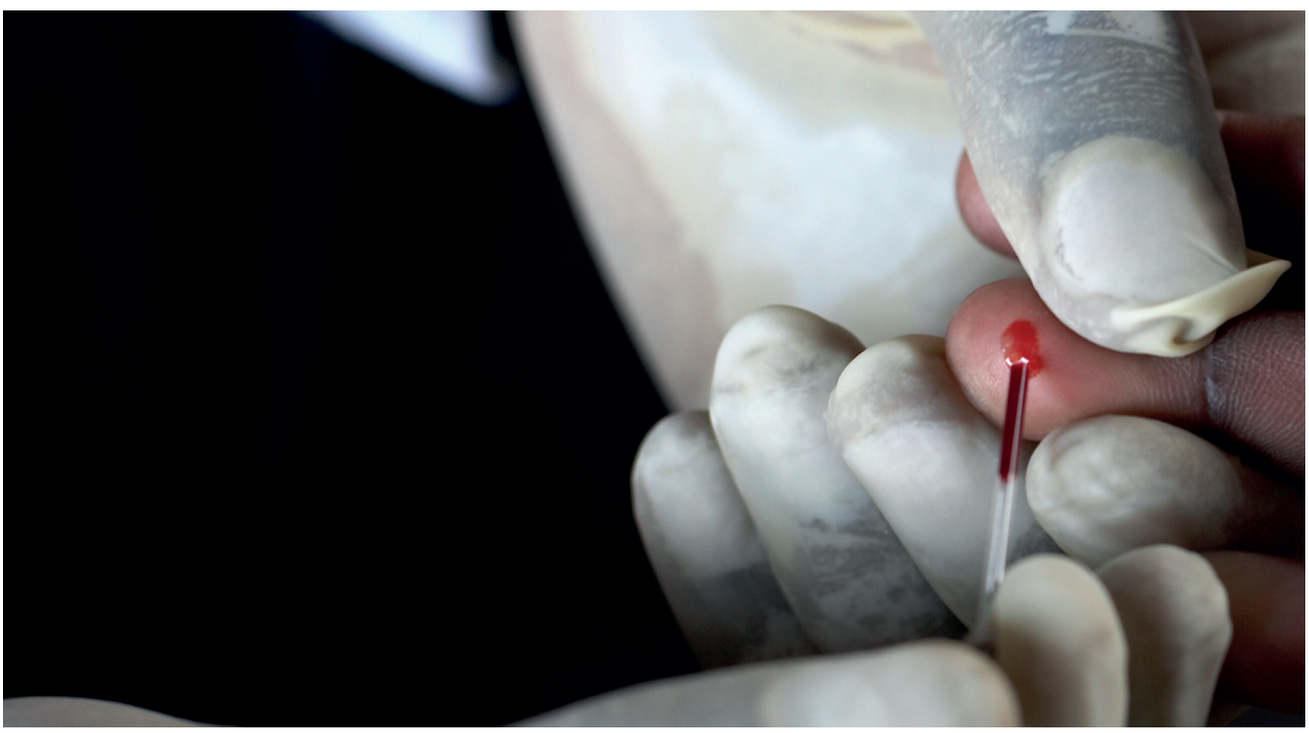
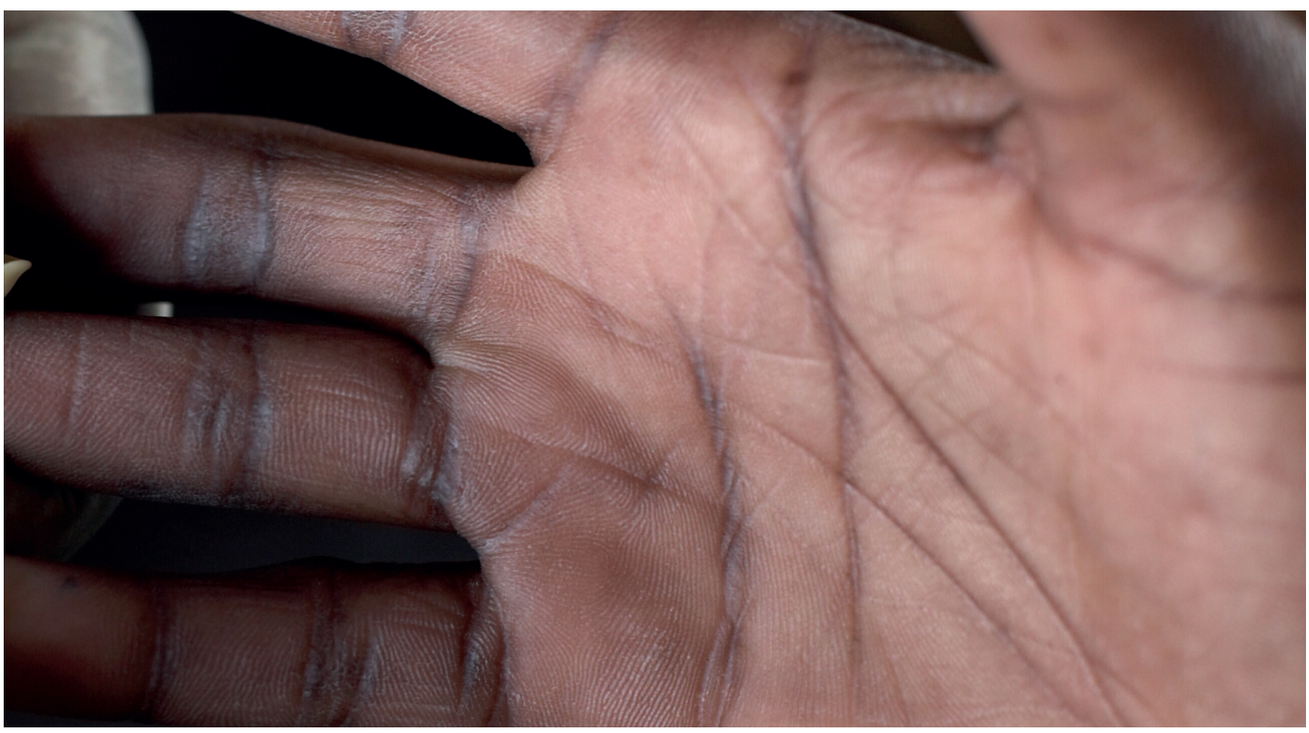


Photo: Andy Hall

SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
Assist at least 60 countries, including those of West Africa, over a five-year period, with the aim of developing the capabilities of each country and furthering existing partnerships. Create health support systems that are adequate for migrants and refugees, eliminating the current shortfalls.	Strengthen the mechanisms for responding to health emergencies. Offer practical assistance, supporting 76 countries and regions so that they meet the International Health Requirements of the WHO. Strengthen the health systems, supporting schemes such as the Healthy Systems, Healthy Lives Roadmap. Provide services to protect and improve the health of individuals throughout their lives.	• Despite some progress, increases in the number of people employed in the health sector are still insufficient. According to WHO data, the number of countries with a density of human resources for health below 2.3% has risen from 57 to 83 countries, showing a specialised personnel deficit of about 18 million in countries of low to average income[5]. • One of the most important challenges right now is the observation of the International Health Requirements of the WHO. No less than 84 of the 196 member states of the WHO have requested and obtained an extension of the deadlines to the end of 2016, in order to be in line with the basic requirements stated in the regulation. There are still considerable shortcomings in the ability to react rapidly, monitor and respond to health emergencies[6]. • A positive signal is the approval of the Health Systems – Healthy Lives roadmap as a basic starting point for fostering coordinated unified action for strengthening health systems[7]. • As regards the monitoring of commitments relating to the strengthening of health systems, something of concern is the lack of common guidelines to measure the support of the G7 countries in pursuing this objective[8].



	AT THE G7-G8 SUMMITS ON HEALTH					
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012	LOUGH ERNE 2013	BRUXELLES 2014
FIGHTING AIDS, TB AND MALARIA	Implement further efforts towards universal access to HIV/AIDS prevention, treatment, care and support by 2010, with particular focus on prevention and integration of services for HIV/TB. Counter any form of stigma, discrimination and breach of human rights; promote the rights of people with disabilities and the elimination of travel restrictions on people with HIV/AIDS.	Come as close as possible to universal access to prevention, treatment, care and support for HIV/AIDS. Support efforts to achieve this aim by making the third voluntary replenishment conference of the Global Fund to Fight AIDS, TB and Malaria in October 2010 a success.	Continue to support the Global Fund to fight AIDS, Tuberculosis and Malaria. Welcome the Patent Pool Initiative launched by UNITAID in order to facilitate the production of affordable broad-spectrum medicines suitable for use in resource-poor settings.			Reaffirm commitment to an AIDS-free generation and to the Global Fund to Fight AIDS, Tuberculosis and Malaria, in order to reduce the burden of these three major infectious diseases on eligible countries and regions

Photo: Geoff Sayer

SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
Fully support the Global Fund to fight AIDS, Tuberculosis and Malaria, in view of its replenishment in 2016.	End AIDS, tuberculosis and malaria, working in partnership with the Global Fund and others. To this end, fully support the 5th Global Fund replenishment process.	• Antiretroviral therapy has reached a global coverage of 46%. The main factor that has led to a decrease in mortalities related to AIDS, which fell from 1.5 million in 2010 to 1.1 million in 2015 (-26%), was improved access to treatment. Improvements have been substantial in areas of the world with the most cases of HIV/AIDS, especially in South and East Africa, where coverage rose from 24% in 2010 to 54% in 2015, reaching a total of 10.3 million people. However, ignorance and prejudice continue to weigh on the overall balance. At the beginning of 2016 there were 72 countries with laws that specifically allow discriminatory attitudes towards people with HIV[9]. Another critical factor is the high percentage (54%) of HIV-positive people who are unaware of their condition[10] . There has been no reduction in the number of infected adults over the past five years and in some regions there has been an increase[11]. • Between 2010 and 2015, the malaria incidence rate fell by 21% globally and in Africa[12]. During the same period malaria mortality rates fell by an estimated 29% globally and by 31% in Africa[13]. 74.6% of the mosquito nets treated with long-lasting insecticide (LLINs) distributed through the Global Fund were provided thanks to the G7 countries[14]. • The number of deaths caused by TB dropped from 1.8 million in 2000 to 1.4 million in 2015, however, the incidence rate dropped by only 1.5% between 2014 and 2015, the year in which TB caused more deaths than HIV. Between 2004 and 2013, 72% of financing by international donors for the fight against TB was channelled through the Global Fund[15]. • G7 contributions to the Global Fund increased by 72% between 2006 and 2015[16]. At the fifth replenishment conference of the Global Fund held in September 2016, the G7 countries donated USD 9.2 billion, out of a total of USD12.9 billion allocated overall for the three-year period 2017-2019[17]. The Global Fund asked donors to invest at least USD13 billion[18]. • Five years after its launch, the Patent Pool initiative made it possible to sign licenses for 12 primary antiretroviral drugs with six patent owners and 59 sub-licenses with 14 producers of broad-spectrum medicines. More than six million antiretroviral drugs recommended by the WHO on a patient-year basis in 117 countries were supplied. Thanks to the lower prices of the therapy, the international community was able to benefit from a saving of USD79 million, equivalent to the treatment of 625,000 people in one year.[19]

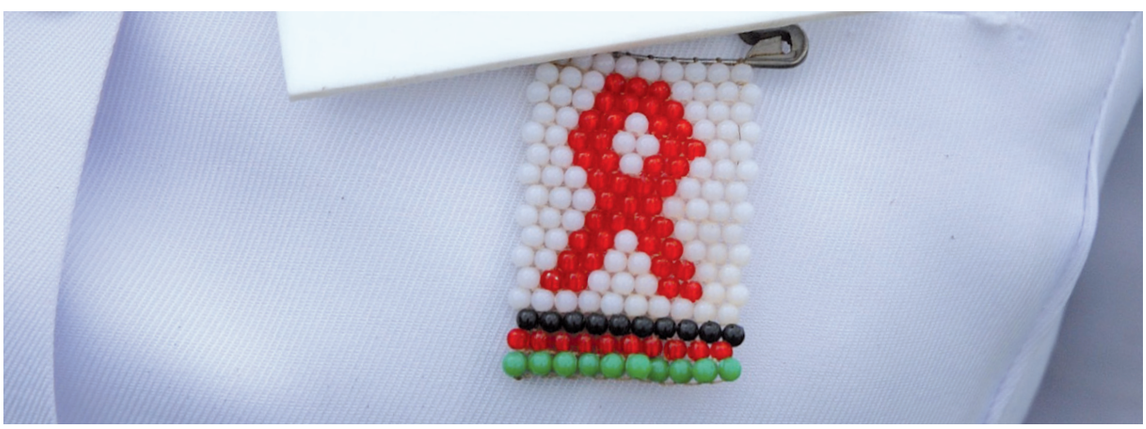


Photo: Eva-Lotta Jansson

	AT THE G7-G8 SUMMITS ON HEALTH			
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012
POLIOMYELITIS	Complete the process of eradicating poliomyelitis.	Confirm the fight for a polio-free world.	Renew the commitment supporting the Global Polio Eradication Initiative.	

	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012
NEGLECTED TROPICAL DISEASES	Combat the spread of neglected tropical diseases through a comprehensive integrated approach.	Continue to support the control and elimination of neglected tropical diseases.		

	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012
ANTIMICROBIAL RESISTANCE				

LOUGH ERNE 2013	BRUXELLES 2014	SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
			Eradicate poliomyelitis.	• Substantial successes in eradicating poliomyelitis have been achieved, but for its complete eradication it is necessary to act in two countries where it is still endemic: Pakistan and Afghanistan.

LOUGH ERNE 2013	BRUXELLES 2014	SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
		Promote research & development, investing in prevention and control, in order to achieve the elimination objectives planned for 2020.	Foster research & development to protect, disseminate and discover new remedies.	• The progress in the prevention and cure of Neglected Tropical Diseases or NTDs) has been negligible. The G8 countries have obtained an overall score of +0.11 on a scale of -1 to +1, with the lowest scores being found in Italy, Japan, United Kingdom and United States[20].

LOUGH ERNE 2013	BRUXELLES 2014	SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
	Work in close cooperation with the WHO to develop a Global Action Plan on antimicrobial resistance.	Develop and implement national Action Plans, also supporting other countries in doing the same. Support the One Health Approach (human, animal and environmental health) and foster cautious use of antibiotics.	Strengthen and actively implement the multi-sector One Health Approach. Identify potential new incentives that encourage R&D in this area.	• In G7 countries there has been an increase in the levels of resistance due to the overuse of antibiotic medicines and improper control of the procedures. The cumulative score for the implementation of national action plans is 0.75 on a scale of -1 to +1. Particularly poor was the commitment of Italy[21], which had one of the highest levels of resistance in Europe[22].

	AT THE G7-G8 SUMMITS ON HEALTH			
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012
SEXUAL AND REPRODUCTIVE HEALTH	Promote gender equality as a key issue for aid effectiveness and to reduce poverty. Support the building of a global consensus on maternal, newborn and child health as a way to accelerate progress of the Millennium Development Goals for both maternal and child health.	Prevent maternal mortality with better access to strengthened health systems and SRH care and services, including voluntary family planning. Take action on all factors that affect the health of women and children. This includes addressing gender inequality, ensuring women's and children's rights, and improving education for women and girls. Promote the integration of HIV and SRH rights and services within the broader context of strengthening health systems.	Improve maternal health and reduce child mortality by delivering the Muskoka commitments. Support the recommendations of the Commission on Information and Accountability for Women's and Children's Health established by the WHO at the request of the UN Secretary General[23].	Report transparently and consistently on the implementation of the commitments to global health, including those made at the L'Aquila Summit and the Muskoka Initiative on maternal, newborn and child health. Condemn and vow to stop violence against and the trafficking of women and girls.

LOUGH ERNE 2013	BRUXELLES 2014	SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
Sexual violence in armed conflicts represents one of the most serious forms of violation or abuse of human rights, international and humanitarian law. Prevent sexual violence in armed conflict as a matter of upholding universal human rights and of maintaining international security, in keeping with UN Security Council Resolution 1820.	Promote gender equality to end all forms of discrimination and violence against women and girls, to end child, early and forced marriage and to promote full participation and empowerment of all women and girls. Remain committed to the Muskoka Initiative and take up the call made at the Saving Every Woman, Every Child Summit in Toronto to accelerate progress on this global priority. Ensure sexual and reproductive health and rights, as well as ending child, early and forced marriage and female genital mutilation and other harmful practices.	Reaffirm the commitment to continue to promote gender equality as well as full participation and empowerment for all women and girls. Strongly condemn all forms of sexual violence in conflict. Support the renewal of the Global Strategy for Women's, Children's and Adolescents' Health as well as the establishment of the Global Financing Facility in support of "Every Woman, Every Child". Support the partners in the so-called developing countries and within the G7 countries to overcome discrimination, sexual harassment, violence against women and girls and other cultural, social, economic and legal barriers to women's economic participation.	Launch tangible initiatives at national and international levels, in line with the *G7 Guiding Principles for Capacity Building of Women and Girls*, in order to achieve gender equality and respect of human rights for women and girls, supporting them in reaching their full potential[24].	• Report the resources allocated to implementing the policy on RMNCH as of 2014. • Support of the resolutions of UNGA and HRC on Forced and Early Marriages (FEM) and Female Genital Mutilations (FGM) including the first substantial HRC resolution of 2015 and the joint programmes set up to put an end to harmful practices in more than 25 countries, where at least one of them is present, and provide support for girls who are already married. • Adopt a specific objective on gender equality in the SGDs, which includes elimination of harmful practices; support for the two joint programmes of UNFPA and UNICEF of which one is aimed at eliminating FGM in 17 countries. • Little more than 50% of the funds has been allocated to the RMNCH, equivalent to a result considered "moderate" by the G7 countries and which therefore requires further efforts. • Monitoring and reporting the national progress regarding FEM and FGM.

	AT THE G7-G8 SUMMITS ON HEALTH					
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012	LOUGH ERNE 2013	BRUXELLES 2014
MATERNAL AND CHILD HEALTH AND IMMUNIZATION	Foster the health of mothers, newborns and children, in order to speed up progress in the pursuit of the Millennium Development Goals.	Muskoka Initiative: mobilise 5 billion dollars in five years.	Monitor and implement the Global Strategy for Women's and Children's Health. Support the Gavi Alliance, especially its pilot project on pneumococcal vaccines (such as those for the prevention of pneumonia, meningitis and septicaemia).			Continue to support the Muskoka Initiative. Ensure universal access to health services and education, improving nutrition and access to immunisation.

Photo: Abbie Trayler-Smith/Panos

SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
Support renewal of the Global Strategy for Women's, Children's and Adolescents' Health and the establishment of the Global Financing Facility for Every Woman, Every Child.	Renewed support for: Global Financing Facility for Every Woman, Every Child; Gavi Alliance; Global Strategy for Women's, Children's and Adolescents' Health.	• It is estimated that the global infant mortality rate has dropped by 53%, from 91 deaths per 1000 births in 1990 to 43 in 2015[25]. • The maternal mortality rate dropped from 385 per 100,000 births in 1990 to 216 out of 100,000 in 2015[26]. • According to the Ise Shima Progress Report, the commitments made within the framework of the Muskoka Initiative were achieved, exceeding the original targets[27]. • The Global Strategy for Women's, Children's and Adolescents' Health, which is part of the Muskoka Initiative, with the support of the United Nations, received more than 40 billion dollars in pledges, involving a number of public and private players. • Starting with its creation in 2000, with the support of donors and a strong commitment on the part of each country, the Gavi Alliance make it possible to vaccinate 440 million children, saving 6 million lives. At the time of the first replenishment of the Gavi Alliance, the G8 countries contributed to refinancing in 2011, with a total of 1.8 billion dollars through direct contributions and innovative financing mechanisms". In January 2015, at the second replenishment of the Alliance, a total of US$ 7.5 billion was promised, with 4.1 billion dollars from G7 countries.

	AT THE G7-G8 SUMMITS ON HEALTH				
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012	LOUGH ERNE 2013
NUTRITION	Support food security, nutrition and sustainable agriculture so that they remain a priority topic in the political agenda. Launch the Aquila initiative on food security with the reduction of malnutrition as one of the principal outcomes. Mobilise 22 billion dollars for the development of sustainable agriculture in the next 3 years.	Launch the Muskoka initiative for neonatal health and the health of children under the age of five, focusing on improving nutrition, reducing the burden of disease and strengthening health systems to provide complete integrated health services to women and children locally. Allocation of 7.3 billion dollars for additional funds in 2010-2015.	Support the Deauville Accountability Report- G8 on health and food security and the need to reach the goals set. Support the strategic coordination of players operating in food safety and nutrition, also reforming the institutional architecture, working particularly to reform and strengthen the Committee on World Food Security (CFS).		Speed up efforts to combat malnutrition Consolidate prompt and appropriate commitments to achieve sustainable global food and nutrition security. Launch of the "New Alliance for Global Agriculture and Food Security" programme. Support of the Summit "Nutrition for Growth."

Photo: Ami Vitale

BRUXELLES 2014	SCHLOSS ELMAU 2015	ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
Continue the commitment to the Muskoka initiative and boost action related to nutrition to improve the health and wellbeing of women and children. Substantial support for global approaches to achieve food security and nutrition. Identification of the Second International Conference on nutrition and Milan Expo as platforms for the post-2015 debate on sustainability and food security and nutrition.	Undertake to save 500 million people in so-called developing countries from hunger and malnutrition and by 2030. Double efforts to support dynamic rural transformations, promotion of responsible investments and sustainable agriculture, assurance of food security and nutrition in crisis and conflict situations. Continue to support actions to empower women, small scale farmers and rural families.	Determination of the vision of G7 countries on food security and nutrition: empowerment of women, improvement of nutrition levels through an approach centred on people, sustainability and resilience in agricultural and dietary systems. Acknowledgement of the 2016 Nutrition for Growth Summit ("N4G") as an important opportunity for progress in the global agenda on nutrition. Confirm the target set at Elmau.	• In recent decades, the world has made significant progress in combating malnutrition: the number of children affected by chronic malnutrition has dropped by more than one third since 1990 when the phenomenon concerned 255 million children, in other words, 40% of the children in the world. The matter of food security was included in the agenda of the last seven G8-7 summits, but the economic and political commitments were not sufficient to meet real needs. Malnutrition affects one third of the world population and 159 million children are malnourished, which is equivalent to 24% of all children. This is going to have an irreversible impact on their physical and intellectual development. Two billion people have access to food which is too poor in trace elements and this has an impact on their health, productivity and capacity to contribute to the economic and social life of their countries. Another two billion people are overweight or obese. • There is still no tangible plan of action for nutrition which includes mobilisation of the resources necessary and the creation of a mechanism of accountability to uphold the commitments made at the G7 summits.

	AT THE G7-G8 SUMMITS ON HEALTH						
	L'AQUILA 2009	MUSKOKA 2010	DEAUVILLE 2011	CAMP DAVID 2012	LOUGH ERNE 2013	BRUXELLES 2014	SCHLOSS ELMAU 2015
UNIVERSAL HEALTH COVERAGE							

Photo: Toby Adamson

ISE-SHIMA 2016	WHAT RESULTS WERE ACHIEVED?
Acknowledge Universal Health Coverage as a necessary condition for achieving all the other global health objectives.	• The present outlook is variable. On one hand, the number of people who have access to essential health services has increased to historic levels; on the other hand there are still serious shortfalls which can be seen in the first monitoring Universal Health Coverage report, produced in conjunction with the World Bank Group and the WHO. As regards the vaccination of children, 84% coverage had already been achieved in 2013 for children aged 12 months. As regards reproductive, neonatal and maternal health, coverage is about to reach 80% and the number of births attended by expert staff is around 73%, while the demand for modern birth planning methods is met for about 76% of women globally. There are still serious shortfalls in access to hygiene services: 36% of the world population, about 2.5 billion people, do not have access to hygiene services and live with the continual risk of dysentery, cholera and typhoid.[28]

2. THE FIGHT AGAINST EPIDEMICS AND THE STRENGTHENING OF HEALTH SYSTEMS

The fight against the main epidemics has made significant progress thanks, in part, to the commitments of G7-G8 countries over the years.

Examples of this are the **Global Alliance for Vaccine Immunization** (Gavi) created in 2000, which plays an essential role in guaranteeing access to vaccinations, and the **Global Fund to Fight Aids, Tuberculosis** and **Malaria**, a public-private partnership founded in 2002 which invests almost 4 billion dollars a year to support health programmes managed in countries by local experts and by the communities worst affected by diseases.

Italy has contributed to both these initiatives. Support for Gavi was provided through the innovative financing mechanisms of Advanced Market Commitment for vaccines against pneumococcus (AMC) and the International Finance Facility for Immunisation (IFFIm). Funding of over 60 million euros a year was provided (from 2008 to 2015), helping to achieve significant results, and it is crucial that these results be maintain in the years to come.

As regards the Global Fund, the initial phase, in which Italy was one of its greatest donors, was followed by a long period of disengagement (2009-2013): firstly, the government failed to make two yearly contributions promised and in the following three years it made no investment in the Fund at all. At the Replenishment Conference of 2013, Italy was back on the donor list, pledging 100 million euros for the following three years. In 2014, it distributed 30 million euros which, together with the bilateral increase, produced the first increase in the Italian ODA for health after the economic crisis and after the minimum level reached in 2013. In 2015 and 2016, our country contributed 30 and 40 million euros respectively. During the final session of the 5th Global Fund Replenishment Conference, held in September 2016, donors made a commitment to contribute USD 12.9 billion in the three-year period 2017-2019, one billion more than the figure pledged at the previous

GLOBAL ALLIANCE FOR VACCINE IMMUNIZATION: RESULTS ACHIEVED

Since its establishment in 2000, Gavi has helped save 8 million lives, thanks to the support of 10 different types of vaccine in poor countries. When the Global Polio Eradication Initiative (GPEI) was launched in 1988, polio was endemic in 125 countries and paralysed about 1,000 children every day. Thanks to efforts to increase vaccination globally, with the participation of Gavi, cases of polio have dropped by 99%, from more than 350,000 a year to 414 in 2014. Between 2016 and 2018, Italy will disburse 82.5 million euros through the IFFIm and 114 million euros thanks to AMC. At the second replenishment of Gavi in Berlin, Italy promised a further voluntary contribution, with a donation of 100 million euros between 2016 and 2020; in December 2016, an agreement was signed by Gavi and the Italian Government to schedule the disbursement of this new contribution. With the new resources made available during the last replenishment (USD 7.5 billion), Gavi will be able to implement the new strategy for 2016-2020, enabling the immunisation of another 300 million children, saving a further 5-6 million lives.

GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA: RESULTS ACHIEVED

The commitment of the partners of the Global Fund has made it possible to increase access to antiretroviral therapy, which is having a positive impact on the likelihood of survival by those affected by HIV and Aids.

Efforts to eliminate the transmission of HIV from mother to child have dramatically reduced the numbers of infected children, from 290,000 cases in 2010 to 150,000 in 2015.

In 2001, when the G8 summit was held in Genoa, the possibility of defeating Aids, Tb and malaria seemed to be a mirage. From 2002 to 2015, the Fund helped save over 20 million lives.

replenishment conference of 2013. Italy has announced a 40% increase in its contribution, pledging 140 million euros for 2017-2019. The Fund had asked for a collective effort to raise at least USD13 billion, so this result is positive. Nevertheless, this amount must be considered as a minimum value, to be increased over the next three years[29].

In spite of recent progress in the fight against three great pandemics (Aids, Tb and malaria) which affect a huge number of countries, there are still worrying signs which require action.

As regards **HIV** in adults, UNAIDS has observed that, for at least the past five years, there have been about 1,900,000 new cases, without any reduction; in Eastern Europe, Central Asia, the Caribbean, Middle East and North Africa the figures are rising. The aim of UNAIDS, confirmed by the Political Declaration of the United Nations on HIV/Aids in June 2016, to reduce the number of cases of new infections to fewer than 500,000 a year by 2020, cannot be achieved if this trend is not interrupted[30]. A report published last year by the Kaiser Family Foundation together with UNAIDS[31] shows that **donor government funding to support efforts to prevent HIV in low- and middle-income countries fell for the first time in five years in 2015**, from USD 8.6 billion in 2014 to USD 7.5 billion. The study analyses the trend of funding through the bilateral channel consisting of the Global Fund and Unitaid. For 13 of the 14 countries examined, the drop in funding is partly due to a significant rise in value of the US Dollar, offset by the drop in value of many other currencies. Even if we consider this factor, the amount of funding to fight HIV declined in most of the countries considered in the study. A change of pace in action against Aids over the next five years would be decisive for freeing the world of this epidemic. On the contrary, if there's no increase in funding, Aids would start to rise and escape control again.

Global health in general and particularly the fight against epidemics are closely connected with the defence of **human rights**. *In the case of HIV, for example, the "***key populations"**[32] *are at greater risk of infection due to stigma, discrimination and a legal system that punishes behaviours considered to be abnormal in certain countries*. **Gender inequality** is the main cause of female vulnerability to HIV[33]. At global level, young women aged 15 to 24 have double the infection rates of males of the same age. Today, more than 7,000 young women become sick every week and the virus is the main cause of death in women of reproductive age (15 to 49 years old), in low and medium income countries[34]. Women therefore represent a large percentage of the people affected by HIV/Aids, because they often have no access to the information and services necessary for their health, especially in relation to sexual and reproductive health, which also prevent sexually transmitted diseases.

Thanks to the efforts made in recent years, the fight against **malaria** has been successful all over the world: from 2000 to 2015, an overall reduction of 37% in new cases and 60% in the mortality rate was recorded. In the last fifteen years, more than six million lives have been saved and the cases of malaria have been reduced by 75% in 57 countries. Almost half of the world population (3.2 billion people) however, still risk contracting malaria and, in 2015 alone, 212 million new cases were recorded worldwide[35]. The two main obstacles are the lack of a really effective antimalarial vaccine and the appearance and spread of resistance of *Plasmodium falciparum* to artemisinin, the drug on which current treatment is based for less severe malaria and which has been largely responsible for success in the fight against the epidemic in recent years.

According to the latest report by the WHO[36], the **Tb** epidemic is more widespread than previously thought. In spite of this, the number of deaths worldwide and the incidence of the disease continue to fall. In 2015, 10.4 million new cases were estimated (5.9 million men, 3.5 million women and 1 million children). 11% concerns patients with HIV. Six countries account for 60% of all cases of Tb: India, Indonesia, China, Nigeria, Pakistan and South Africa, the latter holding the record for Tb-HIV co-infections. Deaths in 2015 reached 1.8 million, of which 400 thousand were related to HIV. The main obstacle to the eradication of Tb is the presence of drug-resistant strains: of 590 thousand cases of Multidrug-resistant Tb, only 19%

have been registered and treated. After more than half a century of black-out, two new anti-tuberculosis molecules have appeared on the market. They are reserved for patients without any other option but, unfortunately, these two new drugs are not sufficient to meet the treatment needs of all Tb sufferers.

Antibiotic resistance does not concern Tb alone: over the years, antibiotic resistance has become increasingly widespread, especially with regard to bacterial strains seemed be unquestionably sensitive to certain drugs. Consequently, **research and development** of new drugs, vaccines and diagnostic techniques is vital, together with a global commitment to introduce policies that control the **price of drugs**, which are becoming more and more expensive, not only in poor countries, which have always had to endure the drama of tremendously expensive drugs and vaccines, but also in rich countries, where equality in terms of healthcare and the distribution of wealth is being constantly threatened by the macro-economic policies of governments. The High Panel of the Secretary General of the United Nations on human rights and drugs published an important report in September 2016. This report points the finger directly at investments in research and development, and pricing of medicinal products, dictated by business interests and not by the assessment of public health, in addition to patents and the power of the pharmaceutical companies[37].

Another key factor to ensure treatment and prevention, defeat the major epidemics and deal promptly with health emergencies, is the creation or strengthening of **sustainable and resilient health systems**. Recently, the Ebola case proved that epidemics spread mainly where health systems are fragile. At the beginning of the HIV/Aids epidemic in southern African countries for example, the spread of the disease was linked mainly to misinformation of the population on transmission and prevention, to the difficulty in diagnosis and to the lack of access to antiretroviral (Arv) drugs. Information campaigns, the involvement of health staff in counselling, access to laboratories equipped for reliable diagnoses, and the availability of affordable Arv drugs, contributed substantially to achieving good results in the fight against the epidemic in the region.

The most recent estimates indicate a potential deficit of 18 million health workers in low- and middle-income countries[38]. The employment, development and training of the **workforce**, as well as the creation of staff loyalty, must respect the principle of **gender balance** and the **health workers of a community** must be considered an integral part of the health system workforce. They provide their communities with health-related information, on matters such as hygiene, reaching even the most remote areas and taking into consideration the culture of the population they are dealing with. They also provide essential services such as monitoring compliance with treatment. The intervention and participation of communities is essential in order to draw up operating strategies and find the best ways to inform people.

A necessary requisite for good health work is a **network of integrated services** which not only has skilled qualified staff but also readily available tools (medical equipment, drugs and medicines, means of transport), in compliance with the dictates of Primary Health Care established at Alma Ata. Another cornerstone for correctly operational health services is **improved data collection and analysis**, to promote the planning of evidence-based services and actions. For a health service to work properly, the local health authorities must be able to organise and sustain an effective and efficient network of services, distributed evenly throughout the territory.

Access to drugs, economic sustainability of treatments for individuals and systems, respect for human rights and effectiveness and efficiency of the health systems concern not only low-income countries but also those passing through a **phase of economic transition**, meaning that their income is no longer classified as low but as medium to high, even if there is a situation of severe inequality regarding access to resources, rights and essential services. Numerous international aid and development organisations, including the Global Fund, are progressively pulling out of many of these countries, and the risk that the large-scale epidemics still afflicting these areas will spread is aggravated by lower bilateral financing.

ADEQUACY OF HEALTH SYSTEMS IN EUROPE TO COPE WITH THE FLOW OF MIGRANTS

In recent years, the European G7 countries, particularly Italy, have been having to cope with a substantial flow of migrants fleeing wars, natural disasters and poverty to find a better life. According to the data of the International Organization for Migration (IOM), 181,436 migrants arrived in Italy in 2016. Landings of migrants in our country have not increased dramatically compared to the previous year.[39] Nevertheless, poor cooperation by many EU countries in receiving these people, Italy's difficulties in absorbing incoming migrants and persisting situations of temporary and inadequate accommodation, management of which is all too often delegated to the private sector, with no effective quality control, have harshened the tones of a debate which regularly flares up amid fears and stereotypical ideas about the impact that migratory flows can have on the spread of serious diseases and global health in general.

In actual fact, immigrants who come to work in Italy have a history of near perfect health: this is the so-called "healthy immigrant effect", extensively cited in literature, which refers to the self-selection that precedes emigration and takes place in the country of origin. Consequently, migrants become sick after arriving in the transit or destination country, not before.

The "healthy immigrant" effect, however, is only partly true today. Journeys to Europe have become increasingly dramatic and life threatening, and the legacy of good health, assuming the person arrives safely, dissolves more and more quickly due to a series of risk factors: traumas experienced in the countries of origin, the psychological malaise connected with being an immigrant, long waits to obtain legal status, the lack of work and income, underemployment in risky jobs without protection, poor housing in a context different to the country of origin, absence of family support, different climate and eating habits, often in addition to an already poor nutritional status, and discrimination in access to health services. In recent years, this interim period between arrival in Italy and the first request for medical care has shorted considerably, from about 10-12 months in 1993-1994 to 2-3 months in 1998-2000.[40]

The health of this population is guaranteed by inclusion in the "national health system" of the countries of arrival, facilitating access to and use of the health services. To do this, the national health system is called upon to strengthen its internal capabilities (technical and organisational), connecting with a broader dimension of health and with disciplines and approaches also adopted by international cooperation (ethno-psychiatry, anthropology, analysis of social and cultural contexts, mediation, conflict resolution, etc.).

3. GENDER BASED VIOLENCE AND SEXUAL AND REPRODUCTIVE HEALTH

Violence against women and girls is one of the most widespread breach of human rights. The phenomenon knows no national, social or economic boundary and is made possible by unequal relations between the sexes and the widespread custom of maintaining silence. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

According to the World Health Organisation (WHO), we are dealing with "a health problem of enormous global proportions" that affects one third of women and girls in the world - as demonstrated by the report published by the WHO in cooperation with the London School of Hygiene & Tropical Medicine and the South African Medical Research Council.[41] 35% of women, or 1 in 3, suffer some form of violence during their lives. The most common is domestic violence and almost one third (30%) of women who have been in a relationship have experienced some form of physical and/or sexual violence by the partner, husband or boyfriend. On a worldwide level, no less than 38% of femicides are committed by the intimate partner. **The ranking of domestic violence is led by Southeast Asia, Mediterranean Arab countries and Africa, all with percentages of around 37%. In Europe,** the situation is better, but not good enough: **more than 25 women out of a hundred are physically or sexually abused by their partners**[42]. The many forms of violence include female genital mutilations (FGM) and forced and/or early marriages, involving millions of very young girls all over the world: 700 million women married before reaching the age of 18, 1 out of 3 before the age of 15; about 200 million women and girls live with FGM.[43] Both phenomena are now also covered by European legislation on violence and are defined and dealt with by the so-called Istanbul Convention.[44]

SOME DATA ON GENDER VIOLENCE

The forms of violence suffered by women and girls include:

- forced and/or early marriage: 700 million women married before the age of 18, with 1 out of 3 being under 15;
- female genital mutilations (FGM): about 200 million women and girls in thirty countries have to deal with the consequences of this practice. In many of these countries, most of the girls were subjected to FGM before the age of five;
- domestic violence: 30% of women have suffered domestic violence during their lives, with the highest regional rates in Africa, the Eastern Mediterranean and East Asia, and 38% of femicides were committed by the victim's partner;
- harassment: 246 million women and girls are molested/abused every year at school or on their way to school; girls are particularly vulnerable, almost all of them say that they do not feel safe going to the toilets when they are at school;
- child labour: 88 million girls are involved in child labour, of these, 48 million do dangerous jobs.

Experiencing violence undermines women's dignity, safety and independence, often with multiple long-term consequences for mental, physical, sexual and reproductive health - including early and unwanted pregnancies, illegal abortions, sexually transmitted diseases, including HIV, and even death.

Sexual and reproductive rights have an impact on the state of wellbeing, with far-reaching social and economic effects. In countries where people have access to complete services for sexual and reproductive health, including adequate information on contraceptive methods and instruments, it is possible to make substantial developmental progress, reducing poverty and favouring economic growth. Better conditions of health for women and girls pave the way to greater opportunities for education, employment, community involvement, political participation and decision-making processes.

The international community acknowledges that it is impossible to realise SDGs without facilitating access to good quality sexual and reproductive health services, especially for more vulnerable people and social outcasts. Ensuring that women receive antenatal and obstetric care by qualified and respectful staff, in a safe environment, guaranteeing prompt access to emergency medical care and good quality obstetric care to those with complications, providing correct information on sexually transmitted diseases, HIV and AIDS - are all indispensable elements in health systems that aim to ensure the good health of the population. Concentrating on prevention also serves the purpose of reducing the costs that the health service has to bear in terms of assistance and care.

This means encouraging healthy, independent and safe sexual and reproductive choices for teenagers and adults, respecting the rights of men and women to be informed, to have access to family planning and contraception which are modern, safe, effective, satisfactory and affordable, so as to reduce the number of unwanted and early pregnancies, to have access to good quality maternal and paediatric health services, and to the prevention and cure of sexually transmitted diseases. At the same time, investment is necessary for the empowerment of women, girls and vulnerable people - fighting to prevent gender inequality and violence. Services aimed at sexual and reproductive health are often those that take in the victims of violence. The creation, improvement and facilitation of access by women and girls to these services not only means guaranteeing a fundamental right, but also dealing with and preventing cases of violence.

This data is supplemented by other data on migration, one of today's major issues, which requires specific attention. Migration, whether driven by the pursuit of economic wellbeing or by natural disasters and wars, is a delicate condition which exposes women and girls to growing vulnerability. At the moment, there are **more than 100 million people** in the world **who need humanitarian aid**, and **about 26 million of them are women and adolescents of childbearing age. This means that the humanitarian aid response needs to give special consideration to the specific needs of this sector of the population, as well as to other problems connected with gender, such as violence and forced/early marriage, which increase under these conditions. It is estimated that 70% of women have suffered some form of violence during their journey or in the settlements.**[45]

Photo: Abbie Trayler-Smith

4. MATERNAL AND CHILD HEALTH

The high number of maternal deaths in some areas of the world reflects the inequalities in access to general health and to sexual and reproductive health services, and emphasises the gap between rich and poor. Almost all maternal deaths (99%) occur in countries with poor economic resources. More than half of these deaths occur in Sub-Saharan Africa and almost one third in South Asia. More than half the cases occur in fragile situations and during humanitarian emergencies. In 2015, the maternal mortality rate in poor countries was 239 for every 100 thousand births, compared to 12 for every 100 thousand births in economically privileged countries. There are also big differences within the same country, between women with different income levels and between those who live in towns and rural areas. The risk of a woman dying due to causes connected with pregnancy or during labour – and the probability of a 15 year-old dying due to these causes – is 1 out of 4900 in rich countries, against 1 out of 180 in poorer countries. In countries designated as fragile states, the risk is 1 out of 54[46]; a figure that shows the harsh consequences that arise when the health systems collapse and access to services is reduced.

In actual fact, most maternal deaths are avoidable, just like the health care solutions to prevent or manage complications are well-known. All women need access to antenatal care, qualified assistance during labour and support during the weeks after giving birth. Maternal and neonatal health aspects are closely connected. In countries with poor resources, almost half of all the mothers and newborns do not receive qualified assistance during or immediately after birth. As a consequence, about 2.7 million newborns die every year and another 2.6 million babies are stillborn.[47] It is particularly important for all births to be attended by qualified professional health personnel, because prompt action and treatment can make the difference between life and death for mothers and their babies. Moreover, more than half the mortalities of children under five are due to diseases that are avoidable and curable using simple methods at affordable prices, yet in 2015, almost 6 million children in the world still died from pneumonia, diarrhoea, malaria or problems connected with malnutrition.[48] It has been a long time since the Millennium Development Goals were adopted and although we can talk about progress concerning maternal and child survival (maternal and child mortalities have dropped by more than half since 1990, with a faster downswing since 2000), goals 4 and 5 have not been fully achieved[49] in most of the 75 countries which recorded more than 95% of maternal, neonatal and child mortalities.

In 2010, during the 36th G8 summit held at Muskoka in Canada, member countries launched a specific and innovative initiative with the aim of speeding up progress toward achieving Millennium Development Goals 4 and 5, with which it was agreed to collectively spend an additional 5 billion dollars between 2010 and 2015, compared to the level of expenditure in 2008 (baseline). According to the "Ise Shima - Progress Report, G7 accountability on development and development-related commitments", all the current G7 countries fulfilled their financial commitments and some even surpassed their own goals. Analysing the Italian figures however, this does not seem to be the case for Italy. Not only was the Italian contribution extremely limited compared to that of other contributors (75 million dollars compared, for example, to over 3 billion dollars of the United Kingdom, the billion promised by the United States, 500 million from France and 400 million from Germany), following the methodological indications proposed by the G8 Health Working Group to calculate the baseline (2008) and commitments for maternal, neonatal and child health, it appears that the bilateral Italian and multilateral commitments ascribable to the Muskoka initiative never grew after 2008 and in some years were even more than halved. The main causes are progressive cuts in bilateral financing since 2009, which began rising again only in 2014, and then, in 2009 – 2013, the absence of Italian contributions to the Global Fund which, together with GAVI, represented the major channel of funding for maternal, neonatal and child health activities.

5. COMBATING MALNUTRITION IN ALL ITS FORMS

Italy is a key player in international matters of food security and it is in Italy that the most important international organisations that deal with it are based: the International Fund for Agricultural Development (IFAD), the Food and Agriculture Organization (FAO), the World Food Programme (WFP) and the European Food Security Agency (EFSA). The last time Italy hosted the G7 summit (then G8) in 2009, the world was beginning to recover from the severe food price crisis of 2007-2008 and food security occupied an important place on the summit's agenda. The Aquila summit launched a global Food Security project, which received pledges for a total of 22 billion dollars in aid for food security, agricultural development, nutrition and infrastructures.

The United Nations Decade of Action on Nutrition - 2016-2025 – intends to boost efforts to improve the nutrition of the world population. A change in how food systems work (the way food is produced, transformed and distributed) is needed, in order to ensure that everyone has access to nutritious food and a healthy diet. This must also be combined with social protection systems and measures to oppose inequality, ensuring that everyone in the world has access to healthier food. Lastly, it is necessary to strengthen the health systems so that everyone has access to essential services connected with nutrition.

Unfortunately, malnutrition in all its forms continues to be a global problem which affects millions of people in the world. It is estimated that about 45% of mortalities of children under the age of five are linked to malnutrition.[50] Every year, 3.1 million children die due to poor nutrition and 159 million children under the age of two are so undernourished that their brains and bodies will never fully develop. The economic consequences of malnutrition are considerable.[51] Every year, 10% of the global GNP is lost and this exceeds the wealth lost due to the global financial crisis of 2008-2009.

Gender-based discrimination and malnutrition are closely linked[52]: the rates of prevalence of female malnutrition exceed the figures for males in Southeast Asia, Latin America and Sub-Saharan Africa. In Ethiopia, Zimbabwe and India for example, the rate of female malnutrition is between 1.5 and 2 times higher than the figure for men. Gender-based inequality in nutrition is present throughout life, from childhood to adulthood. Gender and nutrition are inseparable parts of the vicious circle of poverty. Gender inequality may be both the cause and effect of hunger and malnutrition. It is no mere coincidence that the highest levels of gender inequality are associated with high levels of malnutrition.

Malnutrition is not only a consequence of the lack of food: 42 million children and 1.9 billion adults who are overweight or obese throughout the world are also the victims of malnutrition. Malnutrition is quite simply the adoption of a poor diet. It can be caused by eating insufficient food, too much food, the wrong combination of foods or foods with a low nutritional value, as well as foods contaminated by pathogenic microbes.

Too little food results in undernourishment and this can be detrimental to the growth and development of children and even lead to death. Too much food – especially with high sugar and fat content - causes overweight and obesity and increases the risk of diabetes, heart disease and some types of cancer.

The consumption of foods contaminated with harmful bacteria, viruses or parasites may cause infections that endanger survival. According to the WHO, one person out of three in the world is malnourished.

Current analysis of the phenomenon based on standard geographic indicators would be incorrect.

Bad food habits, in all their forms, are a global problem. It is not unusual to find people with various forms of malnutrition living in the same country, the same community and sometimes even in the same house.

The term "nutrition transition" is generally used to define a change in the average levels of consumption per capita of calories. In the last 40 years, this transition has manifested itself in a transformation of the

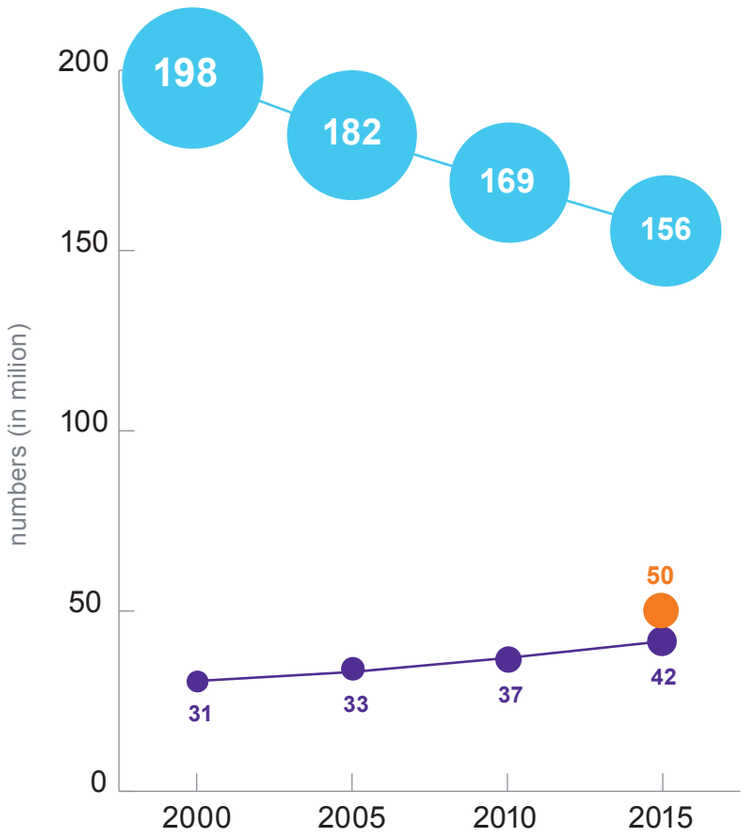
average diet toward higher calorie levels. Nutrition transition however does not mean (nor will it mean) only a general increase in the average calorie content of the diet, but also a marked change in its composition.

From this viewpoint, the first stage of the transition that has taken place so far can be summarised as an "expansion effect". At low income levels, the average energy content of diets has increased, mostly due to the introduction of additional calories from inexpensive foods of vegetable origin (this seems to happen regardless of cultural and religious traditions, traditional eating habits and the specific produce of a given geographic area). The second stage is mostly a "substitution effect" reflecting a shift in choice from carbohydrate-rich foods (cereals, roots and tubers) toward vegetable oils, sugar and foods of animal origin. This effect displays many geographic characteristics and is often influenced by cultural or religious food traditions. These factors determine the extent to which animal products substitute vegetable products and the composition of the animal products introduced into the diet.

Poverty is at the centre of the problem. Undernutrition and obesity are more common in countries with low and medium income and among the poorest communities in high income countries. Eradicating poverty is the key to ending malnutrition in all its forms. At the same time, eradicating malnutrition is the key to economic development because a well-nourished population is a healthier and more productive population.

A recent economic analysis[53] by the World Bank, the Foundation for Development and the American NGO "1000 days", showed how an extra 7 billion dollars are needed every year to fight hunger in the world. This analysis is based on an assessment of the costs necessary to reduce the number of undernourished children by 40%, reduce the number of anaemic women in child-bearing age by 50%, increase the rate of breast feeding only in the first six months to 50%, and increase access to pharmaceuticals that counter the otherwise irreversible effects of malnutrition in children (four of the six World Health Assembly goals for 2025). Investing in these actions in the next 10 years will save 3.7 million people.

Photo: Jerry Galea



Number of stunted, overweight and wasted children
under the age of five, in millions, global figures, 2000-2015

6. BRINGING SERVICES TO COMMUNITIES: THE ROLE OF LOCAL AUTHORITIES

Local authorities often hold jurisdiction over on health and social service matters within a framework of strategic national policies and guidelines to defend people's health. Combining health and social service sectors means basing policies on people rather than disease, as well as considering the socio-cultural factors that determine the health of communities.

Close relations between institutions and the general public, especially on social and health matters, enable local authorities to obtain a great deal of feedback on the quality and effectiveness of the service to the public. On one hand, this feedback can help improve people's lives thanks to a more efficient provision of social and health services. On the other, it allows local authorities to influence the political decision-making process and the national policies in the sector. Repeatability at national level of innovative local experiments is another area where the dynamics between state and region have a virtuous link with the fight against inequality in accessing good quality essential services for everyone.

The key experiences of the local authorities in the social and health sector are as follows:

- Technical-health and social-welfare skills for different areas of specialisation, through the work of the organisations responsible for providing services to the public (e.g.: in Italy, the Health and Social Service departments and Local Hospitals);
- Planning and monitoring social-health services in the area covered (e.g.: in Italy, regional administrations and their competent departments);
- Interaction with central government to ensure that national policies consider the needs of local communities (e.g.: boards and commissions of the State-Regions Conference).

THE ROLE OF LOCAL AUTHORITIES IN FIGHTING POVERTY

Among the various meanings of territory, one is its consideration as an ecosystem characterised by a complex interrelation of history, culture, geography, resources, knowledge and institutions. The local space is the place where interactions between members of the public and public administrations are more immediate, but also where inequalities, vulnerabilities and exclusions are more explicit and directly affect people's lives.

The fight against multidimensional poverty and injustice takes place where there are effective governments and active citizens. In many countries of the world, local authorities administer the public assets and policies of a territory and can be important levers of change to improve people's lives in economic, social, cultural and environmental terms. The effectiveness of local authorities in fighting poverty and injustice is characterised by three key dimensions:

- The closeness to communities and the public, especially the more vulnerable, and knowledge of the critical aspects and potential of the territory;
- The ease in launching and managing dialogue mechanisms and public participation in decision-making processes on matters regarding their lives;
- The role of coordination, involvement and intermediation between public and private players in the local context, whose activities have an impact on sustainable human development

Over the last 20 years, local authorities have become increasingly active in international development cooperation, contributing specialized skills, human and economic resources, exchange of experiences in various sectors, networking skills, etc. Within the sphere of health and social services, this type of activity has grown and contributed to improving people's quality of life in disadvantaged situations or ongoing crises. For example, in 2014-15 **the municipalities of southern Beirut in Lebanon** ensured access to good

quality basic health services, with the technical support of Italian social and health organisations, for 15,000 people of Lebanese or Syrian origin with a minimum fee of 5 dollars. In March 2015, this scheme was considered "good practice" by four Lebanese ministers who then decided to extend the model to a further six regions of the country in 2015-16.[54]

Another example concerns the supply of innovative services to prevent HIV transmission from mother to child in the rural areas of the **Ortambo district in South Africa,** by boosting the role of local authorities and their capacity to plan and monitor local health services and adequately manage rural clinics. In South Africa, this process made it possible to increase the coverage of anti-retroviral treatment for pregnant mothers from 34.2% in 2011 to 90.4% in 2014.[55] Lastly, the health organisations of the Tuscany region have played a major role in **Albania,** over the past ten years, developing relations with their local counterparts and building strategic partnerships in which regional systems cooperate with central government in implementing the health system reform strategy (the hospital funding system, with the introduction of a tariff scheme and reform of the emergency-urgency system).[56]

An analysis of the data on the bilateral Italian ODA for health disbursed through local authorities, recorded in the OECD-DAC database, shows that funding by local authorities cooperating in health matters has been underestimated. There is fragmentary public evidence to show that some municipalities, provinces and regions disburse significant contributions. The CRS database of the OECD, which contains data received from the MAECI, does not always state the name of the donor but often only that of the body implementing the scheme. Tuscany region, for example, is never indicated as one of the funders of health development schemes, while it actually financed various health authorities, hospitals, municipalities in Tuscany and Tuscan NGOs in 2015, disbursing a total of 825 million euros for 25 projects. All these projects are listed in the CRS of the OECD without any reference to the donor, Tuscany Region, mentioning the implementing body only. Using the OECD database, the contributions of the province of Trento, amounting to 1.2 million euros have been traced: in this case too, the amount could be greater because some projects financed could be shown under the name of the implementing body only and not the donor.

Not even the OpenAid database of the Italian cooperation for development[57] provides data which indicates the contributions of the single regions, provinces or municipalities within the total attributed to local administrations. Using the "Annual Report on the implementation of development cooperation policy in 2014" of the Ministry of Foreign Affairs and International Cooperation and the General Directorate for Development Cooperation, we were able to trace other contributions from local authorities for 2014, such as the Veneto Region and Autonomous Province of Bolzano, in addition to the figures for the Tuscany Region. The report for 2015 is not currently available on any sites. There seems to be a general lack of coordination between local authorities and MAECI, which most probably leads to an underestimate of the contributions for decentralised cooperation within the Italian development cooperation and prevents us from fully appreciating the role played and the level of commitment.

In the light of the above mentioned benefits, which the involvement of local bodies brings about in health cooperation projects and in the administrative decentralisation processes in progress in many beneficiary countries, it is therefore desirable for them to play a growing role both in donor countries and in recipient countries. National policies which favour cooperation between territories in terms of technical assistance and the exchange of good practices are also desirable.

7. THE RISKS OF PRIVATISING HEALTH

In the debate on funding for development, the role of the private sector has taken an increasingly central position as a major player to be involved in cooperation projects in poor countries. The reasons for this often arise from considerations on the contribution of technical expertise available in the profit-making sector, greater management efficiency and, last but not least, potential additional resources in a situation where public funding has suffered greatly from the economic crisis. On one hand, the involvement of the private sector, for the reasons stated above, can represent an added value for development programmes. On the other, however, this involvement has to be based on a solid regulatory framework which defines criteria of transparency and accountability, just like every other player operating in development cooperation, guaranteeing the genuine orientation of any investment towards reducing poverty in the areas concerned, respecting the rights of local communities and meeting their needs.

As regards the health sector, the debate on the involvement of the private sector is extremely delicate and particularly exposed to risks of failure in the implementation of effective development policies. The case of the Queen Mamohato Memorial Hospital built in Maseru, capital of Lesotho, in Africa, one of the countries with some of the world's highest poverty and inequality rates, is a perfect example[58]. It was built by a public-private partnership (PPP) entered into in 2009 for a duration of 18 years, with the aim of replacing the old public hospital. Strongly encouraged by the financial branch of the World Bank (IFC – International Finance Corporation), it was presented as an innovative model of involvement of the private sector in the country's public health, the first PPP experiment in the health sector in a low-income country. However, the facts that emerge from the first few years of activity contradict the initial expectations and cause considerable concern and doubts in relation to the actual response that this hospital is capable of providing for the country's public health. The running costs and repayment of interest on the debts taken out to build this hospital are so high that it absorbs more than half of the national budget allocated for health expenditure on its own. This is a huge figure, which aggravates the inequalities in access to health care in the country even more if we consider that the greatest needs of the population are concentrated in rural areas, where there is a serious lack of basic healthcare facilities. So this model is putting considerable strain on the scarce public resources of Lesotho but guaranteeing profits for the private investors. What is more, this model constitutes a risk to the country's public health as it does not ensure adequate access to health facilities by all of its people.

The involvement of the private sector in health services is an extremely delicate matter which requires careful assessment, even more than in other sectors. Evidence of this is also offered by the health insurance models introduced in some countries, which often aggravate inequalities, increasing the gap between those in formal employment, who benefit from greater protection, and the poorer marginalised sectors which are excluded as they cannot pay the premiums.[59] It is estimated that, every year, 100 million people in the world fall into poverty because they have to pay for medical treatment out of their own pockets.[60] A health emergency can condemn a family to poverty or bankruptcy for generations.

The growing commitment toward Universal Health Coverage (UHC), under which everyone has the right to receive the necessary health care without running into financial difficulties, has the potential to improve access to health care considerably and to reduce inequality. Achieving this goal by 2030 is one of the objectives of the Sustainable Development Agenda. Looking at some emblematic and disastrous cases of involvement of the private sector (see the case of Lesotho above) and observing the progress made by some emerging countries (China, Thailand, South Africa and Mexico), it appears evident that the lever for public financing in health (recouping resources from tax revenues) is the path to take to reduce inequalities and ensure fair access to health for all members of the public.[61]

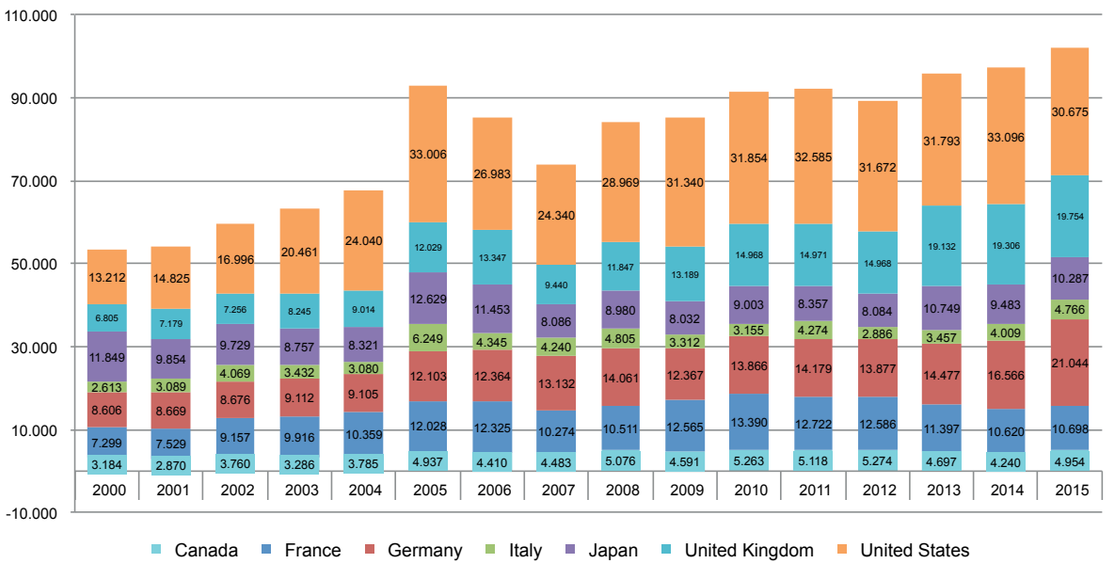
As Italy has experience of a "universal" health system, it should be a crusader for this type of service in its health cooperation projects, exporting to other contexts and strengthening that principle of equity included among the principles of our Constitution, even if in recent years it has been progressively eroded at legislative level and in the application of the norms.

Photo: Aubrey Wade

IN DETAIL: SOME DATA ON OFFICIAL DEVELOPMENT ASSISTANCE FOR HEALTH[62]

In 2015, the total amount of Official Development Assistance (ODA) from G7 countries represented 55.8% of the ODA of all donors throughout the world. In this situation, Italy contributed 2.7% of the global ODA and 4.8% when compared to G7 countries alone.

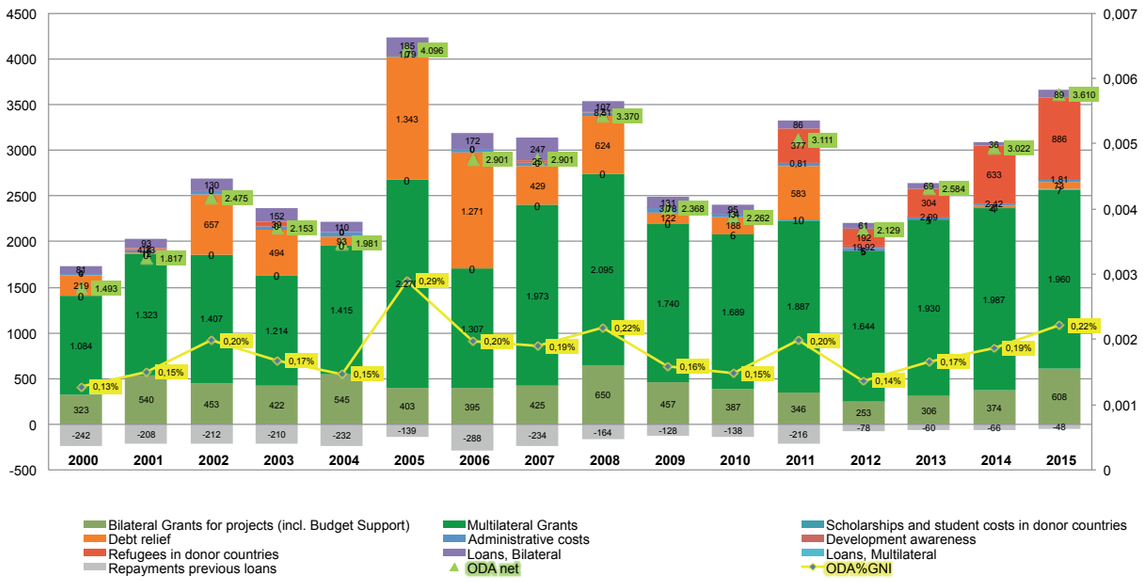
ODA G7 countries 2000 – 2015 (US$ millions, constant values 2014)



In absolute terms, the volume of resources of the Italian ODA grew from 2.6 billion dollars (1.5 billion euros) in 2000 to 6.2 (4.1 billion euros) in 2005, and then started to drop steadily and substantially to the historic minimum of 2.9 billion (2.1 billion euros), reached in 2012; since 2013, the trend has made a decisive upswing – rising to 3.5 billion (2.6 billion euros), 4 billion (3 billion euros) in 2014 and almost 4.8 billion (3.6 billion euros) in 2015.

In spite of the prospects of a gradual realignment compared to the average for European donors, and although the Italian ODA has risen from 0.14% to 0.22% of the GNI in the last four years, Italy is still a long way from reaching the international target of allocating 0.7% of its GNI to ODA.

Composition of Italian ODA 2000-2015 (million Euro and as a % of the GNI)



Although the gradual increase in the Italian ODA planned – given the commitments of the current government – also in the next few years is positive and encouraging, it must be stressed that the aid allocated by Italy has often been inflated by expenses calculated as ODA but never actually transferred to the beneficiary countries: this is the case of considerable expenditure for hosting refugees in Italy in recent years (2011-2015) calculated as ODA. It is also common tendency in many other European donor countries.

In the case of Italy, the ODA actually transferred has risen in the last three years but not to the impressive extent indicated by official data, according to which there was an increase from 2012 to 2015, from 2.1 to 3.6 billion euros, equivalent to almost 1.5 billion euros (an increase of 70%); in actual fact, excluding the costs for refugees, the Italian ODA rose by 40% - equivalent to 786 million euros, from 1.9 to 2.7 billion.

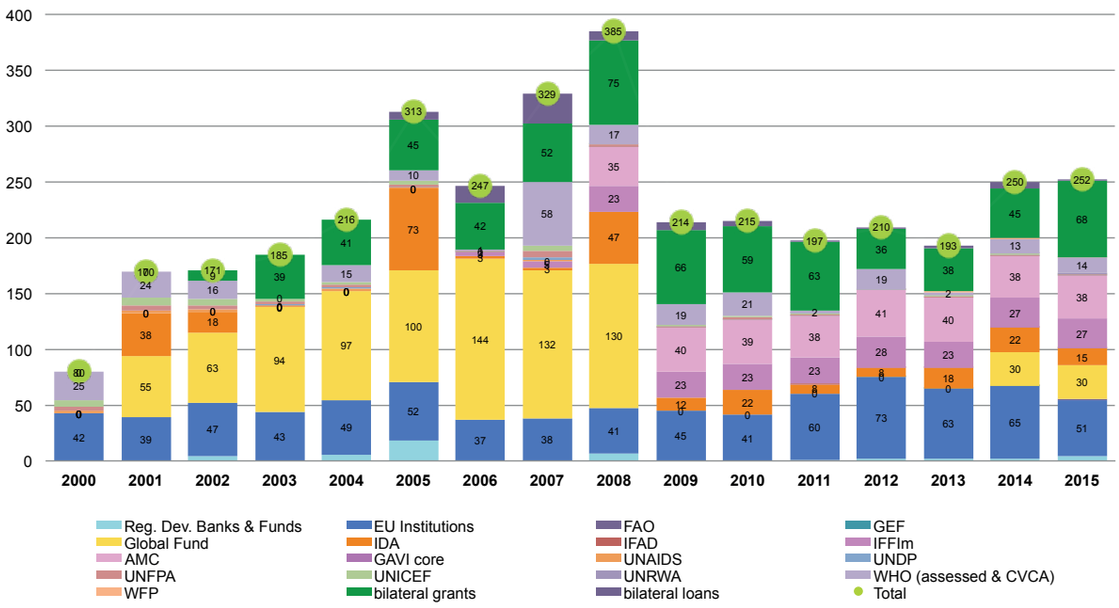
In short, there has been an increase in ODA over the last three years, but only just over half of this is due to a real increase in funds for cooperation, while a good 47% is due to the attribution of costs for refugees in the country as Official Development Assistance.

Likewise, the ODA/GNI ratio has increased, but, net of costs attributed for hosting refugees, it would have reached 0.17% in 2015, and not 0.22%.

In this general picture, the Italian ODA allocated to the health sector in 2015[63] represented 7% of the total resources. If we look at the historic data from 2000 to 2014, we can see that, just like in 2008, the year in which the health sector registered a maximum peak in the allocation of resources, the percentage of the total ODA was around 11%. It is clear, therefore, that although the strategic importance of the health sector in Italy's development cooperation is always declared, the financial resources allocated remain, on average, less than a tenth of the total resources counted as ODA. This figure becomes even more of a touchy subject when compared to the expenditure for hosting refugees calculated, representing 24% (and a good 52% on the bilateral contribution) in 2015.

If compared with the ODA of the DAC donors, the contribution of Italian ODA in 2015 to the health sector was 1.5%, rising to almost 2% if the comparison is limited to G7 countries only. In terms of the health ODA/GNI ratio, in 2015 our country reached 0.015%, a value practically identical to that of the previous year. Of the G7 countries, the only one to reach the 0.1% recommended by the WHO[64] was the United Kingdom (0.101%).Composizione APS sanitario italiano 2000-2015 (in milioni di Euro)

Composition of Italian health ODA 2000-2015 (in millions of Euro)



In terms of the composition of the ODA for health, it is easy to see how, until 2008, much of this aid was channelled through the Global Fund for the fight against AIDS, Tuberculosis and Malaria, to such extent that the main reason for the drop in volume in health cooperation registered between 2009 and 2013 was due largely to the absence of contributions to the Global Fund. Starting in 2014, the year in which Italy recommenced its financial engagement in the Global Fund, there was an increase in resources which, together with the bilateral increase, produced the first increase in the Italian ODA for health since the economic crisis and after the minimum level reached in 2013. It is precisely in the light of the Italian contributions to the Global Fund in 2016 – the last annual contribution of the pledge for 2014-16 amounting to 40 million euros – and considering the commitments made with the new replenishment for 2017-19 (140 million euros for the three-year period), the outlook is that, in the next few years, there will be an increase in the Italian ODA for health.

It should be noted that although the Italian bilateral contributions for health increased in 2015, the total amount of resources remained practically unchanged compared to the previous year: this is mainly because there was a decrease in the Italian contributions to the European Union Institutions (one of the main channels of the Italian ODA for health) and the percentage of resources allocated by these Institutions to the heath sector.

Another important channel of the Italian ODA for health is the Gavi, through its innovative funding mechanisms – the Advanced Market Commitment (AMC) and the International Finance Facility for Immunisation (IFFIm). Although Italy has never financed the Gavi directly, in December 2016 an agreement was signed between the Italian cooperation and the Gavi confirming the commitment of 100 million euros made during the course of the Gavi replenishment conference in January 2015.[65] In 2014 and 2015, there was also a substantial increase in the Italian contribution to the WHO (from 2 million in 2013 to 13 and 14 million respectively, although similar figures were also disbursed in other years in the historic series analysed).

From the breakdown of the Italian ODA for health, it is possible to see a clear prevalence of funding through multilateral channels, while bilateral aid constituted on average less than 25% of the total

ODA for health. After the peak in 2008, resources for health cooperation through the bilateral channel progressively diminished but there was a substantial increase in 2014 and mainly in 2015, which it is hoped will be confirmed also in the years to come.

Of the total Italian bilateral aid for health in 2015, 61% was disbursed through NGOs and civil organisations, 35% through the public sector and the remaining 4% through multilateral organisations for multi-bilateral projects.

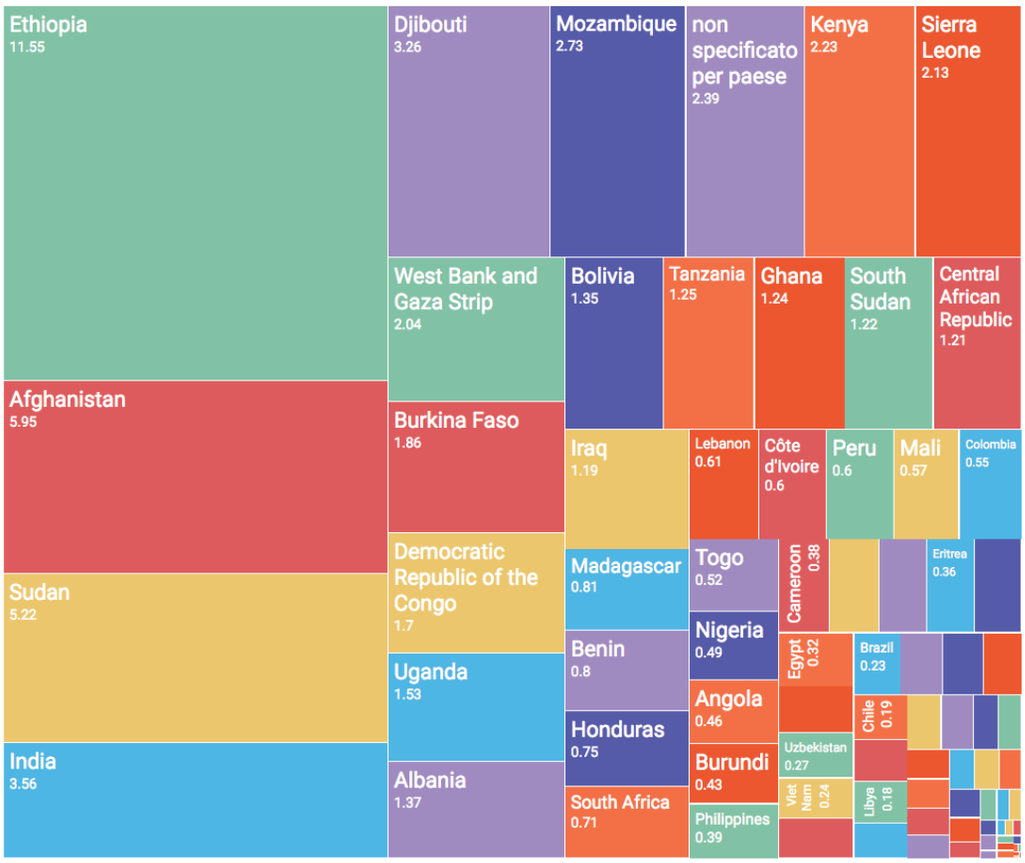
Most of the Italian bilateral aid for health in 2015 went to Sub-Saharan Africa (45 million, 65%).

However, Italian bilateral aid for health is typically very fragmented in terms of beneficiary countries. Italian health cooperation projects involved 84 beneficiary countries in 2015 (83 in 2014), among which Ethiopia is the main beneficiary, receiving 17% of the bilateral aid (almost 12 million euros); Afghanistan received 6 million euros, amounting to 9% of the total, and Sudan 5 million euros, amounting to 5%. Two countries, Djibouti and India, both received more than 3 million euros each (about 5% of the total for each one). These countries are not mentioned as priorities for Italian cooperation for 2014-16 (most of the projects in India however are not financed by the DGDS but through the "8xmille" scheme of the Italian Episcopal Conference - CEI). Lastly, another low priority country, Sierra Leone, received more than 2 million euros, considered as special aid connected in some way with the Ebola epidemic (through the Emergency "5xmille" scheme). In 2014, two of the primary beneficiaries of Italian ODA for health were South Africa and Honduras which, although not among the priorities of our cooperation, received 12% and 11% respectively.[66]

Of the 84 countries that received health aid from Italy in 2015, only 19 received contributions exceeding one million euros, while the remaining 65 countries received contributions of less than one million euros, a symptom of the high fragmentation and dispersion of the aid (confirmed also for the total ODA, with more than 120 countries sharing just over 650 million euros in 2015).

Photo: Annie Bungeroth

Italian bilateral aid for health 2015, Beneficiary countries (values in millions of euro)



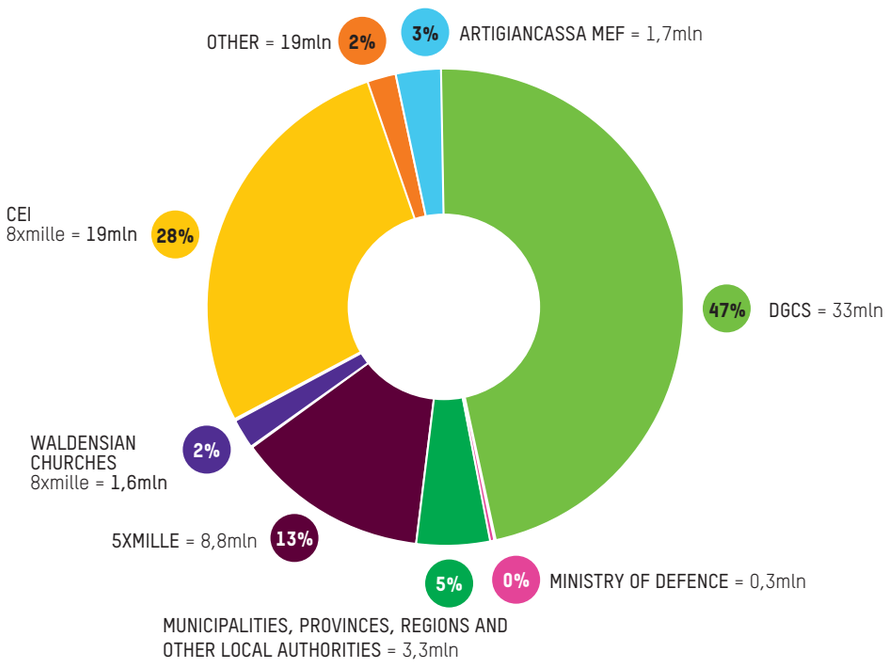
In 2015, 39% of the Italian ODA for health financed "medical services" (27 million euros), 21% on "health policy and administration" (15 million), and 10% on "basic health care" (7 million). The total contribution for the three pandemics, AIDS, tuberculosis and malaria, in 2015 was only 1.5 million euros, almost all of which (97%) was disbursed for the control of sexually transmitted diseases including AIDS. Although this contribution is in addition to the greater resources provided through the multilateral channel and the Global Fund, it should be stressed that, in 2014, the bilateral total for the three pandemics was substantially higher, reaching almost 8 million euros. In the reproductive health sector, in 2015, a total of 2.3 million euros was disbursed, more or less in line with the volume disbursed in previous years, while for family planning, practically no contributions were made in 2015 and in the previous 16 years.

Breaking down the total bilateral ODA for health by funding organisation, we can understand the role and weight of local administrations (regions, provinces and municipalities) in Italian health cooperation compared to that of the DGDS, but also of other central administrations of the state or other institutions. It appears that the DGDS is the major finance provider, with 33 million euros, 47% of the total, followed by the Italian Episcopal Conference - CEI which finances 28% of the bilateral ODA for health (19.5 million euro) with its "8xmille". Municipalities, provinces, regions and other local administrations finance 5% of the total, in other words 3.3 million euros.

It is interesting to note that 13%, 8.8 million euros, refers to 42 NGO projects financed through the "5xmille" taxation system.

In 2015, there were only two health projects, in Honduras and Albania, financed with loans by the Ministry of Economy and Finance (MEF) through *Artigiancassa* for a total of 1.8 million euros; in 2014 health projects financed through loans amounted to 5.8 million euros. In the years to come it will be interesting to follow the role of the *Cassa Depositi e Prestiti* (Deposit and Loan Bank) appointed as the new financial institution for Italian international cooperation for to lending.

Italian bilateral PDA for health 2015 by funding channels (millions of euro %)



RECOMMENDATIONS

Protecting the right to health and ensuring full access to health services is a condition and basic requisite for the development of every country. Inequality in health must be countered by **strengthening national health systems** and promoting policies aimed at achieving **Universal Health Coverage**.

All this implies **greater and more effective investments in health systems**, through greater funding by donor countries in health cooperation and the mobilisation of national resources through a more equitable taxation system and the collection of tax revenues by the beneficiary countries, thus ensuring adequate public services to help all citizens to maintain their health throughout their lives.

We ask the Italian government, in the year of its presidency of the G7 summit, to demonstrate its commitment to health cooperation by improving its current performance and making global health central to the G7 agenda, thus consolidating a renewed commitment by G7 governments to respond to old and new challenges that demand the attention of the international community.

STRENGTHENING OF ITALIAN HEALTH COOPERATION

- **Increase Italian public aid to health development** through both multilateral and bilateral channels. As the overall increase in Italian ODA registered in recent years has been greatly influenced by a high costs to host refugees in Italy, it is essential to ensure that this does not happen to the detriment of the volume of Italian cooperation resources invested in the so-called developing countries in the health sector.
- **Reduce the geographical fragmentation** of Italian public aid to health development, ensuring greater correspondence between countries defined as strategic and countries which are effectively the beneficiaries, in order to optimise resources and make interventions more effective.
- A ensure **greater transparency** in the allocation of resources and their use, creating and implementing a **monitoring and assessment** plan that ensures the **quality of public development aid** also in the health sector. The recent news that in, March 2017, the Italian Agency for Cooperation and Development will take part in the IATA platform (*International Aid Transparency Initiative*), which is the main international platform on the transparency of aid, is welcome [67].
- Enhance the **role of local authorities** in health cooperation schemes in terms of technical assistance, strengthening institutions and the capacity for connection with local communities; improve the coordination between the Ministry of Foreign Affairs and International Cooperation and Italian local authorities to ensure that each cooperation intervention financed by local authorities is registered among the activities that the Ministry of Foreign Affairs and International Cooperation reports to the OECD as cooperation for development.
- Reaffirm the **centrality of public funding** in health cooperation projects in order to reduce inequalities and ensure equal access to health for everyone. Where the involvement of the private sector is appropriate, ensure that this takes place only on condition that a solid **regulatory framework** has been established. **Criteria of transparency and accountability of the private players** must be defined and investments in objectives for reducing poverty must be ensured, respecting the rights and meeting the needs of local communities.

ACCESSIBILITY TO HEALTH CARE

Support the global effort to develop **resilient health systems** and strengthen the **role of communities** in providing health services. It is also necessary to promote policies that do not encourage the **departure of qualified health workers** from countries that suffer from workforce shortages in this sector.

- Promote **research** and **development** and the dissemination of "**knowledge sharing**" of **new pharmaceuticals, vaccines and diagnostic techniques**, to fight **antimicrobial resistance** (AMR)[68]. It is necessary for G7, in coordination with G20, to continue promoting actions aimed at encouraging integration between public and private initiatives to fight AMR, as well as their coordination with actions supported in this context by various international organisations.
- Promote policies that regulate the **price of pharmaceuticals**. This would facilitate access to medicines of higher quality in both G7 and poor countries. It is necessary for G7 countries to take tangible steps to control the rampant inflation of drug prices and to demand greater transparency concerning the real cost of pharmaceutical research and development. This problem can be solved only by creating working groups that include patient associations, civil society, the pharmaceutical industry and international organisations. Moreover, countries can and must exercise their rights on the basis of the agreements of the World Trade Organisation[69] and produce or import generic pharmaceuticals in order to guarantee access by the greatest number of patients even if the patents for these pharmaceuticals have not yet expired. It is essential for G7 to promote initiatives such as The Medicines Patent Pool (MPP)[70]. Through its innovative business model, this organisation promotes the generic production and development of new drug for HIV, viral hepatitis C and tuberculosis in developed countries and access to them in low- and middle-income countries.
- **Pledge to end the epidemics of HIV/Aids, Tb and malaria by 2030,** ensuring universal access to prevention, care and support services, paying special attention to the needs of women, young people and key populations, and increasing funds for the fight against epidemics, fully supporting the Global Fund.
- Help **middle-income countries** create a **transition plan** from external funding to the use of domestic resources, within the framework of global health organisations (Global Fund and Gavi *in primis*) and international organisations (EU and World Bank) appointed to support this transition.

CENTRALITY OF GENDER ISSUE AND HUMAN RIGHTS IN THE HEALTH SECTOR

- Facilitate **universal access to the rights and sexual and reproductive health** for every person, especially those who are more marginalised.
- Promote policies for the **elimination of disparity and discrimination** connected with gender.
- Prevent and **combat all forms of violence against women**, girls and LGBTQ communities, including harmful practices (HP) such as MFG and forced/early marriages. Regarding HPs, to fund the UNFPA/IUNICEF joint programme.
- **Support refugees and migrants**, especially minors affected by conflicts and natural disasters working on empowerment and resilience.
- Ensure **access of young people and adolescents to quality and affordable sexual and reproductive health services**, to information and sexual education in order to remove the negative social impact of gender stereotypes.

- **Mobilize resources and support governments and other key actors to implement plans to improve the WHO** *Global Strategy for Women's, Children's and Adolescents' Health* (2016-2030).
- **Address all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities.**
- Strengthen health systems to collect high quality data in order to respond to the needs and priorities of women and girls and ensuring accountability in order to improve quality of care and equity.

NUTRITION AS A PREREQUISITE FOR ADEQUATE LEVELS OF GLOBAL HEALTH

- Ensure that projects for **food security** and support for **agricultural development** include a **focus on results in terms of nutrition**. In the promotion of attention to nutrition, it is essential to respect the **leadership of poor countries**, using global standards developed by the SUN[71] movement at all stages of planning. Donor investments should be in line with any existing country strategies. Where there are no multi-sector national plans, G7 donors should encourage countries to develop them.
- Fill the current **nutrition funding** gap[72] and ensure that the investments are in line with global targets.
- Develop an **action plan for nutrition,** which includes the mobilisation of resources and the creation of a mechanism of accountability as a tool to reach the target set at the Elmau summit in 2015, to free 500 million people from the risk of hunger and malnutrition by 2030.
- Take on the baton of the ***Nutrition for Growth*** (N4G) event which accompanied the Olympics and, with the support of Brazil, Japan, the United Kingdom and the FAO, host a **summit within the framework of the G7 Italian Presidency** and the United Nations Decade of Action on Nutrition, to raise funds and draw up performing policies on nutrition.

NOTES

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8. Ise-Shima Progress Report, Ise-Shima Summit, G7 2016 http://www.mofa.go.jp/files/000158338.pdf
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60. Oxfam (2014), http://www.oxfamitalia.org/wp-content/uploads/2014/10/PartireAPariMerito.pdf

61. Ibidem.

62. For the total Italian and other G7 countrie's ODA we have used as a reference the database of the Organisation for Economic Co-operation and Development (OECD) Total flows by donor (ODA + OOF + Private) [DAC1] https://stats.oecd.org/Index.aspx?DataSetCode=CRS1#. For the Italian bilateral contributions to health we have used as a reference the database of the Organisation for Economic Co-operation and Development (OECD) Creditor Reporting System (CRS) https://stats.oecd.org/Index.aspx?DataSetCode=CRS1#, considering areas "Health" and "Population policies / programs and reproductive health". To calculate multilateral ODA for health we have used as a reference the database OECD Members' total use of the multilateral system (https://stats.oecd.org/Index.aspx? DataSetCode CRS1 = #) and the DAC members' imputed multilateral Contributions to the health sector, secretariat Estimations, date to 2015 (xls, Jan 2017) and methodology (http://www.oecd.org/dac/stats/aidtohealth.htm). The OECD, based on reporting from the various multilateral agencies that report to the DAC, calculates the flows of each multilateral agency for a given sector - and therefore also for the health sector - as a percentage of the total aid of a single agency; this percentage is then applied to the donors' contributions to each specific multilateral agency. The resulting amounts represent then an estimation of the contribution to the health sector by a donor country through this agency. From our part we then integrated these estimations with data from the most relevant multilateral agencies database, since the OECD's estimations do not always contain all the contributions of a donor country to the most relevant multilateral agencies engaged for health. Particularly in Italy, in these estimations of multilateral contributions made by the OECD-DAC, there are no the data on AMC and GAVI, and several of the annual contributions to the Global Fund. Therefore we correct these gaps by taking from direct sources. For the Global Fund we have used as a reference the data reported in its website (http://www.theglobalfund.org/documents/core/financial / Core_PledgesContributions_List_en /) and the data of the MAECI (Office VIII DGDC-MAECI). While for the GAVI we have used as a reference the data contained in the "Donor Profile - Proceeds to Gavi ITALY Contributions & pledges from donor (2016-2020) as of 30 June 2016"(Http://www.gavi.org/funding/donor-profiles/italy/). The exchange rates for each year, between the dollar and euro, are taken from the Total flows by donor database (ODA + OOF + Private) [DAC1].

63. Data of the OECD database disaggregated by sector are updated to 2015: see Creditor Reporting System database.

64. Macroeconomics and health: 'investing in health for economic Development, Who Commission on Macroeconomics and Health (2001,whqlibdoc. who.int/publications/2001/924154550x.pdf

65. cf. https://www.facebook.com/cooperazioneitalianaallosviluppo/posts/1237771342935258 ; http://www.gavi.org/funding/donor-profiles/italy/

66. The priority countries according to the document "Italian Development Cooperation in the Three-year Period 2014–2016 Guidelines and planning orientation Update: March 2014" : 9 in Sub-Saharan Africa (Senegal, Sudan, South Sudan, Kenya, Somalia, Ethiopia, Mozambique, Niger, Burkina Faso), 2 in North Africa (Egypt, Tunisia); 1 in the Balkans (Albania), 2 in the Middle East (Palestine and Lebanon), 3 in Latin America and the Caribbean (Bolivia, El Salvador and Cuba), 3 in Asia and Oceania (Afghanistan, Pakistan and Myanmar).

67. http://www.open-cooperazione.it/web/news-la-cooperazione-italiana-aderira-alla-piattaforma-iati--PzMWmG1_uloXaz.aspx

68. Global action plan on antimicrobial resistance, OMS, http://www.who.int/drugresistance/global_action_plan/en/,2015.

69. https://www.wto.org/english/tratop_e/trips_e/pharmpatent_e.htm

70. http://www.medicinespatentpool.org

71. http://scalingupnutrition.org

72. http://thousanddays.org/tdays-content/uploads/Investing-in-Nutrition-The-Foundation-for-Development.pdf

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