

# Health and Development: Fifty Years of French Cooperation in Africa

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While France holds in 2011 the presidency of the G8 and G20, a number of events invite us to look back at the key steps of the French technical cooperation in the field of health, including profound changes observed in Africa over the last thirty years with regard to nutrition, health and demographics; the sudden emergence of new health and development actors in the 1990s; followed in the 2000s by profound worldwide evolutions in the mechanisms prioritised to channel development funding, during the very period in which France launched the reform of its official development assistance.

## The position of the French health cooperation since independence in Africa<sup>1</sup>

Between 1960 and 1990<sup>2</sup>, two founding strategies were pronounced at the international level: the Primary Health Care strategy, whose

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1. Title of a reference publication by Bruno Flourey, 'Le discours de la Coopération française en matière de santé depuis les indépendances' in *Santé publique*, No. 4, pp. 367-380. In this very unique article, the author presents the strategies of the French cooperation over the period 1960-1990, during which the programmes recommended by the World Health Organisation (WHO) were implemented by individual states.

provisions were laid down in the Declaration of Alma-Ata in 1978, and the Bamako Initiative launched in 1987. The latter recommended requiring financial contributions from patients, so-called “user fees”; both drugs and monies would be managed at health centre level by user-organisations. This process was referred to as ‘health democracy’<sup>3</sup>.

These perspectives initiate the beginning of a brand new period, distinct from the previous era, which had been described in the following terms: ‘Our military’s health division (Service de santé des armées or SSA) has a long and glorious historical connection to Africa. Through the territorial layout system, the SSA was able to combat major endemic diseases, protect civil and military populations, and make scientific strides. Its humanitarian dimension allowed France to build a unique technical as well as emotional relationship with the African continent.’<sup>4</sup> In the aftermath of Africa’s independencies and during two decades, the World Health Organisation – with bilateral cooperation from several northern countries acting in support to African governments – attempted to cope with major health issues, dominated by infectious and parasitic diseases (malaria, smallpox, plague, yellow fever, leprosy,

tuberculosis, onchocercosis, trypanosomiasis, and so on). In response to these pathologies, the SSA, in line with its colonisation-era interventions, organised the fight against these major endemic diseases into the 1970s.

This focus and organisation would not have been necessary if not for the significant shortcomings of local healthcare. Indeed, mass campaigns only compensated to varying degrees for the low availability of basic healthcare services. It became extremely urgent to inform and educate people on tuberculosis and sexually transmitted infections (STIs) as well as to screen them for infection, but also to protect children from childhood diseases with terrible complications for which effective vaccines were available, and to provide pregnant women the means by which to safely live through pregnancy and childbirth. Lastly, it was necessary to provide care, in dispensaries and hospitals, to the overall population in the event of illness or accident. At the time, the Ministry of Cooperation – which was in charge of designing French international health cooperation policy – was also dedicated to reinforcing the hospital network through the construction of new establishments, mostly university hospitals; improving the initial training received by health professionals; establishing new Schools of Medicine; and developing the network of overseas Pasteur Institutes in any state making the request. Humanitarian doctors created the NGO Doctors Without Borders in 1971, which subsequently split to form Aide Médicale Internationale (AMI) and Doctors of the World (MDM), followed by Action Against Hunger International (AICF), etc. Through technical cooperation, research institutions as well as humanitarian NGOs, the skills of French civil and military doctors – and health professionals overall – flourished and were acknowledged worldwide.

2. See the dossier ‘Afrique : 50 ans d’indépendance’ in *Revue internationale de la politique de développement*, The Graduate Institute Publications (Geneva), No. 1, March 2010, p. 267. See: <http://poldev.revues.org/75>

3. Dominique Kerouedan and Patrick Dauby, ‘Les enjeux de la démocratie sanitaire en Afrique’ in *Médecine Tropicale*, Vol. 64, No. 6, pp. 609-612. See: [www.revuemedecinetropicale.com/609-612\\_-\\_FPR\\_-\\_kerouedan.pdf](http://www.revuemedecinetropicale.com/609-612_-_FPR_-_kerouedan.pdf)

4. General Jacques de Saint-Julien, Inspector-General of the SSA, 1 December 2004, interview with French National Assembly député Pierre Morange.

It was not until the beginning of the 1980s that French cooperation, on the initiative of the Minister Jean-Pierre Cot, became aware of the need to ‘remove the barriers from a medical-centred approach to incorporate it into the global context of development.’<sup>5</sup> It was also around that time that France officially adhered – at the very least theoretically – to international health policies regarding primary healthcare set forth in Alma-Ata by the WHO as early 1978! The interventions rolled out at the time did not take into account this new context, as was observed even several years later: ‘Health systems in developing countries suffer from the inappropriateness, and in particular the overdevelopment of hospital structures in the face of pathologies that require, above all, non-hospital interventions.’<sup>6</sup>

### **Profound evolutions of the French cooperation approach**

In the 1980s, the problems that appeared most urgent were tied to demographic growth and Africa’s persistent economic crisis, to infectious diseases – with the emerging AIDS epidemic, the resurgence of tuberculosis and, as always, malaria – but also to urbanisation which, because of overcrowding and precarious housing, was creating growing hygiene and sanitation problems. Concurrent to the persistence of endemic diseases and the explosion of the AIDS pandemic in a context of insufficient public spending on health in the face of rising

healthcare costs and demand, healthcare services began to decline, especially, but not only, in hospitals. The operating and other recurrent costs of these health establishments exceeded states’ budgets, whose priorities lay elsewhere: health budgets were consistently under 10 per cent of public expenditure. The declining quality of training provided to new health professionals in establishments and in internship settings caused their skills levels to deteriorate, and professional practices deviated from professional ethical principles. As a result, in the absence of skills and resources, maternal and infant mortality rates remained high in sub-Saharan Africa and Madagascar.

### **Key players: the European Commission and the World Bank**

At the beginning of the 1990s, the African continent was suffering economic hardship caused by the fall of the global price of certain crops, such as cotton, and the rising cost of agricultural inputs. Furthermore, the AIDS epidemic was spreading rapidly and its dramatic growth – which increasingly negatively affected mortality at the end of the 1980s – mobilised people to act. AIDS became the leading cause of death among young African adults in the early 1990s. During the discussions leading up to the Lomé IV Agreement, the African, Caribbean and Pacific states asked their European partners for the first time to help them cope with the health situation – particularly the devastating AIDS epidemic<sup>7</sup>. Meanwhile, the African states began to feel the effects of structural

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5. Jean-Pierre Cot, *À l'épreuve du pouvoir*, (Paris: Le Seuil, 1984), p. 219.

6. Michel Aurillac quoted by Bruno Floury in ‘Le discours de la Coopération française en matière de santé depuis les indépendances’ in *Santé publique*, No. 4, p. 369.

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7. ACP-EU Joint Assembly, ‘Quatrième Convention de Lomé du 15 décembre 1989’ in *Le courrier ACP-CEE*, Vol. 120, No. 41, 1990.

adjustment policies, which led to significant budgetary cuts in social sectors and to a drop in civil service recruitment levels. In response to criticism on this topic, the World Bank published two reports: 'Investing in Health'<sup>8</sup>, followed one year later by a strategic document proposing specific new orientations for 'Better health in Africa'<sup>9</sup>. In the space of two decades, the World Bank thus became the most influential actor in terms of health and development policy in a large number of African countries, many of which are French-speaking. During this time, they acquired genuine expertise in an area it was previously unfamiliar with. The strategies put forward by the WHO and the World Bank, whose relationship was stormy, had an increasingly significant impact on the health cooperation choices of the French Ministry of Cooperation in southern countries, although its adherence to them was ambiguous, late in coming, somewhat forced and, moreover, non-exclusive. In 1999, the strategic choices announced by the Directorate General for International Cooperation and Development (DGCID) were none other, for the most part, than those recommended several years before by the WHO and the World Bank. The European Commission did not deviate significantly from these strategies either.

Besides funding development actions primarily through loans rather than grants, the World Bank differentiated itself from other actors, including France, through the position it publicly defended regarding the financing of care and the choice of its healthcare priorities based on the analysis of the cost-effectiveness ratio of interventions. According to the World

Bank, only basic primary healthcare and a selection of public health programmes would be financed by the government of the beneficiary country, while more costly hospital care concerning only a small proportion of the population (and deliberately the most wealthy) should be financed by the patients themselves, or by private insurance companies subject to competitive bidding and offering a range of services. At the time, this was a clear reference to the United States' model of healthcare financing. The European Commission, meanwhile, provided specific support to the development of blood transfusion safety and access to essential medicines policies and strategies by financing the development of procurement and distribution centres at national level. Together, these two institutions promoted health systems reforms and financing mechanisms through the Bamako Initiative.

At the same time, the United Nations system as a whole contributed to the development of strategies put forward by the WHO with frequently limited financial and human resources, with the exception of the 1985-90 period. At that time, UNICEF, impelled by James Grant, took over the universal vaccination initiative for children, which revived the Expanded Programme on Immunisation (EPI) with very significant results. With support from the European Commission and the World Bank, the bilateral cooperation of France, Belgium, America, Canada, Germany and other states extended their actions to French-speaking countries. France supported European strategies to promote health – as initially formulated in 1994 – with even more enthusiasm since it alone financed 25 per cent of the European Development Fund.

8. 'Investing in Health', (World Bank, 1993).

9. 'Better Health in Africa' (World Bank, 1994).

## **From tropical diseases to public health policy: health cooperation in the 1990s**

At the instigation of the French Minister of Cooperation, Marcel Debarge, the 'Health Year' laid the groundwork for a change of direction in French policy over the course of the following decade, notably in a significant increase in the financial and human resources dedicated to an 'integrated project approach', in which public health and the economic analysis of the health sector reached an unprecedented scale. Throughout the 1990s, French cooperation's intervention techniques were transformed following the rather radical change in the paradigm that previously underlay its actions. Military doctors became the minority<sup>10</sup> as they were gradually replaced by civilian doctors; then local doctors rapidly replaced French doctors; lastly, French doctors also began to withdraw from Schools of Medicine and from university hospitals. Henceforth only very limited numbers of public health professionals were sent to work in the field, placed in advisory roles to ministries of health or to executives within national, regional or hospital-based health administrations. Yet this was also the decade of the French technical cooperation's urban health projects in Bamako, Abidjan, Niamey, etc. French cooperation policy thus aimed to both reinforce systems and to incorporate actions at every level of the pyramid of care to prevent and treat major pandemics (AIDS, tuberculosis and malaria). Reducing

maternal and child mortality was a priority common to all of these projects. The fight against parasitic diseases received support mainly through funding provided by multi-lateral organisations.

'Urban health' expanded in the capitals of West African countries and in Madagascar, complementarily to the support provided by UNICEF to the Bamako Initiative in rural areas. The Abidjan Health Project, conducted in the city's most populated neighbourhoods from 1991 to 2000, is emblematic of the French technical cooperation during this period, owing both to its design – in and of itself very innovative – and structure, and to the volumes of funding allocated. The approach consisted in reinforcing the capacities of local public healthcare services while extending health coverage through alternative services administrated by user associations known as community health centres. The results achieved by these programmes designed to support the development of private, non-profit health centres were spectacular. Health coverage rose and the centres' level of autonomy enabled them to recruit more qualified, non-civil servant health professionals in greater numbers. The availability of medicines also improved, which increased the attractiveness of the centres, thereby resulting in higher levels of patient confidence, which in turn led to heightened interest in preventive care. The outcome was a very sharp rise in the use of preventive and curative services. It was thus, in urban areas<sup>11</sup>,

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10. Their number further declined between 2000 and 2005, from seventy-six to twenty-six.

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11. For example, in rural areas in Madagascar, where the population is much poorer, financial participation is much more difficult to implement. The Bamako Initiative was less successful and raises ethical questions in these contexts.

that France took a very clear stand in favour of the Bamako Initiative<sup>12</sup>.



© Idrissa Diarra, Painting “Rural health”, photograph taken by Dominique Kerouedan

Moreover, beginning in 1994, French cooperation became a driving force behind the institutional, technical and financial support provided in a number of areas such as the founding of people living with HIV/AIDS organisations, and their involvement in preventing sexual and maternal transmission of HIV, in screening for HIV and counselling patients, in the treatment and activities related to impact-mitigation of

AIDS on families in West Africa. The WHO<sup>13</sup>, UNAIDS<sup>14</sup> and the International Therapeutic Solidarity Fund (FSTI) as well as ESTHER programmes created by Bernard Kouchner in 1998 and 2002<sup>15</sup> respectively, were inspired by these concepts and actions. The staying power of these community health centres and community actions of persons living with HIV remains a source of amazement close to twenty years after their inception. These models were backed by the World Bank and continue to inspire the European Union Delegation in Abidjan, which is looking into supporting and expanding the community health centres. Aren't all of these dimensions – diseases, systems, associations, partnerships – high on the agenda of health issues being discussed worldwide in 2011?

In terms of research, we can look to the example of the creation by the Bamako School of Medicine – with support from French cooperation – of the Department of Epidemiology of Parasitological Diseases, now the Malaria Research and Training Centre (MRTC). Such action shows that Africa has begun to occupy the space it deserves on the international arena by building and maintaining teams of very high-level researchers alongside teams working in Africa from the Mérieux Foundation, the Overseas Pasteur Institutes (IPOM), the Institute of Research for Development (IRD)

12. These programs were the subject to several evaluations and publications:

- Joseph Brunet-Jailly (ed.), *Innover dans les systèmes de santé, expériences d'Afrique de l'Ouest*, (Paris, Karthala, 1997).

- Jean-Pierre Olivier de Sardan and Thierry Berche (eds.), *Santé en capitales. La dynamique des systèmes de santé des capitales ouest-africaines*, (Abidjan, Editions CEDA, 1999).

- Didier Gobbers and Philippe Eono (eds.), *La recherche en santé au service du développement*, based on the Projet Santé Abidjan, 1993-2000, (Abidjan, Editions CEDA, 2001).

- Dominique Kerouedan (ed.), Final report and evaluation of the project 'Appui à la mise en place de la politique de district sanitaire au Niger. Commune de Niamey 2', CREDES for the French Ministry of Foreign Affairs, September 2003.

13. Prevention policies concerning the mother-to-infant transmission of HIV in Côte d'Ivoire, developed by a local multi-disciplinary working group, preceded the international directives in this area.

14. Joint United Nations programme on HIV/AIDS created in 1996 ([www.unaids.org](http://www.unaids.org)).

15. International Therapeutic Solidarity Fund (ITSF) and Ensemble Pour Une Solidarité Thérapeutique Hospitalière en Réseau (ESTHER, [www.esther.fr](http://www.esther.fr)) followed by the European ESTHER Alliance ([www.esther.eu](http://www.esther.eu)).

and the French National Agency for Research on HIV/AIDS and Viral Hepatitis (ANRS).

In terms of medicines, French cooperation supported the creation and development of the Réseau Médicaments et Développement (ReMeD), a non-governmental organisation whose training initiatives and institutional support to the institutions and policies governing access to basic and generic medicines are acknowledged by national and international partners across French-speaking Africa, as well as at European level.

## **Technical expertise provided by French health cooperation**

The most noteworthy feature of the French technical cooperation throughout all these years was the fact that it had a major asset and instrument distinguishing it from other cooperation: technical experts directly recruited by the Ministry of Cooperation at the time. Technical experts, absorbed by the day-to-day realities and national contradictions of development, acquired unique and irreplaceable experience over the years, working with often outstanding national partners. These genuine development experts are also a very precious source of knowledge regarding hands-on health and social issues, contributing both to public health decision-making on a national scale and feeding into the French and international political orientations. In 1982, French on-the-ground technical expertise alone accounted for 50 per cent of all technical assistance provided to developing countries by developed countries.

Thanks to the diversity and the flexibility of this expertise, innovative experiments<sup>16</sup> were initiated at the end of the 1980s, which have

since proven their effectiveness and now form the cornerstones of health system development:

- the creation of community health centres, which provide public health services within a public-private partnership;

- in a pilot approach, the promising settlement of country doctors who paved the way towards the provision of medical care in rural areas by non-civil servant professionals. This project received strong support from the association *Santé Sud* in many French-speaking African countries<sup>17</sup>; *Santé Sud* Mali was awarded a Prize at the Global Workforce Alliance Conference held in Bangkok in January 2011.

- the creation of community health insurance schemes, designed to provide healthcare coverage to supplement public financing.

In August 1992, a group of technical assistants founded the Association of Health Professionals in Cooperation (ASPROCOP), which in the 1990s became the French Ministry of Cooperation's service provider for the continuous training of technical assistants in the health field. The association took noteworthy stands in the 2000s in its dealings with the French High Council on International Cooperation, the French National Assembly, the Economic and Social Council, the *Coordination Sud* network, and various other national bodies as well as European and international institutions, including the WHO.<sup>18</sup>

## **The French technical cooperation reform**

The innovative and meaningful new dynamic of the 1990s suddenly slowed at the end

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16. Joseph Brunet-Jailly (ed.), *Innover dans les systèmes de santé, expériences d'Afrique de l'Ouest*, (Paris, Karthala, 1997).

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17. [www.santesud.org](http://www.santesud.org)

18. [www.asprocop.org](http://www.asprocop.org)

of the decade, due to the reform of official development assistance (ODA).<sup>19</sup> The French Ministry of Cooperation, created in 1961, was done away with in 1998 and absorbed by the Ministry of Foreign Affairs, leaving only one Secretary of State for Cooperation. This reform introduced the Agence Française du Développement (AFD, or French Development Agency, based on the French Development Fund) and the Inter-Ministerial Committee for International Co-operation and Development (CICID), chaired by the Prime Minister. The Ministry of Foreign and European Affairs and the Ministry of Finance, Economy and Industry jointly fulfil its secretariat duties. Under pressure from the Ministry of Finance, ODA adopted the methods of intervention employed by most donors in the 2000s. This reform also included a drastic reduction of the budgets allocated to cooperation, especially those dedicated to technical assistance with direct management. In 1991, more than 400 technical assistants working in Africa's health sector were financed by the Ministry of Cooperation. This figure had dropped to 221 by 2001, to fewer than 100 in 2006, and to roughly 50 in 2010.<sup>20</sup> Decisions made by the CICID in 2004 and 2005 placed the implementation of cooperation financing in favour of the health sector, among others, under the responsibility of the AFD. French technical assistance is now recruited either via an

international call for tenders put forward by the project owner (in general the ministry of health benefitting from AFD grants or loans); or, for civil servants, by the public interest group France Coopération Internationale, whose name changed to France Expertise Internationale in 2011.

Deprived of its financial and human resources, bilateral French expertise capacities have been severely diminished, which considerably reduced France's political visibility precisely where its health cooperation was acknowledged, demanded and needed on the African continent and at the international level, as predicted and deplored by the independent reports mentioned below. And while France drastically reduced its bilateral contribution in favour of health systems, the Belgian, German, Canadian and European technical cooperation were also substantially reducing their bilateral aid to French-speaking African countries.<sup>21</sup>

The discontinuation of bilateral instruments in favour of support for major global initiatives is a movement that extends far beyond French borders, and that translates locally into disease/system imbalances<sup>22</sup> that compromise overall aid effectiveness. This is undoubtedly the most obvious lesson to be learned from the challenges encountered throughout the decade in our progress toward achieving the Millennium Development Goals.

19. Serge Michailof and Alexis Bonnel, *Notre maison brûle au Sud. Que peut faire l'aide au développement?*, (Paris, Fayard/Commentaire, 2010).

20. Marc Gentilini, 'La coopération sanitaire française dans les pays en développement', Opinions and Report by the Economic and Social Council, 16 and 17 May 2006.

21. There is a lack of studies on these countries' equal access to aid financing and on the impact of this support (or absence thereof) on populations' health, or even on the beneficiary region's political stability.

22. The fight against transmittable diseases through specific action receives more funding than the overall of health systems strengthening, even though the latter would more effectively contribute to achieving the health-related Millennium Development Goals (MDG).



## **The 2000s: globalisation, the Millennium Declaration and innovative financing**

Over 180 national and institutional representatives met in 2000 to sign the Millennium Declaration, which defined eight goals to be achieved by 2015 – the famous Millennium Development Goals (MDG). Major challenges are faced by public authorities and civil society in Africa, together with the international community, in order to attain, or move closer to these goals. Three objectives (Nos. 4, 5 and 6) are directly related to health and concern, respectively, reducing child mortality, improving maternal health, and combating infectious diseases – including AIDS, tuberculosis and malaria – which kill six million people per year worldwide, mostly in Africa. Populations' universal access to the prevention and treatment of AIDS and tuberculosis have been top priorities for the international community since the August 2006 international AIDS conference in Toronto named 'Time to Deliver'. France has always held a leading position at the global level with very strong policy on AIDS prevention and treatment. It confirmed this position in 1997 at the international conference on AIDS and STIs in Abidjan through statements by President Jacques Chirac and Minister Bernard Kouchner, which provided the first real political impetus in favour of ensuring access to antiretroviral (ARV) treatments in southern countries. In a similar vein, France was one of the early supporters of the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva in 2002, led by Kofi Annan, then Secretary-General of the United Nations. Unlike most donors, who recommended giving priority to the financing of prevention, the

French government defended a mandate before the Fund's Board of Governors to promote the financing of global strategies to prevent and treat the three diseases. This approach was approved.

By the early 2000s, with the Okinawa and Genoa summits, health had become a topic of G8 agenda in its own right. This helped to accelerate the creation of the Global Fund, to promote initiatives such as action in favour of neglected diseases, and to promote the principle of free healthcare for pregnant women and children under 3 years old in those countries wishing to do so.

Throughout the 2000s, the sources of financing for development assistance became increasingly diversified with the creation of global public-private partnerships such as the Global Alliance for Vaccines and Immunisation (GAVI) in 2000, the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria in 2002, and the International Health Partnership (IHP+) in 2007. The private foundations of Bill & Melinda Gates and Bill Clinton increasingly contribute to worldwide health initiatives. The International Drug Purchase Facility (UNITAID), which levies a tax on airplane tickets, is a French initiative – one of the first concrete applications of the 'innovative financing' initiative promoted by President Jacques Chirac at the Davos Forum in January 2005 following on from studies entrusted to Inspector-General Jean-Pierre Landau<sup>23</sup> beginning in 2003.

Emulating the French initiative, Brazil, Chile, Norway and the United Kingdom created UNITAID in September 2006, through which over one billion dollars have been pledged

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23. Jean-Pierre Landau, 'Les nouvelles contributions financières internationales', Working Group Report, (Paris, La Documentation française, 2004).

since 2006 in ninety-four countries to support sixteen projects in the fight against AIDS, tuberculosis and malaria. The International Financial Facility for Immunisation (IFFIm), founded in October 2006 to benefit GAVI programmes, raises funds by borrowing from international markets, thanks to long-term state commitments. Finally, the Advanced Market Commitment (AMC), put forward by Italian minister Giulio Tremonti and managed by GAVI enabled the simultaneous introduction of the pneumococcal vaccine in rich and low-income countries.

In the 2000s, faced with the urgency and magnitude of pandemics and seeking to make a major, rapid impact, France gave priority to global initiatives at the expense of its bilateral contribution, and to the fight against disease at the expense of its support to health systems, which more easily benefit from bilateral instruments. The amounts available to the French Development Agency to support the health sector of countries within the priority solidarity zone are now very minimal. The changes throughout the past decade have been so radical that Jean-Michel Severino and Olivier Ray speak of three 'revolutions' tied to the diversification of the goals aimed at protecting global public goods, to the key players – whose numbers are also consistently rising – and to the so-called innovative instruments that go as far as tapping into the resources of international financial markets.<sup>24</sup> These authors encourage us to take stock of these changes and their implications in terms of developing new systems to measure

24. See Jean-Michel Severino and Olivier Ray, 'The End of ODA (I). Death and Rebirth of a Global Public Policy,' Centre for Global Development Working Paper 167, (May 2009), and Jean-Michel Severino and Olivier Ray, 'The Birth of Hypercollective Action', Centre for Global Development Working Paper 218, (June 2010).

and analyse their impact. This is the challenge that awaits us.

## Independent appraisals of France's support to health and development

Over the past twenty years, regulation mechanisms have been introduced to enable cooperation to find its niche. In the 1990s, the permanent Observatory on French cooperation, the Association of Healthcare Professionals in Cooperation (ASPROCOP) and several independent project evaluation reports took a stand on the choices made by public institutions. In 2002, France's High Council on International Cooperation (HCCI) made a statement on French policy in the area of health cooperation and development research.<sup>25</sup> Between 2005 and 2008, several reports were commissioned by the Prime Minister and the government.<sup>26</sup> The Social and Economic Council issued an opinion in 2006 based on the report by Professor Marc Gentilini highlighting the uniqueness and value of French health cooperation's forty years of experience.<sup>27</sup> These highly eminent authors unanimously deplore the lack of human and

25. See 'La Coopération dans le secteur de la santé des pays en développement', (Paris, HCCI, June 2002).

26. See Pierre Morange, 'Évaluation de l'action de la France en faveur de la réalisation des Objectifs du Millénaire pour le développement dans le secteur de la santé ; articulation des aides bilatérales et coordination avec la participation de la France aux programmes multilatéraux du secteur de la santé', Report to the Prime Minister, (Paris, La Documentation française, 7 June 2005), and Philippe Kourilsky, 'Optimiser l'action de la France pour la santé mondiale. Le cas de la surveillance et de la recherche sur les maladies infectieuses', (Paris, La Documentation française, April 2006).

27. Marc Gentilini, 'La coopération sanitaire française dans les pays en développement', Opinions and Report by the Economic and Social Council, 16 and 17 May 2006.

financial resources allotted to bilateral aid, as well as the effects of the reform of cooperation institutions on the role, image and effectiveness of French official assistance dedicated to health development in Africa.

More recently, reports by the European Court of Auditors (2009 and 2011), Global Fund independent 5-y evaluation reports (2008 and 2009), as well as an analysis of the policy challenges of the Global Fund 5-y evaluation (Kerouedan, 2010, <http://factsreports.revues.org/635#text>) have been published in addition to the independent evaluations of World Bank's support to Health in Africa, or GAVI Alliance and UNAIDS programmes published in 2009. These publications all question the impact of new mechanisms to channel official development assistance dedicated to health (sectoral and general budget support, global public-private partnerships, etc.) and warn of the need to support these remotely-managed financing programmes by providing bilateral technical and strategic expertise to these countries, within the framework of national capacity building policies.

From a more global perspective, a Member of Parliament in France, Henriette Martinez, as well as Nicolas Tenzer and the *Coordination Sud* network, respectively made recommendations with a view to improving the effectiveness of France's multilateral interventions, maintaining the international presence and influence France deserves, fulfilling the promises of its ODA and ensuring a better balance between bilateral, multilateral and international aid.

In our view, it is absolutely crucial to value and to promote France's technical expertise in the field of development at a time when the shortage of health workers and more broadly of health administrators, is worsening to the point of becoming 'a crisis'. Designing a policy in relation to what could be the contribution

of French expertise in the field of development within the framework of the Inter-Ministerial Committee for International Cooperation and Development (CICID) is more vital than ever, so that the lessons learned over the course of fifty years of outstanding French cooperation in support to health and development Africa will not be forgotten.

### **What is at stake under France's Presidency of the G8 and the G20 in 2011**

The French presidency of the G8 and G20 offers a unique opportunity to capitalise on lessons learned and to ensure the consistency between a large number of commitments made over the course of the last decade. Beyond the commitment made by the G8 in Muskoka in 2010 to take more effective action in favour of maternal and child health, in the context of the launch of UN Secretary-General Global Strategy for Women's and Children's Health, France takes responsibility to work to improve women access to reproductive health services. This would be one of the chief elements of French action in the coming years. This effort must not focus exclusively on combating maternal mortality, the target of MDG 5. It begins with the recognition of women rights to control their sexuality and fertility, and should move forward by ensuring their access to culturally, geographically and financially accessible health preventive and care services.

France's expectations in relation to the Global Fund to fight HIV/AIDS, TB and Malaria, are consistent with the level of financial commitments made, as well as ongoing work conducted between the World Bank, GAVI Alliance and bilateral donors, with respect to all aspects of health systems strengthening in recipient

countries. To ensure the traceability and proper use of Global Fund monies, full ownership thereof must be taken by the countries, which themselves are in charge of implementing the projects and ensuring that the strategies chosen are relevant and effective. A sound performance monitoring and evaluation process is also necessary. In all of these areas, the recipients must be able to mobilise expertise in order to progressively acquire it. This entails helping to building solid health systems enable to providing relevant solutions. This approach requires a worldwide effort to overcome the shortage of health workers<sup>28</sup> – through interventions in training, retention, regulated migration, security and decent wages – and by the widespread and strict enforcement of the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the World Health Assembly in 2010, thanks to France's steadfast involvement.

The countries and international organisations that attended the 2008 Accra High Level Forum on Aid Effectiveness and Harmonisation, pledged to restore more effective and harmonious aid, in which partner and country duties are evenly distributed. But the G8 cannot continue to be development's alone donor: we all must continue to reflect on these issues, giving increased attention to the role of the G20 and extending the focus of analyses beyond mere economic stability. In the same vein as what the Michelle Bachelet Commission

is striving to implement in terms of social protection in a globalised world, the G20 nations have started to take part in the collective development effort, especially as it relates to global public goods, including health in particular, the education and respect of young girls and women, the fight against climate change and the promotion of a safe and healthy environment. These are the challenges that the G20 must tackle, beginning now.

France's contribution to health and development in its former colonies is undoubtedly the most exemplary area of development cooperation of the past five decades.

The major challenges of French cooperation for the upcoming years have to do with:

- the necessary rebalancing of efforts in favour of health systems strengthening, in which French cooperation has acquired extensive experience, and the repositioning of bilateral and multilateral aid;

- carving out a place for French technical and financial support to low and middle-income countries governments and civil society, alongside international partners, in line with the principles of the Paris Declaration on Aid Effectiveness and Harmonisation, the provisions of the International Health Partnership<sup>29</sup> and those of the European Union Code of Conduct on Complementarity and the Division of Labour;

- the key priority of training personnel in order to guarantee the skills of future health professionals and enable the development of research;

- the role France will play, alongside international partners, in the areas of health insurance coverage and social protection, as well as the prevention and treatment of non-communicable

28. Michèle Barzach and Gustavo Gonzalez-Canali, French representatives of the 'Task Force for Scaling up Education and Training for Health Workers', co-chaired by Lord Nigel Crisp and Commissioner Bience Gawanas. OMS-Global Health Workforce Alliance, 'Scaling up, Saving Lives,' 2008 Report: [www.who.int/workforcealliance/documents/Global\\_Health%20FINAL%20REPORT.pdf](http://www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf)

29. [www.internationalhealthpartnership.net](http://www.internationalhealthpartnership.net)

diseases such as cancer, diabetes, cardiovascular and respiratory diseases, all of which constitute major global challenges for the coming decades, including in the south.

The most important issue for France will undoubtedly be to find the political courage and means to restructure its development cooperation policy around the principle of solidarity in favour of a continent where demographic growth is expected to remain spectacular for at least another generation. France's historical responsibility certainly means ensuring that French-speaking countries have equal and fair access to financing from global initiatives,

particularly those that France chooses to support: the European Development Fund, the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, GAVI Alliance and IFFIm, UNITAID, taxes on financial transactions and other forthcoming mechanisms designed to mobilise funding in favour of development assistance. France will have to ensure that the vast experience it still possesses concerning development in French-speaking Africa is not lost. Its contributions are all the more important since it shares a common administrative framework and professional references with these countries. ■