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Fit for purpose: THE EU'S ROLE IN GLOBAL HEALTH IN THE ERA OF COVID-19

COVID-19

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Although COVID-19 is having a significant impact on the economy, politics and health, it did not cause a fundamental change in the rules of the game when it comes to the EU's limited role as a global health player. The block needs to address persistent coordination issues between the EU and its member states – as well as across EU institutions – if it wishes to enhance its effectiveness and credibility in this arena. A robust updated global health strategy that links the various fields of EU intervention would help to make its action more impactful and consistent. But a strategy and high-level political commitment alone will not do the trick. Political imagination will need to go into easing Europe-wide collaboration.

The EU's political messages on international cooperation to face the pandemic are welcome, as are timely new initiatives in many areas of EU action. But questions remain on the scale of the response as well as its impact.

The new EU budget 2021-2027 will be the most important opportunity to catalyse funds and to strengthen EU action on global health. But the topic of health will need to climb a long list of priorities to form a meaningful part of EU programming. At the moment, despite the evident fragility of the global health response to COVID-19, the economic recovery is still the main preoccupation for policymakers – in Europe and beyond. The pandemic also represents an opportunity to build a more equal partnership with Africa, building on the ability of African societies and governments to quickly adopt effective measures.

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Acronyms

ACT	Access to COVID-19 Tools
AIDS	Acquired immunodeficiency syndrome
AMR	Antimicrobial Resistance
AU	African Union
BMJ	British Medical Journal
BRICS	Brazil, Russia, India, China and South Africa
CBRN	Chemical, biological, radiological and nuclear
CDC	Centres for Disease Control and Prevention
CEPI	Coalition for Epidemic Preparedness Innovations
COVID-19	Coronavirus disease 2019
CRS	Common Reporting System
DAC	Development Assistance Committee
DGs	Directorates-General
DG CLIMA	Directorate-General for Climate Action
DG DEVCO	Directorate-General for International Cooperation and Development
DG ECHO	Directorate-General for European Civil Protection and Humanitarian Aid Operations
DG NEAR	Directorate-General for Neighbourhood and Enlargement Negotiations
DG RTD	Directorate-General for Research and Innovation
DG SANCO	Directorate-General for Health and Consumers
DG SANTE	Directorate-General for Health and Food Safety
DSW	Deutsche Stiftung Weltbevölkerung
EEAS	European External Action Service
EBRD	European Bank for Reconstruction and Development
ECDPM	European Centre for Development Policy Management
EC	European Commission
EDCTP	European and Developing Countries Trials Partnership
EIB	European Investment Bank
EP	European Parliament
ERA	European Research Area
ESI	Emergency Support Instrument
EU	European Union
GAP	Gender Action Plan
Gavi	The Global Alliance for Vaccines and Immunizations
G7	Group of Seven

G8	Group of Eight
G20	Group of Twenty
GloPID-R	Global Research Collaboration for Infectious Disease Preparedness
GHSA	Global Health Security Agenda
GHSI	Global Health Security Initiative
HR/VP	High Representative of the Union for Foreign Affairs and Security Policy
InnovFin	EU finance for innovators
IPPF	International Planned Parenthood Federation
ISS	Institute for Security Studies
LMIC	Low and middle-income countries
MFF	Multiannual Financial Framework
N.d.	No date
ODA	Official development assistance
OECD	Organisation for Economic Cooperation and Development
R&I	Research and innovation
SARS	Severe acute respiratory syndrome
SDGs	Sustainable Development Goals
SIPRI	Stockholm International Peace Research Institute
SWP	Stiftung Wissenschaft und Politik
TFEU	Treaty on the Functioning of the European Union
UK	United Kingdom
UKCDR	UK Collaborative on Development Research
UNFPA	United Nations Population Fund
US	United States
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization

1. Introduction

After an initially slow response to the COVID-19 pandemic, the European Union (EU) has sought to assume a leading role in the international response to the crisis and has repeatedly called on other countries to treat medical technologies as a global public good. The EU has not been immune to an environment marred by geopolitical rivalry and inward-looking politics, which led it, for example, to restrict exports of medical goods to benefit its own citizens (Tondel and Eunice Ahairwe 2020). But its political messaging and ensuing action have sought to form a contrast with what some commentators have called ‘medical or vaccine nationalism’: the quest of governments to secure medical supplies in competition with, and sometimes at the expense of, other countries.

Overcoming the coronavirus crisis is not just a health imperative. It is also an urgent economic, social and political need and a precondition for returning to some sort of normality or, more aspirationally, for ‘building back better’, i.e. using the crisis to build a more sustainable socioeconomic future. The US under President Trump has taken an unequivocally inward turn (Boseley 2020), which has further strengthened European aspirations to defend multilateralism and international cooperation in response to COVID-19 and its aftermath. Indeed, the COVID-19 crisis is both an opportunity and a challenge for the EU to play a more prominent global role on health, in line with its ambition to become a strong geopolitical actor and a ‘guardian of multilateralism’.

But can the EU achieve this ambition? And if so, how? Based on desk research and 10 semi-structured interviews with EU and member-state officials, civil-society representatives and international partners conducted in June and July 2020, we seek to understand the scale and scope of the EU’s global health role and offer perspectives on its future role in this area. We look at the EU’s global health role in addressing the COVID-19 outbreak and analyse the extent to which the pandemic is changing the parameters for EU action. We offer a strategic overview of the EU’s past and current action in different global health-related realms and, without giving firm answers, at least raise key questions about the EU’s ambitions and potential to follow through. These questions will need to be thought through crucially over the next 12 months, not only because the coronavirus is likely to continue to dominate our lives, but also because the EU will need to decide how it is going to prioritise its political objectives and spend its resources for 2021-2027.

We found that reactions to the EU’s initial response to the pandemic in terms of providing international aid were lukewarm on account of its limited financial scale, the fact that it consisted mainly of the reallocation of resources and the repackaging of existing programmes, and also because of the difficulty of tracking actions (Jones et al. 2020; Bilal and Di Ciommo 2020). The EU’s limited legal competences in health, as well as an initial lack of internal coordination in responding to the COVID-19 crisis in Europe, are a great challenge to the EU’s international credibility, since upscaling its global health role would need to be built on a strong home base.

Yet there seems to be an appreciation and buy-in of the political messages in favour of solidarity and collective action that the EU has chosen to convey (Todd 2020). More generally, as a diplomatic player, a major aid donor, a research and innovation (R&I) leader and through its dual mandate on domestic and international health issues, the EU could bring much needed leadership, resources and expertise to the table. The EU’s international partners appreciate its role as a global convenor and funder of global health initiatives. Its contributions to R&I – especially its collaborative work with African countries and its efforts to promote open science – generate added value. Brought together, these assets could give the EU more leverage in global health that could lead to better health outcomes, both for its own citizens and for its partners.

Although there seems to be some high-level political willingness to change course, the COVID-19 crisis has not changed the EU's core priorities and working methods to an extent that is sufficient to place health at the core of EU external action. Health will need to climb a long list of other priority areas in the EU's programming of future international cooperation resources under the 2021-2027 budget. The emphasis has rapidly shifted to dealing with the socioeconomic impact of the coronavirus crisis, more in line with the EU's main strengths and mandate, and the overarching climate change and digital priorities of the geopolitical Commission that were set before the pandemic.

The risk is that, despite a long-standing awareness that supporting developing countries' health systems is the best insurance against outbreaks, the EU's engagement will fade in the face of other priorities. This is despite the economic havoc wreaked by the coronavirus crisis. Unless resolved, intractable coordination issues affecting the EU institutions and member states will continue to undermine the EU's effectiveness and credibility in this field.

2. The EU's limited space to act on global health

The EU's limited mandate on health and the major health gaps between member states have been a hindrance in managing the COVID-19 crisis internally in an orderly and coordinated fashion. More generally, this situation accounts for the EU's difficulty both in managing internal health crises and in establishing its external credibility as a global health actor. A stronger Europe would be in a better position to help others in the world, for example, by using common emergency stocks of medical equipment to help more vulnerable countries or by possessing greater negotiating clout vis-à-vis the pharmaceutical industry.

In fact, the COVID-19 pandemic has prompted a debate about boosting the EU's competence in health policy. This includes the question of strengthening European health sovereignty, which the German Council Presidency has set as a priority in response to growing geopolitical competition (Deutsch 2020c; Deutsch 2020d; Keating 2020; Grossetête 2020; Ministère de l'Europe et des Affaires étrangères 2020a). In June 2020, Denmark, France, Germany, Spain, Belgium and Poland signed a letter calling for *'a common European approach, so that the EU and its member states find themselves better prepared for a second outbreak of the virus and future pandemic crises'*.¹ But despite the many arguments in favour of a stronger and unified Europe in global health, **the crisis does not seem to have changed the rules of the game**, so to speak, of EU involvement in this realm and, more fundamentally, of how the EU and its member states work together.

European Commission (EC) President Ursula von der Leyen stressed the need for health sovereignty and crisis preparedness in her State of the Union address on 16 September 2020. She called for European agencies to be strengthened, and raised the question of health competences and convening a Global Health Summit in Italy in 2021 (European Commission 2020h). While this demonstrates a high-level political appetite to strengthen the EU's role in this area, it remains to be seen whether any action will be taken in practice. A rediscussion of health competences is likely to raise eyebrows, especially during a crisis in which member states may want to appear united and focus attention on action. There is still no consensus on this point, despite significant changes in the policy environment as a result of the COVID-19 crisis (Hackenbroich et al. 2020). If the EU wishes to play a greater role in global health, **it needs to get its own house in order first**.

At first sight, the EU seems to have plenty of scope for intervention. Article 168 of the Treaty on the Functioning of the European Union (TFEU) states that *'a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities'*, including in the international arena and by fostering cooperation with third countries and competent international organisations. The EU can issue additional regulations on, for

¹ This would, for instance, entail [common strategic stocks of critical medicines and medical products](#).

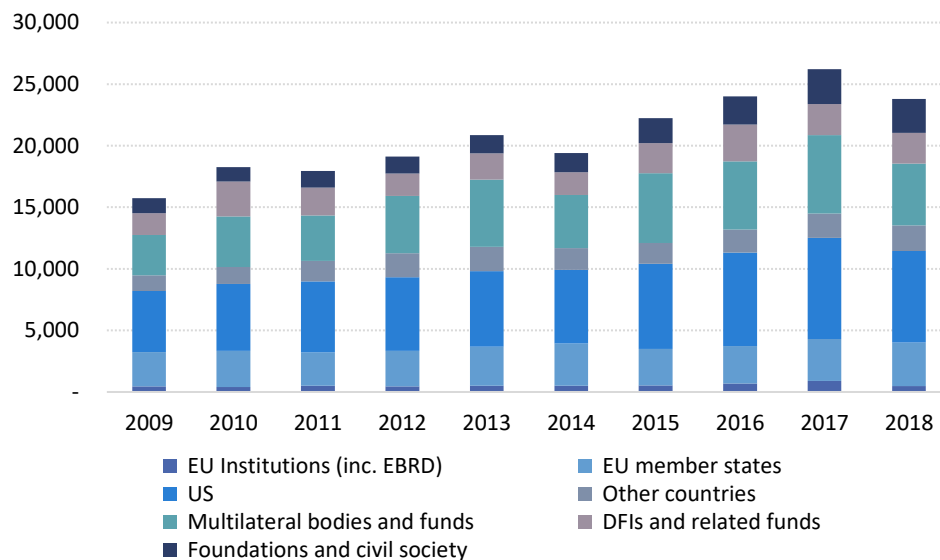
example, the internal market, and social, consumer, trade or environmental policies in order to achieve its public health objectives (Pushkarev 2019; Greer et al. 2014).

In reality, the EU's ability to be a global health actor is greatly curbed by its **limited legal mandate on health**. Apart from regulation of medicines and medical products, the member states have ample autonomy in health policy, regulation and implementation (Grossetête 2020). In fact, according to the TFEU, the EU can only '*support, coordinate or supplement the actions of the Member States*' (article 6), who are responsible for defining their health policies and for organising and delivering health services and medical care.

Significant intra-EU differences in healthcare funding and quality affect the EU's external credibility and assertiveness in this field (Bergner and Voss 2020; European Commission 2017). On the one hand, such differences can work against the provision of external support to certain richer developing countries, on the grounds that member states also have many challenges of a similar nature. On the other hand, ensuring that the standards the EU promotes globally for '*strong, good-quality and resilient health systems*' (European Commission 2017: 11) are respected at home would bolster the EU's legitimacy and influence in global health.

While financial contributions are not all that international engagement is about, the EU institutions have never been major contributors to global health. **The aid given by EU institutions to the health sector has consistently been far below that of other major players.** For example, the US contributed €7.4 billion and the UK contributed €1.6 billion in 2018, whereas EU institutions disbursed only €469 million.² The EU member states together contributed €6.3 billion in the same year. As a share, EU member states collectively contributed 15% of total aid to the sector. While significant, this is much less than the US, which alone accounted for about 30% (Figure 1).

Figure 1: The EU institutions' financial contributions to the health sector are dwarfed by other donors



Source: authors' calculations based on DAC CRS data.

² Health aid includes the Development Assistance Committee (DAC) Creditor Reporting System (CRS)'s codes Health (120) and Population Policies/Programmes and Reproductive Health (130). Only bilateral funding is included, i.e. there is imputation of un-earmarked funding back to the original donor. While this leaves a less comprehensive picture in financial terms for each donor, bilateral funding – which is programmed by donors directly – gives a better picture of their priorities. The EU Institutions include the European Commission, the European Development Fund and the European Investment Bank. Data in the paper also include contributions from the European Bank for Reconstruction and Development, which disbursed €47 million in 2017.

In **2010**, the adoption of a **Communication**, jointly drafted by the European Commission's Directorates-General (DGs) for international development (DG DEVCO), research (DG RTD), and health and consumers (DG SANCO), and the **Council Conclusions on the EU's role in global health**, pictured an ambitious role for the EU as a promoter of '*equitable and universal health coverage of quality health services*' (European Commission 2010: 5). They showed a willingness to establish a common European vision, voice and action on global health matters, a commitment that had never been '*so boldly displayed before*' (Aluttis et al. 2014: 1).

Although the Communication pre-dates the Sustainable Development Goals (SDGs), it already endorsed a holistic approach to global health as a public good and a '*worldwide improvement of health, reduction of disparities, and protection against global health threats*'. It acknowledged the huge relevance of socioeconomic determinants on health, including gender and the environment, aimed to guarantee access to healthcare for all, and expressed a desire to achieve consistent action across the various EU domains of development and humanitarian aid, trade, research and ensure policy coherence for development. Last but not least, it called for the World Health Organization (WHO) to be strengthened. The agenda quickly lost momentum, however, and little progress was made in implementing its goals, due to the fragmentation of the European global health community, the member states' resistance, the EU's limited mandate on health, and the rise of other priorities and other crises (Aluttis et al. 2014).

A number of our interviewees claimed that the COVID-19 crisis now called for an **update of the 2010 communication**. In their view, an updated Communication would throw a new lifeline to the EU's global health profile, align its mandate with the SDGs, and better support the EU's geopolitical priorities and partnerships in a more complex international order (Aidfonds et al. 2020).

Others, however, feared that a new communication might take one step forward and two steps back. Political attention is currently absorbed by infectious diseases and health security. While they are both core to global health, to some, such a focus could come at the expense of a broader, interconnected, rights-based approach. An accompanying concern is a potential backtrack on other sensitive issues, such as sexual and reproductive health rights, on which member states strongly disagree.

While an updated communication could clarify the EU's ambitions in this area, **broader issues would need to be tackled**, including the EU's mandate on health and the need to find workable and more productive arrangements with member states. Health is not one of the priorities of the current EU leadership and is not an obvious area in which the EU has added value to offer, so political energy is likely to be expended elsewhere.

Nonetheless, there may be some regrets in a year or so's time that the EU did not at least attempt to carve a stronger space for itself in global health in the midst of an unprecedented global crisis.

3. The multiple strands of the European health-related response to COVID-19

The EU's response to the COVID-19 crisis has been multifaceted, cutting across multiple areas and involving many partners. Overall, the EU has managed to act rapidly in the face of an unprecedented and fast-evolving crisis. Our research showed **deep appreciation of the EU's role**, especially as a promoter of a multilateral, equitable response and as a committed international partner on R&I. Conversely, the EU's response has been less discernible at a national or regional level. Moreover, many questions have been asked about the EU's ability to follow through on its diplomatic stance in favour of collective action and about the impact that its response is having on the ground.

The EU has a lot to build upon in bringing together the different strands of its action, but has failed to exploit this potential fully to date.

3.1. Diplomacy and multilateralism: where the EU shines

The interviews highlighted the fact that the diplomatic and multilateral dimensions of the EU's response to COVID-19 have been its strengths. The EU's performance at a global level was commended as an example of much-needed global leadership (Todd 2020). One of our interviewees said that *'the EU said the right thing at the right time'*. Another stressed that, while the EU has not historically played a leadership role in global health, it has adopted new ways of working and new models of leadership and partnership in the response to the COVID-19 pandemic.

Since April 2020, the European Commission has engaged with a number of actors in aligning efforts, for example, as part of the [Access to COVID-19 Tools \(ACT\) Accelerator](#), a unique collaborative venture encompassing countries, international organisations, civil society, industry and beyond to speed up the creation of COVID-19 tests, treatments and vaccines and ensure equitable access.

The EU has also consistently pushed a narrative of global collaboration, taking up the challenge to fill the leadership gap left by the US. This was particularly visible at the 4 May [Coronavirus Global Response pledging conference](#), which sought to ensure that all new medical technologies are available globally at an affordable price, regardless of where they are developed. The event raised a total of [€9.8 billion](#), mostly from European actors operating under the Team Europe banner (see section below). However, how much of this is actually new money remains unclear and the event has been criticised for *'looking more like a global public relations exercise than the engine for a new cohesive effort to fight the disease'* (Paun et al. 2020). While participation was wide and went well beyond Europe, the event was not attended by the United States, Russia and India, and China's participation was mainly symbolic.³

As a follow-up, the European Commission launched a new campaign, entitled ['Global Goal: Unite For Our Future'](#), with the support of [Global Citizen](#),⁴ culminating in a Global Pledging Summit on 27 June. The campaign mobilised €6.15 billion in additional funding through grants, loans and guarantees.⁵ European Commission President Ursula von der Leyen pledged €4.9 billion of new funds and [pledged](#) to *'convince high-income countries to reserve vaccines not only for themselves but also for low- and middle-income countries'* (Council of the EU 2020; European Commission 2020a).

On a multilateral front, the EU has reiterated its support for the WHO and the organisation's coordinating role in the global public health response. One major – and hitherto unique – instance of EU leadership in multilateral fora was the EU's successful proposal for a COVID-19 resolution at the World Health Assembly (WHA) in May 2020 (WHA 2020).⁶ The resolution was hailed as a *'victory for EU diplomacy'* as well as a *'demonstration of the EU's convening power'* (Wintour and Borger 2020; DEVCO/B4 Presentation at a EuropeAid [Infopoint](#), 28 May 2020). This was because the EU managed to rally swift support from 145 WHA member states on a very complex issue and also because *'it would have been difficult to arrive at such a good text if it was coming from other regions'* (interviewee, July 2020). Disappointedly, however, it failed to recognise vaccines as a global public good.⁷

³ Coronavirus Global Response partner countries include Austria, Belgium, Canada, France, Germany, Italy, Mexico, Morocco, New Zealand, Norway, Saudi Arabia, South Africa, Spain, the United Arab Emirates and the UK as well as the EIB, the Wellcome Trust and the WHO.

⁴ Global Citizen is a *'movement of engaged citizens who are using their collective voice to end extreme poverty by 2030.'*

⁵ [Details of the pledges.](#)

⁶ The WHA is the WHO's decision-making body. The resolution was backed also by Australia, New Zealand and the African Union (AU).

⁷ Instead, it recognises the role of extensive immunisation against COVID-19 as a global public good.

3.2. Team Europe: an EU response without much emphasis on health

Another visible element of the EU's international response to the pandemic has been the 'Team Europe' package. Launched in April 2020, Team Europe aims to support partner countries in the fight against the pandemic. It has set three priorities:

- the emergency response to the immediate health crisis and related humanitarian needs;
- strengthening health systems and water and sanitation systems, as well as reinforcing partners' preparedness and response capacity;
- providing immediate support to attenuate the social, economic and political consequences of the crisis.

The focus is on the most vulnerable countries and those most at risk, in particular in the EU's neighbourhood and Africa (European Commission 2020a; Council of the EU 2020b). A key aspect of the Team Europe package is that it brings together resources from the EU, its member states and financial institutions, including the European Investment Bank (EIB) and the European Bank for Reconstruction and Development (EBRD).

The European Commission and the EIB reallocated €15.6 billion from existing programmes. Together with contributions from EU member states and the EBRD, the overall figure reached [€36 billion on 8 June 2020](#). However, most of the resources are intended to mitigate the socioeconomic impact of the pandemic (€12.28 billion). Much lower sums have been dedicated to '*responding to the immediate health crisis and the resulting humanitarian needs*' (€502 million) and '*strengthening health, water and sanitation systems, as well as partner countries' capacities and preparedness to deal with the pandemic*' (€2.8 billion).

Beyond responding to the pandemic, this latter strand of action is crucial to maintain functioning health systems at a time when resources have been reallocated to combating the outbreak. The question is then whether the EU could make additional efforts to ensure that the longer-term health response is of an adequate nature and scale. However, our interviews confirmed that health will not be the focus of the Team Europe initiatives in the next EU programming phase.

Box 1: Examples of EU support for partner countries' health systems

In **Niger**, Team Europe is seeking to increase intensive care capacity and better integrate emergency responses in the health system in the long term. In **Libya**, the EU supports the delivery of essential care for other health conditions, ensuring that primary healthcare services operate. In **Madagascar**, the EU is trying to integrate the COVID-19 response into a wider programme encompassing health security and universal health coverage, social protection and education.

The EU's budget support has also been used to keep paying health workers and medical supplies, for example, in the **Democratic Republic of Congo**. The EU has helped to mobilise resources for health in **Ethiopia**, where a public finance programme funded the emergency response and where the EU's active engagement with the [Global Financing Facility](#) assures continuity of care for mothers and children.

Source: [DEVCO/B4 presentation at a EuropeAid InfoPoint event](#), 28 May 2020

Mounted rapidly, the EU's global response remained restricted in its financial scope due to the limited resources available at the end of the EU's 2014-2020 budget cycle. No fresh funding was made available and the response package consisted essentially of repurposing and reorienting existing aid resources and programmes towards the COVID-19 crisis. These limitations helped to make the EU '*a rather meagre payer, but not really a global player*' (Jones et al. 2020: 1). Indeed, the Team Europe €36 billion package – which covers more than simply health funding

– is small compared to the resources dedicated internally or spent by other global actors (for example, the World Bank’s USD 160 billion (World Bank 2020)).

Box 2: The gender dimension: a crucial part of any health response

The Council Conclusions on the Global Response to COVID-19 stress that emergencies, including the current pandemic, exacerbate pre-existing gender inequalities, and highlight the importance of keeping a strong gender equality perspective at all levels (Council of the EU 2020b: 2). Similarly, a joint statement by HR/VP Josep Borrell and Commissioners Jutta Urpilainen and Janez Lenarčič identifies women and girls as a priority in the COVID-19 response. It states that:

‘All analysis, measures and actions taken should be inclusive and gender- and age-sensitive and mitigate risks of gender-based violence. Healthcare and protection services must be fully available to address women’s needs and rights, including sexual and reproductive health and rights. Full and effective participation of women in the decision-making processes at all the stages of coronavirus response and recovery must be ensured.’ (EEAS 2020)

Gender differences exist in compliance with hygienic measures and in risk factors. While men are more likely to die because of the virus, women are at a greater risk of exposure (Boniol et al. 2019: 5). They make up 70% of the health workforce, perform most care duties in their communities and make up the majority of cleaning and janitorial staff. While healthcare workers have been prioritised for testing and protection from the virus, other at-risk categories are in danger of being neglected (Oertelt-Prigione 2020).

Women also risk suffering more from the indirect consequences of COVID-19: for example, maternal mortality has increased due to disruptions in healthcare provision and the restrictions placed on mobility and services under the lockdown (Robertson et al. 2020; Oertelt-Prigione 2020). Family planning and maternal care are often among the first services to be cut during economic crises, leaving women and girls more exposed even when the outbreak is over (UN 2020). Furthermore, women’s mental and physical health is more at risk due to a surge in domestic violence.

Despite this, our interviews revealed little preparedness among EU officials to translate commitments into actions and not much urgency to view the response through a gender lens, even among some civil-society and research actors. We did not detect significant consideration for the special situation of women and girls, either as part of individual actions or within major programmes. While some programmes have adopted a gender lens in response to the crisis, the approach has been piecemeal. This is an area requiring urgent attention in the 2021-2027 programming process and the new Gender Action Plan.

3.3. Research and innovation: an area in which the EU offers added value

The efforts of European Commission President Ursula von der Leyen to mobilise governments to commit to COVID-19 research have been ‘very credible’ and have raised the profile of the EU as a global player in health research and development (interviewee, June 2020). The EU has taken a flurry of initiatives that are difficult to track in full and that are in a state of continuous evolution.⁸

The Joint EC-HR/VP Communication on the Global EU response to COVID-19 emphasises the role of R&I in tackling the pandemic, including by improving research capacities in partner countries and facilitating access to vaccines in vulnerable countries (European Commission 2020a). Horizon 2020, the EU’s research and innovation programme, was quickly mobilised to tackle the threat of the coronavirus, in particular to support:

- epidemiology, preparedness and response to outbreaks;
- the development of medical technologies such as diagnostics, treatments and vaccines; and
- infrastructures and other research resources.

⁸ For details, see the European Commission submission to the Organisation for Economic Cooperation and Development (OECD)’s Survey on the Science Technology and Innovation policy responses to COVID-19.

On 4 May, President Von der Leyen announced a [€1 billion investment](#) in the COVID-19 response from Horizon 2020. This is a combination of existing initiatives relating to infectious diseases, as well as specific actions on COVID-19. As part of this pledge, the EU is supporting the Coalition for Epidemic Preparedness Innovations (CEPI), which invests in vaccine development for emerging infectious diseases. While this commitment is welcome, it has raised concerns that the crisis could divert funding away from other infectious diseases and health issues.

The EU has joined other organisations in a push to make COVID-19-related research findings and data available on an open access basis. The [COVID-19 Data Portal](#) facilitates data-sharing and analysis among European and global research communities, with the aim of speeding up research and the application of research findings to the fight against COVID-19. The EU has also invited its fundees to join its [Manifesto for EU COVID-19 Research](#), which aims to amplify and speed up the dissemination and use of research results for Horizon 2020-funded projects. More detailed guidelines urge researchers *‘to provide immediate open access to their related publications, data and any other output possible’* (European Commission 2020c). Such a powerful narrative will need to be followed by adequate implementation of policy commitments. It will hopefully lead to better open science policies in the future EU framework programme which will make open access a requirement for funding with limited derogations.

An important aspect of EU action involves the coordination of coronavirus-related R&I in the European Research Area (ERA). The first [ERAvsCORONA Action Plan](#) spells out concrete actions for enhanced coordination, collaboration, data-sharing and funding among the 27 member states. The plan states that internal coordination is *‘an important prerequisite for stepping up global cooperation, essential to tackle corona related issues’*.

It is too early to make an assessment of the EU’s R&I initiatives for tackling the COVID-19 pandemic. We will need to closely monitor certain elements of it.

First, global coordination is now underway. But this is not happening under a European flag. The EU’s main added value is its ability to better coordinate research and give it adequate scale to avoid duplication and fragmentation of efforts. The EU should therefore seek to improve collaboration as much as possible. The main mechanism for coordination is the [Global Research Collaboration for Infectious Disease Preparedness \(GloPID-R\)](#), a network of research funding organisations now mobilised to coordinate funders in support of COVID-19 research globally.⁹ Although the EU funds the GloPID-R secretariat and is a co-chair, only a handful of EU member states have joined to date. A number of questions remain unanswered, notably as to whether other EU member states will join and what role the EU could play in representing them or in facilitating cooperation among member states in the network. Admittedly, research undertaken in Europe can have a global impact and European innovations can be adapted for use elsewhere. Nevertheless, the ERAvsCORONA Action Plan does not spell out how to link internal and external collaboration. While efforts have been made to improve coordination in COVID-19 research, they form part of a pre-existing and fragmented field.

Secondly, the issue of scale is a frequently raised point: what resources are available and how are they distributed across initiatives? One often cited example is the much larger scale of US investments in vaccines than Europe. The ratio is about 1:11, i.e. USD 9.3 billion in US investments compared with USD 843 million for the European Union according to *The Economist*. The US have also invested in a wider range of vaccines (*The Economist* 2020). Thirdly, the jury is still out on whether and how quickly the EU’s innovation architecture will be able to deliver results. The EU has mobilised many parts of its system of innovation, such as the European Innovation Council Accelerator pilot scheme, the EIB’s InnovFin instrument and the European and Developing Countries Clinical Trials Partnership

⁹ The European members of GloPID-R are the European Commission, France, Germany, Italy, the Netherlands, Norway and Spain. Working jointly with the UK Collaborative on Development Research (UKCDR), GloPID-R has promoted a [global dataset](#) of COVID-19 funded projects and has formed a [COVID CIRCLE](#), an initiative to coordinate funders, connect researchers and gather lessons learned about outbreak responses, especially in lower-resource environments.

(EDCTP), a flagship partnership between Europe and sub-Saharan Africa. But scalability is one of the weak spots of the EU's R&I system and some of the limitations risk affecting COVID-19 related actions (European Commission 2018; European Commission 2017c). In addition, health research takes a long time to reach clinical practice, requiring a long-term outlook, sustained investments and policies tailored to optimise such delays (Morris et al. 2011).

3.4. Vaccine strategy: trying to combine domestic concerns with international solidarity

On 17 June 2020, the European Commission presented an EU Strategy for COVID-19 vaccines, the aim of which is to accelerate the development, manufacture and deployment of vaccines against COVID-19. The strategy states that *'it is essential that all 27 EU member states have access to a vaccine as early as possible'* (European Commission 2020d: 2) and proposes a joint and centralised EU approach. The strategy seeks to:

- guarantee the quality, safety and efficacy of vaccines;
- secure access to vaccines for Europeans 'while leading the global solidarity effort' (European Commission 2020d: 2); and
- safeguard equitable and timely access to a vaccine at an affordable cost.

The strategy is built on two main pillars:

1. securing the production of vaccines in the EU and guaranteeing sufficient supplies for the member states (for an initial amount of €2.7 billion);¹⁰
2. injecting some flexibility into the EU's regulatory framework to expedite the development, authorisation and availability of vaccines while ensuring their quality, safety and efficacy.

Coming up with a vaccine against the coronavirus has been the cornerstone of the European Commission's coronavirus response. The vaccine strategy is in line with this approach and is designed to achieve a coordinated response among member states, avoid harmful competition for medical technologies, and guarantee advantageous market conditions for the purchase of vaccines for Europeans. This is essential in a context in which a race to secure vaccines has involved high-income countries such as the US or the UK as well as individual EU member states, whereas the EU reportedly is lagging 'far behind' in terms of vaccine doses secured (Posaner 2020).¹¹ The strategy focuses decisively on securing vaccines for Europeans, although it recognises that *'high-income countries have a responsibility to accelerate the development and production of a safe and effective vaccine and make it accessible for all the regions of the world'* (European Commission 2020d: 1). In July 2020, the Commission expressed its readiness *'to explore with international partners if a significant number of countries would agree to pool resources for jointly reserving future vaccines from companies for themselves as well as for low- and middle-income countries at the same time.'* (European Commission 2020e).

¹⁰ This would be achieved through Advance Purchase Agreements signed with vaccine producers and funded from the Emergency Support Instrument (ESI). EU member states can top up the ESI to finance more supplies.

¹¹ For example, France, Germany, Italy and the Netherlands secured a separate advance agreement for 400 million doses with AstraZeneca in June 2020, due to concerns that the European Commission was not moving quickly enough (Deutsch 2020a; Deutsch 2020d; Government of the Netherlands 2020). This deal is to be transferred to the European Commission. In parallel, Belgium, Denmark, France, Germany, Poland and Spain have been pushing the European Commission to play a bigger role and assume a greater financial risk in boosting vaccine production capacity.

Box 3: The COVAX facility: a strong attempt to deliver vaccines globally

The EU is taking part in the [COVAX](#) facility (which is co-led by the WHO, Gavi - The Vaccine Alliance and CEPI) on behalf of its member states plus Iceland and Norway. Sixteen member states have also signalled their interest in participating on their own accounts.¹² As recently as September 2020, 156 countries agreed a deal to purchase two billion doses by the end of 2021. It is not clear how bilateral arrangements made by individual countries, collective agreements such as the EU Vaccine Strategy, and facilities such as COVAX will work together. For instance, at the time of writing, the detailed terms and conditions for the EU's participation and contribution to COVAX were yet to be worked out, although the European Commission stated that *'[t]he EU's participation in COVAX will be complementary to the ongoing EU negotiations with vaccine companies.'* (European Commission 2020f).¹³

In practice, and despite the commitment to equal and fair distribution (which some consider as 'unprecedented' (Elder quoted in Furlong 2020)), countries are playing on multiple fronts to secure what has become a strategic asset, not just for the health of their populations, but also for their economies. There is a real fear that 'vaccine nationalism', coupled with a race for profits, could cut access for the most vulnerable and poor people, especially in developing countries (Vallaud-Belkacem 2020).

There have also been calls for more transparency about the deals which have been agreed (Furlong 2020). As highlighted by Charlie Weller, the head of the Wellcome Trust's vaccine program, *'[i]n the first year after a vaccine is found, there just won't be enough doses to go around. Therefore, the mechanisms to allocate scarce resources fairly are going to become absolutely critical'* (Furlong 2020). Manufacturing capacities are limited and uneven across the globe and would need to be scaled up without detriment to the production of other medical supplies. Thus, while EU efforts and leadership are laudable, the follow-up to its multiple actions will be even more crucial if trust is to be built and equitable results delivered. This means offering equal and affordable access to medical equipment and technologies, including to a vaccine and including in low and middle-income countries (LMICs).

4. From emergency response to global health: the missing link

Thus far, the EU's COVID-19 response has primarily been a rapid response focused on tackling the emergency of a quickly spreading disease with unprecedented social and economic consequences. As we document above, this has taken multiple forms, some with potential longer term implications for global health. Cementing a link between the current emergency response and long-term global health action is one of the challenges for the future.

The 2017 European Consensus on Development committed the EU and its member states to *'continue to support partner countries in their efforts to build strong, good-quality and resilient health systems, by providing equitable access to health services and universal health coverage'* and by putting *'the strengthening of horizontal health systems at the core of health development programming'* (European Commission 2017a: 11). Strong health systems and universal access to care are essential elements in fighting outbreaks and meeting the SDGs (Labonté and Gagnon 2010; Bergner and Voss 2020). In the words of Dr Tedros Adhanom Ghebreyesus, the Director-General of the WHO,

¹² Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Ireland, Italy, Luxembourg, Malta, the Netherlands, Portugal, Spain and Sweden, plus Iceland and Norway have submitted [non-binding confirmations of intent to participate in the COVAX Facility as of 21 September 2020](#).

¹³ The EU is planning to transfer 88 million doses to eligible Advanced Market Commitment (AMC) countries. Under its Advanced Purchase Agreements, it requires manufacturers to make their production capacity available to supply all countries and calls for the free flow of vaccines and materials with no export restrictions. For instance, a pharmaceutical company called Sanofi-GSK, with whom the Commission signed an Advanced Purchase Agreements, will endeavour to provide a significant proportion of its vaccine supply through the COVAX facility (European Commission 2020l).

‘outbreaks are inevitable, but epidemics are not. Strong health systems are our best defence to prevent disease outbreaks from becoming epidemics’ (Adhanom Ghebreyesus 2017).

Some European Commission officials recognise that the COVID-19 crisis could bring more attention to bear on this aspect of the EU’s role. Yet a 2012 thematic evaluation of European Commission support for the health sector found mixed evidence of the degree to which European Commission assistance has helped to strengthen the management and governance of health systems, suggesting that partner countries’ governments need to take the lead, including through national financing (Particip 2012). More generally, *‘[t]he lingering lesson from Ebola is that, once the crisis passed, long-term funding for health system strengthening did not really materialise’* (Poole quoted in Ali 2020).

Another aspect to consider is the EU’s capacity to work on preparedness and response to outbreaks, including its capacity to fund preventive and early actions in LMICs. DG DEVCO does not have a specific funding mechanism or line item for preparedness and response to outbreaks. This means that limited resources are available for funding surveillance, labs, and other preparedness capacities (Glassman et al. 2019).

A number of our interviewees expressed hope that the spotlight that has been turned onto global health during the pandemic will not be unplugged in haste when the emergency recedes or when the world is struggling to deal with the full economic and political crisis. Addressing the health crisis and building future resilience are preconditions for sustainable recovery. The COVID-19 health crisis has jeopardised progress in many areas – from global health coverage to education and food security – and it will take a long time even to get back to pre-crisis levels of wellbeing. Poverty levels are projected to rise sharply compared with past estimates, with COVID-19 pushing 71 to 100 million people into extreme poverty in 2020 and even more in 2021 (Gerszon Mahler et al. 2020). As Bill and Melinda Gates put it in their [2020 Goalkeepers Report](#), *‘we have celebrated decades of historic progress in fighting poverty and disease. [...] This progress has now stopped.’*

4.1. The NDICI programming: health will need to climb a long list of priorities

In the case of the EU, some interviewees made the additional point that a stronger focus on health could help the EU institutions fulfil their commitment to allocate 20% of ODA-eligible funds under the Neighbourhood, Development and International Cooperation Instrument (NDICI) to human development, and support efforts to achieve the SDGs. Despite all the powerful arguments in favour of a stronger involvement in health, our evidence suggests that, while attention might be maintained at a global and top political level, it will be much harder to retain this focus at a country level and as part of the next NDICI programming cycle. Health will need to climb a long list of priorities, both at the EU and among partner countries. EU priorities include the Green Deal, digital and data, education, growth and jobs, along with migration, governance and multilateralism. Economic concerns are now uppermost in the minds of partner countries.

The NDICI programming due over the next 12 months will need to address the question of how to balance the need for a speedy economic recovery with the need to address the health crisis and support the health sector more broadly, including as an insurance against future outbreaks. The fact that programming guidelines are likely to envision programming based on broader priorities to be achieved through multiple actions across sectors, rather than limit the number of sectors for interventions to three as was the case in the past, may encourage the EU to embrace health interventions more easily.

The EU is planning to present a renewed Gender Action Plan (GAP III 2021-2025) for EU external action, likely to reinstate the EU gender targets. NDICI programming will need to ensure that 85% of official development assistance (ODA)-eligible interventions have a gender equality and women empowerment dimension and 5% of those focus on this dimension as a principal objective. Despite raising the number of gender-related actions, the EU is not on course

to reach this target. Mainstreaming will need to improve and attention will need to be paid to building adequate capacities for gender-sensitive actions, including in areas such as nutrition, sexual and reproductive health and rights and the protection of women in crisis situations (European Commission 2019b).

4.2. R&I in health: long-term investments at risk

The COVID-19 crisis has revived interest in the role of science for the public benefit. However, this has not been enough to protect EU R&I resources in the latest iteration of negotiations for the future Multiannual Financial Framework 2021-2027 (MFF 2021-2027). EU research ministers confirmed the cuts to Horizon Europe, the mainly domestic future EU framework programme for R&I, agreed in Council negotiations in July (Council of the EU 2020d). Of the agreed €85.5 billion for Horizon Europe, the Health Cluster is supposed to receive only €6.9 billion, plus a reduced internal EU health programme of €5.4 billion under the Next Generation EU (all data in current prices) (Council of the European Union 2020h). The latter is to be programmed under Horizon 2020 and will potentially cover COVID-19 impacts beyond health. In addition, the proposed EU4Health programme, which is partially open to third countries, was slashed from €9.4 billion (European Commission proposal of May 2020) to just €1.7 billion in the Council negotiations in July 2020 (European Commission 2020g).

Condemnations have been expressed in various quarters, including the European Parliament (EP), about the cuts to forward-looking programmes such as R&I (Zubaşcu 2020). Cutbacks in these areas hit particularly hard compared with the funding devoted to cohesion (in support of Europe's poorer regions) and agriculture, which together absorb almost 70% of the future [EU budget](#).

International collaboration and openness to the world are central to the EU's R&I approach, including collaboration with lower-middle income countries and Africa (see section 6). These countries will still receive funding under Horizon Europe. Enhanced collaboration with these countries is of strategic importance in order to protect the health of European citizens from cross-border health threats, but also to benefit from expertise and innovations elsewhere. Wider EU external action objectives also benefit from the EU's international exposure on global health and from collaboration on R&I (Di Ciommo and Thijssen 2019; DSW/ECDPM 2020).

5. The EU's added value in global health and its challenges

5.1. The EU's added value in global health stems from different realms

According to the 2010 Communication on the EU's role in global health and the 2017 Consensus on Development, the EU's added value in global health stems from a combination of its leading roles in trade and development aid, as well as its values and experience of universal and equitable quality healthcare (European Commission 2010; European Commission 2017a). The EU can also bring its political expertise to bear through its international channels in the health sector. The fact that the EU deals with other policy areas gives it a much broader scope of action than that of specialist health organisations (Bergner and Voss 2020). A 2012 thematic evaluation of European Commission support for the health sector found that technical assistance and the promotion of global public goods for health were areas in which the European Commission clearly added value and was recognised as a high value-added partner, thanks to its experience with and promotion of regional integration. Yet the evaluation also noted that *'[i]n most other areas, it is hard to define a unique European Commission contribution, which is, of course, not to downplay the massive financial resources that it has supplied'* (Particip 2012: 68).

The EU's support for global health initiatives is highly appreciated by its international partners and goes beyond the COVID-19 response to encompass a longer term presence in the field. Both interviewees and civil-society representatives praised the EU for its latest [€300 million pledge](#) for Gavi in 2021-2025, made at the Global Vaccine Summit on 4 June 2020.¹⁴ Support for Gavi is crucial in order to ensure that routine immunisation continues and is not rolled back as a result of the crisis.¹⁵

The EU institutions have calculated that they spend €1.3 billion on 17 bilateral health programmes and another €1.3 billion through global initiatives such as the Global Fund, Gavi, the Global Financing Facility, the United Nations Population Fund (UNFPA) and the WHO under the current financial framework (2014-2020) (European Commission 2019a).¹⁶ It is clear from the data that the EU institutions' contributions have not been particularly substantial (see Table 1). The €300 million pledge to Gavi is indeed exceptional as it represents more than the total EU contributions to Gavi to date (The European Sting 2020). One interpretation of the mismatch between the appreciation for the EU's role and the actual nature of the data is that the former springs from the role that the EU has played in the current crisis, which is notable, and, more broadly, the aspiration that this performance could strengthen the role played by the EU and the member states together in the future. The high level of appreciation might also be linked to the fact that the EU is good at 'selling itself' as a funder.

Table 1: EU institutions' contribution to global health

	WHO (2018-2019)	Gavi (2016-2020)	Global Fund (2017-2019)
EU	USD 131 million (3.05%)	USD 241 million (3%)	USD 532 million (4.7%)
US	USD 893 million (15.18%)	USD 1,090 million (12%)	USD 3,718 million (32.8%)
UK	USD 435 million (7.91%)	USD 2,303 million (25%)	USD 1,569 million (13.8%)
Germany	USD 292 million (5.33%)	USD 697 million (8%)	USD 814 million (7.2%)

Note: The % figure is the percentage of aggregate contributions to each organisation; Source: [WHO](#), [Gavi](#), [Global Fund](#)

The EU institutions also have a certain amount of **convening power and political leverage**, as well as a presence in international organisations and global health initiatives' governing bodies. The EU is considered to have significant experience in health diplomacy to offer to its member states' staff (Battams et al. 2014). The pooling of resources and expertise is also regarded as an added European value, as the diversity of national experiences within the EU can indeed be pooled and shared.

Regarding the **EU as an aid donor**, the 2012 evaluation noted that the European Commission was involved in almost every aspect of health, using a wide range of financing instruments, modalities and aid channels, although, at the time, it lacked a strategy for health cooperation (Particip 2012). The evaluation also found that, because of its development cooperation cycle, the European Commission was in a weak position to take long-term trends into account. Insofar as it can be identified, the European Commission's global health actions focused primarily on short-

¹⁴ [Gavi pledge and FX scenario workbook](#).

¹⁵ Vaccination rates are falling to 1990s levels due to COVID-19 (BMGF 2020).

¹⁶ It is worth noting that, while the EU is committed (and requested its member states in 2010) to decreasing the fragmentation of funding to the WHO and gradually moving away from earmarked WHO funding towards funding its general budget, in 2019, earmarked contributions still represented more than 75% of the WHO budget. Among the member states, the proportion of earmarked funding (or 'specified voluntary contributions') is lower than 10% for 14 of them, and goes up to 83% for Luxembourg, 79% for Germany and 58% for the Netherlands.

term problems and solutions, and paid insufficient attention to the longer time frame of health sector development (Particip 2012).

Research and innovation is another area of added value. Global health research benefits hugely from coordination and scale, so the supranational level offered by the EU is a distinct advantage. Horizon 2020 contributed to research into vaccines and treatment for Ebola and Zika and has offered continued support for the EDCTP. Despite the cuts proposed by the Council in July 2020, the Horizon Europe programme is still regarded as an attractive programme by international partners, thanks to its networks and scale. It remains to be seen whether this added value and the follow-up programme to the EDCTP will be fully exploited.

Much of the EU's added value exists in potential rather than being actually realised, either in full or in part (Council of the EU 2019). The EU does not leverage its funding or its assets (from its world-class health expertise, research and pharmaceutical development and manufacturing industry (Jones et al. 2020:)) in a way that maximises its influence in global health. This is partly due to the fact, as explained in section 2, that the EU's competences in health are limited. An additional issue is the limited coordination with member states, which *de facto* limits the range of what is possible, both politically when EU and member states speak with one voice, and financially, when they pool resources.

5.2. Realising the EU potential: coordination challenges

The extent to which the EU can play a more significant role in global health depends crucially, on the one hand, on bringing together the different strands of its action and, on the other hand, on working better with member states. Better coordination would help make the most of the EU's and member states' long-standing and diversified experience in global health and would ensure that common objectives were better resourced. Coordination challenges within the EU and with member states are tall-order issues whose resolution requires changing the 'rules of the game' around inter-institutional relations and getting the member states to play ball.

Responsibilities for the different components of the health agenda are segmented across DGs according to their mandates. For example, the DG for Health and Food Safety (DG SANTE) and the DG for Research and Innovation (DG RTD) have mainly domestic mandates for health policy and R&I respectively. DG DEVCO, the DG for Neighbourhood and Enlargement Negotiations (DG NEAR) and the DG for European Civil Protection and Humanitarian Aid Operations (DG ECHO) have international mandates. All of them have been involved in the COVID-19 response and contribute to EU global health actions within the scope of their mandates. While coordination mechanisms exist, through the interservice group involving the DGs NEAR, DEVCO, SANTE and RTD, and the intention is to work collectively, this is a challenging endeavour, partly due to the huge number of issues that fall under health. Different mandates and priorities can get in the way of a more integrated approach and require either senior leadership direction or mediation to solve conflicts around difficult choices (Glassman et al. 2019).

Policy coherence across various parts of the EU is a related challenge (Battams et al. 2014: 544; Tondel and Eunice Ahairwe 2020). Despite the EU's Health in All Policies approach, which seeks to mainstream health in all relevant EU policy processes, actors such as the European External Action Service (EEAS) and the DG for Climate Action (DG CLIMA) have scant regard and extremely limited resources for global health (Bergner and Voss 2020). Our interviewees also signalled a need for more awareness of the global dimension of health on the part of DG SANTE.

A lack of coordination with member states, compounded by lengthy decision-making mechanisms (interviewee, July 2020), have made it difficult for the EU institutions and member states to agree on common positions and speak with one voice. This raises the question of whether it is possible to discern a common EU vision on global health

(Kickbusch and Franz 2020; Steurs et al. 2018). According to Deutsche Stiftung Weltbevölkerung (DSW), *‘[w]hile the 2010 Council Conclusions allowed the EU to speak with a clearer voice on some health issues, EU Member States appear to have taken an opportunistic approach: coordinating, collaborating or abandoning coherence when interests diverge.’* (WASH Matters 2020: 9). As interviewees pointed out, this hampers the EU’s credibility when it calls for international unity, particularly if national visibility takes precedence over unified positions (interviewees, June and July 2020).

On a more positive note, where issues are concerned that fall fully within the competence of the member states, the latter have often chosen to consult each other in international fora in order to reach common positions (Council of the EU 2019). Another encouraging sign is that EU interventions at the WHO have become more comprehensive and political rather than technical (Kickbush and Franz 2020).

Commitment to health security by the EU member states also remains inconsistent. For example, only three member states have signed up to the Global Health Security Initiative and only nine EU member states are members of the Global Health Security Agenda (Glassman et al. 2019).¹⁷ The fact that the European Commission’s role in health security is limited mainly to coordinating with and supporting coherence among the member states has led some experts to conclude that *‘EU institutions are currently punching below their weight on global health security.’* (Glassman et al. 2019: 28).¹⁸

‘Team Europe’ arose during the COVID-19 pandemic as a label for identifying the EU’s collective package for combating the pandemic internationally. This has now evolved to encompass a more political approach and branding of collective European action, including global initiatives and under the future programming of the NDICI, notably in the form of Team Europe Initiatives. Team Europe has enhanced strategic communication and visibility for Europe as a whole, a crucial aspect of external action in an age of communication wars. The Team Europe approach also seems to have revived the interest of some member states in Europe-wide cooperation in external action, and extended the scope of involvement to other actors such as the European development finance institutions.

While the Team Europe package and approach frame the European COVID-19 response and form a source of joint branding for European participation in global health initiatives, the relevance of Team Europe to health would appear to be limited. Team Europe initiatives under the NDICI programming will focus on the list of EU priorities, in which health does not feature. Moreover, it is unclear how Team Europe relates to joint programming, joint implementation and better working together, all of which could be of great relevance if Europe is to play a stronger role in health cooperation with partner countries.

An additional concern is how Team Europe as an approach will overcome some of the stumbling blocks to further Europe-wide collaboration that arise from divergences in EU and member states’ interests, different working methods, and the different circumstances prevailing in partner countries. These will all play out in the next programming phase and may or may not facilitate more cohesive European action on global health.

The French President, Emmanuel Macron, and the German Chancellor, Angela Merkel, have shown strong leadership alongside European Commission President Ursula von der Leyen in the global response to COVID-19. They have been

¹⁷ The [Global Health Security Initiative](#) (GHSI) is an informal, international partnership among like-minded countries and organisations for strengthening public health preparedness and responses to threats of chemical, biological, and radio-nuclear (CBRN) terrorism, as well as pandemic influenza. The [Global Health Security Agenda](#) (GHSI) is a multi-stakeholder group that works to achieve the vision of a world safe and secure from global health threats posed by infectious diseases.

¹⁸ Action in Antimicrobial Resistance (AMR) is a field in which the EU has shown leadership over the past decade. According to Kickbush and Franz, the progress made in this area is an example of how political momentum can be shared among member states, with Germany even ensuring that the topic was discussed at G7 and G20 meetings (Kickbush and Franz 2020).

highly vocal in pushing for political and financial support for the WHO, while calling for reform of the embattled agency and a better multilateral health architecture (France 24 2020; Ministère de l'Europe et des Affaires étrangères 2020b). Though encouraging, this type of engagement would be welcome from the EU as a whole rather than from individual yet powerful member states, especially when it comes to issues of collective relevance such as strengthening the WHO's leadership role.

Political momentum also comes from **EU Council Presidencies**. For instance, the 2019 Finnish Presidency, in cooperation with its trio partners Romania and Croatia, launched a multiannual project called 'Strengthening the role of the EU in global health cooperation'. The project centred on discussing how the EU could achieve better results in global health cooperation and create awareness of the global dimension of health in the Council's Working Party on Public Health (Council of the EU 2019; interviewee, July 2020).¹⁹ This suggests that, even though the project did not produce much change, there was a political appetite in 2019 for strengthening the EU's and member states' contribution to global health. This momentum was picked up by the German Presidency of the Council (1 July 2020–31 December 2020), one of whose priorities is to increase the EU's engagement in global health and strengthen the EU's future capacity to respond to health crises (Donor Tracker 2020b).

6. From donor to partner: working 'with' Africa on global health?

Despite the widely held view that the pandemic would quickly devastate Africa's fragile health systems, the impact so far has been less dramatic than expected. Although the figures are likely to be underestimates, the continent had just above 1.5 million confirmed cases in October 2020. It has the lowest number of COVID-19 mortalities of any continent and accounts for less than 4% of deaths globally.²⁰

African countries did not wait for external support and measures were put in place very early on to slow down community spread. This applies, for example, to Ethiopia, Ghana, Sierra Leone and Liberia (Medinilla et al. 2020; Zewdu n.d.; Hirsch 2020). The Africa Centres for Disease Control and Prevention (Africa CDC) created a COVID-19 task force on 5 February, before a single case had been recorded on the continent. Senegal has developed a quick USD 1 COVID-19 testing kit and scientific trials for herbal medicine. Manufacturing capacity in several countries has been dedicated to building ventilators and producing masks (Travaly and Mare 2020; Travaly et al. 2020; Tondel and Eunice Ahairwe 2020). An Africa CDC-led initiative was established for pool procurement and distribution of pharmaceutical products and health equipment to member states, and in June 2020, AU chairperson, Cyril Ramaphosa, launched the African Medical Supplies Platform as a single online marketplace to enable the supply of COVID-19-related critical medical equipment in Africa (Cilliers et al. 2020).

This has all been despite the fact that many African health systems are fragile and under-resourced. In addition, according to the UN, 56% of sub-Saharan Africa's urban population lives in overcrowded slums, and only 34% of households have access to handwashing facilities. These conditions, plus a lack of means of stockpiling food or practising self-isolation, make it very hard to withstand shocks such as COVID-19 (Caparini 2020; Nyenswah 2020).

¹⁹ As part of this project an 'Informal Expert Group on the EU's role in global health' was created. The Presidency partners committed to consult other member states, relevant Commission representatives and global health experts and can decide whether to submit concrete recommendations for consideration by the Council (Council of the EU 2019).

²⁰ Underestimation is due to a lack of testing capacity in many countries. Only 12 of Africa's 54 countries have tested more than 10% of their population (Sangafowa Coulibaly et al. 2020). Testing and surveillance gaps led the International Rescue Committee to state that Africa is 'fighting the pandemic in the dark' (IRC 2020). [Latest updates on the COVID-19 crisis from Africa CDC.](#)

Many LMICs in sub-Saharan Africa are already disproportionately affected by communicable diseases such as HIV/AIDS, malaria and tuberculosis, and COVID-19 has caused major disruptions to essential health services.

Africa has been one of the European Commission's focus areas of intervention in the fight against COVID-19, in line with the continent's increased relevance to Europe (Medinilla and Teevan 2020). Out of the €36 billion Team Europe package, €4.8 billion was allocated to sub-Saharan Africa (Council of the EU 2020f). The EU's response includes:

- strengthening regional health security organisations;
- strengthening research capacities in sub-Saharan Africa;
- underpinning the implementation of the Africa Joint Continental Strategy for COVID-19 led by the Africa CDC;
- supporting the services provided by the Africa CDC's network of Regional Collaborating Centres and National Public Health Institutes (European Commission n.d.).

Box 4: Examples of EU support for African continental initiatives

The European Commission, the EIB and the Bill and Melinda Gates Foundation have joined forces to provide €105 million in co-funding for the African Health Diagnostics Platform, which supports increased access to cost-effective, quality diagnostic testing services for low-income populations in sub-Saharan Africa (European Commission n.d.).

The Africa CDC received an additional 500,000 COVID-19 test kits from the German Government through the Federal Ministry for Economic Cooperation and Development. As part of the EU's global coronavirus response, the test kits were delivered by an EU Humanitarian Air Bridge flight in August.

The shipment forms part of a €10 million package of immediate in-kind support for the African Union in response to the COVID-19 pandemic. In total, almost 1.4 million kits for the extraction and detection of the SARS-CoV-2 virus will be made available to African Union member states as part of this initiative.

Source: [European Commission Factsheet; AU](#)

6.1. Health receives a big share of EU aid...

Collectively, African countries are the largest recipients of European aid for health, from both the EU institutions and its member states. Between 2014 and 2018, African countries received, on average, 57% of EU institutions' bilateral health aid. The EU institutions gave Africa €247 million worth of aid for health in 2018, less than in previous years. Many African countries were among the leading recipients of EU institutions' aid for health in 2018. The Democratic Republic of Congo (€37.1 million) and Ethiopia (€35.3 million) were the largest recipients among African countries in that year, with Turkey (€53.5 million) topping the list.

As with the EU institutions, so a large share (48%) of member states' bilateral aid for the health sector goes to Africa. EU member states collectively allocated €1.6 billion in 2018, in line with past disbursements. Ethiopia was by far the largest recipient of member states' aid for health in 2018, at €169.3 million, followed by Mozambique (€95.5 million). The amount of regional health aid given to Africa was also significant (with €170.8 million going to sub-Saharan Africa and €158.7 million to Africa overall).

6.2. ... despite a fairly low profile in policy frameworks

Against this background, health has a fairly low profile in the Joint Communication entitled 'Towards a comprehensive strategy with Africa' that was released in March 2020 (European Commission 2020i), just before the outbreak of the pandemic (Tadesse Abebe and Maalim 2020).

The June 2020 Foreign Affairs Council Conclusions on Africa were more ambitious on health and the strengthening of health systems, preparedness and response capacities. Its aims included promoting the African pharmaceutical and medical industry and cooperation on R&I in respect of endemic infectious diseases (Council of the EU 2020g). The fact that the Conclusions recognise African countries' experience in dealing with pandemics as well as the mutual benefits of knowledge-sharing is a positive step in line with the partnership approach envisioned in the Joint EU-Africa Strategy published in 2007 (but never fully realised) and reiterated in the EU-Africa Strategy (European Commission 2020i).

The Communication on the EU global response to COVID-19 also commits the EU to tackling challenges *'together with Africa'* (European Commission 2020a). The African Union is likely to prioritise health security in its future partnership with the EU. Taking these priorities into account will be crucial to the EU-AU partnership if the EU is to be a credible actor in the field of health.

The AU sought to assert itself in the development, production, procurement and distribution of future coronavirus vaccines by hosting a virtual conference with AU Ministers of Health in June 2020. This focused on the role that the continent hopes to play (Africa CDC 2020). The resulting communique outlines the areas that an African COVID-19 vaccine development and access strategy would prioritise, in terms of securing an adequate supply of vaccines and removing barriers to vaccine roll-out. These include:

- advocating for Africa to receive a sufficient global allocation, in order to ensure timely access to a potential COVID-19 vaccine;
- supporting Africa's efforts to secure the necessary vaccine supply by providing the requisite financial resources;
- supporting the development of a continent-wide clinical trial network; and
- ensuring that the vaccine can be effectively delivered to target populations (Africa CDC 2020).

EU support on these strands would be important and in line with the priorities that African stakeholders have set for themselves. Access to the vaccine will be crucial, given that *'[f]or many years Africa has struggled to get access to new technologies, including vaccines. It can take a decade for a new technology ... to find its way into African health systems in a way that could be called 'scaled up.'*" (Dr Matshidiso Rebecca Moeti, regional director for Africa at WHO quoted in Jerving 2020).

6.3. Strengthened R&I discussions between Africa and Europe as a result of COVID-19

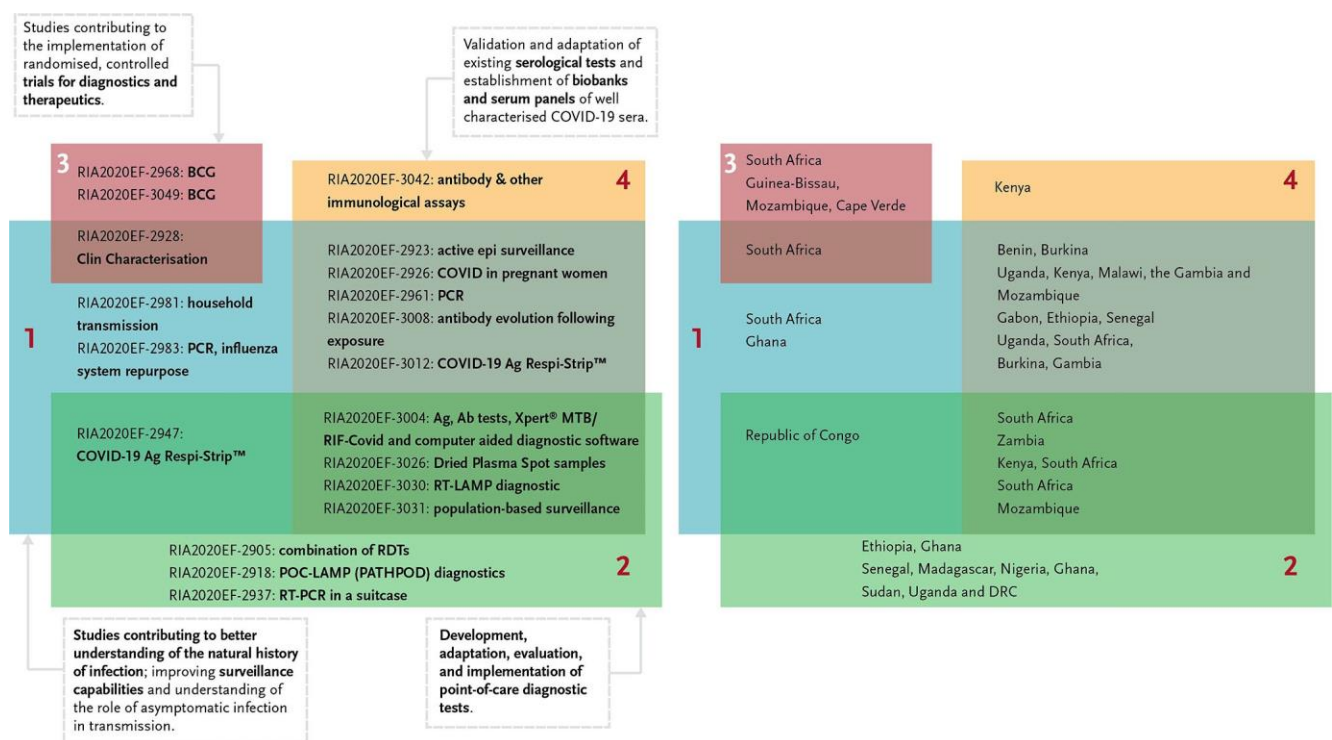
R&I ministers from EU and AU countries met for the first time in July 2020, at a meeting that focused on public health and equitable access to COVID-19 medical technologies (European Commission 2020j). This followed an EU-AU High Level Policy Dialogue on Science, Technology and Innovation, held in June 2020, which signalled a rise in political interest in R&I collaboration on health. Although public health was identified as an area for collaboration, the Ministers proposed a relatively narrow focus and included equitable access to COVID-19 medical technologies and the role of the [European and Developing Countries Clinical Trials Partnership](#) (EDCTP, a flagship health research initiative between Europe and sub-Saharan Africa) in strengthening clinical trials capacity in Africa (European Commission 2020j). Putting forward a strong vision for EU-AU collaboration on health is particularly important as the EU has been preparing a new [Communication on the future of R&I and the European Research Area](#) in which international collaboration will also feature.

The **EDCTP** has been mobilised for three types of actions in response to COVID-19:

- guaranteeing the continuity of ongoing projects;
- on a case-by-case basis, reorienting existing activities towards COVID-19 research;
- activating the emergency funding mechanism for *ad-hoc* COVID-19 research in sub-Saharan Africa.

The EDCTP has [funded 20 projects](#), 12 of which are coordinated by African institutions, and which are intended collectively to improve local capacities to respond to the virus in sub-Saharan countries (see figure 2). Projects are funded by the EU, France, Sweden, South Africa, and the UK. The ECDTP is also working with the Africa CDC to train epidemiologists and biostatisticians, an investment for both the short and the long term.

Figure 2: EDCTP COVID-19 projects



Note: The codes indicate the number of the project; the colour of the squares indicate the research topic and their overlap within individual projects. Source: EDCTP.

The EDCTP is a unique partnership that works with sub-Saharan Africa on global health. In their view, it continues to be relevant to the fight against poverty-related and infectious diseases and to the relationship between Europe and Africa. There is scope for improving the strategic use of its resources, the transparency of grant procedures, and synergies with other EU programmes, and also for strengthening partnerships with the participating states and other stakeholders, including additional funders (European Commission 2017b). The proposed 'EU-Africa Global Health Partnership' that is to replace the current EDCTP is expected to build on the EDCTP experience, including with a new partnership model and a deeper and wider involvement of different actors (European Commission 2020k).²¹

²¹ The April 2020 Communication on the EU's global response to COVID-19 states that the resources of the existing EDCTP, which currently focuses on sub-Saharan Africa, could be increased to enable its extension to the southern Mediterranean countries (European Commission 2020a).

6.4. An opportunity to build co-ownership?

COVID-19, along with broader dynamics such as the ‘Black Lives Matter’ movement (raising wider questions of the decolonisation of knowledge), has deepened the debate on the nature of international knowledge partnerships. Our interviewees claimed that *‘many in Europe think of a one-way collaboration’*, in which Africa has little to offer to Europe and in which Africans cannot participate on an equal footing with Europeans in research projects. African innovations and indigenous knowledge are sometimes neglected and considered of little added value for other settings. As a result, co-ownership is difficult to build and *‘equitable research participation is [...] still a vision rather than reality.’* (Berner-Rodoreda et al. 2019: 4).

The COVID-19 crisis may open new opportunities to improve co-ownership and balance partnerships, for example, by raising sensitivity to African national research agendas (interviewee, July 2020). Limitations on travel, the more extensive use of technology and the unavoidable contextualisation of public health measures such as social distancing could produce a shift in power towards local researchers and priorities (Maswime et al. 2020). This could also facilitate research on indigenous remedies and medicines, which are often difficult to propose as research topics in internationally funded projects. Shifting this balance is a tall order in contexts in which most research is internationally funded. It will require a change in the mindset of European and African policy-makers, as well as African funding in order to grow along with stronger infrastructures and institutions (Travaly et al. 2020; Di Ciommo and Thijssen 2019).

Our interviewees mentioned the [Africa Rapid Grant Fund](#) as an example of innovative collaboration since it shifts research administration responsibilities to Africa and links research to communication and policy advice. As a sign that times are changing, the African Academy of Science has published a [priority-setting exercise for COVID-19 research](#) which helps to identify the specific needs of the African context.

Beyond research, *‘the COVID-19 pandemic provides an opportunity to reprioritise and upscale EU support to Africa’s healthcare systems’*, especially given that the pandemic has severely undermined the prospects for achieving SDG3 (Tadesse Abebe and Maalim 2020). Beyond the discussions around equitable access to a COVID-19 vaccine, other infectious diseases as well as weak healthcare systems need to be taken into account in the EU’s long-term response. A deeper engagement with the African health security architecture needs to be prioritised. Although Africa bears one-quarter of the global burden of disease, it has only 2% of the world’s doctors (Chelala 2019) and accounts for only 1% of total global health expenditure. African states also spend five times their healthcare budget to service their external debts (Tadesse Abebe and Maalim 2020).²²

6.5. Long-term prospects for health in the EU-AU partnership

It is encouraging to see that, in the long term, the EU will seek to strengthen the preparedness and response capacities of the Africa CDC, as well as those countries with the weakest health systems, and also to harmonise regional surveillance systems and health workforce development (European Commission n.d.). This shows long-term thinking beyond the immediate COVID-19 response. It remains to be seen, of course, whether and how these plans will be followed through.

Another element that will be crucial both to COVID-19 and to future pandemics is boosting the local production of diagnostics, drugs and personal protective equipment as well as vaccine development in Africa to ensure better

²² This is despite the fact that, in 2001, [AU member states](#) pledged to set a target of allocating at least 15% of their annual budget to improving the health sector and urged donor countries to scale up support.

access to these (Keeton 2020). There is already vaccine manufacturing capacity in Senegal, Egypt, Tunisia, Ethiopia and South Africa (Jerving 2020).

While the COVID-19 pandemic has revealed the weakness of underfunded health systems in Africa, it also represents an opportunity to test the EU's commitment to an equal partnership with Africa. R&I is a promising cooperation area, although results in the past have been mixed in terms of co-ownership of the research agenda. Beyond the EU's willingness and ability to genuinely work with Africa, the extent to which it supports African health systems and the African health security architecture in the long term once the crisis recedes will have to be monitored.

The incentives for African political leaders to invest in health security will also have to be improved (Williams et al. 2020). Moreover, European policy responses aimed at domestic health security and competitiveness in the international market (such as responses directed at healthcare value chains) will also have to be coherent with development policy interests, especially in relation to African countries. In the rush to foster economic recovery in Europe and extinguish the public health crisis, conflicts could well emerge between European policies focusing on domestic objectives and those targeting international development, particularly in developing countries in Africa (Tondel and Eunice Ahairwe 2020).

7. Conclusions: prospects for the EU in global health are uncertain

The COVID-19 pandemic is a real test for the EU's international leadership ambitions. To some extent, the EU has risen to the healthcare and political challenge of mounting an effective response to the pandemic by putting together a collective and comprehensive 'Team Europe' package, leveraging its research and innovation assets, and catalysing bold, multilateral action at a time when global governance is being questioned. It has successfully promoted global initiatives, such as the ACT Accelerator, and has positioned itself as a convener of both state and non-state actors.

Yet, given the scale and urgency of the challenge, the EU's response would have been much stronger had there been more coherence among the various areas of action and more coordination with member states. Better coherence and more coordination within Europe could be achieved only if the 'rules of the game' with member states and within EU institutions were to be changed. It would also require prioritising health in an already packed political agenda. A robust strategy linking the various levels and spheres of EU intervention would help to make EU action on global health more impactful and consistent.

But a strategy alone will not do the trick. Political energy needs to be expended on overcoming the bottlenecks that arise from the EU's limited health competences, the differing mandates of EU institutions and their limited resources, the divergent interests and views of EU member states that hamper stronger collaboration across the EU institutions and with member states – while still preserving the variety of European experiences in health and their respective added values.

The EU's standing as a global health actor suffered greatly from its inability to control the crisis within its own borders at the onset of the outbreak. While the German EU Council Presidency and the leadership of the European Commission would appear to have generated a political momentum for strengthening health sovereignty and European structures for crisis preparedness, it is unclear whether this momentum will hold beyond the crisis, given the many other pressing priorities, and be able to reverse long-standing battles over health competences.

The linkages between domestic and international EU action on health also need to be reinforced. Although many effective plans have been made and the EU possesses good capabilities, if it wants to be a strategic global player, it will need to adopt a more joined-up approach to global health beyond humanitarian and development assistance to include services with a domestic mandate, but with international relevance. The shared sense of purpose that drove the EU's response to COVID-19 needs to be retained in adopting an EU-wide approach that can harness the best of EU institutions across DGs – for example on R&I, trade, health, international partnerships and others. Partner countries would benefit much more from such integrated and comprehensive offers than from aid alone. Such an integrated approach also lies the core of the SDGs and should inform any future new EU strategy for the health sector.

Where international cooperation is concerned, Team Europe could form an opportunity to deepen collaboration at the EU and among the member states. However, it would first need to resolve some of the ambiguities about what novelties it entails and how different – or similar – it is to other initiatives with similar aims (such as working better together, joint implementation and joint programming). A close monitoring of Team Europe and public, open communication about its achievements and limitations will be crucial.

If the EU wishes to play a bigger role in global health, it will have to upscale its support for health systems as a whole, as opposed to simply producing a narrow emergency response to future outbreaks. This is the soundest health investment for the economy and for human development and is in line with the approach outlined in the 2010 Communication on the EU's role in global health. It will require action at country, regional and global level.

The best opportunity for catalysing funds and strengthening action on global health will come after 2020, once a new seven-year EU budget is in place and a new programming process is about to start. If the EU is to play a bigger role in global health at a country, regional or global level, or in all of them cohesively, this should be reflected early on in consultations with partner countries, regional bodies and global institutions. Linkages between country, regional and global actions should be reinforced. This is particularly relevant as the MFF 2021-2027 allocates most EU funding to geographic areas, i.e. countries and regions, with a focus on Africa and the EU's neighbours. This means that the EU will seek to tailor action more to context, based on a better knowledge of context, and that the EU will dialogue with partner countries about shared priorities. Whether health will make the cut in the programming process depends in part on the messaging emanating from partner countries and regions as to whether health is a priority. At the time of writing, despite the evident fragility of the global health response to COVID-19, economic recovery is uppermost in policy-makers' minds, both in Europe and globally. Yet health outcomes and the success of socioeconomic measures cannot easily be disentangled and should go hand in hand. While there is likely to be some resistance to 'jumping from one sector to another', as one of our interviewees put it, a more strategic programming for priority areas, rather than just sectors, could help exploit linkages across domains – for example, linking digital entrepreneurs with health responses or job creation with a better trained, equipped and rewarded health workforce.

Finally, the COVID-19 crisis represents an opportunity to test the EU's commitment to an equal partnership with Africa. Health was a low-priority area in previous EU policy frameworks, most recently in the EU's Africa Strategy released in March 2020. Although the pandemic has revealed the challenges posed by weak investments in healthcare systems in Africa, it has also demonstrated the resilience of African societies and governments and their ability to take early, innovative measures. These experiences should form the basis for a 'win-win' partnership and mutual learning between Europe and Africa.

R&I is a promising area for such cooperation. This year was supposed to be crucial for Africa-Europe relations, with the sixth AU-EU summit scheduled for October 2020. The COVID-19 situation has forced the summit to be postponed

to 2021, which might make it more difficult to feature health more prominently in the partnership if momentum fades.

Given the political urgency of finding an effective response to this and future pandemics, and given the EU's other strategic priorities and deep-rooted structural challenges, a sustained and consistent effort will be needed from the EU and member states in order to carve out a bigger role for themselves on global health. The programming process, the new Gender Action Plan, the negotiations on a future EU-Africa partnership, the structuring of future partnerships for R&I and a potential new health strategy all offer opportunities for this.

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