Thematic evaluation of the European Commission support to the health sector

Final Report
Volume IIa

August 2012

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particip

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Thematic evaluation of the European Commission support to the health sector

Final Report

The report consists two volumes:
Volume I: Main report
Volume II: Annexes

Table of contents

List of tables

List of figures

List of boxes

List of acronyms

AACA	Afghan Assistance Co-ordination Authority
ABRP	Appui budgétaire pour la Réduction de Pauvreté
ACP	Africa, Caribbean and Pacific Countries
ADB	Asian Development Bank
AHDPF	Aids and Health Development Partners Forum
AIDCO	EuropeAid Co-operation Office
AIDOS	Syrian Health Counselling Centres
AIDS	Acquired Immunodeficiency Syndrome
ALA	Asia and Latin America group of nations
ANC	Antenatal care
ARTF	Afghanistan Reconstruction Trust Fund
ARV	Antiretroviral drugs
ASIA-LINK	EC programme to promote regional and multilateral networking between higher education institutions and in Europe and developing countries in Asia
AWP	Annual Work Programme
BAD	Banque Africaine de Développement
BL	Budget Line
BLHD	Bureau of Local Health Development
BM	Banque Mondiale - World Bank
BHSP	Basic Health Services Package
BS	Budget Support
CAF	Country Assistance Framework
CAG	Support Unit and Management in DRC
CAMEG	Supervision Committee of Medical Provision
CBG	Capacity Building Groups
CCH	Caribbean Co-operation in Health
CCM	Country Co-ordination Mechanism (of the GFATM)
CDC	US Centres for Disease Control
CDMT	Cadre des Dépenses à Moyen Terme
CE	Comission européenne - European Commission
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CG	Consultative Group
CGHN	Consultative Group on Health and Nutrition
CHAI	Clinton Health Access Initiative
CHT	Chittagong Hill Tracts
CIS	Countries of the Commonwealth of Independent States
CM	Co-ordination Mechanisms
CMB	Couverture médicale de base (Morocco)
CNCS	National AIDS Council
CNPS	Comité National de Pilotage de la Santé
COP	UN Climate Conference in Copenhagen
CRC	Convention on the Rights of the Child
CRIS	European Commission's Common RELEX Information System
CS	Civil Society
CSO	Civil Society Organisations
CSLP	Cadre Stratégique de Lutte contre la Pauvreté
CSE	Country Strategy Evaluation
CSO	Civil Society Organisation
CSP	Country Strategy Paper
CSP	Consolidation Support Programme
DAC	Development Assistance Committee

DAG	Donor Assistance Group
DAG	Donor Active Group
DALY	Disability Adjusted Life Year
DANIDA	Danish International Development Agency
DCI	Development Co-operation Instrument
DCI-ENVI	Environmental Budget Line 2007-2013 of the European Commission
DCI-Food	Food Budget Line 2007-2013 of the European Commission
DCI-Sucre	Sugar Budget Line 2007-2013 of the European Commission
DCP	Delegated Co-operation Partnership
DFID	Department for International Development
DG DEV	(former) EC Directorate-General for Development
DG DEVCO	EuropeAid Development and Co-operation
DG ENLARG	EC Directorate- General for Enlargement
DG RELEX	(former) EC Directorate for External Relations
DG RTD	EC Directorate- General for Research and Innovation
DHMT	District Health Management Team (Zambia)
DHS	Demographic and Health Survey
DK	Denmark
DoH	Department of Health
DP	Development Partners
DPS	Provincial Health Directorates
DPG	Development Partners Group
DPGH	Development Partner Group on Health
DR	Disbursement Rate
DRC / RDC	Democratic Republic of Congo
DWG	Donor Working Group
EADB	East African Development Bank
EAMR	External Assistance Management Reports
EBAS	Health Project on Human Resources in Ecuador
EC	European Commission
ECA	European Court of Auditors
ECHO	EC Humanitarian Aid & Civil Protection Department
EC-TA	European Commission - Technical Assistance
EDCTP	European and Developing Countries Clinical Trials Partnership
EDF	European Development Fund (for ACP countries)
EEAS	European External Action Service
EIDHR	European Instrument for Democracy and Human Rights
ENP	European Neighbourhood Policy
ENPI	European Neighbourhood Policy Instrument
EPDPHC	European and Developing Countries Clinical Trials Partnership
EPHS	Essential Package of Hospital Services
EPI	Expanded Programme on Immunisation
EQ	Evaluation Question
ERASMUS	European Community Action Scheme for the Mobility of University Students
EU	European Union
EU MS	European Union Member States
EUD	European Union Delegation
EUR	Euro
EVA	Evaluation Budget Line
FA	Financial Agreement
FASS	Le fond d'achat des services de santé
FDA	Food and Drug Association
FED	European Development Fund

FHF	Family Health Fund
FLEGT	Forest Law Enforcement, Governance and Trade
FM	Financial Mechanisms
FMS	Financial Management System
FNDP	Framework Of The National Development Strategy
FOOD	EC Food Budget Line
FOURmula ONE (F1)	FOURmula One for Health (implementation framework for health sector reforms in the Philippines)
FP7	Research Framework Programme Number 7
FY	Financial Year
GAERC	General and External Relations Councils
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM - CCM	Global Fund to Fight AIDS, Tuberculosis and Malaria – Country Coordinating Mechanism
GH	Ghana
GHS	Ghanaian Health Service
GHWA	Global Health Workforce Alliance
GIBS	Co-ordination Group of Donors in the Health Sector
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoBF	Government of Burkina Faso
GoL	Government of Laos
GoSA	Government of South Africa
GoT	Government of Tanzania
GoTL	Government of Timor Leste
GRZ	Government of Zambia
GRZ / CP	Government of Zambia and Co-operation Partners
HDC	Health Development Councils
HDI	Human Development Index
HEF	Health Equity Fund (Laos)
HEMA	Health Project in Vietnam
HFIN	Health Finances
HIO	Health Insurance Organisation
HIPC	Heavily Indebted Poor Country
HIV/ VIH	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNI	Health Net International
HNP	Health, Nutrition & Population (Bangladesh)
HNPSP	Health, Nutrition & Population Support Programme
HPSP	Health Sector Policy Support Programme
HPSP	Health and Population Sector Programme
HQ	Headquarter
HR	Human Resources
HRD SPSP	Human Resource Development Sector Policy Support Programme
HRH	Human Resource for Health
HSF	Health Service Fund
HSP	Health Sector Policy
HSP	Health Sector Support Programme
HSPD	Health Sector Policy Dialogue
HSPSP	Health Sector Policy Support Programme
HSRA	Health Sector Reform Agenda
HSRDP	Health Sector Rehabilitation and Development Programme

HSRP	Health Sector Reform Programme (Egypt)
HSS	Health Sector Strengthening
HSSP	Health Sector Support Programme
HSSP	Health Sector Strategic Plan
HSWG	Health Sector Working Groups
IAU	Internal Audit Unit
ICC	Inter-Agency Coordinating Committee
ICD	Internal Classification of Diseases
ICPD	International conference on Population and Development
IDB	International Development Bank
IDC	Infectious Disease Control
IDP	Internally Displaced Persons
IEC	Information, Education and Communication
IFMIS	Integrated Financial Management Information System
IHP	International Health Partnership Initiative
IHR	International Health Regulations
ILO	International Labour Organisation
IMF	International Monetary Fund
IMG	Independent Monitoring Group
INCO-Copernicus	EC Research Programme on Health
INCOP	Public Electronic Purchase Corporation in Nigeria
INGO	International Non-Governmental Organisation
INTAS	EU Financed Health Research Project
IPPF	International Planned Parenthood Federation
JANS	Joint Assessment of National Strategies
JAR	Joint Annual Review
JAS	Joint Assistance Strategy
JAST	Joint Assistance Strategy for Tanzania
JASZ	Joint Assistance Strategy for Zambia
JBIC	Japan Bank for International Co-operation
JC	Judgement Criteria
JDG	Joint Donor Group
JEU	Joint Evaluation Unit
LA	Local Authority
Lao PDR	Lao People Democratic Republic
LGA	Local Government Authorities
LGU	Local Government Unit
LRRD	Linking Relief, Rehabilitation and Development
M&E	Monitoring and Evaluation
MAIS	Model of Integrated Health Care
MCH	Mother and Child Health
MDA	Ministries, Departments and Agencies (Ghana)
MDBS	Multi-Donor-Budget-Support
MDG	Millennium Development Goals
MEDA	Mediterranean Basin and Middle-East group of nations (EU financial tool serving the Mediterranean region)
MEDA-ENPI-TACIS	EC Budget lines for Neighbourhood countries
MEG	Medicaments essentiels géneriques
MMR	Maternal Mortality Ratio
MNCH	Maternal Neonate and Child Health
MoF	Ministry of Finance
MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health

MOHFW	Ministry of Health and Family Welfare
MoHP	Ministry of Health and Population
MOHSW	Ministry of Health for Tanzania including Zanzibar
MoPH	Ministry of Public Health
MoPHP	Ministry of Public Health and Population
MoU	Memorandum of Understanding
MPH	Ministry of Public Health
MS	Member State
MTBF	Medium Term Budgetary Framework
MTDP	Mid-Term Development Plan
MTEF	Medium-Term Expenditure Framework
MTF	Mindanao Trust Fund
MTR	Mid-term Review
MZN	Mozambican Metical
NAC	National Association for children (South Africa)
NAO	National Authorising Officer
NEPAD	New Partnership for Africa's Development
NESP	National Education Strategic Plan
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHDI	National Human Development Initiative
NHIS	National Health Interview Survey
NHP	National Health Programme
NHS	National Health Service
NIP	National Indicative Programme
NIS	Newly Independent States
NPHCDA	National Primary Health Care Development agency
NRHM	Indian Health Programme
NRVA	National Risk and Vulnerability Assessment)
NSA	Non-State Actors
NSAF	National Social Aid Fund
NSA-LA	National Social Aid Fund Latin America
NSGRP/MKUKUTA	National Strategy for Growth and Reduction of Poverty
OCHA	UN Office for the Co-ordination of Humanitarian Affairs
ODA	Official Development Aid
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation & Development
OECD-DAC	The Development Assistance Committee of the Organisation for Economic Co-operation & Development
OLAS	On Line Accounting System
OOP	Out Of Pocket Payments
OVC	Orphans and Vulnerable Children
PADS	Common health basket fund in Burkina Faso/Health Project in DRC
PAF	Performance Assessment Framework
PAHO	Pan American Health Organisation
PALOP	ACP group of countries using Portuguese as official language
PAPES	Health Programme in El Salvador
PAPNDS	Health programme in DRC
PAR	Programme for Rehabilitation
PARPA	Plan for the Reduction of Absolute Poverty [=Mozambique's PRS]
PASS	Programme d'appui sectoriel à la réforme du système de santé
PASSE	Health Sector Programme in Ecuador
PATS	Transitional Support Programme to the Health Sector

PDF	Philippines Development Forum
PDPHCP	Partnership for Delivery of Primary Health Care Programme
PE	Public Expenditure
PEN	National Strategy Plan (Plan stratégique national)
PER	Public Expenditure Review
PESS	Health Sector Strategic Plan
PfA	Project for Actions
PFM	Public Financial Management
PGBS	Partnership General Budget Support
PHC	Primary Health Care
PHIC	Philippine Health Insurance Corporation
PIN (NIP)	Programme Indicative National
PIU	Project Implementation Unit
PLWH	Health Programme in Ecuador
PMTCT	Prevention of Mother-to-Child Transmission of HIV and AIDS
PMU	Project Management Unit
PNDS	Plan National de Développement Sanitaire
PNHA	Philippines National Health Account
PoA	Programme of Action
POSSE	Health Programme in Ecuador
PPP	Public-Private Partnership
PRBS	Poverty Reduction Budget Support
PRD	Poverty Related Disease
PROARES	Post-earthquake rehabilitation programme in Ecuador
ProS II	Health programme in Mozambique
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
PS9FED	9th EDF Health Programme in the DRC
R&D	Research and Development
RA	Republic Acts
RAMED	Regime d'Assistance Médicale
RBM	Results-Based Management
RBM	Roll Back Malaria Partnership
RCH	Reproductive and Child Health
RDC	Democratic Republic of Congo
RDF	Revolving Drugs Funds
RG	Reference Group (of the present evaluation)
RH	Reproductive Health
RHIYA	Reproductive Health Initiatives of Youths in Asia (EC financed regional intervention)
RMC	Co-ordination Mechanisms in South Africa
ROC	Republic of Congo
ROM	Results-Oriented Monitoring
RSP	Regional Strategy Paper
RV	Retro-Viral
SA	South Africa
SAG	Sector Advisory Group
SANTE	EC Budget Line for Health issues
SARS	Severe Acute Respiratory Syndrome
SASP	Support to Structural Adjustment
SBS	Sector Budget Support
SCP	Sustainable Consumption and Production
SDAH	Sector Development Approach for Health

SFPA	Syrian Family Planning Association (SFPA)
SGPF	System for Budget and Financial Management
SICA	Specific International Co-operation Action
SIDA	Swedish International Development Agency
SIHSIP	Support to the Implementation of the Health Sector Investment Programme
SPSP	Sector Policy Support Programme
SRH	Sexual and reproductive health
SRSS	Stratégie de renforcement du système de santé
SSP	Support to Sector programmes
STD	Sexually Transmitted Disease
STI	Sexually transmitted infections
SUCOP	Health /HIV/AIDS programme in South Africa
SWAp	Sector-Wide Approach
SWG	Sector Working Groups
TA	Technical Assistance
TACIS	Technical Assistance to the Commonwealth of Independent States – (EU support programme to Eastern European and Central Asian group of nations / region)
TAG	Technical Advisory Group
TAIEX	EC Budget Lines for former neighbourhood countries
TB	Tuberculosis
TEMPUS	EC programme on vocational education
TF	Trust Fund
TFET	Trust Fund managed by the World Bank in Timor Leste
TFIPP	Health Sector Programme in Bangladesh
TL	Team Leader
TLDPM	Timor-Leste and Development Partners Meeting
ToR	Terms of Reference
TRIPS	Trade-Related Aspects of Intellectual Property Rights
TSA	Treasury Single Account
TWG	Technical Working Group
TZ	Tanzania
UE	Union européenne - European Union
UHI	Universal Health Insurance
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFCCC	UN Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/Aids
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
USAID	United States Agency for International Development
USD	United States Dollars
W&S	Water and Sanitation Sector
WB	World Bank
WG	Working Group
WHIP	Wider Harmonisation In Practice, Zambia
WHO	World Health Organisation
WTO	World Trade Organisation
ZSGRP/MKUZA	Zanzibar Strategy for Growth and Reduction of Poverty

Annex 1: Detailed answers to the Evaluation Questions

1 EQ1 To what extent has EC support contributed to enhancing the quality of health services?

1.1 JC 11 Availability of essential drugs improved due to EC support

We assessed this JC based on two indicators, the first asking whether the EC had contributed to putting in place national policies guaranteeing access to essential medicines and the second asking whether the EC had contributed to an actual improvement in availability of essential medicines in clinics and pharmacies.

The first indicator proved to be somewhat jejune, as in many countries constitutional and policy guarantees of access to essential medicines exist but are meaningless in practice. High prices and stock-outs in public facilities remain major barriers to access to needed medication in many countries receiving EC support. The country cases studies show that in some countries (e.g. *Afghanistan* and *Egypt*), by directly financing primary health care facilities, the EC has implicitly guaranteed access to some essential medications. EC support to the Global Fund, which has subsidised or guaranteed access to medications related to the diseases of poverty, has had the same impact. In only one case study country, the *Philippines*, did the EC directly contribute, through TA and policy advice, to legislation which significantly affected access to essential medicines.

There is less ambiguity regarding the second indicator. Through a wide range of interventions, the EC has significantly contributed to improving availability of essential drugs. Evidences from the country cases highlights that, in *Afghanistan* and *Egypt*, as mentioned, the EC was involved in direct provision and similar impacts could be found in countries such as *Ecuador* and *Lao PDR* where projects, in the first case sector support in three underserved provinces and, in the second, NGO projects, supported primary health facilities where essential medicines were available. According to the health inventory, the EC contributed Euro 34 million (representing 0,8% of total direct EC support) directly to drug availability over the evaluation period and to this should be added the indirect contribution through support for the Global Fund. Support for health care finance reform, as in the *Philippines* and *Moldova*, can have the indirect effect of enhancing access to pharmaceuticals because it relives pressure on medical facilities to generate funds by the sale of drugs.

In general, though, the evidence from country case studies, interviews, EUD survey and the inventory continues to be that essential medicine availability is much better in the private sector than the public sector and is one reason why even poor persons eligible for care in public health facilities often resort, at considerable expense, to the private sector. The direct support for medicines emanating from the EC is miniscule compared to total expenditure on medication.

This JC has been reasonably well covered by evidence gathered to date. However, specific evidence on drugs related to the diseases of poverty has not been taken into account, nor has the EC's support for vaccines and immunisation. A full understanding of the pharmaceutical sector at country level unfortunately requires a level of analysis that is not practical given the constraints of this evaluation.

1.1.1 I-111 National health policies guarantees access to drugs, officially recognised as essential

There is an important difference between EC contribution to the formulation of policies related to access to essential medicines – which includes not only guarantees enshrined in instruments such as the national health policy, but also policies on regulation, importation, etc., of pharmaceuticals – and contribution to implementation of those policies. We have found very little evidence in the country case studies that the EC has been actively involved in encouraging governments to guarantee access. While a few countries may lack any such policy guarantee, the more common situation is that the guarantee is meaningless because actual access continues to be limited by high prices, slow customs clearance, poor distribution, etc. It is in these areas related to pharmaceuticals that the EC is more likely to contribute to policies promoting better access than in promoting guarantees per se. Examples probably include GBS policy dialogue in countries such as *Burkina Faso* and *Ghana*. Among case study countries, by far the deepest involvement of the EC in such issues was in the *Philippines*. Through the Health Sector Policy Support Programme, the EC was involved in TA and capacity building in a range of agencies responsible for policy at various stages of the pharmaceutical supply change, in addition to contributing to the passage of major reforming legislation during the evaluation period. In a number of countries, such as *Afghanistan* and *Egypt*, the EC financed distribution of essential medicines (through the Basic Package of Health Services in the former case and distribution of the Basic Benefits Package through Family Health Centres in the latter). This is, however, more relevant to the next Indicator, I-112, than to this one.

The EC/ACP/WHO Partnership on Pharmaceutical Policies (Euro 25 million, 2004-200 9 had as objectives improved access to, quality of and utilisation of essential medicines in the ACP countries through policy improvements. At the time of the mid-term reviews (2006) delays in start-up had been experienced, the team felt that the range of proposed activities was too broad and the absence of a Project Implementation Unity was blamed for slower than expected progress.

Not treated explicitly in the country case studies, but important to note, is EC support of the Global Fund. The GFATM has supported access to medication, especially AIDS-related medication but also malaria drugs and tuberculosis treatments, across the world. These efforts, to which the EC contributed, have been especially important in increasing access to ARV treatments in heavily AIDS-affected countries in Africa. EC support of GAVI has also directly financed the availability of vaccines.

Box 1: EC contribution to policies related to access to essential medicines: Country Case Study evidence

ACP

While the national drugs policy in Burkina Faso was adopted prior to the evaluation period, the three EC budget support programmes implemented during this period have helped to government to operationalise the strategy. It is not known whether the EC also contributed to policy formulation, although it is probably safe to assume that it did via the GBS-based policy dialogue.

In the DRC, the major role of the EC in supporting essential drug policy has been via its leading role in co-ordination, e.g. holding a workshop bringing together major actors in the drug supply chain. The extent to which these activities focused on policy, as opposed to implementation, is not known.

Similarly in Ghana, there is evidence that EC support through GBS helped government to implement its essential drugs policy, but as in Burkina Faso above, there is only a supposition that policy dialogue through GBS contributed to policy formulation.

No relevant evidence for EC contribution to essential drugs policy was found in South Africa or in Zambia.

Asia

In Afghanistan, the EC has contributed, through TA, to the Pharmaceutical Affairs Unit of the MoH. Pharmaceuticals policy, however, is severely constrained by the fact that virtually all medicines are imported and the private sector accounts for 70% of distribution. Through provision of the Basic Package of Health Services, the EC has provided significant support for the availability of basic medicines, but this is simply provision, not formulation of policy.

No information relevant to the Indicator was found in Bangladesh.

Lao PDR follows closely WHO recommendations and protocols in its policy relating to essential drugs and there is no evidence of EC contribution to the adoption of these policies.

In Philippines, through the Health Sector Policy Support Programme, the EC supported agencies responsible for licensing, accreditation and certification functions relating to essential medicines. Through TA, the EC contributed to significant legislative reform relating to essential medicines and, in supporting reform of PhilHealth, the EC provided TA elated to the financing and procurement of medicines. It is safe to conclude that EC support contributed significantly to important policy reforms designed to guarantee access to essential medicines.

ENP

Guarantees related to access to essential medicines long ante-date the evaluation period in Egypt. By supporting roll-out of the family health model, the EC assuredly contributed to access to essential medicines, but the policies guaranteeing that access were already in place. It could be argued that by providing TA to put the Health Insurance Organisation (incorporating the family health model) on a financially sustainable basis, the EC is indirectly supporting universal access to essential medicines.

In Moldova, there is no explicit entitlement to essential medicines.

Latin America

EC interventions in Ecuador did not deal with pharmaceuticals policy.

1.1.2 I-112 Average availability of selected essential medicines in public and private health facilities, including pharmacies

There is little doubt that the EC contributed significantly to enhanced availability of essential drugs in a number of circumstances and via a range of interventions, although the situation remains far from satisfactory in many if not most countries receiving support. Based on country case studies (see the following), in at least two countries, *DRC* and *Afghanistan*, the EC was essentially the key player in essential drug access either nationally (the first case) or in regions targeted by the EC (the second case). In *DRC*, it is not going too far to say that the national drug availability itself is due to EC support. In *Afghanistan*, essentially all basic health care, including medicines, in ten provinces is financed by the EC (curative and secondary care is, however, another matter). In addition, sector support promoted drug availability in *Ghana* and *Zambia*. On the other hand, most improvements in South Africa appear to antedate the evaluation period, although the role of the Global Fund in promoting availability of drugs to treat and prevent the diseases of poverty should not be forgotten.

If there is one thing that comes through in multiple country case studies, it is the ambiguity of the situation. In many countries – *Afghanistan*, *Ghana*, *Philippines*, *Bangladesh* and others -- positive EC contributions are identified, only to be qualified by the observation that drug availability and access continue to be problematic. What must be appreciated is the complexity of the pharmaceutical supply chain, which includes TRIPS, customs, regulatory issues, the complementary roles of the public and private sectors, etc. There appear to be a number of basic approaches that the EC has followed. One is simply providing medicine, as in *Afghanistan*. According to the global inventory of EC health assistance, some € 34 million of EC direct support to the health sector in 2002-2010 consisted of providing medicines, representing about 0.8% of the total direct support (see the following table). To this should be added the EC contribution to the Global Fund, which has subsidised or completely financed access to essential medicines related to the diseases of poverty, just as its contribution to the Global Alliance for Vaccines and immunisation has promoted vaccination.

Table 1: Direct EC support to the health sector: Amounts (€ million) contracted for interventions on essential drugs, infrastructure and HR, 2002 and 2010

Interventions	Contracted amount (€ million)
Essential drugs	34
Infrastructure	361
Human Resources for health	137

Source: Particip inventory

Box 2: Average availability of essential medicines: Country Case Study evidence

ACP

In Burkina Faso, improving availability of essential medicines was one of the goals of the national health strategy 2000-2010 and data reported in the case study show a significant decline in the number of health care facilities experiencing shortages between 2002 and 2006. The EC contributed to this improvement in the context of GBS, where access to essential drugs was one of the variable tranche triggers.

The EC also contributed significantly to an improvement in the availability of essential drugs in the DRC. Support under the 8th and 9th EDF put in place a system for delivering medicines that was considered by the CSE 2007 as being effectively the only source of pharmaceutical supply in the country. The emphasis was on reliable provision of good-quality generic drugs. The EC also supported pharmaceutical availability in Tanganyika province in the context of LRRD. These positive impacts have been documented in a range of project reports, reviews and evaluations and amount to a major positive impact in a severely disadvantaged country.

In Ghana, under the Health Sector Support Programme (HSP) 1998-2004, EC support contributed to increasing availability of drugs and there may have been some continuing contribution under GBS. However (and despite improvements registered since 2004), in 2008 there were still widespread shortages of drugs reported, especially in rural areas where outages were more the rule than the exception. The frequent result is to force the patient to resort to much more expensive private pharmacies.

In South Africa, sector support as well as programmes targeted directly at HIV/AIDS contributed to enhancing essential drug availability. However, the major gains appear to have been made prior to the evaluation period and the case study did not uncover any evidence of time trend in more recent years.

In Zambia, improving access to essential drugs is one of the goals of support to the health sector under EDF 9 and particularly of the large "Supporting public health service delivery" sector policy support programme under EDF10. The case study cites a mid-term review concluding that drug provision is improved and stock outages are less reported, but concludes that the EC made little contribution.

Asia

In Afghanistan, the EC essentially supported all access by poor people to medicine in the ten provinces where it financed the Basic Health Service Package. The case study reports evidence that an index of nationwide essential drug availability rose from 65% to 85% between 2004 and 2008. An evaluation of the BHSP services in Kunduz nonetheless reported problems and drug availability data are sometimes difficult to interpret. However, all facilities in the province reported that they were receiving regular supplies of essential drugs.

In Bangladesh, availability of essential drugs is tracked by several monitoring indicators for the Health, Nutrition and Population Sector Programme (HNPSP) implemented since 2003. However, annual monitoring reviews have failed to provide statistical information on any of these drug indicators and both the mid-term review 2008 and annual programme review 2009 made negative comments about trends in pharmaceutical availability. In addition to sector support, the Primary Health Project in Cox's Bazaar financed by the EC registered some success in improving access to pharmaceuticals.

Little relevant information was gathered in Lao PDR, although studies document the very poor availability of essential medicines in remote villages. EC-financed INGO health projects will have contributed to improved availability in the districts where they were implemented. EC policy dialogue and support for health sector reform does not appear to emphasise pharmaceuticals.

In the Philippines, no statistical data on the Indicator has been found. However, both the HSPSP and the Mindanao HSPSP included access to essential drugs among their goals and there have been major regulatory and legislative improvements. EC-supported TA has strengthened the supply chain down to the local level. The case study cites evidence that the drug supply situation is still far from ideal, but EC support has probably made some contribution to improvement.

ENP

Availability of pharmaceuticals has not been a problem in Egypt; the problem has been their high price. The provision of the Basic Benefit Package as financed by the EC through the HSPSP has been the major EC impact on affordable access to essential drugs.

No evidence related to this Indicator has been found in Moldova. It was noted, however, in the CSE 2007 that, although essential drugs are supposed to be free, patients continued to pay for essential drugs such as insulin.

Latin America

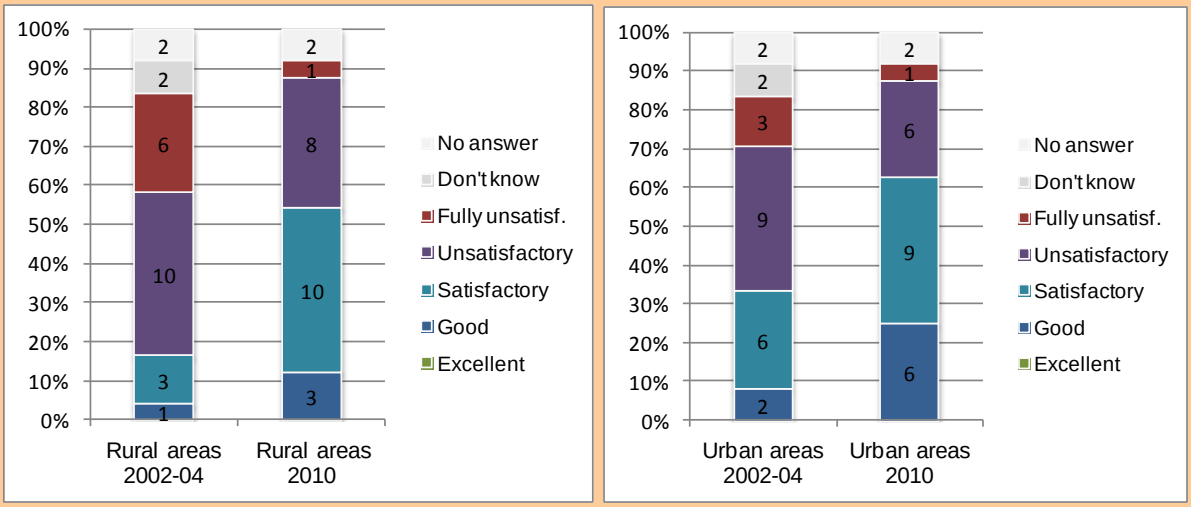
No information related to this Indicator was found in Ecuador.

There is also the strong contribution through sector budget support to improved pharmaceuticals policy; the *Philippines* being the major example. However, not only sector, but GBS may contribute to better pharmaceutical availability, as suggested by the examples of *Ghana* and *Burkina Faso*. To judge from the EUD survey (see following box), an increasing proportion of responding Delegations saw the situation as improving over the evaluation period and a number mentioned specific interventions of the EC that had contributed to better drug availability.

Box 3: Average availability of essential medicines: EUD survey evidence

The number of EUDs that rated availability of drugs as "good" increased from one in 2002-04 (EUD Barbados) to three in 2010 (EUDs Barbados, Syria and Afghanistan). The number reporting "satisfactory" also improved considerably from three out of 24 in 2002-04 to nearly half in 2010. In urban areas, according to the EUDs' perception, the situation has globally improved and the countries with either satisfactory or good availability of essential drugs, increased from one in three in 2002-04 to two in three in 2010. In rural areas, still six out of 24 EUDs in 2002-2004 (*India, Philippines, Timor-Leste, Zambia, South Africa* and *El Salvador*) characterised the availability of essential drugs in rural areas to be "fully unsatisfactory. This number was reduced to only one (EUD *El Salvador*) in 2010. EUD's reporting "unsatisfactory" availability in rural areas dropped slightly between 2002-04 and 2010. These trends are illustrated in the figures below.

Figure 1: Results of the survey to EUDs: Availability of essential drugs



Source: EUD Survey, 2011, Particip GmbH

Overall, EUDs gave the EC credit for promoting increasing availability of drugs. Delegations giving specific examples included *Philippines*, which cited support for legislation, *Nigeria*, which cited support for vaccines and immunisation as well as for the infrastructure which enhanced storage and distribution of medicine; *Morocco*, which cited GBS and *Mozambique*, which responded that policy dialogue under sector budget support which contributed to essential drug availability.

The MoH survey was a particularly valuable data source for assessing this Indicator. As shown in the following table, most countries answering the survey reported significant improvements over the evaluation period in the availability of essential drugs in both rural and urban areas. MoH responses on the contribution of the EC were, however, vague and unhelpful.

Table 2: Results of the survey to MoHs: Drug supply in health care facilities

Country	Rural areas		Urban areas	
	Drug supply in health care facilities: 2002	Drug supply in health care facilities: 2010	Drug supply in health care facilities: 2002	Drug supply in health care facilities: 2010
Syrian Arab Republic	50%-70%	50%-70%	70%-90%	70%-90%
Lao	30%-50%	50%-70%	50%-70%	70%-90%
Egypt	50%-70%	More than 90%	50%-70%	More than 90%
Yemen	30%-50%	10%-30%	50%-70%	30%-50%
Afghanistan	50%-70%	70%-90%	30%-50%	50%-70%
Moldova	30%-50%	More than 90%	50%-70%	More than 90%
Burkina Faso	70%-90%	More than 90%	70%-90%	More than 90%
Morocco	50%-70%	More than 90%	50%-70%	More than 90%

1.2 JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support

We assessed this JC based on two related Indicators, the mix of primary and secondary care facilities, the proportion of facilities with appropriate equipment and sufficient budget for maintenance and operating expenses[1]. The efficiency of EC interventions providing infrastructure and equipment was often impaired by the inadequate attention paid to maintenance and operating costs. As a result, the use-life of EC-financed equipment is lower than could have been achieved.

To put this in perspective, we can cite results of the EUD survey. As the following table makes clear, human resources, not infrastructure or budget, was regarded as the main factor constraining progress over the evaluation period.

Table 3: Top four factors constraining quality most mentioned by EUDs

Constraining factor	Commented by:
Lack of enough qualified human resources	EUDs in Lao, Philippines, Bangladesh, Moldova, Syrian Arab Republic, Nigeria, Yemen, Egypt, Burkina Faso, Congo, Zimbabwe, El Salvador, Zambia
Governance and sector management issues	EUDs in Barbados, Philippines, India, Moldova, Syrian Arab Republic, Burkina Faso, Nigeria, Yemen, Ecuador
Lack of infrastructures and equipment	EUDs in India, El Salvador, Moldova, Yemen, Zimbabwe, Zambia
Limited Public health financing	EUDs in Vietnam, Lao, Philippines, Yemen, Nigeria, Burkina Faso

Source: EUD survey

Where infrastructure and equipment were mentioned, factors cited included population growth (EUD *India*) and the exacerbating factor of macroeconomic crisis (EUDs *Zimbabwe* and *Zambia*). In passing, inclusion of Moldova is surprising, since Moldova inherited an exceptionally dense health infrastructure from the Soviet era and has been the beneficiary of considerable EC support for rehabilitation, re-furbishing and re-tooling.

With hindsight, focusing on the mix of primary and secondary health care facilities may have been a mistake, since most of the information available dealt simply with number of facilities available, not the mix. This means that some caution must be applied in situations where infrastructure is imbalanced. In *Moldova* and many other post-Soviet states, for example, the problem was too many hospitals, often with low bed occupancy rates and not enough primary ambulatory facilities. So it is not surprising that one of the goals of EC support was to reduce the number of superfluous hospital beds.

Over the evaluation period, according to the inventory, the EC contributed € 361 million directly to infrastructure. Note that this is not, in general, an EC focal area, as donors, such as the World Bank, are in a stronger position to offer the major finance needed to finance infrastructure development. However, in assessing Indicator I-121, we identified a number of countries where the EC financed or supplied

[1] Initially, the second part of the indicator had been separate, as I-123 Increased proportion of health facilities with adequate budget for maintenance and recurrent expenditures, Given that virtually no evidence was found relating to this Indicator, the two were merged, to be able to use, to a certain extent, the relevant information.

infrastructure – *Afghanistan*, *Ecuador*, *Egypt*, *Philippines* and *Ghana* among them. This was generally in under-served areas or serving a particular need (e.g. family clinics in Egypt). In the *Philippines* and *Moldova*, the EC also provided TA which aimed to improve health facility planning and rationalise infrastructure. Respondents to the EUD survey broadly supported the view that the infrastructure situation had improved over the evaluation period. In *India*, according to the 2007 Country Strategy Evaluation (Volume 2, page 75), the EC supported the rehabilitation of dilapidated primary health care infrastructure and the provision of a basic package of health services.

Some EC support to infrastructure should be seen in the context of support to decentralization, in which case the recent thematic evaluation on decentralisation is relevant. It states that, in most of its support to decentralisation, the EC has contributed to some expansion of local infrastructures, not necessarily specifically in the health sector, but more broadly (e.g., roads), with the effect of improving access to services[2].

Related to the issue of provision of appropriate equipment, again, responding EUDs were generally of the view that the equipment situation has improved over the evaluation period. Reasons cited included GBS which loosened fiscal constraints, changed government priorities and direct EC support for the provision of infrastructure and equipment. The EC provided equipment directly in cases where it financed infrastructure development. While information related to the adequacy of budget for maintenance and recurrent expenditures has remained scarce, it is possible that EC supported GBS, by means of the policy matrix and increasing budgetary resources, has helped making more current budget available to health facilities. EC support for improved health care finance would have similar results.

1.2.1 I-121 Improvement in the mix of primary and secondary health facilities

Between 2002 and 2010, the EC contributed Euro 361 million in direct support for the provision of health infrastructure (see Table 1, inventory data). In three of the case study countries, *Afghanistan*, *Egypt* and *Ecuador*, the EC directly supported significant infrastructure expansion (see following box). In the first, this took the form of building primary health care facilities in ten provinces, in *Egypt* the EC supported the construction and equipping of Family Health Centres in pilot provinces and in *Ecuador*, new facilities were constructed in three under-served provinces. New facilities were also provided via NGO-implemented projects in Mindanao Province of the *Philippines* and in under-served areas of *Lao PDR*. To this work must be added EC support for equipment and rehabilitation in many settings; for example, in *Moldova*, rehabilitation was much more important than construction of new facilities. While infrastructure was not a focus in any of the ACP countries studies, it is possible that GBS in *Burkina Faso* and *Ghana* facilitated expansions in primary health care facilities. The EC has also supported programmes to rationalise health facility planning, as in the *Philippines*.

Box 4: Improvement in the mix of primary and secondary facilities: Country Case Study evidence

ACP

In *Burkina Faso,* there was a significant increase in the number of primary facilities between 2000 and 2006, but this barely kept pace with population growth. The expansion may have been facilitated by EC GBS. Between 2005 and 2008, an EC-supported project constructed two maternity hospitals and rehabilitated twelve primary health centres.

In *DRC*, the rural population went directly to hospitals instead of using primary health facilities. The EC contributed to lessening this problem, but not so much by investment in facilities as in improving the availability of drugs, equipment and human resources.

Because of a lack of time series data, it is not possible to state with any certainty whether the EC contributed to improvement in this Indicator in *Ghana*. In the early years of the evaluation period, the EC contributed to expansion of health infrastructure through the Common Donor Health Account. The 2006 review of the Health Support Programme saw little improvement in service provision, although strengthening of primary services and reorientation of secondary and tertiary service to support primary were among the goals. General budget support may have contributed to fiscal space to expand infrastructure, however the evaluation of the Multi-donor Budget Support found that, while expenditure on health had increased during the MDBS period, this had not translated into improvements in the scale or quality of services.

In *South Africa*, through the Partnerships for the Delivery of Primary Health Care sector support programme, the EC contributed to rehabilitation and equipping of primary care facilities.

In *Zambia*, the mix of primary and secondary health facilities did not change over the evaluation period and no

[2] Particip (2012): Thematic global evaluation of the European Commission support to decentralisation processes, 2012, p. 48

evidence of EC involvement in health infrastructure was found.

Asia

In rolling out the Basic Package of Health Services in the ten provinces of *Afghanistan* where it provides finance, the EC has contributed to an enormous increase in the number of primary health care facilities and some improvement in referral hospitals. EAMRs and ROMs contain specific information on successes in Kunduz and Laghman Provinces. Health infrastructure has been provided, but problems remain in the form of inadequate staffing, access problems related to remoteness and security and the absence of an effective case management system.

No relevant time-series information was found in *Bangladesh*. Evidence presented in the case study shows, however, that an EC project contributed to the expansion of maternal and neonatal health facilities.

In *Lao PDR*, there has been significant infrastructure expansion over the evaluation period, but this was not a focus area for the EC. EC-financed NGO health projects provided some infrastructure, as did the regional Reproductive Health Initiative for Youth in Asia project; however, infrastructure was not a large component of any EC-financed interventions.

The main need in the *Philippines* is not simply for expansion, it is for rationalisation of health infrastructure, which includes eliminating redundancies. Through the Health Sector Policy Support Programme, the EC has provided TA that has helped to identify needs and propose approaches. In the Mindanao Health Sector Policy Support Programme, as well, the EC has helped officials (this time at the local level) to analyse needs. An EC-supported NGO project aimed at displaced people in Mindanao financed the construction of fifteen community-level health facilities.

ENP

In *Egypt*, under the Health Sector Reform Programme, the EC financed the construction of 125 Family Health Units in pilot Governorates. Ambiguity in the budgetary data found makes it hard to state whether the follow-on Health Sector Policy Support Programme-II devoted significant sums to infrastructure development. There is no doubt, however, that policy advice and TA provided under HSPSP-I and HSPSP-II helped government to formulate policy aimed at rationalising infrastructure and improving the mix of primary and secondary facilities.

Under both Tacis and ENPI, the EC has contributed to strengthening primary health care infrastructure in *Moldova*. ENPI evaluations and review missions identify facility rehabilitation as the main focus of these efforts. No information was found on the extent to which EC support has improved the availability of higher-level health infrastructure.

Latin America

In *Ecuador*, the EC sector support programme in three under-served provinces constructed 27 new health facilities (prior to the project, there were 127 such units) and carried out many improvements. This can be considered a major contribution to primary health care infrastructure supply.

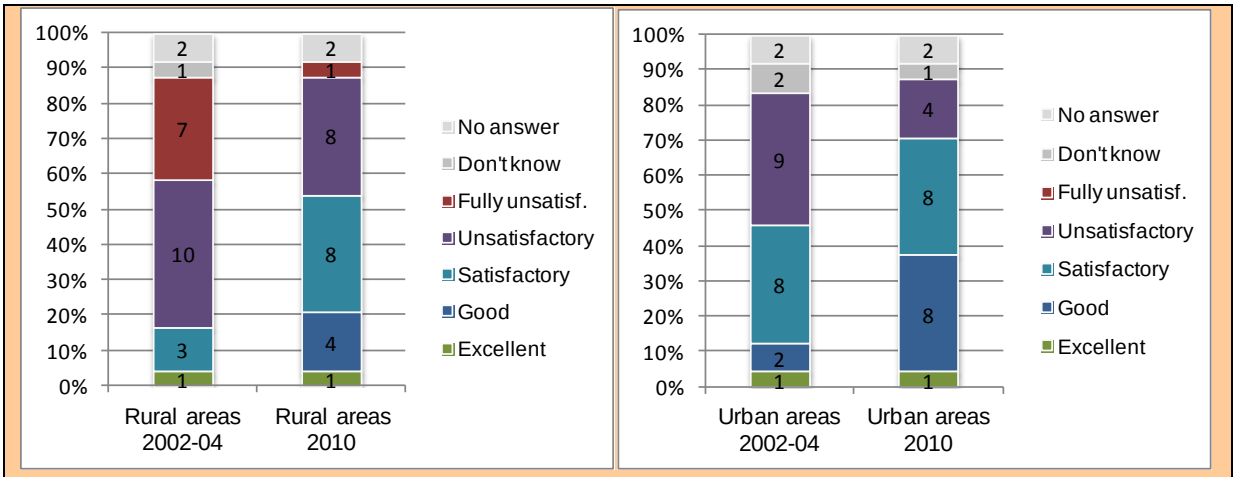
Evidence from the EUD survey suggests that, in most countries, EUD respondents believed that infrastructure had improved over the evaluation period. This held true for both primary and secondary facilities and for both urban and rural areas.

Box 5: Improvement in the mix of primary and secondary facilities: EUD survey evidence

Rural primary. The survey gives evidence that there was generally an improvement in the availability of rural primary care facilities (see Figure 2). 17 out of 24 responding EUDs reported that availability was “completely unsatisfactory” or “unsatisfactory” in 2002-04, whereas in 2010, 13 of the same 24 regarded the situation as satisfactory, good, or excellent. EUDs accounting for the shift were Lao PDR (where, as we saw above, the EC played little role), India, Nigeria, Vietnam, Bangladesh, Afghanistan, Morocco, Congo and Zambia. There is also evidence of improvement in primary health care facility availability in urban areas, with the number of EUDs describing availability as “good” rising from 2 out of 24 in 2002-04 to 88 out of 24 in 2010. The EUD Timor-Leste specifically credited EC reconstruction and provision of mobile services.

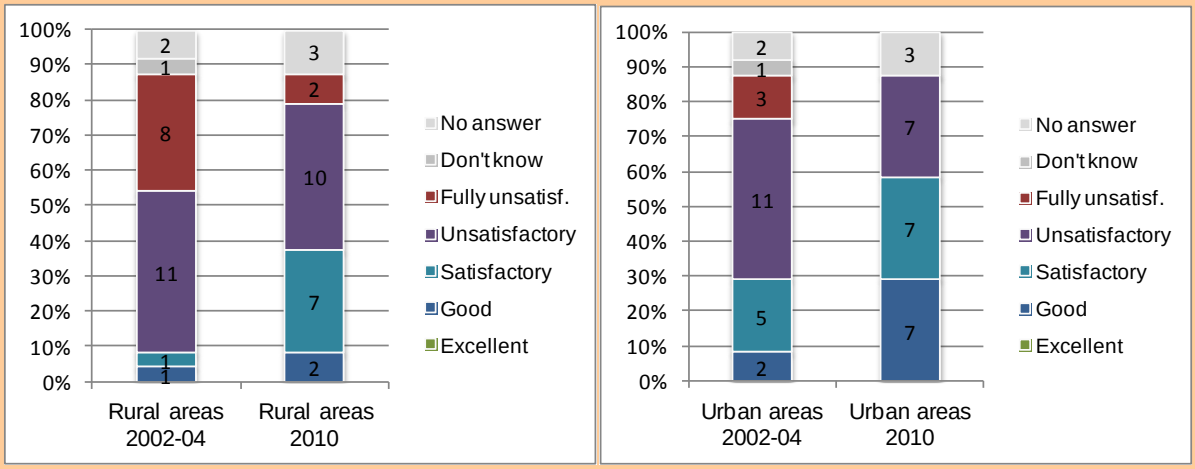
Rural secondary. There is also evidence of a perceived improvement in the availability of rural secondary care facilities (see Figure 3). 8 out of 24 EUDs perceived availability in rural areas to be “completely unsatisfactory” in 2002-04, as opposed to only 2 in 2010.

Figure 2: Results of the survey to EUDs:: Availability of primary health care facilities



Source: EUD Survey, 2011, Particip GmbH

Figure 3: Results of the survey to EUDs:: Availability of secondary health care facilities



Source: EUD Survey, 2011, Particip GmbH

Urban primary. 9 responding EUDs characterised the availability of primary health care infrastructure in urban areas to be unsatisfactory in 2002-04, a figure that dropped to 4 in 2010. At the same time, the number reporting "good" rose from 2 to 8.

Urban secondary. The same trend is evidence here: "good" rose from 2 to 7 while "unsatisfactory" declined from 11 to 7 and "completely unsatisfactory" declined from 3 to nil.

As shown in the tables below, most MoHs responding to the survey reported a significant improvement in the availability of both PHC and secondary-level facilities over the evaluation period, especially in urban areas. When asked about the EC's contribution, however, answers were not clear except in the case of secondary facilities, where a number of MoHs pointed out that all EC assistance focused on PHC. An exception is *Afghanistan*, where the EC contributed to equipping provincial hospitals.

Table 4: Results of the survey to MoHs: Availability of primary health care

Country	Rural areas -		Urban areas	
	Primary health care facilities -2002	Primary health care facilities: 2010	Primary health care facilities: 2002	Primary health care facilities:2010
Syrian Arab Republic	Good	Good	Good	Good
Lao	Unsatisfactory	Satisfactory	Satisfactory	Good
Egypt	Unsatisfactory	Good	Unsatisfactory	Good
Yemen	Unsatisfactory	Unsatisfactory	Satisfactory	Satisfactory
Afghanistan	Unsatisfactory	Good	Unsatisfactory	Good
Moldova	Unsatisfactory	Satisfactory	Satisfactory	Good
Burkina Faso	Unsatisfactory	Good	Satisfactory	Satisfactory
Morocco	Unsatisfactory	Satisfactory	Satisfactory	Good

Source: MoH survey

Table 5: Results of the survey to MoHs: Availability of secondary health care

Country	Rural areas		Urban areas	
	Secondary health care facilities: 2002	Secondary health care facilities: 2010	Secondary health care facilities: 2002	Secondary health care facilities: 2010
Syrian Arab Republic	Satisfactory	Good	Good	Good
Lao	Unsatisfactory	Satisfactory	Satisfactory	Good
Egypt	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory
Yemen	Unsatisfactory	Unsatisfactory	Satisfactory	Satisfactory
Afghanistan	Unsatisfactory	Satisfactory	Unsatisfactory	Good
Moldova	Satisfactory	Good	Satisfactory	Good
Burkina Faso	Don't know	Don't know	Good	Good
Morocco	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory

Source: MoH survey

1.2.2 I-122 Increased proportion of health facilities with appropriate equipment

Problems with equipment include insufficient budgets and poor procurement procedures. Little relevant evidence of EC support was found in the ACP case study countries. Many of the health facilities provided by the EC (see Indicator I-121 above) were also equipped, e.g. in *Afghanistan*, *Egypt* and *Ecuador*. In *India*, according to the 2007 CSE, the EC was also active in equipping rural health clinics. In *Nigeria*, also according to the most recent CSE, the EC's provision of equipment was largely related to the cold chain and served to significantly strengthen the country's immunisation programme. In *Ecuador*, the EC re-modelled existing health infrastructure through the post-earthquake rehabilitation programme PROARES, but lack of basic equipment including furniture was cited as a weakness. In some cases, the problem leading to the under-equipping of facilities is budgetary. This may represent scarcity either of investment funds, i.e. the equipment is not purchased in the first place, or inadequate budgets for maintenance. Procurement procedures are often a problem and, in the *Philippines*, part of the EC's policy dialogue and TA under health sector policy support was devoted to streamlining equipment procurement mechanisms. Procurement of equipment under the Health Sector Development Programme was criticised in the 2009 Country Strategy Evaluation (Volume 2, page 42), mostly for excessive delays due to EC procurement procedure requirements. Exceptionally, a significant proportion of equipment provided went to secondary and tertiary facilities.

Box 6: Proportion of health facilities with appropriate equipment: Country Case Study evidence

ACP

In *Burkina Faso*, the state of equipment in health centres remains uneven but there was general improvement over the evaluation period. The only evidence found of direct EC contribution was the provision of equipment to Maternal and Child health Centres between 2005 and 2008.

In *DRC*, a great deal of evidence was gathered to support the view that the EC generally contributed to availability of quality health care, but very little of this evidence specifically dealt with the provision of equipment. The Transitional Support Programme to the Health Sector (PATS), implemented 1998-2005, provided equipment to many health centres; subsequently, however, a significant portion of this equipment disappeared. The 9th EDF Health Programme provided over € 3 million in equipment to 160 health centres.

In *Ghana*, the Health Sector Support Programme (1998-2004) may have contributed to equipment through the

common donors' fund, but the extent is not measurable. No information was found on whether GBS had indirectly contributed to increased budget for equipping health facilities. However, regarding budgets for maintenance and recurrent expenditure, there is some indication that GBS had led to increased budgetary allocations to the health sector; at the same time, however, a review of MDBS found no discernible improvement in the quality of health care.

While information was obtained on increased primary health care facility capacity in *South Africa*, none of this information related to EC contribution. No information at all on equipment was found in *Zambia*.

Asia

In *Afghanistan*, the EC supported the provision of basic equipment in the process of financing the provision of the Basic Package of Health Services in ten provinces. 80% of clinics are reported to have basic equipment.

While the EC supported equipment provision in *Bangladesh* under the Health, Nutrition and Population Sector Programme, the 2009 Annual Progress Review cited problems with availability of basic equipment. This was a qualitative assessment, as none of the related quantitative indicators were provided. The budgetary allocation for health facilities was a target in this programme, however, the target for 2009 was not met according to the Annual Programme Review.

No relevant information was found in *Lao PDR*: Similarly in the *Philippines*, no hard evidence was found. However, the World Bank continued to report problems of defective and unutilised equipment and, despite TA from the EC, there continue to be problems with procurement. As for the *Philippines*, however, a great deal of documentary evidence indicates that the EC was very active in supporting better financial management and resource allocation in the health sector through its Health Sector Policy Support Programme. Whether this succeeded in increasing budgets for maintenance and recurrent expenditure is unknown.

ENP

Apart from a snapshot situation view at the beginning of the evaluation period, no information relevant to this Indicator was found for *Egypt*.

In *Moldova*, which always had dense health care infrastructure but suffered from a lack of budgetary resources to maintain it, the case study cites data indicating that equipment availability is very poor. The EC has, however, supplied equipment and most of this was found to be in relatively good condition.

Latin America

In *Ecuador*, the health sector support programme in three provinces constructed and rehabilitated a significant number of clinics, in each case ensuring that they were equipped up to Ministry standards.

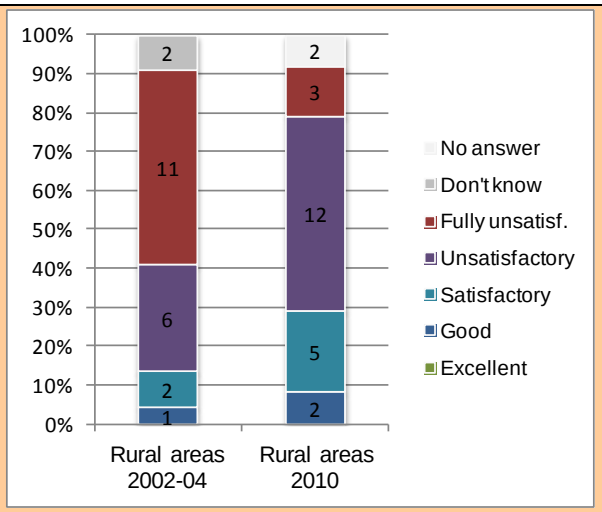
EUDs responding to the survey reported continuing problems but generally were of the view that the situation had improved between 2002 -2004 and 2010 (see following box). Reasons cited included GBS which loosened fiscal constraints, changed government priorities and direct EC support for the provision of infrastructure and equipment.

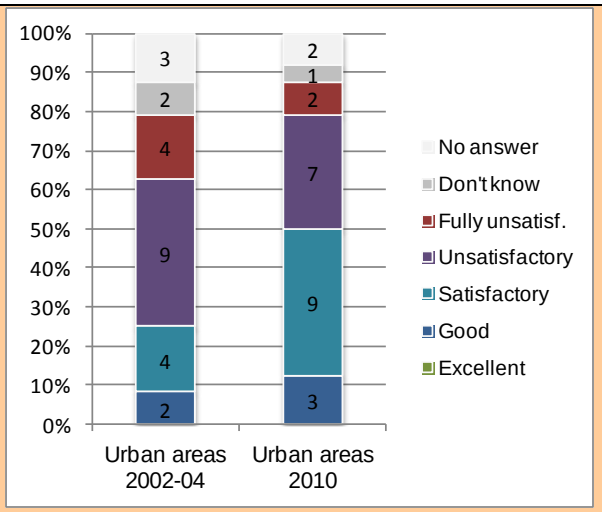
Box 7: Coverage with facilities having appropriate equipment and budget for maintenance and current expenditure: EUD survey

Rural primary. While 11 out of 24 EUDs regarded the situation as regards rural facilities as "completely unsatisfactory" in 2002-04 and only 3 out of 24 in 2010, this must be tempered by the fact that most of the improvement was accounted for by movement into the "unsatisfactory" category, which rose from 6 (2002-04) to 12 (2010).

Urban primary. Twice as many EUDs (9 as against 4) judged the situation in 2010 to be "satisfactory" as opposed to 2002-04. The increase was mirrored by a decrease in the "unsatisfactory" and "completely unsatisfactory" categories.

Figure 4: Results of the survey to EUDs:: Coverage with primary health care facilities with appropriate equipment and budget for maintenance and expenditure



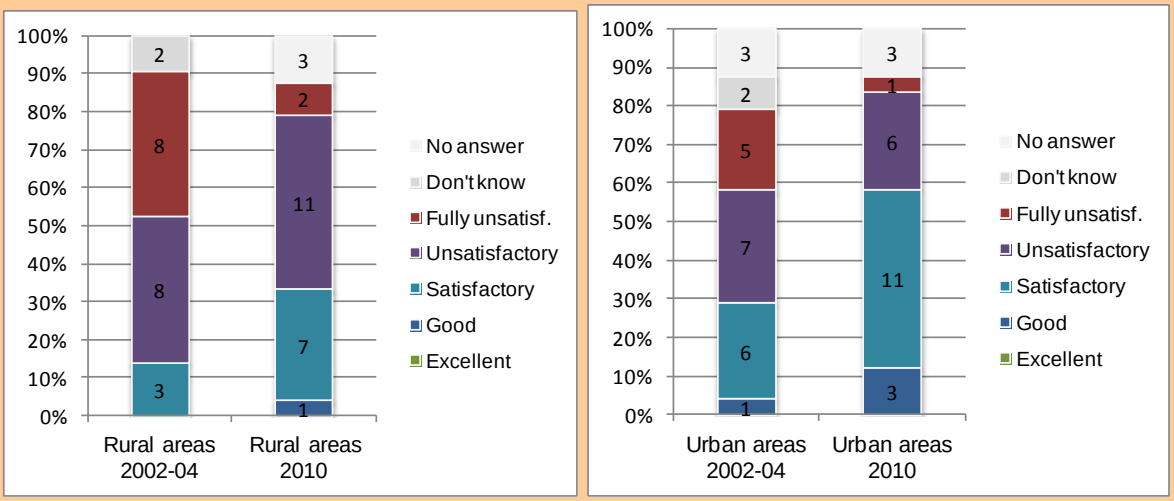


Source: EUD Survey, 2011, Particip GmbH

Despite improvements, many EUDs reported continuing problems. EUD *India* commented for example that "*Many Indian states still lack sufficient numbers of primary facilities, SPSP supports - maintenance budgets and functions to learn utilising reform budget for maintenance and equipment - capacity to spend is constrained due to weak or inexistent caretaker-manager relations and public health management skills, due to lack of incentives (living, educational and cultural facilities) in rural areas, due to corruption*". Other EUDS such as EUD *Nigeria* and EUD *Philippines* highlighted problems to ensure sustainability. Both recognised that the EC has contributed immensely to the improvement of coverage with primary health care facilities with appropriate equipment and budget for maintenance and current expenditure; however they both argued that sustainability after the projects ended remain a challenge. For other EUDs the problem remains mainly in the lack or limited decentralization of the financial resources. EUD Zimbabwe argued in this direction and stated "*Still today (meaning the moment of responding this survey, June 2011) there is no decentralization of financial resources. This was still the case in 2002. Equipment is obsolete.*"

Other EUDs offered explanatory reasons for the improvements observed from 2002-04 until 2010. These comments were mainly in the direction of factors such as (i) budget support (highlighted by EUD *Morocco*), (ii) prioritization of the health sector by the national government (highlighted by EC *Ecuador*) and (iii) EC investments in infrastructure and basic medical equipment (highlighted by *Mozambique* and *Moldova*), contributed to improve the coverage with primary health care facilities in rural areas with appropriate equipment and budget for maintenance and expenditure.

Figure 5: Results of the survey to EUDs:: Coverage with secondary health care facilities with appropriate equipment and budget for maintenance and expenditure



Source: EUD Survey, 2011, Particip GmbH

Rural secondary. 8 of 24 responding EUDs felt that the situation was "completely unsatisfactory" in 2002-04 but only 2 in 2010. Some of these EUDs felt that the situation has progressed to "unsatisfactory," others felt that the situation had progressed all the way to "satisfactory."

Urban satisfactory. The trend was similar; there was a sharp drop in the "completely unsatisfactory" description, a slight drop in "unsatisfactory," and compensating increases in "satisfactory and "good."

A number of EUDs pointed out that EC support targeted primary, not secondary, health care; only one (EUD India) cited any support to secondary health care at all.

Almost all MoHs responding to the survey reported that there had been an improvement over the evaluation period in the equipment of primary health care facilities. Only *Yemen* and *Burkina Faso* reported that the equipment situation is still unsatisfactory. The MoH in *Moldova* indicated that the TACIS program Support for Strengthening Health Reform in Primary Health Care in Moldova made a major contribution to equipping family medicine centres. In *Morocco* and *Burkina Faso*, MoHs cited sector budget support and general budget support, respectively, as having contributed to the equipping of PHC facilities. Most MoHs also reported an improvement in the equipment situation in secondary health facilities.

Table 6: Results of the survey to MoHs: Equipment of primary health care

Country	Rural areas		Urban areas	
	Primary health care facilities: 2002	Primary health care facilities: 2010	Primary health care facilities: 2002	Primary health care facilities: 2010
Syrian Arab Republic	Satisfactory	Good	Good	Good
Lao	Unsatisfactory	Satisfactory	Satisfactory	Satisfactory
Egypt	Unsatisfactory	Good	Unsatisfactory	Good
Yemen	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Afghanistan				
Moldova	Unsatisfactory	Satisfactory	Satisfactory	Good
Burkina Faso	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Morocco	Satisfactory	Excellent	Satisfactory	Excellent

Source: MoH survey

Table 7: Results of the survey to MoHs: Equipment of secondary health care

Country	Rural areas		Urban areas	
	Secondary health care facilities: 2002	Secondary health care facilities: 2010	Secondary health care facilities: 2002	Secondary health care facilities: 2010
Syrian Arab Republic	Satisfactory	Good	Good	Good
Lao	Unsatisfactory	Satisfactory	Satisfactory	Satisfactory
Egypt	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory
Yemen	Unsatisfactory	Satisfactory	Unsatisfactory	Satisfactory
Afghanistan				
Moldova	Satisfactory	Good	Satisfactory	Good
Burkina Faso	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Morocco	Fully unsatisf.	Satisfactory	Fully unsatisf.	Satisfactory

Source: MoH survey

Data on budgets for operations and maintenance were generally unobtainable. The MoH survey contained two questions on the subject (for primary and secondary health facilities) but respondents appear to have interpreted the question as referring to overall budgets, not to budgets dedicated to operations and maintenance. Only in Afghanistan as a "Good" answer registered, all others ranged from "fully unsatisfactory" to "satisfactory". In the case of PHC, no improvement over the evaluation period was reported; in secondary, some improvement was noted in a few countries.

1.3 JC 13 Improved availability of qualified human resources for health due to EC support

An abundance of evidence was gathered on most of the indicators related to this JC but, surprisingly in view of the importance of the issue, relatively little consistent time-series statistical evidence. Before taking up the indicators, it is worth pointing out again that the lack of needed human resources was the single most-often cited constraint to improving health care quality cited by EUDs responding to the survey. 16 EUDs responded to the question "What are the top four factors constraining health care quality; of these, 13 mentioned human resources. Exacerbating factors included low salaries (EUD *Burkina Faso*), low skill levels (EUD *DRC*) and "brain drain." Only one EUD – perhaps, not surprising, *Zimbabwe*, where macroeconomic collapse was severe and opportunities for emigration of health professionals were high – cited the distortions in the labour market caused by donor interventions in health. Other EUDs cited the deterioration of training capacity to the unattractiveness of working in rural or remote regions.

Figure from the inventory shows that EUR 136 million was dedicated directly to interventions focusing on Human Resources for Health. The breakdown of this category is shown in the following figure.

Table 8: Human Resources for health – overview of EC support to the sub-sector: Inventory

	Breakdown of the sub-sector: Human Resource for Health (EUR)	% within the HRH sub-sector
Health workers training	120,276692	88%
Retention Human Resources	12,030,019	9%
Evaluation, Audits, TA	2,300,441	2%
MoH capacity building	1,425,385	1%
Total HRH	**136,032,539**	
	Proportion of HRH within total EC support to health	
Total direct support to the health sector	4,118 million	**3,3%**

Source: CRIS data base, Particip analysis

We approached the JC through three Indicators; with hindsight, the last partly duplicated the first. The first was simply availability per capita of doctors and nurses. The second had to do with levels of training. The third had to do with attrition; which of course, is related to the first as a matter of mathematical logic and with health worker absenteeism.

Despite the fact that there is a major global focus on human resources for health, the search for globally consistent data, e.g. from the WHO Global Observatory for Health, did not yield much. At the country level, as well, while country case studies found evidence in almost all countries of problems with human resources for health, consistent data comparing two points in time were scarce. This is perhaps less serious than it

might appear, because it is clear that the problem is often not the number of health professionals itself, it is their geographical distribution. Rural areas are clearly disadvantaged and remote areas (e.g. in the *Philippines* or *Lao PDR* among the case study countries) are the most disadvantaged of all.

Some EC interventions have directly targeted human resources, whether at the regional level (e.g. a Migration and Asylum budget line project on better managing migration of health professionals in Africa) or by supporting training institutions (e.g. *Lao PDR*, *Ghana* and Moldova). Direct training and provision of community health workers has occurred in a number of settings, most significantly in *Afghanistan*, where the EC's impact has been especially important in increasing the number of female community health workers. Whether these improvements will be sustainable in the future is a question.

EUDs acknowledge that attrition and absenteeism (on which we have little information) are major problems. In some countries (e.g. *Zambia*), the EC financed health worker retention schemes. They were implemented under the Human Resources for Health Strategic Plan adopted in 2006. The case study cites some evidence that this is resulting in a reduction in high attrition rates. EC sector budget support contributed significantly to financing retention schemes, but data available do not permit a precise statement of impact. Moreover, *Zambia* is the only ACP country for which hard evidence related to absenteeism and the EC response was found. World Bank research has documented the scope and scale of the problem. Through its two programmes supporting public health service delivery (10th EDF) and Retention of human resources for health, the EC has contributed directly to reducing absenteeism. However, most EUDs responding to the survey regarded the availability of skilled health professionals in rural areas to be still "unsatisfactory" or "completely unsatisfactory" in 2010. Asked to describe the main reasons for shortages of human resources, the respondents to the MoH survey cited a familiar range of constraints: low status, salaries and incentives for health workers, poor working conditions encourage health personnel to remain in urban areas (*Syria, Laos, Moldova and Burkina Faso*) or the pay gap between public and private sector (*Afghanistan).*

Following the intensified discussion on HRH within the donor community and with partner countries towards the end of the evaluation period[3], the EC signed a contribution agreement for the WHO/GHWA-managed programme aiming at 'Strengthening Health Work Force Development and Tackling the Critical Shortage of Health Workers'. According to the final evaluation report (May 2012), this programme has already "*made an impressive contribution to implementation of the HRH Global Strategy and plan of action agreed at the First Global Forum in Kampala (2008)".*

Box 8: EC financed programme: Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers.

This programme has been launched in 2009 as an outcome of the 2008 Global Forum on Human Resources for Health held in Kampala and is managed jointly between the WHO and the Global Health Workforce Alliance (GHWA). The EC has signed a contribution agreement with the WHO in order to provide financial support. This ambitious 3.5-year programme (foreseen end: July 2012) targeted 29 countries[4] addressing the global, regional and country level.

Main objectives

- Objective 1: Strengthening governance for heath workforce
- Objective 2: Improvement of health workforce evidence and information: Global and Regional Health Workforce Observatories
- Objective 3: Establishment of mechanisms for effective management of HW migration and retention
- Objective 4: Scaling up health workforce production
- Objective 5: Supporting countries in addressing their critical HRH bottlenecks for priority health service

The overall objective of the programme was to promote a better knowledge, understanding and advocating of the HRH shortage issue. This was done by financing activities aiming at creating baseline data on the HRH situation and actual and upcoming needs (e.g. different Health Workforce Observatories; feasibility studies for financing of funds, assessments of investment requirements, support to the establishment of exchange platforms, etc.) as well as capacity building and awareness raising in HRH units of MoHs.

In order to establish mechanisms for the management of HW migration and retention a 'Code of Practise on health workforce migration' was adopted in 2010.

Results of the programme evaluation

[3] The First Global Forum on Human Resources for Health in Kampala in 2008 could be seen as starting point.
[4] Of which 15 have been the focus of support by WHO/AFRO, six by WHO/EMRO and eight by GHWA.

The final evaluation of the programme highlights the important role of the programme in creating a common platform for joint action and, as such, can be regarded as a starting point to strengthen global health governance, thus reacting on the *"plethora of parallel global heath institutions"*[5]. However, it also mentions the problem of sustainability. It appears clearly that without further funding achievements of the 3-year period cannot be taken further. Furthermore, lack of clear distribution of roles between WHO and GHWA has hampered the effectiveness of implementation, just as discrepancies between countries with strong HRH leadership capacities (e.g. Cameroon) and countries with less staff availabilities and competences.[6]

Component number four ""Scaling up health workforce production" addressed the issue of health worker availability, especially better education condition for health workers for defined priority health services. The final evaluation report is in general very positive on the programme outcome; however, the specific objective targeting the increase of health workforce has been assessed as being too ambitious and thus only partly reaching its initial objectives. Reasons for the limited success were the complexity of the issue and the inadequate allocation of funds and staff time to implement the programme components, according to the evaluation report.

As a direct output the donor community developed a Code of Practise on health workforce migration; however, the evaluation report notes the continuing of international recruitment of HW. The introduction of a periodic voluntary reporting to the WHO planned for 2012 might offer ways to call on recruiting WHO member states.

Source: Draft final evaluation report, Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers, Sante/2008/153-644. May 2012.

In assessing the second indicator through country case studies, a number of examples of direct EC provision of health worker training were found. These ranged from training community health workers (e.g., *Afghanistan*, *Lao PDR*, *South Africa*) to arrangements that benefited national schools of public health (e.g., *Lao PDR*, *Ghana*, *Moldova*). Sometimes training was specifically oriented to family medicine (*Egypt*, *Moldova*).

Any action that improves working conditions in the health sector will tend to alleviate problems of attrition. Where the EC has financed improved infrastructure and equipment, it will have simultaneously addressed issues of attrition and absenteeism (subject to the cautions above). Training is a double edged sword; on the one hand, EC training contributes to career prospects in the public health sector, but on the other hand, it may promote brain drain into donor-financed projects, into private practice, or abroad. Without better data and in the face of sometimes contradictory evidence from country case studies, it is hard to reach a strong conclusion regarding this JC. That the EC is trying to address the issue is without question, as evidenced by the 2006 Communication and the fact that human resources are identified as one of the key foci of EC health sector strategy which has materialised in a EC contribution agreement with two main global stakeholders in this field (WHO and GHWA) aiming at Strengthening Health Workforce Development and tackling the critical shortage of health workers. Yet the situation remains serious, especially in rural areas, in many countries. Overall, judging from the persistence of the problem, EC interventions to relieve the human resources crisis in health do not appear to have been effective, making generalisations of the "What works?" type difficult to make. EC actions have improved the availability of data, increased the capacity of human resource planners in Ministries of Health, raised awareness and shared experiences at the regional level; however, there is no sign of tangible impact on the basic on-going problem. The reason for weak sustainable impact is that the gap between the salaries and working conditions in the public health sector and those available working in donor-financed projects, in the private sector, or emigrating abroad are so wide. Retention must be measured over a span of years and schemes that are effective in retaining young medical graduates for two to five years may still fail in the longer term. The globalisation of health training – many doctors and nurses from low-income countries will have received significant education or professional training, including certification, abroad – eases the emigration process. Also competing with effectiveness is the fact that, despite pledges and codes of good conduct, destination country health sectors continue to aggressively recruit needed health care workers from poor countries, especially those that are English or Romance language-speaking.

1.3.1 I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population

The crisis in human resources for health is multi-dimensional. It includes rural-urban imbalances exacerbated by inability to keep rural health workers in post, international migration of health workers (with Europe as a

[5] *Strengthening health workforce development and tackling the critical shortage of health workers".* Draft final report, May 20112, p.35.

[6] *Strengthening health workforce development and tackling the critical shortage of health workers".* Draft evaluation report, May 2010; p. 33,

major receiving region) and loss of public sector health workers to donor-financed positions. In countries severely affected by the HIV/AIDS epidemic, attrition to due death and disease are significant, as is reluctance to work in the health sector To these problems must be added weaknesses on the supply side, with many training institutions having suffered from neglect over the years.

Given the seriousness with which donors and aid beneficiaries alike regard the problem, it is surprising that reliable time series data have proven to hardly exist – with the exception of "Physicians per 1,000 people." Even the data on that important variable are not available consistently enough to permit generalisation.

Table 9: Desk study countries: Physicians (per 1,000 people), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados				1.81					
Burkina Faso			0.05				0.06		
Congo, Dem. Rep.			0.11						
Ghana	0.09		0.15				0.11	0.09	
Mozambique			0.03		0.03				
Nigeria		0.28					0.40		
South Africa			0.77						
Timor-Leste			0.10						
Zambia			0.12		0.06				
Zimbabwe	0.06		0.16						
Tanzania	0.02				0.01				
Asia									
Afghanistan				0.20				0.21	
Bangladesh			0.26	0.30		0.30			
India			0.60	0.60					
Lao PDR			0.35	0.27					
Myanmar			0.36				0.46		
Philippines	1.15		1.15						
Yemen, Rep.			0.33					0.30	
Vietnam	0.56						1.22		
ENP									
Egypt, Arab Rep.				2.43				2.83	
Moldova		2.64			2.66	2.67			
Morocco			0.51			0.56		0.62	
Syrian Arab Republic					0.53		1.50		
Latin America									
Ecuador									
El Salvador	1.24				1.50		1.60		

Source: http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=

Indicator Name	Physicians (per 1,000 people)
Short definition	Physicians include generalist and specialist medical practitioners.
Long definition	Physicians include generalist and specialist medical practitioners.
Source	World Health Organisation, Global Atlas of the Health Workforce. For latest updates and metadata, see http://apps.who.int/globalatlas/.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Nonetheless, a fairly consistent picture emerges from the country case studies (see following box).

In the ACP countries, brain drain to English-speaking countries is a major problem. In three of the case study countries, *Ghana*, *South Africa* and *Zambia*, evidence was found that addressing human resource problems was integrated into EC support, whether GBS or sector support. To this should be added the fact that, late in the evaluation period, through its Migration and Asylum budget line, the EC supported a World Bank project

aimed at better management of health worker migration in Africa. In *Mali*, the Country Strategy Evaluation (Volume 1, p.4) reported that both sector and general budget support had contributed to better availability of health personnel.

The *Philippines* is the world's largest exporter of skilled health workers, but the EC's extensive health sector support programme in that country did not focus on human resources. In large part this is because the main problem in the Philippines is the regional imbalance, with remote and underserved communities lacking health workers. Not only availability per se is a problem, the considerable budgetary power wielded by local government executives has led to persistent under-funding of health. By working in the area of health care finance in the Philippines, the EC is indirectly tackling the human resources problem.

Other EC interventions also indirectly contribute to addressing the human resource issue. When clinics are equipped or rehabilitated or when planning procedures in the health sector are strengthened through TA and capacity building, working conditions are improved. Increasing reliance on sector support, if this is the trend, may reduce somewhat the problem of human resource distortions introduced by donor assistance. The problem of vertical programmes (such as those financed by the Global Fund) siphoning human resources from the public health sector has been much discussed by experts, with the result that the Global Fund is making efforts to strengthen health systems generally.

Responses to the EUD survey demonstrate the geographical nature of the human resource problem, with most regarding availability in rural areas as much worse than availability in urban areas. A number of EUDs reported improvements in the urban situation between 2002 -2004 and 2010, but the great majority considered the rural situation to be "unsatisfactory" or "completely unsatisfactory" in both 2002-04 and 2010. Absenteeism and retention, not the sheer number of doctors and other skilled health workers, were cited as the main concern by a number of delegations.

Afghanistan represents a special case in which one of the EC's successes has been in recruiting and posting female health workers. This has proven to be workable and has resulted in demonstrable improvements in the access of women and girls to primary health care.

Vietnam serves as a good example of how perverse government policies can worsen the human resources problem. According to the 2009 Country Strategy Evaluation (Volume 2, p. 42), administrative changes (Decree 171/172) introducing specialisations at the District level sucked personnel (especially doctors) from the Commune to the District level. The capillary action continues to the Provincial level, where working conditions and equipment are better and hospitals essentially operate on a fee-for-service basis.

India is another interesting care. Overseas brain drain of doctors, a serious problem in the 1980s, has significantly slowed. Now, however, the burgeoning private health sector is giving rise to an "internal brain drain." The Health and Family Welfare Development Programme, 1998-2007, total budget 240 million Euro) did not expressly address human resources issue (a significant omission) but did indirectly support better distribution by supporting the overall decentralisation process (2007 Country Strategy Evaluation).

Box 9: Key health workers per 10,000 population: Evidence from Country Case Studies

ACP

Taken as a whole the density of health care workers in *Burkina Faso* increased, at least between 2005 and 2008. The number of nurses and midwives per 10,000 population rose from 5.4 to 7.1 while the number of doctors remained constant at 0.6. No information was obtained on whether EC support contributed to improved human resources for health.

No information related to EC support to human resources for health was found in the *DRC*.

Brain drain of health workers is a central issue in *Ghana*, as is the mal-distribution of health workers within the country. Unfortunately it is not possible to reconcile MoH data showing a doubling of the number of doctors per capita between 2001 and 2009 with WHO statistics showing no change between 2002 and 2009. Whereas the MoH estimates that there were over 6 nurses per 10,000 population in 2009, the WHO gives an estimate of 1. Both health sector support and general budget support have identified human resources for heath as a performance indicator. The evaluation of multi-donor budget support found that, while policy steps had been implemented, progress in this area was thin.

Brain drain is also a major issue in *South Africa*, as are losses to HIV/AIDS. The only time-series data points found were for the number of nurses: 171,645 in 2000 to 220,817 in 2009. No new information on EC contribution was presented in the country case study, but it was noted that the previous health evaluation found an EC contribution to improved human resources for health through a joint action with the WHO.

The profile of *Zambia* is similar to that of South Africa. Human resources plans have been in place since 2006 and a major assessment was done in 2008. The EC's "supporting public health service delivery" sector programme contains a major human resource component and, together with its partners in policy dialogue, the EC monitors the human resources performance indicators of the health sector strategic plan 2006-2011. Not enough time series data were gathered to paint a strong picture of improvement, but there may have been some improvement and the EC is clearly active in addressing human resource problems.

Asia

There was no significant change in the number of skilled health workers per capita in *Afghanistan* over the evaluation period, however, this was due in part to EC and other donor efforts to create incentives to stay. Evaluation of the EC's work in providing the Basic Package of Health Services drew attention to advances in recruiting needed female staff. A ROM report found that the proportion of facilities with at least on qualified female staff member had risen from one in four in 2002 to three in four in 2007. However, recruitment and retention of female staff remains a major problem, in large part due to security considerations.

In *Bangladesh*, not time series data were found, but all assessments report that the human resources situation is dire. The EC'S Health, Nutrition and Population Support Programme has actively tried to improve Ministry of health human resource policies and the Annual Progress Report for 2009 noted a number of positive steps being taken. There is, as yet, no evidence that these re proving effective. EC-financed projects have also been responsible for financing small numbers of additional health workers directly.

In *Lao PDR*, shortage of health workers in remote regions is the main human resource problem. The EC's GBS programme includes human resource for health as an indicator, but no report is yet available on progress. EC-financed NGO projects provided a small number of health workers directly and supported the training of community health workers.

The *Philippines* has been the subject of enormous policy interest because it is the world's leading exported of health workers and, at the same time, disadvantaged regions of the country are grossly under-served. The EC'S HSPSP does not directly address human resource issues. However, migration of health workers is a major subject of policy dialogue with Government. In addition, the Mindanao HSPSP contained a number of actions designed to improve the human resources situation. Ranging from training to needs mapping to management to retention strategies and the 2010 Philippines CSE concluded that there had been a significant impact. A major EC-financed integrated rural development project also contributed directly to increasing the number of health workers in target areas.

ENP

The number of health workers is not the main concern in *Egypt*, it is their geographical distribution. The EC's interventions in Egypt did not directly target human resource needs, although the provision and equipping of Family Health Centres should have helped to increase human resource for health in target governorates.

In *Moldova*, as in many post-Soviet countries, the problem was not a shortage of doctors; it was too many specialists and not enough family physicians. In the early years of the evaluation period, the EC supported retraining of physicians through Tacis. At least in the first half of the evaluation period, there was an increase by about a third in the number of family physicians, an increase for which the EC can take at least part of the credit.

Latin America

In *Ecuador*, through the POSSE sector support programme the EC supported the training of new health care workers for the three target provinces.

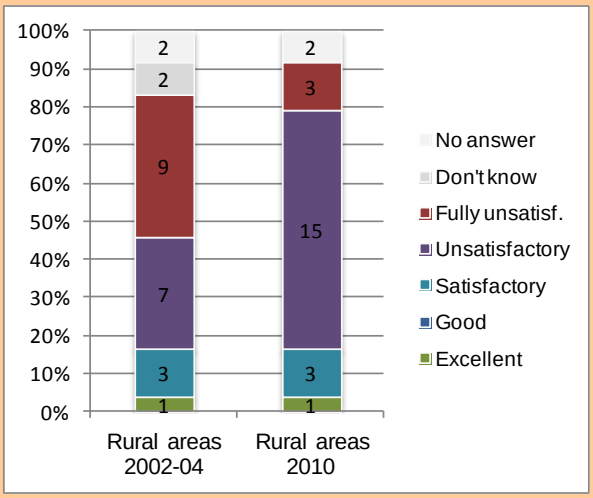
Box 10: Human resources for health: EUD survey evidence

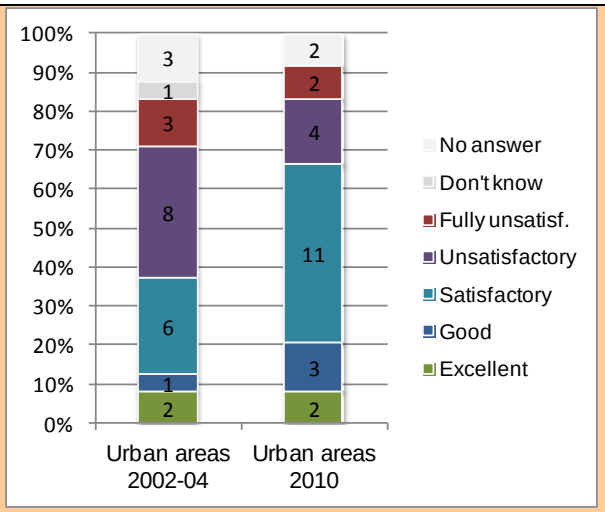
The EUD survey paints a generally unsatisfactory picture of human resources for health in rural areas. Of 24 responding EUDs, nine characterised the availability of physicians in rural areas as "completely unsatisfactory" and seven as "unsatisfactory." While the number giving the extremely negative "completely unsatisfactory" rating in 2010 was only 3, still, the "unsatisfactory" rating was selected by 15 out of the 24. Overall then, 16 of 24 found the situation either "completely unsatisfactory" or "unsatisfactory" in 2002-2004 while 18 out of 24 found it so in 2010.

The urban situation is quite different, with 11 out of 24 reporting that the situation was "completely unsatisfactory" or "unsatisfactory" in 2002-04 but only 6 in 2010. This was mirrored by significant increases in the numbers reporting that urban availability of physicians was "satisfactory" or "good." EUDs such as India, Vietnam, Afghanistan, Burkina Faso, Zimbabwe, Mozambique, Egypt, Moldova, Yemen and Ecuador cited EC policy work and capacity building as reasons for the improvement.

Coverage with medical doctors

Figure 6: Results of the survey to EUDs: Coverage with medical doctors



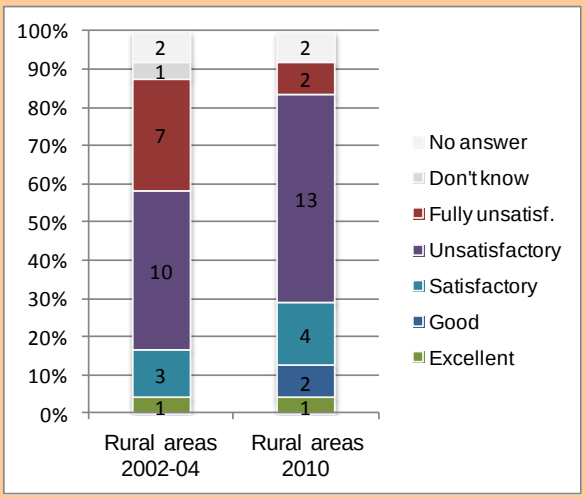


Source: EUD Survey, 2011, Particip GmbH

A number of EUDs identified absenteeism and retention, not the sheer number of doctors, as the major problem. This was the case for example of Yemen where, according to the EUD, *"Absenteeism is a well-known problem since all medical professionals are allowed to have second practices, from where, actually, their income comes. The answer needs to be looked not in terms of number of doctors but rather as number of hours in service and/or opening hours of a health facility"*. EUD Ecuador also commented in this regard and, in addition, highlighted that sustainability remains a challenge after the EC programmes end: *"We (EUD Ecuador) have financed during 2007-2010 the EBAS (1 doctor, 1 nurse, 1 gynaecologist; 1 social health promoter), groups in the provinces of Chimborazo, Cotopaxi and Bolivar provinces. But the EC programme terminated in 2010. Due to the low salaries in the public sector, doctors (now) only work 4 hours"*. Zimbabwe cited the collapse of university training in 2007-2009 and poor retention. EUD Zambia commented that they (EUD Zambia) *"have provided support to the MoH in supporting the Human Resources for Health Strategic Plan which included the Rural Retention Scheme by providing non-monetary incentives"*.

Coverage with nurses/midwifes

Figure 7: Results of the survey to EUDs:: Coverage with nurses/midwifes



Source: EUD Survey, 2011, Particip GmbH

Responses relating to the availability of nurses and midwives roughly paralleled those for physicians. There was a slight perceived reduction in the number of EUDs reporting the situation as "completely unsatisfactory" or "unsatisfactory" in rural areas, but the overall proportion remained high. For urban areas, the number regarding the situation as completely unsatisfactory or unsatisfactory declined from 10 to 7.

Among MoHs responding to the survey, two – Egypt and Afghanistan – reported significant improvement in the availability of doctors *in both urban and rural areas.* In *Egypt*, availability of staff was a sector budget support conditionality. In *Afghanistan*, as we have seen, the EC directly funded clinics through NGO projects, although the MoH noted the continuing shortage of female doctors. Egypt and Afghanistan also reported improvements in the availability of nurses / midwives.

Table 10: Results of the survey to MoHs: Coverage with doctors

Country	Rural areas		Urban areas	
	Coverage with doctors: 2002	Coverage with doctors: 2010	Coverage with doctors: 2002	Coverage with doctors: 2010
Syrian Arab Republic	**Satisfactory**	**Good**	Good	Good
Lao	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Egypt	Unsatisfactory	Good	**Unsatisfactory**	**Good**
Yemen	Fully unsatisf.	Fully unsatisf.	Satisfactory	Satisfactory
Afghanistan	**Unsatisfactory**	**Good**	**Satisfactory**	**Good**
Moldova	Fully unsatisf.	Fully unsatisf.	Excellent	Excellent
Burkina Faso	**Unsatisfactory**	**Satisfactory**	**Satisfactory**	**Good**
Morocco	**Fully unsatisf.**	**Unsatisfactory**	**Unsatisfactory**	**Satisfactory**

Source: MoH survey

Table 11: Results of the survey to MoHs: Coverage with doctors

Country	Rural areas		Urban areas	
	Coverage with doctors: 2002	Coverage with doctors: 2010	Coverage with doctors: 2002	Coverage with doctors: 2010
Syrian Arab Republic	**Satisfactory**	**Good**	Good	Good
Lao	Unsatisfactory	Unsatisfactory	Unsatisfactory	Unsatisfactory
Egypt	Unsatisfactory	Good	**Unsatisfactory**	**Good**
Yemen	Fully unsatisf.	Fully unsatisf.	Satisfactory	Satisfactory
Afghanistan	**Unsatisfactory**	**Good**	**Satisfactory**	**Good**
Moldova	Fully unsatisf.	Fully unsatisf.	Excellent	Excellent
Burkina Faso	**Unsatisfactory**	**Satisfactory**	**Satisfactory**	**Good**
Morocco	**Fully unsatisf.**	**Unsatisfactory**	**Unsatisfactory**	**Satisfactory**

Source: MoH survey

Asked to describe the main reasons for shortages of human resources, MoH cited a familiar range of constraints. In *Syria*, low status, salaries and incentives for nurses were reported. In *Lao PDR*, lack of incentives and poor working conditions encourage health personnel to remain in urban areas. *Yemen* also reported low salaries, lack of incentives and poor work conditions. In *Afghanistan*, not surprising, security was a major concern, in addition to lack of accommodation, opportunities for the education of children and the pay gap between the public and private sectors. With EC support, health workers with NGO contracts receive preferential treatment, but this does not apply to health employees of the government. In *Moldova*, poor living conditions and low pay in rural areas were cited. In *Burkina Faso*, health sector salaries were reported to be unattractive. In *Egypt*, health workers turnover remains high despite incentives that were instituted as part of health sector budget support conditionality. In countries lacking effective incentive and retention schemes a range of reasons was given: In *Lao PDR*, local authorities were reported to be unwilling. The MoH in *Yemen* cited confusion over whether the Ministry of Civil Services or MoH should be responsible. In *Burkina Faso*, a human resources plan is in the process of being draw up and, in *Morocco*, it was felt to be inequitable to single out the health sector for incentives.

1.3.2 I-132 Improved availability and standards of health worker training

The main evidence sources for this indicator are the country case studies. In a number of countries (e.g. *Ghana*, *Lao PDR*, *Moldova*, *DRC*), the EC directly supported training schemes at the national school of public health. In *Lao PDR*, this was through a regional programme (Asia-LINK) and in *Moldova* through a partnering arrangement with a European university. In the *DRC*, the EC directly supported training. In *South Africa*, by supporting the putting in place of a career path for community health workers, the EC addressed training needs; similarly in *Egypt* by supporting the move to a family medicine-oriented health service delivery model. As described above, the EC was responsible for training and putting in post qualified female health workers in *Afghanistan*, with significant impact on the utilisation of health services by women and girls. In a range of settings and often through NGO-implemented programmes, the EC supported the training of community-level health workers; regional programmes (e.g. the regional malaria control programme in Southeast Asia) and Global Fund-financed programmes also contributed. In summary, the EC has contributed significantly to training efforts. According to the Country Strategy Evaluation Nigeria (Volume 2,

p. 117), the EC financed substantial training of immunisation workers in *Nigeria*, although high attrition and turnover continued to be a challenge.

Box 11: Availability and quality of health worker training: Country Case Study evidence

ACP

In *Burkina Faso*, the number of health centres meeting standards for the training of staff was a criterion for releasing the variable tranche of budget support over the entire evaluation period. According to the disbursement note of the EUD regarding the "conditions spécfique à la tranche fixe macroéconomique" for 2007, the tranche has been released as all indicators were met, including the indicators related to the poverty reduction strategy (health and education sector). More specifically, the note notes a positive trend in health indicators, such as the indicator "Respect des normes en personnel CSPS". The EC also supported training of health workers directly through one HIV/AIDS project.

In the *DRC*, through its Programme of Transitional Support to the Health Sector, the EC supported training of health professionals at the national School of Public health. Positive results in availability of skilled human resources in peripheral areas were documented by a review undertaken in 2005. Support for training under the 9th EDF received a poorer assessment.

According to evidence presented, improving the training of human resources was not a focal point of the Health Sector Support Programme in *Ghana*, although an increase in university training intake can be observed during the middle years of the evaluation period. Training needs related to HIV/AIDS were financed by the EC, WHO and the Global Fund.

In *South Africa*, places in university training programmes remain unfilled due to lack of employment opportunities. The Partnership for Delivery of Primary Health Care and HIV/AIDS-oriented SUCOP programmes has attempted to address the training shortage. Evidence suggests that the first of these had significant impact towards the middle of the evaluation period, in part by creating a career path for community health workers. Further significant impacts on training were documented by reviews and assessments taken at the end of the evaluation period.

Little information was found on *Zambia*, but EC-supported initiatives by the MoH attempted to increase the number of training places and to raise training requirements in the context of improving health sector human resource retention.

Asia

In *Afghanistan*, the EC has been actively involved in training community-level health workers, especially women, through its NGO projects. Special emphasis has been given to the training of midwives. These efforts have led to a significant improvement not only in the availability of health workers per se, but in their level of training.

In *Bangladesh*, the EC made some contribution to improved training standards through the Health Nutrition and Population Support Programme. The evaluation of the Cos's Bazaar primary health care project also documented direct contribution to curriculum development and training.

In *Lao PDR*, the EC supported training at the Institute of Public Health both through its NGO-implemented projects and the regional Asia-Link programme supported training exchanges between Lao PDR, Vietnam and Belgium. In the early years of the evaluation period, the EC-financed regional malaria control programme supported the training of community workers and the regional Asia Reproductive Health Initiative for Youth in Asia programme financed training at district and provincial level. Significant amounts of training were also financed indirectly via the EC's support for the Global Fund. In general, it is safe to say that the EC significantly contributed to an improvement in training availability and standards over the evaluation period.

In the *Philippines*, the EC under its HSPSP supported major efforts to analyse the human resources situation and design training solutions to the problems identified. The Mindanao HSPSP instituted licensing requirements for health professionals and provided training for community health workers in the province through its NGO project focusing on internally displaced persons. A problem generally encountered is the under-investment in health worker capacity at the local government level.

ENP

In *Egypt*, the EC incorporated family medicine training components into the Health Sector Reform Programme during the first half of the evaluation period, resulting in the training of about 1,000 physicians. While support for training included under HSPSP and the Family Health Units financed had standards for training, no information on direct support is available.

In *Moldova*, the Support to Health Sector Reform Programme supported the re-orientation of existing training curricula and the re-training of health workers in the direction of family medicine. A twinning arrangement between the School of Public Health and the University of Rennes was supported. The subsequent Health Promotion and Disease Prevention project supported the development of curricula and training materials and ultimately, over 2,000 persons received training.

Latin America

No information on EC support related to this Indicator was found in *Ecuador*.

A problem common to many developing country health systems was the proliferation of often poorly trained specialists, with a resulting dearth of adequately trained general physicians. Re-orientation of training was a frequent component of EC interventions. In *Moldova*, the EC supported the re-training of specialists in family medicine and in *Egypt*, the EC supported the training of about 1,000 family physicians.

The 2009 launched global programme "S*trengthening health workforce development and tackling the critical shortage of health workers"* (for more details on the programme see Following the intensified discussion on HRH within the donor community and with partner countries towards the end of the evaluation period, the EC signed a contribution agreement for the WHO/GHWA-managed programme aiming at 'Strengthening Health Work Force Development and Tackling the Critical Shortage of Health Workers'. According to the final evaluation report (May 2012), this programme has already "made an impressive contribution to implementation of the HRH Global Strategy and plan of action agreed at the First Global Forum in *Kampala (2008)".*

Box 8: EC financed programme: Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers.

This programme has been launched in 2009 as an outcome of the 2008 Global Forum on Human Resources for Health held in Kampala and is managed jointly between the WHO and the Global Health Workforce Alliance (GHWA). The EC has signed a contribution agreement with the WHO in order to provide financial support. This ambitious 3.5-year programme (foreseen end: July 2012) targeted 29 countries addressing the global, regional and country level.

Main *objectives*

Objective 1: Strengthening governance for heath workforce

Objective 2: Improvement of health workforce evidence and information: Global and Regional Health Workforce Observatories

- Objective 3: Establishment of mechanisms for effective management of HW migration and retention
- Objective 4: Scaling up health workforce production
- Objective 5: Supporting countries in addressing their critical HRH bottlenecks for priority health service
- The overall objective of the programme was to promote a better knowledge, understanding and advocating of the HRH shortage issue. This was done by financing activities aiming at creating baseline data on the HRH situation and actual and upcoming needs (e.g. different Health Workforce Observatories; feasibility studies for financing of funds, assessments of investment requirements, support to the establishment of exchange platforms, etc.) as well as capacity building and awareness raising in HRH units of MoHs.
- In order to establish mechanisms for the management of HW migration and retention a 'Code of Practise on health workforce migration' was adopted in 2010.
-
- Results of the programme evaluation
- The final evaluation of the programme highlights the important role of the programme in creating a common platform for joint action and, as such, can be regarded as a starting point to strengthen global health governance, thus reacting on the *"plethora of parallel global heath institutions"*. However, it also mentions the problem of sustainability. It appears clearly that without further funding achievements of the 3-year period cannot be taken further. Furthermore, lack of clear distribution of roles between WHO and GHWA has hampered the effectiveness of implementation, just as discrepancies between countries with strong HRH leadership capacities (e.g. Cameroon) and countries with less staff availabilities and competences.

Component number four ""Scaling up health workforce production" addressed the issue of health worker availability, especially better education condition for health workers for defined priority health services. The final evaluation report is in general very positive on the programme outcome; however, the specific objective targeting the increase of health workforce has been assessed as being too ambitious and thus only partly reaching its initial objectives. Reasons for the limited success were the complexity of the issue and the inadequate allocation of funds and staff time to implement the programme components, according to the evaluation report.

As a direct output the donor community developed a Code of Practise on health workforce migration; however, the evaluation report notes the continuing of international recruitment of HW. The introduction of a periodic voluntary reporting to the WHO planned for 2012 might offer ways to call on recruiting WHO member states.

Source: Draft final evaluation report, Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers, Sante/2008/153-644. May 2012.

), is an indicator for increased action towards HRH towards the end of the evaluation period. One of the five components addressed the issue of health worker availability, especially better education condition for health workers for defined priority health services. The final evaluation report is in general very positive on the programme outcome, however, the specific objective targeting the increase of health workforce (Component no 4 "Scaling up health workforce production" has been assessed as being too ambitious and thus only partly reaching its initial objectives (an exception is a feasibility study for establishing a fund to support access by health professions to textbooks, diagnostic equipment and educational resources (AFRITEX).

Reasons for the limited success were the complexity of the issue and the inadequate allocation of funds and staff time to implement the programme components, according to the evaluation report.[7]

1.3.3 I-133 High health worker attrition and absenteeism addressed

As mentioned in assessing I-131, many EUDs responding to the survey cited attrition and absenteeism, not the number of health workers, as the major issue affecting human resources for health. A common practice, explicitly cited by EUD *Yemen* but also prevalent in *Egypt*, is that public health doctors, because of their low salaries, treat patients in a private capacity, as well, often in the same public clinics. The result is a "two track" system, with long waiting times and low-quality service during the public access hours and a significant improvement in the quality of care after-hours.

Little direct evidence on attrition and absenteeism was gathered, but the assessment of I-131 is relevant. EC actions to put in place quality infrastructure with adequate equipment will discourage attrition and absenteeism by improving working conditions. To the extent that EC support promotes better financing of the health care sector, especially higher salaries, the same will result. In some cases, such as *Egypt* and *South Africa*, the EC has helped to support the putting in place of family and community medicine career paths. However, the limited statistical evidence and most of the qualitative evidence, is that health worker attrition continues to be very high. One of the few countries where EC support has directly attacked attrition, with some evidence of impact, is *Zambia*.

Box 12: Health worker attrition and absenteeism: Country Case Study evidence

ACP

Health worker attrition, whether from rural to urban employment, from public sector to donor project employment, or via international migration, is a major problem in *Burkina Faso*, but not one that the EC's country programme has directly addressed. Under its Migration and Asylum budget line, however, the EC did finance a World Bank-led effort to promote better management of the migration of health professionals in Africa.

Measures to combat health-worker absenteeism in *Burkina Faso* took place in the context of the human resources for health development policy. No interventions occurred after 2004 and no evidence of EC involvement was found. Similarly, no evidence of EC support was found in the *Democratic Republic of the Congo*. Absenteeism does not appear to be a significant problem in *Ghana*. No evidence of direct support to address the problem was found in *South Africa*, but EC support has generally contributed to improving working conditions.

In *South Africa*, the EC has recognised the importance of high attrition rates, but related support is only indirect, e.g. financing facilities with improved working conditions.

In *Zambia*, a retention scheme was implemented under the Human Resources for Health Strategic Plan adopted in 2006. The case study cites some evidence that this is resulting in a reduction in high attrition rates. EC sector budget support contributed significantly to financing retention schemes, but data available do not permit a precise statement of impact.

Moreover, Zambia is the only ACP country for which hard evidence related to absenteeism and the EC response was found. World Bank research has documented the scope and scale of the problem. Through its two programmes Supporting public health service delivery (10th EDF) and Retention of human resources for health, the EC has contributed directly to reducing absenteeism.

Asia

EC support in *Afghanistan* has not successfully solved the problem of high health worker attrition, particularly attrition of community health workers. Financial support continues only as long as the relevant NGO continues to be funded to provide the Basic Package of Health Services. However, deployment of health workers to their own villages reduces attrition and the feasibility of keeping female health workers in post has been established.

Attrition does not appear to be a major problem in *Bangladesh*. However, absenteeism is reported to be a problem in the country, but no specific information was found. In *Lao PDR*, attrition to the international aid sector is the major problem. The EC GBS programme included improving the timeliness of payments to health workers in the public sectors as one of its triggers, but no monitoring information has been found.

No relevant information has been found for the *Philippines* although, as stated above, the EC has contributed substantially to policy studies and assessments of the human resources for health situation.

ENP

The main attrition problem in *Egypt* is "on the job" attrition, i.e. when a doctor uses a public health appointment merely to generate patient flow for private practice. This is a function of the low pay in the public health service, a problem which EC support has helped to analyse, but has not addressed directly. Operating in their public health

[7] Sante/2008/153-644 Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers. Draft final evaluation report, May 2012.

role, physicians may offer only poor quality of service, which dramatically improves once public visiting hours are over and the physician is available for consultation in his private capacity in the same clinic.

In *Moldova*, migration of younger and better-trained health workers to Europe continues to be a problem. The EC supported a Migration and Asylum budget line project that helped to address this problem.

Latin America

No information relevant to this Indicator was found in *Ecuador*.

As mentioned already in the indicator 132, the global programme "S*trengthening health workforce development and tackling the critical shortage of health workers",* implemented by WHO and GWHA Health aimed at tackling attrition at country, regional and global level. The main objective of the programme was to promote a better knowledge, understanding and advocating of the HRH shortage issue. This was done by financing activities aiming at creating baseline data on the HRH situation and actual and upcoming needs (e.g. different Health Workforce Observatories; feasibility studies for financing of funds, assessments of investment requirements, support to the establishment of exchange platforms, etc.) as well as capacity building and awareness raising in HRH units of MoHs. Furthermore, in reaction to the global Forum on Human Resources for Health, one component of the programme was to establish mechanisms for the management of HW migration and retention. As a direct output the donor community developed a Code of Practise on health workforce migration, however, the evacuation reports note the continuing of international recruitment of HW. The introduction of a periodic voluntary reporting to the WHO planned for 2012 might offer ways to call on recruiting WHO member states. The final evaluation of the programme highlights the important role the programme in creating a common platform for joint action and as such is a starting point to strengthen global health governance and end the *"plethora of parallel global heath institutions"*[8]. However, it also mentions the problem of sustainability. It appears clearly that without further funding that achievements of the 3-year period cannot be taken further. Furthermore, lack of clear distribution of roles between WHO and GHWA hampers the effectiveness of implementation, just as discrepancies between countries with strong HRH leadership capacities (e.g. Cameroon) and countries with less staff availabilities and competences.[9]A very similar programme is the regional project *"Support to the development of human resources for health in African Countries of official Portuguese language (PALOP)"* which also aims at identifying the needs for HRH by an extensive analysis of the HRH situation and develop exchange possibility and knowledge sharing especially in Portuguese. As the project will come to an end mid-2012 no final evaluation, shading light on the outcomes of the project is yet available.

1.4 JC 14 Increased or maintained quality of service provision due to EC support

We assessed this JC based on indicators covering quality assurance mechanisms, clinical protocols and client satisfaction. The country case studies show that, where the EC has supported direct provision of health care, quality assurance mechanisms have been in place, usually implemented by NGOs. This was the case, for example, in *Afghanistan, Egypt* and *Lao PDR*. In a few countries such as *Moldova* and *South Africa*, quality assurance was a significant component of EC support implemented (usually by NGOs). The EC was particularly active in this regard in the *Philippines*, where TA supported efforts to strengthen the capacity of decentralised local authorities to monitor the quality of care provided. A similar conclusion applies to Indicator I-142 on the dissemination and application of clinical protocols – if the EC provided the facility or support to the operation of the facility, such protocols were implemented. However, it needs to be kept in mind that developing treatment protocols is typically the responsibility of agencies such as WHO. In a number of settings, such as *Afghanistan, Egyp*t and Mindanao province of the *Philippines*, clinical protocols were implicitly disseminated through the development and provision of basic care packages. In two cases, *Moldova and Egypt*, strong evidence was found that there had been improvements in client satisfaction to which EC support contributed. However and despite strong EC support for health sector reform, it is not possible to document an improvement in client satisfaction in the *Philippines*. It was, however reported in the Thematic Evaluation of Decentralisation that EC-supported public-private partnerships (PPPs) improved health care quality at local level[10]. In *South Africa*, by contrast, PPPs were less successful because national

[8] *Strengthening health workforce development and tackling the critical shortage of health workers".* Draft final report, May 20112, p. 35.

[9] *Strengthening health workforce development and tackling the critical shortage of health workers".* Draft evaluation report, May 2010; p. 33,

[10] Particip (2012): Thematic global evaluation of the European Commission support to decentralisation processes, 2012, p. 66

guidelines on PPPs were poorly suited to the needs of local governments and, to a large extent, PPPs were introduced as precondition for EC funding rather than fully appreciated by local stakeholders.

1.4.1 I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)

In countries where the EC has been directly responsible for providing health facilities, we have no direct evidence, but it can safely be stated that those responsible (typically NGOs) have put in place quality assurance mechanisms. For example, even in a country such as *Lao PDR* where quality assurance was not a focus area, NGO clinics financed by the EC were up to international standard. Quality assurance mechanisms were also embedded into family health clinics financed by the EC in *Egypt*.

In other case study countries, by contrast, the EC supported interventions directly intended to promote quality assurance. In *Afghanistan*, the Basic Scorecard for NGO-operated facilities financed by the EC incorporated quality assurance aspects, although security reduced the ability of EUD staff to monitor. Quality assurance was generally incorporated into EU health sector programmes, for example in Bangladesh. In the *Philippines*, promoting quality assurance was one of the focus areas of EC support to the FOURmula 1 health sector reform; it was also a focus area for sector support in *Moldova.*

Overall, it can be concluded that EC support increased the implementation of quality assurance mechanisms, particularly where infrastructure was provided.

Box 13: Quality assurance mechanisms: Country Case Study evidence

ACP

In *Burkina Faso*, putting in place quality assurance mechanisms was one of the action points in the 2000-2010 health sector development plan. However, no information was found on whether progress has been made or EC support was a factor. No information relevant to the indicator was found for the *DRC*. In *Ghana*, the EC supported health information management, which is related to the accreditation scheme, but with only very weak results.

Major progress has been made in improving quality assurance in *South Africa*. Both the HIV/AIDS SuCoP programme and the Partnership to Deliver Primary Health Care project made significant contributions to designing and implementing quality assurance mechanisms. Quality assurance mechanisms are in place in vertical health programmes, for example those supported by the Global Fund.

No information relevant to the Indicator was found in *Zambia*.

Asia

In *Afghanistan,* quality assurance is the responsibility of the NGO operating EC-supported primary care facilities. A Basic Scorecard has been developed with strong aspects of quality assurance. However, the inability of EUD staff to visit facilities has reduced the extent to which quality assurance can be enforced. In *Bangladesh*, monitoring indicators dealing with quality assurance mechanisms are contained in Annual Programme Reports but not reported on. Under the Health, Nutrition and Population Support Programme, progress is reported on indictors related to accreditation, but more specific information is not given. Quality assurance has not been an area of EC support in *Lao PDR*.

In the *Philippines*, the main agency responsible for quality assurance and accreditation is PhilHealth, an organisation which has benefited from substantial EC support in the context of the FOURmula 1 health sector reform. TA financed by the EC under the Health Sector Policy Support Programme contributed to designing benchmark standards and strengthening capacity to support local government units in assuring the quality of facilities under their supervision. As part of this, a local scorecard was developed and integrated into the planning process. The case study presents no information on how successfully quality has been improved, but strong evidence that this has been a major concern of EC support and that tangible steps have been taken.

ENP

No information specific to the Indicator was presented for *Egypt;* however, the EC directly supported Family Health Units in pilot governorates. In *Moldova*, improving quality assurance mechanisms was a component of the Sector Policy Support Programme and a 2010 review mission reported that EC support had resulted in progress.

Latin America

In *Ecuador*, there has been progress on strengthening accreditation and quality assurance mechanism, but no information was found on whether EC support has contributed.

1.4.2 I-142 Clinical treatment guidelines available, disseminated and applied

The development of clinical protocols is generally the responsibility of WHO or, in some cases, agencies such as UNFPA or UNICEF. In a few countries such as *South Africa, Afghanistan* and *Moldova*, country case studies found evidence that EC activities had directly contributed to dissemination and application of clinical protocols. In virtually all countries, however, where EC support put in place health care facilities, whether in *Lao PDR* or *Philippines* (through the Mindanao HSPSP) or *Egypt*, it can be assumed that international clinical protocols were followed in EC-financed facilities.

Box 14: Clinical protocols: Country Case Study evidence

ACP

In *Burkina Faso* and *Democratic Republic of the Congo* and *Ghana*, no relevant information was found. In *South Africa*, a 2009 review of the Partnership for delivering primary health care project noted that EC support led to the dissemination of standard international treatment protocols and clinical guidelines to all benefiting health facilities. No relevant information was found for *Zambia*.

Asia

In *Afghanistan*, the Basic Scorecard contains some indicators relating to patient treatment which have the effect of promoting clinical protocols. In *Bangladesh*, no evidence is available on EC contribution through the Health, Nutrition and Population sector project; however, at least one NGO-implemented sexual and reproductive health project disseminated international clinical protocols. In *Lao PDR*, as well, it can be assumed that EC-supported NGO projects promoted the adoption of clinical protocols but there is no further evidence of direct or indirect EC support. In the *Philippines*, EC support through the HSPSP contributed to developing a standard primary care package and piloted this at four sites; the Mindanao HSPSP also supported efforts to make a standard package of obstetric and neo-natal care available.

ENP

In *Egypt*, the Health Sector Reform Programme supported the development and dissemination of family practice clinical guidelines. In *Moldova*, monitoring documents confirm that the EC contributed directly to the development of a range of clinical protocols which have been applied to standardise treatment across the health system.

Latin America

In *Ecuador*, no evidence relevant to EC support was found.

1.4.3 I-143 Client satisfaction with the quality of health care services

Relatively few data on client satisfaction were found in case study countries. *Ghana* and *South Africa* represented polar opposites, with clients reporting a reasonably high level of satisfaction with care received in public clinics in the first and a high level of dissatisfaction in the second. No data were found which would permit comparison of two points in time. In *Egypt*, the level of satisfaction with sexual and reproductive health care received in EC-supported clinics was significantly higher than reported for clinics not receiving EC support. In *Moldova*, as well, there was solid evidence of an increase in client satisfaction over the evaluation period that can be ascribed to EC interventions. On the other hand, the *Philippines* represents a disappointment, as the underutilisation of facilities by the PhilHealth insured population, even poor families, gives clear evidence that quality of care is perceived to be low despite intense EC support for improvements.

Box 15: Client satisfaction: Country Case Study evidence

ACP

In *Burkina Faso*, evidence for a "snapshot view" of client satisfaction was found for 2005, but no evidence on time trend. No relevant information was found in *Democratic Republic of the Congo*. Some information was found in *Ghana*, but not enough to establish a time trend. In general, client satisfaction appears to be reasonably high. The opposite is the case in *South Africa*, where the DHS found evidence of broad dissatisfaction. No information is available for *Zambia*. Since client satisfaction reflects a broad range of factors, it is probably safe to say that EC support has made some contribution related to this Indicator in all the countries where it has worked.

Asia

In *Afghanistan*, client satisfaction has failed to improve despite EC support to delivery of primary health care. The inconvenience and stress of travel under insecure conditions may contribute to this. No relevant information was found in *Bangladesh* or *Lao PDR*. In *Philippines*, while it can safely be said that the EC has made some contribution to maintaining or improving client satisfaction, indirect evidence – underutilisation of PhilHealth insurance by the insured population – suggests that client satisfaction remains very low.

ENP

No time series data were found in *Egypt*, however, a comparative study of client satisfaction with reproductive health services provided by clinics receiving HSPSP-II support and clinics not receiving it found that clients of the EC-supported clinics were more satisfied. Solid evidence has been found in *Moldova* that the level of client satisfaction improved over the evaluation period and that the EC's sector policy support programme contributed to this trend.

Latin America

Limited evidence from *Ecuador* suggests that the EC-supported health sector support programme in three provinces contributed to an increase in client satisfaction, largely through improved equipment and infrastructure.

2 EQ2- To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor?

2.1 JC 21: The cost of basic health care services are reduced for households due to EC support

We assessed this Judgment Criterion based on five Indicators – change in the share of health spending that is out of pocket, change in the proportion covered by social security change in public / private health insurance contribution rates and change in the proportion of the population covered by public health insurance or enrolled in other public schemes. It can be said at the outset that we found virtually no reliable statistical and relatively complete information on the penultimate of these and dropped it, still considering that the other indicators were sufficient to provide reasonable answers the JC.

Data point to different trends across countries in the share of total health spending that is out of pocket. Out-of-pocket payments discourage families from seeking needed health care and can be a major source of impoverishment. There is broad evidence that reducing the role of out of pocket payments has been a central EC policy goal in its project and sector support interventions. TA was provided in countries such as *Egypt* and *Philippines* and, in the first case, direct support to provision of a basic family health package was provided in pilot provinces; in neither country case, however, can a significant downward trend in the importance of out-of-pocket payments be identified. Low quality of public services, the growing availability of non-essential medical services and rising incomes and expectations may all play a role. Very different are the examples of *Ghana* and *Burkina Faso*, which experienced major increases in the role of public finance of health care services over the evaluation period, changes that gave rise to striking reductions in the share of out-of-pocket spending in total health expenditure. Both countries benefited from EC-supported GBS and it is possible that policy dialogue and the fiscal space created played a role in encouraging this trend. Unfortunately, GBS documents consulted so far give little insight into precisely how GBS encouraged increased public improvement in health finance. An exception is *Zambia*, where there is stronger evidence that GBS resulted in better communications between social sector ministries and the Ministry of Finance, leading to increased social sector budgets.

In a number of countries benefiting from EC support, such as *Zambia* and *Afghanistan*, there is no social security scheme covering health. Interpreting “social security” loosely, the EC has provided support to strengthening and expanding national health insurance schemes in a number of countries. In *Moldova*, while the share of the national health system was unaffected, EC policy advice and TA contributed significantly to putting the health insurance system on a more sustainable financial basis and generating additional resource that could be used in improving quality. However, there is widespread dissatisfaction with the compulsory health insurance programme because premiums are perceived to be high (and are rising) while the availability of diagnostics, treatments and drugs remains well below expectations. In *Lao PDR*, in the context of GBS, the EC has supported policy dialogue and policy advisory work on instituting health insurance, but despite expansion in numbers, this remains in a nascent phase. In the *Philippines*, in addition to a broad and deep range of TA related to health care finance in general and the PhilHealth national insurance scheme in particular, public health insurance remains underutilised even by the covered population due to quality issues and problems of access, usually geographical in nature.

The last indicator refers specifically to expansion in public health coverage. In *Moldova*, the goal of EC support was not expanding coverage which was already high) but improving finances and quality. *Ghana* saw a significant increase in membership of the national health Insurance Scheme, but it has not been possible to ascribe this to EC support in the context of GBS. In *Egypt*, there was also a significant increase in membership of the public insurance scheme, for which the EC can probably take some of the credit, especially through its HSPSP-II programme.

Finally, the case of *Afghanistan* deserves special mention. In that country, virtually all basic health care is provided through distribution of the Basic Health Services Package, which is financed in its entirety in ten provinces by the EC. Absent this intervention, the cost of basic health care in these provinces would be prohibitive.

Under Indicator I-213, we present general EU Delegation survey evidence that the proportion of the population benefiting from some form of public health finance guarantee – whether direct access to free health care or an insurance scheme – has increased. This is to some extent a result of EC support to health care reform.

Overall, from the information gathered, it appears that the EC has made some contribution to reducing the cost of basic health care services for households. In a few cases it has been via direct provision of health care, but that is somewhat outside the scope of this EQ. When it comes to health care financing systems,

neither the EC nor any other donor has the resources, or the desire, to finance the large sums required. However, through TA and capacity building, the EC has focused policy makers on the financing issue and supported the strengthening of the range of financing approaches encountered.

2.1.1 I-211 Change in proportion of health spending out of pocket

Out-of-pocket expenditure as a share of total health spending is typically considered as the product of private spending as a share of total spending and out-of-pocket as a share of private. The classic pattern of development is that, with economic growth and modernisation, private as a share of total declines as government programmes are established and public budgetary resources expand. At the same time, rising incomes stimulate demand for private insurance, reducing out of pocket as a share of private. The net result, strongly observed in cross-section and at least in most countries over the long-term in time series, is that out of pocket expenditure declines as a portion of the total as development proceeds. There are, however, exceptions where growth in health care spending remains almost entirely out of pocket. For example, according to the 2009 CSE of Vietnam (Volume 2, p. 5), public expenditure on health has stagnated (according to WHO) or declined (according to the World Bank) as a share of total health expenditure. The World Bank estimates that public expenditure on health declined from 6.9 to 5.1% of total government expenditure between 2000 and 2006, while over the time there was strong growth in overall health spending-90% of it out of pocket. This is broadly agreed to have had negative impacts on poverty. There is often is disconnection between legal side of health care finance and what occurs in practice. According to the Ministry of Health in Afghanistan, for example, health care provision is free according to the law, but 75% of actual spending is out of pocket.

The tables below present the trends for the desk study countries. Aggregate statistics show that the main factor driving change in the share of total health expenditure that is out-of-pocket has been expansion or shrinkage in the role of the public sector (not change in the share of private spending covered by insurance). This suggests that EC support for health care financing reform, whether delivered through sector budget support or GBS (e.g. with supportive policy dialogue), can play an important role. It also suggests, but no more, that the expansion of fiscal space made possible by GBS may encourage (together with the policy matrix) governments to take on a larger role in financing health care. In fact, as we have found elsewhere, there is little evidence that GBS has been associated with an increase in the budgetary share of health.

As the case studies summarised below illustrate, a number of trends can be observed in countries supported by the EC. If there is an observation that can be made worldwide (see following tables), it is that, with a few exceptions such as *India* and *Tanzania*, out-of-pocket as a share of private has changed little over the evaluation period – i.e., private insurance penetration has not significantly increased. Movement in the share of out of pocket as a proportion of total has been dominated by movement in the share of private in total i.e., it is the expansion or shrinkage in the public sector role that has been the dominant variable. Beyond this, few worldwide generalisations are possible. The number of countries where the public sector has taken on a greater of total spending is about the same as the number of countries where its role has diminished.

There is abundant evidence that reducing the share of out-of-pocket payments has been a central EC policy goal. This is understandable since such payments are a significant cause of impoverishment in the case of catastrophic health care spending (typically defined as in excess of 25% of annual income) and, even when they do not impoverish, have a disproportionately negative impact on lower-income families. Out-of-pocket payments have often repeatedly been shown to discourage needed use of health care services. In countries such as *Egypt* and *Philippines*, the EC provided substantial TA and policy advice aimed at reducing out-of-pocket payments, but with little impact; these have remained about the same in the first case and even increased in the second. In *Moldova*, the impact of significant EC support to health insurance reform was not to reduce out-of-pocket payments, but rather to shift the financing of public health insurance from government (which did not have the needed budgetary resources) to employer-employee contributions, with the result that salaries in the health sector were raised and the quality of services provided was improved. In two African countries, *Ghana* and *Burkina Faso*, the role of the public sector in financing health increased dramatically but documents consulted during the Desk Phase provided no evidence of how the EC may have contributed to these important shifts. Both were recipients of General Budget Support, however, raising the possibility that fiscal space was created. *Afghanistan* represents an extreme case where essentially all basic health care is free and health care spending, overwhelmingly on curative and tertiary care, is virtually all out of pocket. In Afghanistan, the EC did not concentrate on health care finance, but health care provision (although there was a TA on finance). *Lao PDR* is an example of a country where the EC has supported health care finance reform, but this is still in its infancy and out-of-pocket spending rose over the evaluation period. Some of this, as elsewhere, is simply because, with economic growth, demand for quality health care rises. However and also as elsewhere (e.g. *Philippines*, *Vietnam*) even the poor prefer costly private sector care to public care because the quality of the latter is so low, an issue dealt with in other EQs.

Given the narrow nature of the evidence base, no credible statements can be made about the differences in EC approach as between regions or fragile states. However, it is probably safe to assume that the EC's attention to financing, as opposed to provision, issues increases along with a country's level of development.

The following box presents some detailed findings emerging mainly from the country cases and the EUD survey and underpinning the mixed picture regarding out of pocket spending.

Box 16: Out of pocket spending: Main findings from the country cases and the EUD survey

ACP

In *Burkina Faso*, the share of out of pocket spending declined dramatically, from 52.9% to 35.6% between 2002 and 2009. The reason was a sharp decline in the share of total health expenditure accounted for by private spending. There is not likely to have been much EC support to improvement in this Indicator, although one of the variable tranche for 2002-2004 budget support and the MDG contract was reducing medical service costs. MDG contract was focused on reduction of health service and drug costs.

In *Ghana*, there was also an impressive decline in the share of total health expenditure that was out of pocket, from 50.7% in 2002 to 35.6% in 2009. No evidence of EC contribution was identified.

South Africa represents a case where out of pocket payments are reported to have risen from 14.2% to 17.7% between 2002 and 2009. The EC's support related to this Indicator has been limited to incidental technical assistance under the Public Health Sector Support Programme.

In *Zambia*, out of pocket spending rose from 27.8% of the total in 2002 to 30.2% in 2009. This occurred before the major EC commitment to health through the 2009 Supporting Public Health Service Delivery in Zambia sector support programme. Prior to this, almost all EC support was devoted to the problem of health worker retention.

Asia

In *Afghanistan*, the proportion of health spending that is out of pocket remained at nearly 80% over the evaluation period, but this extreme figure needs to be put in context. Most basic health services re, in fact, provided free through the Basic Package of Health Services, supported by the EC in ten provinces. What health spending occurs is almost entirely on curative and higher-level care which is, in turn, virtually all paid for out of pocket. Complicating the picture somewhat is the fact that informal payments for officially free MoH care is common and NGOs often charge user fees for services outside the BPHS. Perhaps the best overall characterisation of the situation is that, since the EC has contributed very significantly to making free basic health care available, what sending does occur is on non-basic health care, not the area in which the EC has chosen to concentrate.

In *Lao PDR*, out of pocket spending rose from 50.1% of total health care expenditure to 61.3% between 2002 and 2009. There is no evidence that EC projects and GBS sought to reduce out of pocket payments, although GBS contains support to the MoH in its efforts to increase health insurance coverage.

The *Philippines* represents a troubling case in which, despite strong efforts by Government and significant support in the form of TA and capacity building by the EC, out of pocket payments have steadily increased as a share of total health care spending. WHO data show the share of out of pocket spending in total health expenditure rising from 46.8% in 2002 to 53.6% in 2009. High out of pocket spending is the result of underutilization of insurance by insured persons. The EC provided significant support for health finance reform under the FOURmula One for Health reform programme, one of whose central goals is to reduce the burden of out of pocket payments on poor families. This support consisted of technical assistance, policy advice and capacity building under the HSPSP, as well as under the Mindanao HSPSP, which has specifically aimed to broaden insurance coverage among under-served populations. The HSPSP mid-term review found that, while HSPSP TA on health finance has been effective in delivering support, Government is having a hard time meeting the ambitious goals for health care finance that have been set forth.

EUD *Philippines* reported that financial protection from the costs of ill-health, measured in terms of out of pocket payments is getting worse in the country. This is despite the implementation of universal health insurance (UHI). In 2006, the share of health spending in per capita expenditures was at its highest levels in the past 18 years. Poor households in the Philippines were spending a higher share of their disposable income on health care as compared to the better-off. Out-of-pocket spending as a share of total health spending is very high and has increased. The EU Delegation survey contained no question related to out-of-pocket spending.

ENP

In *Egypt*, out of pocket sending did not change significantly as a share of total health care spending. A core goal of the ECE-supported Health Sector Reform Programme was reduction in out of pocket payments by providing affordable care through Family Health Units and the institution of the Basic Benefits Package. The HSPSP-I and II placed greater emphasis on health care finance, supporting and piloting a Family health Fund in five governorates. In conclusion, the EC supported work on health care finance designed to reduce out of pocket payments but any such impact has been very limited.

Moldova provided the only example of a post-Soviet health system, where prior to the evaluation period, about half of all health spending (80% of this on pharmaceuticals) was out of pocket. While the Health Sector Policy Support Programme, started close to the end of the evaluation period and the much smaller precursor Health Sector Reform programme both supported work on health care finance, most of this was devoted to increasing the role of public health insurance. As we discuss below, there has been a very large increase in the share of Government health spending financed by social security funds (effectively, compulsory health insurance), but the

share of private expenditure, virtually all of it out of pocket, in total health spending has remained essentially unchanged. Based on WHO data, the share of out of pocket spending in total health spending was 42.8% in 2002 and 45.3% in 2009, suggesting no improvement in the Indicator over the evaluation period. However, alternative data from a research report suggest that there was a significant decline in the share of out of pocket payments between 2000 and 2005. However, experts report widespread dissatisfaction with the mandatory insurance scheme and widespread under-the-table payments to medical staff, whose salaries are grossly inadequate.

Latin America

In *Ecuador*, the EC's contribution through sector support was to provision in underserved provinces, not to health care finance.

To summarise, the EC has supported health care reform in many countries, one of the goals being to reduce the incidence of out of packet payments. In some countries such as *Egypt* and the *Philippines*, the results are disappointing. Intriguing and calling for further analysis, are the cases of *Ghana* and *Burkina Faso*, where substantial decreases were achieved in the context of GBS, but we have not strongly established that GBS contributed. In general, it needs to be remembered that the EC's main contribution to health care finance will have to be through policy dialogue and TA, both through sector support and GBS and, in the second case, through sector support. The EC and no other donor, can realistically contribute directly to health care finance except at the micro-level where health care is essentially provided (e.g. *Afghanistan*).

Table 12: Out-of-pocket health expenditure (% of private expenditure on health), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	77.19	79.07	80.00	80.54	81.25	80.70	80.56	80.56	
Burkina Faso	94.27	92.23	95.15	94.25	91.28	93.73	92.95	92.96	
Congo, Dem. Rep.	84.58	85.00	86.04	85.52	85.70	86.04	85.49	76.24	
Ghana	79.44	79.35	79.27	79.07	77.46	78.62	78.80	78.59	
Mozambique	46.70	48.11	49.30	46.78	45.38	36.18	28.20	43.56	
Nigeria	90.43	96.22	95.34	95.80	95.57	95.53	95.40	95.55	
South Africa	23.13	23.17	28.75	29.83	30.05	29.71	29.68	29.63	
Timor-Leste	25.57	25.57	25.57	25.57	25.57	25.57	25.57	25.57	
Zambia	76.96	75.54	71.36	60.69	67.15	67.63	74.50	74.50	
Zimbabwe									
Tanzania	83.47	87.31	79.41	77.64	54.31	65.12	65.12	65.12	
Asia									
Afghanistan	98.94	98.94	98.94	98.94	98.94	98.94	98.94	98.94	
Bangladesh	96.00	95.72	95.92	96.22	96.31	96.52	96.52	96.52	
India	92.34	91.77	89.55	87.91	82.65	75.88	74.38	74.38	
Lao PDR	68.76	76.64	75.69	75.44	76.12	76.12	75.92	75.80	
Myanmar	98.37	98.19	98.22	99.19	94.90	95.13	95.50	95.50	
Philippines	77.97	78.43	80.23	80.92	80.87	83.32	82.49	82.81	
Yemen, Rep.	94.83	96.18	97.28	97.95	92.48	98.44	98.53	98.57	
Vietnam	90.42	89.57	89.07	89.54	90.20	90.23	90.23	90.23	
ENP									
Egypt, Arab Rep.	98.39	98.44	98.43	98.37	98.24	98.03	97.70	97.72	
Moldova	93.24	94.05	96.40	97.20	97.50	97.56	97.77	97.79	
Morocco	81.74	81.66	81.38	83.48	86.25	86.31	86.31	86.31	
Syrian Arab Republic	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
Latin America									
Ecuador	85.68	84.18	85.23	85.25	85.53	85.93	87.29	87.29	
El Salvador	93.38	93.30	92.53	91.67	88.93	88.99	88.78	87.93	

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Regional									
Arab World	84.64	83.33	83.40	83.00	82.62	83.27	82.29	82.16	
East Asia & Pacific (developing only)	87.79	85.69	84.92	83.84	81.80	81.40	81.59	81.79	
Europe & Central Asia (developing only)	79.42	80.77	82.46	83.19	82.65	82.89	82.42	82.25	
Latin America & Caribbean (developing only)	77.58	77.15	76.69	74.13	73.05	70.34	69.05	68.76	
Middle East & North Africa (developing only)	91.84	90.95	91.71	92.57	93.47	94.24	94.23	94.43	
South Asia	91.29	90.98	89.00	87.67	83.29	77.68	76.45	76.94	
Sub-Saharan Africa (developing only)	53.86	55.45	54.86	56.75	58.45	60.31	63.82	63.06	
Income									
Heavily indebted poor countries (HIPC)	85.17	85.59	85.65	84.28	82.65	84.44	85.09	85.19	
Least developed countries: UN classification	86.82	87.29	86.16	84.85	83.13	85.99	86.57	86.54	
Low & middle income	81.92	80.70	80.03	78.89	77.64	76.32	76.27	76.42	
Middle income	81.82	80.57	79.92	78.78	77.57	76.16	76.10	76.25	

Source: World Bank 2010

Indicator Name	Out-of-pocket health expenditure (% of private expenditure on health)
Short definition	Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.
Long definition	Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.
Source	World Health Organisation National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual

Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.

Table 13: Health expenditure, private (% of total health expenditure), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	31.60	34.41	35.45.	35.61	35.24	36.00	36.19	35.71	
Burkina Faso	56.09	53.57	46.32	40.46	43.14	29.73	40.95	38.30	
Congo, Dem. Rep.	94.92	81.68	79.45	73.26	68.61	64.06	79.94	76.07	
Ghana	63.80	62.26	51.67	46.78	44.83	38.17	41.36	46.77	
Mozambique	25.08	27.46	30.65	25.81	27.44	24.92	22.66	24.52	
Nigeria	74.42	77.60	67.31	70.83	68.14	68.64	63.32	63.65	
South Africa	61.31	60.54	63.57	61.70	60.09	59.17	60.34	59.87	
Timor-Leste	27.77	25.53	34.28	23.87	20.33	23.86	26.55	29.02	
Zambia	36.15	38.39	42.72	45.14	39.29	44.31	40.51	40.50	
Zimbabwe	-	-	-	-	-	-	-	-	
Tanzania	55.34	50.52	56.82	51.49	41.12	27.17	28.07	26.41	
Asia									
Afghanistan	80.42	80.69	76.62	75.77	73.67	76.40	78.50	78.50	
Bangladesh	60.32	62.35	61.22	65.10	63.51	65.61	68.57	67.13	
India	76.82	77.21	77.28	76.10	75.18	74.20	72.36	69.73	
Lao PDR	72.86	72.98	82.48	82.70	81.45	81.09	82.44	80.87	
Myanmar	84.76	87.67	86.49	91.02	85.63	88.28	91.21	90.28	
Philippines	59.99	59.77	61.47	60.77	64.64	65.23	64.94	64.71	
Yemen, Rep.	48.75	54.19	62.15	66.14	68.41	70.25	69.92	72.04	
Vietnam	70.00	68.64	73.17	74.10	67.67	60.68	61.51	61.34	
ENP									
Egypt, Arab Rep.	59.74	59.63	59.54	59.36	55.82	58.79	57.81	58.87	
Moldova	45.91	48.33	45.93	50.17	51.56	50.87	49.40	46.32	
Morocco	74.03	73.44	72.59	71.32	67.24	63.67	63.71	65.62	
Syrian Arab Republic	54.23	51.75	52.03	49.50	25.25	57.29	61.22	68.95	
Latin America									
Ecuador	62.34	61.08	58.75	59.90	56.40	57.70	57.74	51.59	
El Salvador	53.36	52.73	50.63	47.29	37.92	40.79	40.37	39.57	

Source: World Bank July 2011

Legend: Indicator Name	Health expenditure, private (% of total health expenditure)
Short definition	Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations and direct service payments by private corporations.
Long definition	Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations and direct service payments by private corporations.
Source	World Health Organisation National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global

General comments	financial crisis. The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 14: Out of pocket spending as a share of total health care expenditure

Country Name	2002	2003	2004	2005	2006	2007	2008	2009
ACP								
Barbados	24.4	27.2	28.4	28.7	28.6	29.1	29.2	28.8
Burkina Faso	52.9	49.4	44.1	38.1	39.4	27.9	38.1	35.6
Congo, Dem. Rep.	80.3	69.4	68.4	62.7	58.8	55.1	68.3	58.0
Ghana	50.7	49.4	41.0	37.0	34.7	30.0	32.6	36.8
Mozambique	11.7	13.2	15.1	12.1	12.5	9.0	6.4	10.7
Nigeria	67.3	74.7	64.2	67.9	65.1	65.6	60.4	60.8
South Africa	14.2	14.0	18.3	18.4	18.1	17.6	17.9	17.7
Timor-Leste	7.1	6.5	8.8	6.1	5.2	6.1	6.8	7.4
Zambia	27.8	29.0	30.5	27.4	26.4	30.0	30.2	30.2
Zimbabwe	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Tanzania	46.2	44.1	45.1	40.0	22.3	17.7	18.3	17.2
Asia								
Afghanistan	79.6	79.8	75.8	75.0	72.9	75.6	77.7	77.7
Bangladesh	57.9	59.7	58.7	62.6	61.2	63.3	66.2	64.8
India	70.9	70.9	69.2	66.9	62.1	56.3	53.8	51.9
Lao PDR	50.1	55.9	62.4	62.4	62.0	61.7	62.6	61.3
Myanmar	83.4	86.1	85.0	90.3	81.3	84.0	87.1	86.2
Philippines	46.8	46.9	49.3	49.2	52.3	54.3	53.6	53.6
Yemen, Rep.	46.2	52.1	60.5	64.8	63.3	69.2	68.9	71.0
Vietnam	63.3	61.5	65.2	66.3	61.0	54.8	55.5	55.3
ENP								
Egypt, Arab Rep.	58.8	58.7	58.6	58.4	54.8	57.6	56.5	57.5
Moldova	42.8	45.5	44.3	48.8	50.3	49.6	48.3	45.3
Morocco	60.5	60.0	59.1	59.5	58.0	55.0	55.0	56.6
Syrian Arab Republic	54.2	51.8	52.0	49.5	25.3	57.3	61.2	69.0
Latin America								
Ecuador	53.4	51.4	50.1	51.1	48.2	49.6	50.4	45.0
El Salvador	49.8	49.2	46.8	43.4	33.7	36.3	35.8	34.8

Source: World Health Organisation, Global Health Observatory 2011

2.1.2 I-212 Change in share of health expenditure financed by social security schemes

Social security schemes are relatively unimportant in most countries and, in point of fact, this Indicator could easily have been merged with I-213 on enrolment in public health schemes of whatever nature. Results from the EUD survey indicate that only in half of countries responding there was a public health financing scheme in place. Where there was, very few (three out of ten answering the question) considered that the public financing scheme was effective. The *Philippines*, with a long history of public health insurance, is a particularly disappointing case as insurance coverage continues to fail to translate into effective utilisation of available services. No health financing scheme at all is generally in place in fragile states.

From the country case studies it is known that there was major expansion of public health insurance in *Ghana* over the evaluation period; this was presumably related to the large increase in the proportion of health care financed by the public sector noted above. Note that "insurance" is a bit of a misnomer since the Fund is financed from a range of sources. No EC contribution was identified. In several countries (*Zambia*, *Afghanistan*) there does not appear to be a social security scheme covering health. In the *Philippines*, the Mindanao Health Sector Policy Support Programme promoted the extension of coverage to persons in disadvantaged settings, although nationwide, even the covered population underutilises available services. In *Lao PDR*, the EC has supported the development of health insurance schemes through TA, but these are in a nascent stage.

While it does not emerge from the case studies or EUD survey, it is broadly known that public health care finance schemes are most prevalent in Latin America, due to the strong Bismarckian social insurance tradition prevailing since the beginning of the twentieth century. It is also broadly known that these schemes are often regressive and fail to address the needs of the poor.

In *Moldova,* the share of government health spending financed by social security grew dramatically following the introduction of compulsory health insurance. The Public Health Reform programme aimed, among other things, at strengthening health insurance, as did the HSPSP. There is no question that the EC contributed significantly to the expansion of public health insurance (I-213 Change in proportion of the population

covered by public health insurance / enrolled in the public health scheme). However, experts report that informal out-of-pocket payments remain high to compensate for doctors' low salaries, quality of care is unsatisfactory and there is rising dissatisfaction with the mandatory insurance system, particularly in view of the steadily rising contribution rate. The impact has been to relieve pressure on government health finances rather than a reduction in the share of private health spending in the total.

While the EUD survey did not directly ask a question related to this indicator, it did ask whether a public health care financing scheme was available to the general public. Out of 24 EUDs giving their answer to this question, 12 (*Vietnam, Lao PDR, Philippines, Timor-Leste, Myanmar, Morocco, Moldova, Nigeria, Egypt, DRC, Ghana and Ecuador)* answered in the affirmative. Ten EUDs (*India, Bangladesh, Yemen, Syrian Arab Republic, South Africa Zambia, Zimbabwe, Burkina Faso*, *Barbados and El Salvador*) responded negatively whilst two indicated that they didn't know. Further information from the EUD survey, including views on effectiveness, is given below.

2.1.3 I-213 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

In a number of countries supported by the EC, there has been significant increase in membership of the public insurance scheme. *Ghana* is a dramatic example, although no evidence was found that EC support contributed directly to development of the public scheme. The possibility of GBS contribution cannot be excluded. In *Egypt*, a significant impact has been found. Membership in the public scheme rose from 50% to 57% over the evaluation period and improving public health insurance coverage was a goal of EC support throughout (especially under HSPSP-I). Note that the EUD estimates current coverage to be about half. The EC supported Family Health Funds in five provinces which were integrated with the Health Insurance Organisation in order to provide a basic heath package. While the expansion of coverage cannot be directly attributed to EC interventions, it is safe to say that the strengthening of the health insurance system, while much remains to do, owes something to consistent EC support over the evaluation period. This included technical assistance in the form of actuarial analyses. *In Lao PDR*, the EC has provided policy advice and expansion of health insurance is an Indicator under GBS, however, it must be understood that whatever expansion of coverage has taken place is minimal and remains at the pilot level. EC programmes in *Zambia* did not focus on health insurance. As stated previously, while EC policy support contributed to strengthening public health insurance in *Moldova*, this did not amount to expanding coverage (already relatively high under the Soviet system) but rather to shoring up finances to improve sustainability and improve the quality of the system. Coverage is wide, but dissatisfaction is equally wide.

The following box presents some detailed findings emerging from the country cases.

Box 17: Change in proportion of the population covered by public health insurance / enrolled in the public health scheme: Main findings from the country cases

ACP

In *Ghana*, all citizens are in principle required to enrol in the National health Insurance System. Since its introduction in 2005, coverage is estimated to have risen to 60%, although there is some dispute about the exact proportion. The Joint Evaluation of Multi-donor Budget Support in Ghana drew attention to the failure of the NHIS to successfully meet the problem of health service user fees for the poor.

In *South Africa*, under its HIV-AIDS support programme SuCoP, the EC financed a major study of a potential national health insurance system. However, no such system is in place.

In *Zambia*, there was an attempt to institute Social Health Insurance, but this was interrupted in 2009 amid accusations of fraud. EC heath programmes in Zambia focused on MDG outcomes, not on health care finance.

Asia

There is no public health insurance scheme in *Afghanistan*.

In *Lao PDR*, there is some movement to put in place Community-based Health Insurance the informal economy workers and health Equity Funds for the very poor. However, less than 3% of the population is covered so far. Over the evaluation period, there is no evidence that EC support led to the development of health insurance schemes; however, the GBS programme that commenced in 2008 includes proportion of the population enrolled in such schemes as an indicator.

ENP

In *Egypt*, the Health Insurance Organisation under the Ministry of Health and Population covers 57% of the population, up from 50% at the beginning of the evaluation period. This does not include farmers, persons in the informal sector, the self-employed and housewives. The EC has significantly supported strengthening HIO under the HSRP and the HSPSP I and II. This support has taken the form of technical assistance as well as piloting innovative health financing schemes integrating the Family Health Fund and HIO in five governorates. The case study could not attribute the expansion of HIO coverage to EC support, however, the EC has generally been

involved in strengthening the availability of health care finance to the poor through innovative policies that include the HIO. However, the out-of-pocket share, according to the EUD, remains about 70%

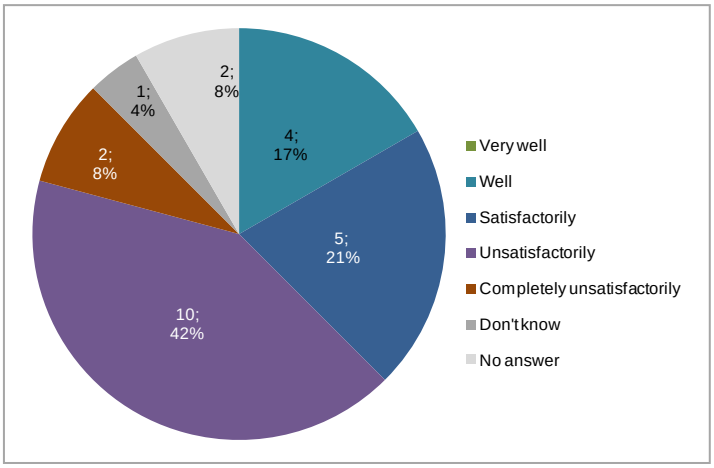
In *Moldova*, public health insurance coverage was broad even before the evaluation period. The problem was that, completely dependent on state funding, financial resources were woefully lacking. EC policy support focused on increasing the financial sustainability of public health insurance, which has been accomplished by mobilising employee and employer contributions. Coverage per se has not significantly changed, but extra resources have translated into higher salaries and better-quality medical facilities. Even so, salaries remain inadequate, which has led to widespread informal payments for treatment. This, combined with lack of diagnostic tools and treatments and rising health insurance premiums, has fuelled dissatisfaction.

Latin America

EC support on *Ecuador* focused on provision, not financing.

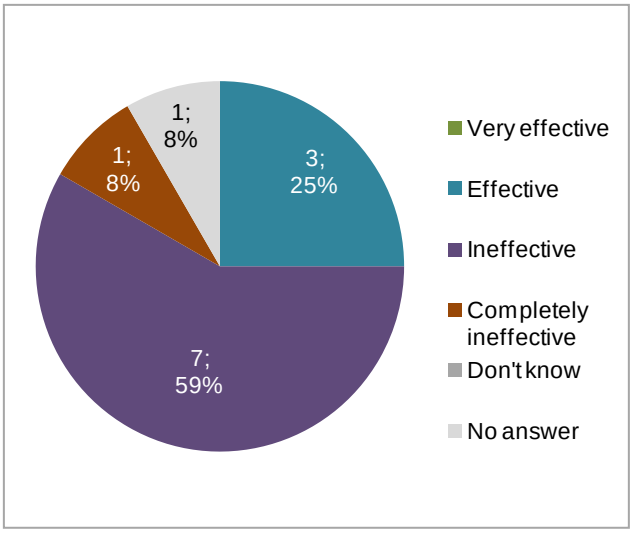
From an availability point of view, public health schemes are common. However, many of these are reported by EUDs to be ineffective (see figures below).

Figure 8: *Results of the survey to EUDs: Availability of a public health care financing scheme to the general public (in absolute figures - number of EUD respondents - and %)*



Source: EUD Survey, 2011, Particip GmbH

Figure 9: *Results of the survey to EUDs: Effectiveness of the public health care financing scheme in financing needed care (in absolute figures - number of EUD respondents - and %)*



Source: EUD Survey, 2011, Particip GmbH

Of twelve EUDs who answered whether the public scheme was effective, only three (*Egypt*, *Moldova* and *Morocco*) considered that these schemes were effective in financing needed care. In *Egypt*, nonetheless, the EUD reports that the share of out of pocket payments remains about 70%. In *Moldova* the EUD reported the existence of a mandatory health insurance scheme in which the employee and the employer pay a premium

of 3.5% each. The most vulnerable layers of population (children, pregnant women, mothers with four children and more, unemployed persons, retired persons, disabled, students) are insured by the state, which pays the contribution directly to the National Health Insurance Company. The latter is responsible for pooling the funds, contracting health care providers and monitoring the provided health services. As in Egypt, the EC provided support to health insurance reform in Moldova. In *Morocco,* the EUD commented that the Ministry of Health provided a budget planning and developed an annual MTEF that tries to decline the various programs transverse and vertical to avoid the overlap between programs exist that sometimes block the management.

Seven EUDs (*Lao PDR, Philippines, Vietnam, Timor-Leste, Nigeria, DRC* and *Ecuador*) considered the schemes ineffective and one of them (EUD *Myanmar*) said it was completely ineffective. In *Lao* PDR, the EUD said that it was still quite early to see results since different public health financing schemes started in 2001/2002 but there was a slow rolling out. The EUD *Philippines* declared that despite the implementation of universal health insurance under the Philippine Health Insurance Corporation (PHIC of 1995), coverage in the country remained low particularly for the poor and that health insurance coverage was no guarantee of financial protection and enhanced access to good quality health services due to the limited nature of PHIC benefits and the difficulties in accessing these benefits. In *Vietnam*, the EUD commented that the main problems rose from 1) the fact that the national budget for health care as well as the funds of the health insurance fund that should pay the health facilities were both not linked to the performance of the health facilities; and 2) distortions of health financing arising from decentralisation and hospital autonomy.

Ministries of Health who responded to the MoH survey gave mixed reports on how well the health financing system met the needs of the poor and persons with special needs. *Syria* and *Morocco* both gave high marks to their respective systems. In *Egypt*, the MoH reported that exemptions for the poor functioned inadequately and *Yemen* reported that there is essentially no health finance policy. Relating to the Egypt response, it also needs to be remembered that exemptions can impair sustainability. There is some question in *Ghana*, for example, whether a system that offers exemptions to some 70% of the population can be maintained and there are reports that cash-strapped clinics regularly refuse patients exemptions to which they are entitled.

In *Vietnam*, according to the 2009 CSE, the goal is to attain universal coverage by 2014 by expanding voluntary coverage while simultaneously widening the categories of persons for whom insurance is compulsory. At present, compulsory categories include formal sector employees; in addition to which, the GoV fully subsidises health insurance cards for the poor, children under 6 and persons over 85. Farmers and members of the urban informal sector, as well as students, can enrol voluntarily. In fact, of the 40% of the population covered by insurance, about three quarters are covered compulsorily while only one quarter are voluntary. Reasons include lack of income and the low quality of services available. Fewer than 50% of formal-sector workers are estimated to be covered and there are massive gaps in coverage of the poor. Some of the latter have to do with problems of identification, others have to do with the fact that it is local officials who must certify that the recipient is poor, raising the problem of stigma. A programme in place to subsidise half the health insurance fees of the “near poor” has had very mediocre success because of similar problems of targeting.

If one were to summarise all the evidence, there was some EC contribution to broadening membership in public health financing schemes, but progress has been limited. The EC cannot, for obvious reasons, directly finance public health schemes except at the micro-level where it provides health care. Its TA and sector support have often sought to broaden the availability of health care finance. There have been some successes, but in a number of countries such as Philippines, results have been disappointing. In that case and probably in others, the quality dimension assumes importance; public health care may be financed, but its quality may be perceived to be low.

2.2 JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC

We assessed this Judgment Criterion based on two Indicators: the putting in place with EC support of cost waiver and subsidy schemes for target groups with special needs and additional health care service consumption as a result of EC support for health care financing.

A broad range of subsidy and cost-waiver schemes were identified in the country case studies, some directly supported by the EC, some indirectly supported and some which may be completely unrelated to EC support. The *Egyptian* Family Health Fund was supported both by TA and through direct financial input from the EC in pilot Governorates. In *Afghanistan*, free basic health services have been provided in ten provinces with EC support. In *Ghana*, nearly 70% of the population is theoretically exempt from fees in the compulsory National Health Insurance System; in fact, exempt populations are often denied care, but it is agreed that

children, the elderly and pregnant women effectively benefit from exemptions. GBS in Ghana may have helped create fiscal space for these exemptions, just as EC GBS in *Burkina Faso* may have helped to create room to subsidise maternity services in supervised facilities. An important indirect support for subsidised or free services is EC support for the Global Fund, which provides services such as ARV therapy and TB testing / treatment in heavily AIDS-affected countries. Most of the admittedly few respondents to the MoH survey reported that cost waiver and subsidy schemes were in place and reasonably effective. However, there are countries such as *Vietnam* where it is clear from the 2009 CSE that difficulties in identifying the poor and social stigma limit the effectiveness of health insurance subsidies.

Despite EC contribution, in the EUD survey only a third of responding EUDs felt that health financing policy was addressing the needs of the poor "satisfactorily" or "well." Responses from the MoH survey were mixed.

Answering whether EC support resulted in additional consumption of health care by households is fraught with issues. While aggregate health expenditure data are widely available, data on actual household consumption are rare. Service utilisation data are more likely to be available. Here, too, there are ambiguities, for example, between needed health care and the non-essential care which is increasingly available. Improved access and reduced price must be set aside rising income as a cause of increased consumption of health care services.

Despite these complications, a reasonable amount of evidence from country case documentation indicates that EC support has resulted in additional utilisation of basic health services by households. This is clearly the case in *Afghanistan* where the EC finances distribution of a basic health benefit package in ten provinces and in *Ecuador* where, similarly, the EC supported provision of health care services in three under-served provinces. In *Ghana*, the introduction of compulsory health insurance resulted in an increase in service utilisation, which was one of the elements of the Multi-donor Budget Support programme; unfortunately, MDBS evaluation estimates are grossly lower than National Health Authority estimates. Moreover, in other countries evidence of EC impact is lacking. In *Zambia*, the increase in health care service utilisation when user fees were abolished was unrelated to EC support[11].

It should be added that findings from document analysis are largely confirmed by the EUD survey, where virtually all EUDs responding to the relevant question were of the view that public health schemes supported by the EC resulted in greater household consumption of health care services.

Taken together, document analysis, the case studies and the EUD survey indicate that the EC has contributed significantly in a range of settings to the reducing the cost of health care to those with special needs, with resulting increases in utilisation of health care services.

2.2.1 I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs, such as children, the elderly, persons living with HIV/AIDS and the disabled

A large number of such schemes were identified by the case studies, some supported by the EC directly, some indirectly with a high degree of probability and some likely unrelated to EC support. The following box provides some details regarding these schemes.

The *Egyptian* Family Health Fund, completely donor supported, is not a cost waiver or subsidy scheme per se but has much the same effect. The EC has supported it through TA as well as directly in five pilot provinces. In *Ghana*, GBS may be related to the fact that 70% of the population is exempted from paying National Health Insurance System fees. Not in doubt is that the widespread exemptions are problematic from the standpoint of long-term financial sustainability. The operation of the exemptions scheme has been questioned, but at least children, the elderly and pregnant women are likely to successfully claim exemptions. One reason why clinics often fail to recognise exemptions is that the insurance fund has been slow in reimbursement. The EC's contribution to the Global Fund may take some of the credit for expanded availability of ARV treatment in the country. EC GBS may also have contributed to fiscal space which permitted the government of *Burkina Faso* to subsidize childbirth in health facilities and the Global Fund also finances ARV treatment. The Global Fund was a major provider of ARV treatment in *South Africa*, as well as in *Zambia*. The provision of the free Basic Health Services Package in ten provinces of *Afghanistan* is conceptually not far from support for cost exemption or subsidy schemes. Under the Mindanao Health Sector Policy Support Programme in the *Philippines*, the EC supported a programme whereby the poor in disadvantaged communities had their PhilHealth contributions paid for out of the public purse, although it was noted that political considerations were often determinant of when communities did and did not support

[11] No relevant time series data were found for Moldova.

the poor. In *Moldova,* EC policy support for the strengthening of public health insurance contributed to government's ability to cover compulsory health insurance contributions for selected target groups. In *Vietnam*, as discussed above, identification of the poor is one problem weakening the operation of health insurance subsidies.

No regional generalisations can be made based on case study countries. It is known from other work, however, that special schemes for the elderly, the disabled, the indigent, etc. are under-funded as well as underutilised (i.e., take up is low) in Southeast Asia, mostly due to stigma.

Box 18: Cost waiver and subsidies schemes in place for the poor and persons with special health care needs: Main findings from the country cases

ACP

In *Burkina Faso*, a fee subsidy for childbirth has helped to increase the proportion of births taking place under skilled supervision. EC-funded budget support may have contributed to the fiscal space which made this subsidy possible. Free ARV therapy supported by the EC is an example of an indirect EC contribution. However, apart from technical assistance, the EC has made no specific direct contribution to improving the accessibility of health services to the very poor.

In *Ghana*, so many groups are exempted from National Health Insurance System fees that less than a third actually pay in. Exempt groups include children, the elderly, pregnant women, pensioners and the indigent. Some specific services, such as vaccination, are cost-free. An innovation is that clinics are able to submit statements of fee revenue lost through exemptions and request reimbursement. However, despite this, it is reported that poor people rarely receive the exemptions to which they are entitled. Children, the elderly and pregnant women are, by contrast, likely to receive exemptions. The Joint Evaluation of Multi-donor Budget Support noted the poor implementation of exemption schemes, in part because of delays between claims for reimbursement and payment.

In *South Africa*, free ARV therapy for HIV/AIDS patients financed by the Global Fund is supported in part indirectly by the EC. Apart from this, no evidence has been found of EC contribution to cost waiver or subsidy schemes.

In *Zambia*, as well, no evidence was found that the EC contributed to cost waiver or subsidy schemes, yet EC support for the Global Fund would have contributed indirectly to free ARV therapy treatment.

Asia

In *Afghanistan*, the Basic Health Services Package provided free with EC support in ten provinces is the mainstay of health care in those provinces (other donors cover the rest of the country). The NGOs implementing the BHPS serve the health needs of about 5 million Afghans. In four provinces, as well, the EC supports the Essential Package of Hospital Services.

In *Lao PDR*, there is no evidence that the EC has contributed to special health care schemes for populations with special needs.

ENP

In *Egypt*, Ministry of Health and Population facilities should, in principle, be providing free services to the poor. The Family Health Fund is a hybrid cost-recovery and insurance scheme, not a waiver or subsidy scheme. Increasing consumption of health care by the poor is a key goal of HSPSP-II instituted near the end of the evaluation period, suggesting that this is still a problem area. The fact that significant number of poor people continue to turn to the private sector for health care is evidence that, despite supporting health care finance reform, the EC has not succeeded in having large impact.

In *Moldova*, compulsory health insurance contributions for children, students, the officially registered unemployed, pensioners and pregnant women are paid for by the state. The Reserve Fund is used to finance health care for the uninsured (mostly poor) population. The EC did not directly support these initiatives, however, it was involved in supporting the effort to strengthen health insurance generally.

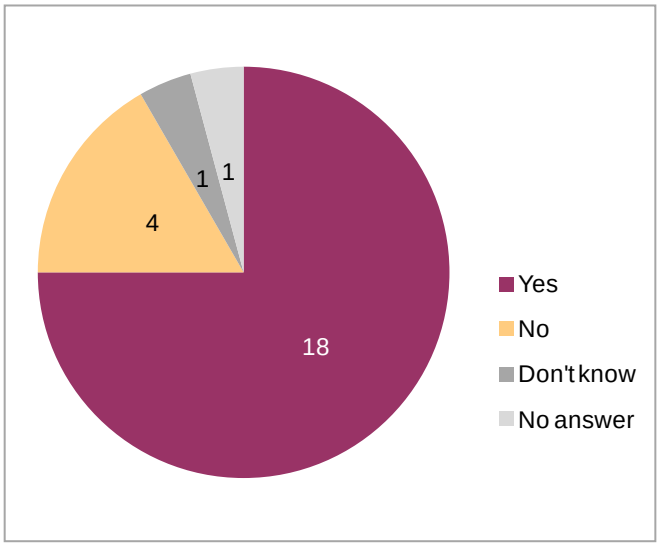
Latin America

No information relevant to the Indicator was found in *Ecuador*.

Almost all EU Delegations responding to the survey were able to point to cost waiver or subsidy schemes, or policies very close to them. 18 of the 23 EUDs answering the question indicated the existence of cost waiver schemes for vulnerable groups such as children, the elderly, persons living with HIV/AIDS and the disabled were in place: in *Philippines, Vietnam, Myanmar, Lao PDR, Afghanistan, Egypt, Moldova, Yemen, Syrian*

Arab Republic, Morocco*, Barbados, Burkina Faso, Mozambique, Zambia Zimbabwe, DRC, South Africa and Ecuador.* .

Figure 10: Results of the survey to EUDs: Existence of cost waiver schemes for vulnerable groups such as children, the elderly, persons living with HIV/AIDS and the disabled (in absolute figures - number of EUD respondents - and %)



Source: EUD Survey, 2011, Particip GmbH

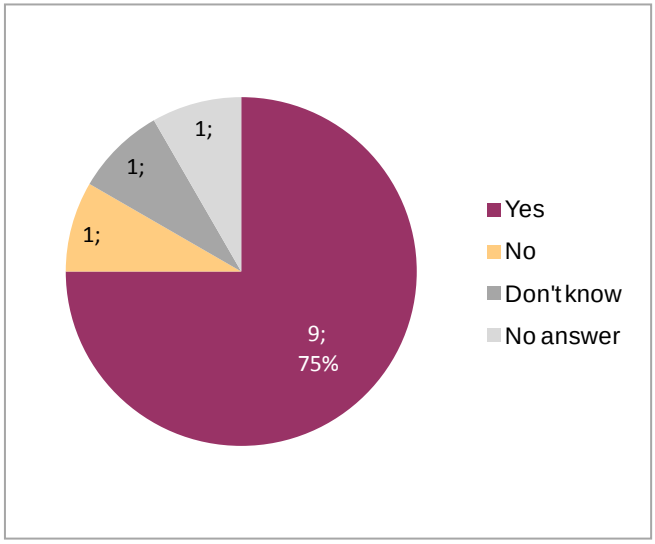
Only four EUDs (*India, Bangladesh, Timor-Leste* and *El Salvador*) reported that such cost waiver schemes were not (yet) in place. In the view of these EUDs the main reasons cited were lack of concern for the welfare of the poor, insufficient budgetary resources and administrative inefficiency. Moreover, in *Bangladesh*, primary health care is free, reducing the need for a waiver scheme.

In Asian countries such as *Philippines*, *Lao PDR* and *Vietnam*, the problems of identifying the poor were cited; in *Myanmar*, the health scheme for the poor does not function well and *Afghanistan* has no such scheme at all. Problems of targeting the poor were also raised by EUD *Egypt*. In *Zambia* (as in *Ghana*, see above), clinics tended to refuse exemptions to persons who were entitled to them. These EU Delegations are only representative, a full enumeration of responses is given in Annex.

A range of sources of EC contribution to putting cost waiver schemes in place was cited by the EUDs. This included policy dialogue, sometimes through GBS; inclusion of improved health coverage of the poor as a condition for GBS and TA and capacity building for health sector financial reform. No EU Delegation explicitly mentioned the fiscal space created by GBS and it is impossible to prove empirically that GBS resulted in additional resources for health, but the argument is an appealing one. However, it should be pointed out that only one third of 22 responding EU Delegations reported that health financing policy was addressing the needs of the poor "satisfactorily" or "well." The survey only allows a few generalisations to be made regarding regional specificities: For Asia, all EUDs identify GBS (increasing the fiscal envelope) and TA related to health care finance, as main EC contributions to increasing the availability of cost waivers and subsidies to populations with special needs. In ENP countries, EUDs in the region see general support to health financing reform as well as GBS as main tools that have helped to put cost waiver schemes in place.

Asked whether the country's health finance policy was addressing the needs of the poor and of persons with special health care needs, 10 out of 22 responding EUDs rated efforts as "unsatisfactorily" and two out of 22 rated them as "completely unsatisfactory." Only one third of the respondents answered this question either with "satisfactory" or "well". The countries answering "satisfactory" (five out of 22 respondents) were *Lao PDR, Afghanistan, Nigeria, DRC, Morocco* whereas *Egypt, Syria, South Africa and Zimbabwe* responded "well".

Figure 11: Results of the survey to EUDs: Health finance policy addressing needs of the poor (in absolute figures - number of EUD respondents - and %)



Source: EUD Survey, 2011, Particip GmbH"

All of the countries with a "satisfactory" or "well" ranking have reported policies in place that explicitly address the needs of the poor and/or people with special care needs.

Evidence on cost waiver schemes was also obtained from the MoH survey. *Syria* reported simply that care was free for the poor and persons with special needs. In *Lao PDR*, health care for children under 5 has been free for five years. In *Yemen*, the MoH reported that the policy was unclear and that individual clinic managers took the decision on what care to provide free of charge. In *Burkina Faso*, as previously noted, delivery in public health facilities is heavily subsidised, as is obstetric and neonatal care. In *Morocco*, these services have been completely free of charge since 2008. In *Moldova*, a long and broad list of persons are exempt from paying health insurance fees: students, pensioners, pregnant women, the unemployed, etc.

To summarise, again, the EC is not in a position to directly finance cost waiver and subsidy schemes over the long term; this is the budgetary responsibility of governments. EC TA and policy advice promoted such schemes and in pilot situations, the EC implicitly finances such schemes by providing health care to populations in need. Particularly in ACP countries, the EC's contribution to the Global Fund may be assumed to have provided access to subsidised or free HIV/AIDS treatment, as well as to medicines related to the other diseases of poverty.

2.2.2 I-222 Health care financing schemes result in additional health care consumption by households

Aggregate health care spending estimates are universally available, but these are far from reliable guides to actual household health care service consumption. Explicit data on health care consumption, while available based on household surveys in a number of countries and, have not been systematically analysed in assessing this indicator. Issues of real versus nominal, needed versus unnecessary medical care, the role of accessibility, quality, incomes, etc. make it inappropriate to adopt a formal approach. Rather, qualitative views have been sought from documents reviewed in the course of country case studies and in the EUD surveys.

The following paragraphs summarises evidences from the country case studies.

In *Egypt*, it was impossible to judge whether EC support for the Family Health Fund provision of the Basic Health Services Package actually increased consumption. Monitoring indicators employed by the EC were provided only little information on actual health-seeking behaviour

In *Ghana*, by contrast, documents consulted affirmed that the introduction of health insurance had increased actual service utilisation, which was one of the indicators in the policy matrix of the EC-supported Multi-donor Budget Support programme. An unfortunate complication is that the evaluation of MDBS estimates of increases in service utilisation are grossly lower than those of the National Health Insurance Authority.

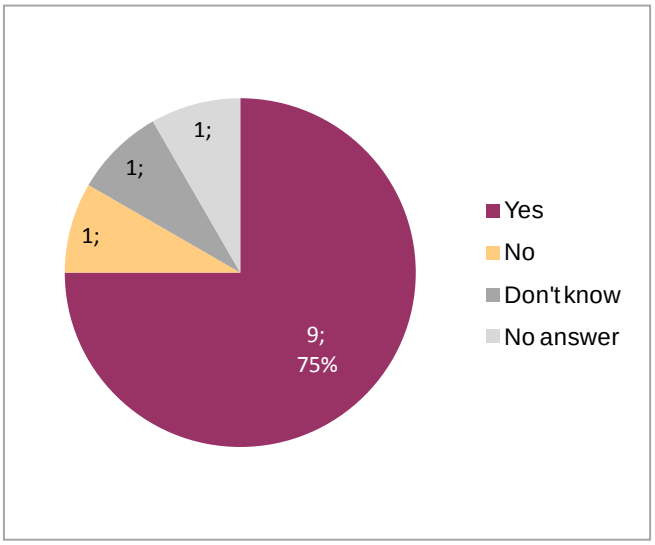
Almost all health care in *Afghanistan* and all basic health care, is donor-financed. The EC contributed directly to increase health care service utilisation, not by contributing to improved financing per se, but simply by providing the Basic Benefit Package free of charge in ten provinces. ROM reports for Afghanistan show that

the distribution of the Basic Benefit Package in ten provinces supported by the EC has led to a tangible increase in utilisation of health services, especially by women and girls.

The proposition that the existence of public health schemes increased household consumption of health care was supported by virtually all of the 12 EU Delegations responding to the survey to the relevant question. The only exception was the *Philippines*, where expansion of health insurance coverage has paradoxically co-existed with an increase in out-of-pocket payments. Much of the reason appears to be that failure to utilise health services has as much to do with access (closely tied to geographical remoteness) as it does with financial means.

In *Zambia*, abolition of user fees led to a noticeable increase in service utilisation, however, EC support at this time was not a relevant consideration. According to the EUD, evidence from *Moldova* suggests that reform of the public health insurance system, supported by the EC, was associated with a significant increase in service utilisation. Particularly, in the area of secondary and tertiary care, as well as emergency services, the insured were far more likely than the uninsured to seek care. However, these are "snapshot," uninsured-vs.-insured data, they are not time series data. An unintended consequence of the strengthening of health insurance is that, since the very poorest are disproportionately uninsured, disparities in health service utilisation may have actually widened.

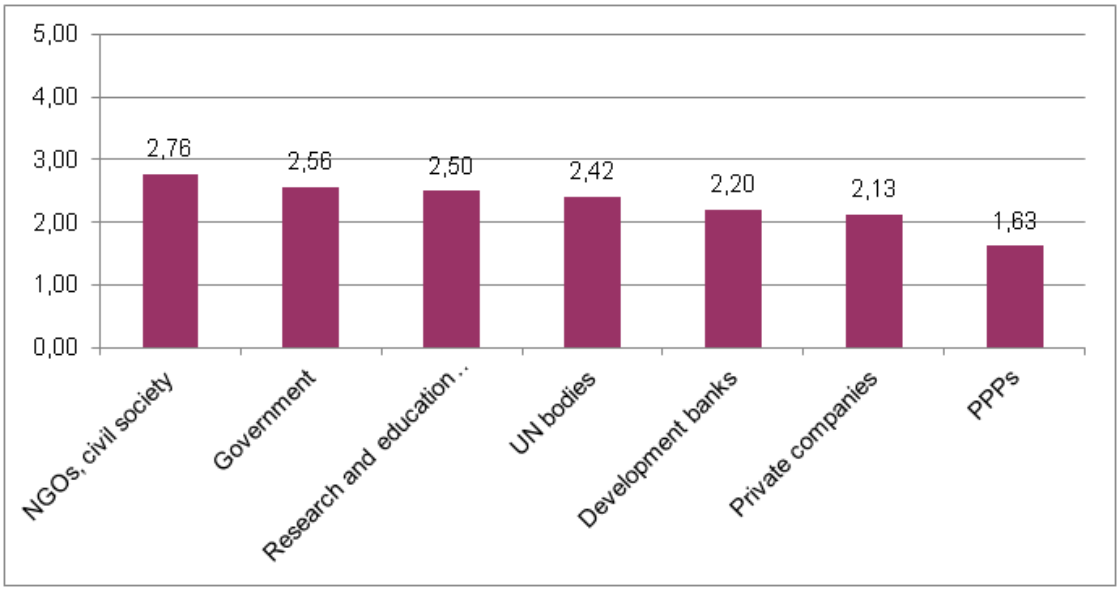
Figure 12: *Results of the survey to EUDs: Perception on public health care financing scheme resulting in additional health care consumption by households (in absolute figures - number of EUD respondents - and %)*



Source: EUD Survey, 2011, Particip GmbH

EUDs were generally of the view that EC aid channelled especially through NGOs and governments had increased the affordability of health care to the poor. This is also expressed in the total number of "good" responses for the first category, compared to the latter. However, in the qualitative comments EUDs recognised the essential role that governments play in providing health services. Increased affordability does not (witness the Philippines) invariably translate into increased consumption, but it often does.

Figure 13: Results of the survey to EUDs: Perception of the impact of EC support on affordability of health, per channel



Legend: 5 =Excellent, 4= Good, 3=Satisfactory, 2=Unsatisfactory, 1=Fully unsatisfactory

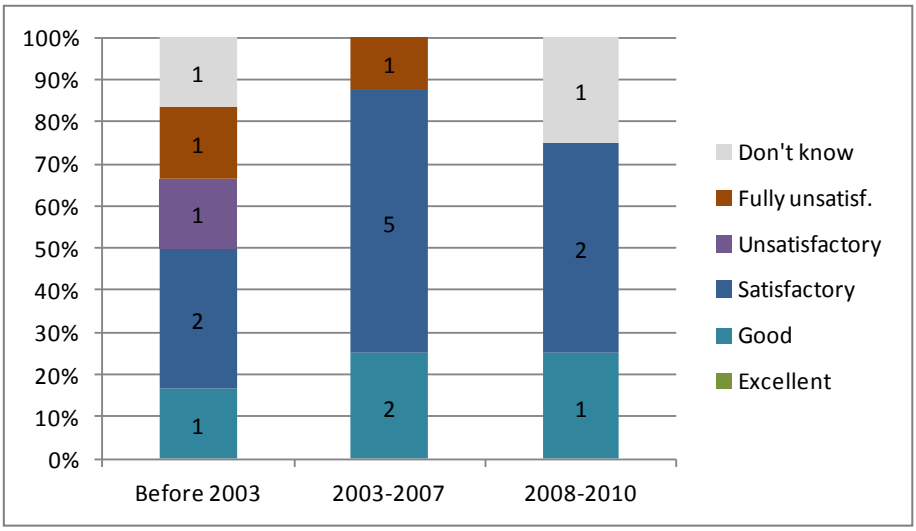
Source: EUD Survey, 2011, Particip GmbH

Channel	Excellent	Good	Satisfactory	Unsatisfactory	Fully unsatisfactory	Weighted Average
NGOs, civil society	0	7	8	3	0	**2,76**
Government	0	2	10	4	0	**2,56**
Research and education institutions	0	2	4	0	0	**2,50**
UN bodies	0	0	7	4	0	**2,42**
Development banks	0	2	3	2	1	**2,20**
Private companies	0	1	3	1	2	**2,13**
Public-Private-Partnerships	0	1	2	1	1	**1,63**

Source: EUD Survey, 2011, Particip GmbH

Another question investigated the EUD's perception of the impact of SPSPs (in whatever form) on affordability of health services. In 2003-2007 and 2008-2001, a clear majority of SPSPs were ranked "good" or "satisfactory, this pointing to the potential usefulness of this form of support.

Figure 14: Results of the survey to EUDs: Perception of effects of SPSPs on affordability of health



Basis:: 18 SPSPs

Source: EUD Survey, 2011, Particip GmbH

Unfortunately, the EUD survey only yielded a few answers relating the likely effect of GBS programmes on the affordability of health. However, at least for the period 2007 to 2010, three out of four EUDs felt that GBS in their country had had a positive impact on the affordability of health care services.

2.3 JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC

We assessed this Judgment Criterion based on two Indicators, EC support for TA and the provision of expertise in health care finance and EC support for enhanced communication and co-operation between Ministries of Health and Finance.

Regarding the first, evidence was found that, even in countries where health care finance was not a focus in the health sector, the EC supported TA did provide some expertise relevant to finance. For example, even in *Afghanistan*, where the focus was almost entirely on provision, the EC financed some studies (not TA strictly speaking) relevant to health care finance. In other countries, such as *Egypt*, the *Philippines*, *Lao PDR* and *Moldova*, TA on health care finance was a major contribution to health sector reform (source: country case studies). This is also corroborated by the findings from the EUD survey, where by far the majority of respondents identified TA along with capacity building as an EC contribution in the area of health care finance. The EUD Philippines reports greatly improved communications between MoH and MoF due to a united donor position, but while this has resulted in a larger budget for MoH, vertical communication remains poor and local budgets for health low.

Much less information was gathered on the specific question of whether EC support strengthened communication and co-ordination between the MoH and the MoF. Two countries where this impact was explicitly identified were *Zambia* and *South Africa*. For the *Philippines*, the EC supported better co-ordination in health finance generally, but especially given the complication decentralised context, this involved much more than simply improving communications between MoH and MoF. In general, the impression left by the country case studies and the interviews with EUDs and MoHs is that MoHs remain ineffective in their dialogue with MoFs, which is one reason why budgetary allocations for health remain weak in most countries.

2.3.1 I-231 EC supported technical assistance provides expertise on health care finance

Overall, there is broad evidence that the EC contributed significantly, through TA but also through capacity building, policy advice and policy dialogue (some of it via GBS) to improving health care finance policy. From the case studies, the following emerges:

- In *Egypt*, throughout the evaluation period but especially through HSPSP-I, the EC was a major provider of technical assistance in the area of health care finance reform, especially strengthening the Health Insurance Fund and integrating it (in pilot provinces) with a Family Health Fund meant to finance the provision of a Basic Benefit Package. There has been specific progress in reform,

although much still remained to be done at the end of the evaluation period. So in this country, the EC was a major source of TA on strengthening health care finance.

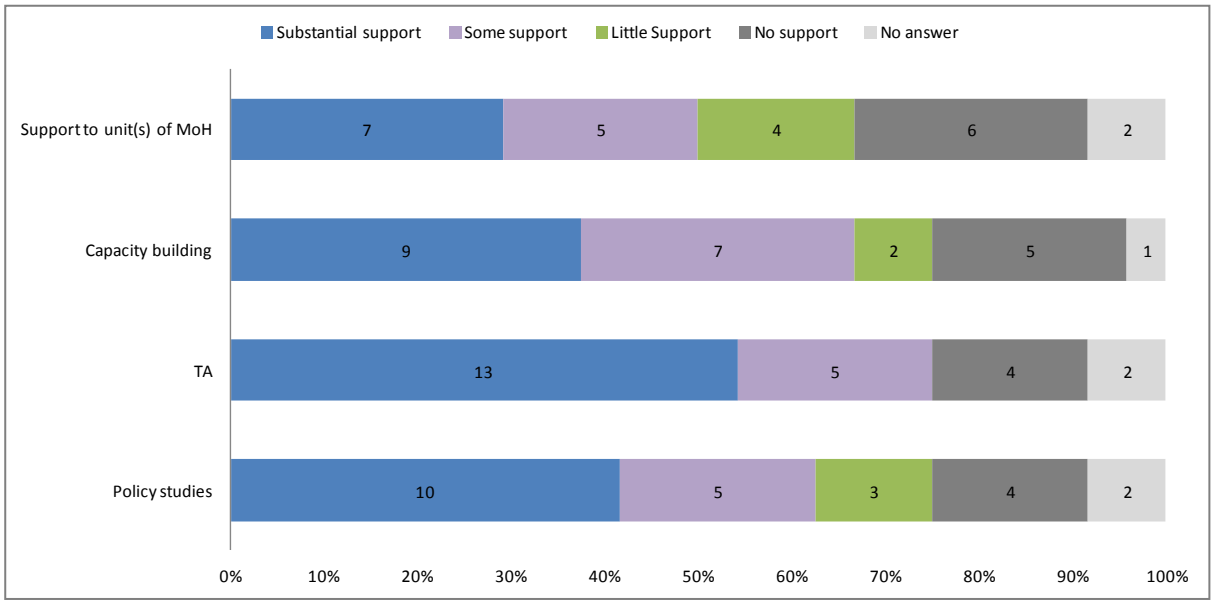
- While TA per se has not been identified as an EC contribution to the strengthening of the *Moldovan* compulsory public health insurance programme, the EC was generally supportive of the reform as well as regards compulsory health insurance.
- In *Lao PDR*, the EC provided technical advice on health care finance related to the piloting of approaches to health insurance, including community-based schemes. This also included TA to a Technical Working Group on health financing strategy which serves as the platform for policy dialogue between donors and Government. As for instance shown in the Lao CSE 2009, these EC efforts have contributed significantly to policy efforts to improve health care finance in this country. Moreover, health financing reform is an indicator in the second GBS for 2009, 2010 and 2011, thus emphasising the importance put on this aspect, overall.
- In the *Philippines*, the EC has been deeply involved, through SPSP to the FOURmula1 reform, in strengthening the PhilHealth insurance component and through a significant amount of TA to health care finance reform at all levels contributed to concrete impacts in the form of improved quality of provincial investment plans and annual action plans. However, according to the EUD, despite TA on health finance reform, progress at PhilHealth has been disappointing.
- So far, no evidence has been found to suggest that the major health insurance reform in *Ghana* was supported by EC TA, although it is possible that GBS conditionality and policy dialogue may have played a role. In *Afghanistan* the EC financed several policy studies, however, provision, not financing, was the main concern of the EC's support.

The EUD survey provides a complementary and relatively detailed picture of the perception of EUDs on their role related to health finance policies. Many EU Delegations cited TA, capacity building and policy support services; a number also identified EC support to health finance units operating within Ministries of Health. Taken as a whole, it is clear that, from EU Delegations' point of view, TA, capacity building and policy advice have been the most significant source of support to improved health care finance policies.

The following figure shows that between a third and half of the surveyed EUDs tend to believe that they provided substantial support to pro-poor health finance policies. However, there are some marked differences related to the areas that were supported most:

- TA is perceived as the main means, followed by policy studies;
- Systematic support to MoH units dealing with the issue occurs to have been the area with the least "substantial support".

Figure 15: Results of the survey to EUDs: Means used by EC to support pro-poor health finance policies



Source: EUD Survey, 2011, Particip GmbH

Looking more specifically at regional differences, the detailed picture regarding health finance emerging from the qualitative answers to the EUD survey is as indicated in the following box. What also emerges is the role of the use of NSAs highlighted by the EUDs as a means to initiate mechanisms of service delivery, or to finance public awareness campaigns which advocated for the poor and/or to conduct preliminary studies relating the preparation of the financing system. The NSA/LA project budget line was cited in all regions.

Box 19: Results of the survey to EUDs: Perceptions of EUDs related to EC support to health care finance policies

ACP region	The EUDs of *Barbados*, *DRC*, *Mozambique*, *South Africa* and *Zimbabwe* have reported the use of policy studies and technical assistance to support pro-poor health finance policies; Capacity building was cited by three EUDs of this group (Barbados, Mozambique and DRC) and only one (Mozambique) reported to have also provided support to the units in the MoH dealing with health finance. While in DRC, the EUD reported that technical assistance was successfully used, both in the long and short term and at central and decentralized levels. The EUD in Mozambique, however, was less satisfied and reported "low quality or motivation of TA" and "lack of capacity of EC Delegation for supervision" which led to "wasted opportunities to improve provincial and central projects".
Asia	Reports from seven EUDs indicated that technical assistance was the most used form of support for pro-poor policies, followed by capacity building and support the units of the MoH dealing with health finance. Policy studies were less reported than in the ACP region. A more detailed look at country level shows that the EUDs who reported the use of policy studies were in *Afghanistan*, *Myanmar*, *India* and *Timor-Leste*. Technical assistance was provided in all of the seven Asian countries, mainly to support the development of Health Care Financing Strategies. The main objectives of capacity building were to upgrade the financial skills of the staff from the MoH at central and decentralized level and to train them on technical aspects of setting up social protection schemes. The EUDs *Timor-Leste* and *Myanmar* indicated that NSA/LA funded reconstruction projects for health facilities and also projects to initiate service delivery to remote areas and to disease specific groups. According to them, donors, including the EC, initially financed the costs of setting up most basic primary care in under-served remote areas (often with large ethnic minority populations) which included pro-poor and exemption mechanisms, including for vertical services such as TB, HIV and malaria). The NSA/LA instrument was used to initiate mechanisms of service delivery, hoping that MoH would pick up the initiative and financing the services.
ENPI-MEDA-TACIS region	Four EUDs from this region (out of five from the sample of 25 - *Moldova*, *Yemen*, *Syria* and *Morocco*) reported the use of capacity building to support pro-poor health finance policies. The EUD Egypt reported using only policy studies like the 'Primary Health Care Provider Network Review of the National Strategy'. The EUD Yemen declared using specific capacity building measures only in the area of reproductive health. The EUD Moldova reported that the four TACIS projects have an important capacity building component and also declared to have used technical assistance for developing the legal framework for implementing the mandatory health insurance system. Syria and Morocco reported to use the four means simultaneously. EUDs *Moldova* and *Syria* also reported the use of the NSA/LA instrument to finance public awareness campaigns which advocated for the poor (in Moldova) and/or to conduct preliminary studies relating the preparation of the financing system.
Latin America	EUD *Ecuador* reported using the four means to an equal degree. For instance, the EC collaborated with consultancies to support actuarial and financial studies of health services. The EC also provided some support to units of the MoH on the above mentioned "actuarial and financial studies of the health services".

Source: EUD survey

Lastly, EUDs from the Asia and ACP regions also clearly indicated general budget support as a useful instrument that had encouraged pro-poor health finance policies. In particular, the EUD to *Lao PDR* and the EUD *Burkina Faso* indicated the use of a variable tranche based on the allocation of resources to health, such as the overall health budget as proportion of the recurrent budget and the number of health staff in 47 of the poorest remote districts in Lao or impact measures such as the MDG performance tranche in Burkina Faso (see also EQ7).

2.3.2 I-232 EC supports enhanced communication, co-operation between MoH and MoF with regard to health finance

Very little evidence was found relating to this indicator. In GBS countries, such as *Ghana*, *Burkina Faso* and *Lao PDR*, it is known that GBS promoted improved policy dialogue but no specific information on communication between the MoH and the MoF was found (see CSEs and, for Ghana, the Evaluation of the MDBS). Only in the country case study of *Zambia* was there concrete evidence that GBS promoted better co-ordination between MoF and social sector ministries related to budgetary allocations. EC monitoring documents for that country report better co-ordination and communication between ministries as a positive outcome of GBS, as does the 2011 evaluation of GBS in *Zambia*. Better communication between MoH and MoF was also cited as a positive outcome of the Partnership for Delivery of Primary Health care project (PDPHC) in *South Africa*. In the *Philippines*, the EC supported TA, as well as a united donor position, contributed to improving communication between different layers of the health financing establishment and, in particular, contributed to strengthening the commitment of provincial decision makers to adequately finance health. Enhanced communication between MoH and MoF led to increased budgetary allocations to MoH, but the crucial variable is local budget allocations to health, which remain low. In *Vietnam*, as found in the 2009 CSE (Volume 2, p. 34), MoH does not engage on an equal basis with MoF and provincial governments and in promoting compulsory health insurance subsidised for the poor, there are no lines of communications between the MoH, the MoF and Vietnam Social Security.

2.4 JC 24 Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC

The EC's policy relating to research and development on global health issues is set out in the 2010 Commission Staff Working Document "European Research and Knowledge for Global Health"[12].

We approached this JC based on two indicators, the first focusing on dialogue with the pharmaceutical industry and the second more generally on promoting North-South partnerships. The documentary review yield little information on the first indicator, apart from DG Research contributions to, e.g. influenza research and pandemic preparedness (notably, contribution to the development of adjuvants which substantially increased global vaccine capacity). However, in the Working Document referenced above, it is described how the EC has participated in the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property Rights and coordinated with major funders of health research at the global level, all with a view to promoting access to pharmaceuticals and promoting research of relevance to developing countries.

Regarding the second indicator, our thematic case study on EC financing of global public goods for health has uncovered evidence of a broad and significant engagement, from framework research programmes to direct finance of initiatives related to immunisation, vaccine development, to pandemic preparedness. Impact in science is typically long-term and unpredictable, but we can safely say that without EC support, there would be much less global research promoting access to drugs and treatments related to malaria, tuberculosis, polio and the major infectious diseases. It is universally accepted that health R&D in all forms, as well as infectious disease surveillance and control, are public goods which require collective action in order to ensure adequate supply. In the case of GAVI, a concrete estimate can be made of the EC's contribution to the vaccination of an estimated 326 million persons in 2000-2010. The EC was also a major supporter of the Global Polio Eradication Initiative. As a supranational organisation, the EC is less susceptible to the free-riding incentive which gives rise to the public good problem. In addition, this is an area in which tangible benefits to European citizens, in the form of the reduction of global infectious disease risks, can be easily established. Much development co-operation is based on altruism, but in the case of public goods for health, self-interest is a significant factor, as well.

2.4.1 I-241 Evidence of EU supported dialogue between major stakeholders and pharmaceutical industry to encourage R&D targeted at diseases of poor countries

In our thematic case study on EC support for the provision of global public goods for health, we have found no evidence so far of EC support to dialogue with the pharmaceutical industry While the EC participates actively in areas such as vaccine development (see next Indicator), no specific support for dialogue on development of pharmaceuticals for poor countries has been found. However, as described in the Staff Working Document referenced above, the EC actively participates in international initiatives to promote pharmaceutical availability in poor countries. Broadening the indicator beyond the pharmaceutical industry,

[12] http://ec.europa.eu/development/icenter/repository/SEC2010_381_EN.pdf

the EC's research Framework programmes have supported Specific International Co-operation Actions (SICAs) in Third Countries, research on international public health and health systems (including INCO partnership with developing-country research institutions) and projects on HIV/AIDS, malaria, tuberculosis and neglected infectious diseases. European and Developing Countries Clinical Trials Partnerships (EDCTPs) provided innovative financing to speed pharmaceutical development. One area where direct dialogue with the pharmaceutical industry can be found is the Innovative Medicines Initiative established in partnership with the European Federation of Pharmaceutical Industries and Associations (EFPIA), which aims to bring together the broad range of stakeholders to accelerate drug development.

A specific area of interest is pandemic influenza. According to the Outcome and Impact Assessment of the Global Response to the Avian Influenza Crisis, Final Report (August 2010), the EC has invested more than € 100 million since 2001 on various influenza research projects covering vaccine development (including adjuvants), diagnostic tests, basic science and social / legal issues. The EC's contribution to development of adjuvants substantially increased global vaccine capacity and pandemic preparedness.

2.4.2 I-242 North-South medical and public health research partnerships supported by EU to produce new medicines and treatments

In the Commission Staff Working Paper referenced above, the EC set forth the global public good argument for health research, described how it is participating in international networks for dialogue and agenda setting (particularly with WHO and affiliated groups) The EC has supported a number of global partnerships which emphasise North-South co-operation. Some of these have already been described in the last Indicator and that discussion will not be repeated here. In addition, through the Development Co-operation Instrument and in part from the intra-ACP envelope of the European Development Fund, the EC provided just over 1% of the direct funding received by the Global Alliance for Vaccines and Immunisation (GAVI). Most of this money was spent on development of new vaccines and encouraging the use of under-utilised ones. The estimate is that between 2000 and 2010, GAVI supported an additional 326 million vaccinations and averted 5 million deaths. The EC has been the sixth-largest supported of the Global Polio Eradication Initiative, which essentially finances vaccination campaigns as well as health system strengthening. It also supported polio immunisation programmes in a number of countries where the disease has resurged or crossed the border from neighbouring countries through its bilateral aid programme. Examples include Ethiopia and Nigeria. The EC has been a major supporter of research and development related to TB (especially multi-drug resistant TB) and was estimated to be the sixth largest provider of support in 2010. The EC is comprised of several research funding programs, such as the EC's Sixth and Seventh Framework Program, the Directorate-General's Research and Innovation division and the European Research Council (ERC). Finally, not directly related to new medicines but extremely important from a global public health point of view, the EC has been the lead agency in marshalling support for the World Bank's Avian and Human Influenza Facility, which seeks to strengthen pandemic preparedness world-wide. Through its Framework research programmes, the EC has also been a major financer of research, including research into influenza vaccines.

3 EQ3: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?

3.1 JC 31 Increase in availability of primary health care facilities

The JC of increase in the availability of primary health care facilities was assessed based on two Indicators: change in number of primary care facilities per 10,000 population and change in the proportion of rural population living in a radius of 1 hour of a primary health care facility. The statistical data were not always readily available especially for the latter of the two.

In general, access to primary care is not equitable within most countries and for many years rural populations were typically the most disadvantaged. It was found in the country case studies that primary health care has been emphasised strongly in the EC direct support to the health sector in the 2002-10 period, compared to secondary health care and that in many cases the EC support was preferably targeted to rural or poorer segments of population. Within the primary/basis health care sector, approximately 12% (€ 360 million) went to infrastructure projects. There is evidence that this has translated into improved access to health care facilities and in many cases disproportionately more so for poorer and disadvantaged populations. Examples can be seen e.g. in *Afghanistan*, *Timor Leste* or *Ecuador*. However, it is important to note that the EC support to primary care facilities has not necessarily resulted in a positive change of the indicator (health facility per capita). This is because effort has also been given to the reconstruction of existing facilities, which is often necessary in post-conflict countries or fragile states, such as for example in the *DRC*. Moreover, even an increase in new health units can be offset by loss of existing ones or rapid population growth over the same period and the indicator remains unchanged or even deteriorates, such as in the *Philippines* or *Burkina Faso*. In some countries, e.g. *Egypt* or *Moldova,* the physical availability of health facilities is not an issue, as sufficient numbers of health facilities exists and contributions to primary care focus on quality and affordability of care, which would not have any impact on the indicators under this JC.

Another aspect of the availability of primary care is the functionality of the health facilities, in its physical dimension described by appropriate equipment and budget for maintenance. While not specifically impacting on the trend in the indicators, there is evidence from the country case studies and the MoH survey that the discrepancy between rural and urban areas in this respect is even larger and might be growing. This underlines the challenge of sustainability of EC interventions aimed at increased primary care availability noted also by some of the EUDs.

Time trend data on the "population within one hour of a primary care facility" were difficult to obtain. It can be noted that while one way of addressing the spatial availability of health care is to contribute to expanding the number of health care units and their equipment in underserved areas (first indicator), this indicator can also be tackled by investments in other types of infrastructure, such as roads improvements or provision of transport options in remote areas. In *DRC*, where distance to health facility was a problem in accessing health especially in rural areas, good improvements in access to facilities were made through the investments in road infrastructure, in the framework of the Support Program for Rehabilitation (PAR II) implemented between 2003 and 2007. It is thus likely that the EC intervention has contributed to reducing the time needed by the rural population to access health care facilities.

It is remarkable that a basic indicator like *"availability of primary health facilities"* is so difficult to obtain from most countries. And if data are available, they are typically aggregate data, which may mean that the emphasis the EC put on increasing availability of primary care in the areas where the EC works, is not fully reflected in national data.

Overall country case studies, EUD survey and MoH survey indicate that the EC support to primary health care contributed moderately to increasing physical availability of care in many countries and often more so for rural and disadvantaged populations. However, sustainability of the interventions, together with lasting inequities between rural and urban populations, remains a challenge. While it is understandable that the EC has focused on access in underserved rural areas, one consequence is that there has been little account taken of urbanisation. Projects and interventions focusing on urban health were largely absent.

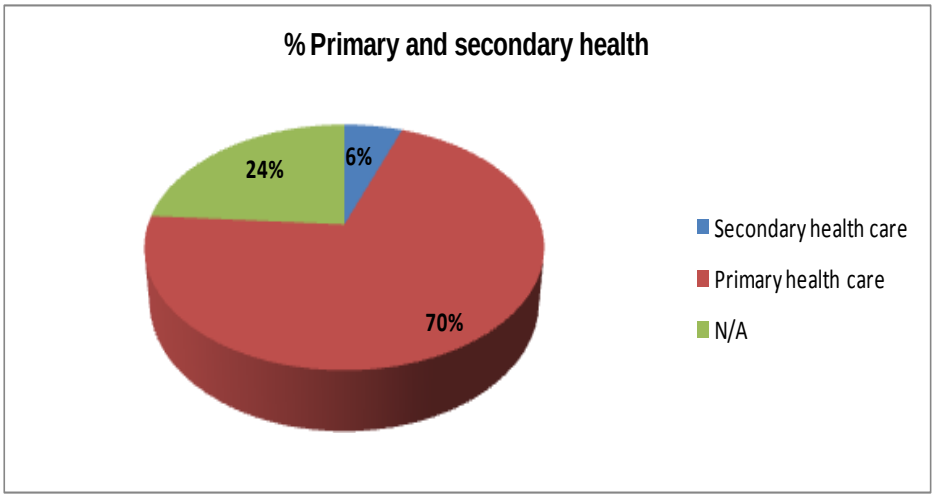
3.1.1 I-311 Change in number of primary care facilities per 10,000 population (towards >1 per 10,000 population); disaggregated by rural/urban and income level, where feasible

The number of primary health care facilities per 10,000 population is one of the WHO indicators of availability coverage and primarily an indicator of outpatient service access.[13] The distribution of public primary care facilities among rural and urban health districts is a measure of equity in access, as rural areas are often inhabited by poorer segments of population and access to health care is frequently made more difficult due to geographical remoteness. While there is no universal benchmark as to what the ideal availability ratio should be, less than 1 primary health care facility per 10,000 population can be considered unsatisfactory and developing countries generally strive to increase the network of primary health care facilities. Such increases in absolute numbers of facilities over time can then be offset by rapid increases in population size over the same period, resulting in stagnation or even worsening of the availability ratio. On the other hand, decrease in the indicator does not necessarily have to signify deterioration of primary care coverage – in countries undergoing a transformation of the health care system such decrease can mean a rationalisation of the network of health units. In some cases, e.g. in post-conflict situations, the information on facilities available should be also complemented by the information on the percentage of facilities that are fully functional and equipped to present a complete picture of primary care availability. This is relevant for example in the *DRC* where the EC programme focussed on health care facility rehabilitation and thus contributed to the increased use of existing primary health infrastructure, or for *Ecuador*, where one component of the post-earthquake reconstruction programme helped remodel existing health infrastructure.

There are no aggregate statistics available for this indicator covering all countries published by WHO or similar organisation. Individual countries' data are often available from the national MoHs or other reports in varying degree of disaggregation and of the depth in time dimension allowing for trend observation.

The EC direct support to the health sector in the 2002-10 period strongly emphasised support to primary health care, compared to secondary health care or unspecific interventions, with 70% of the financial volumes were aimed at this purpose, delivered via projects and various forms of SPSPs.

Figure 16: Direct EC support to the health sector: Breakdown of direct support by primary health and secondary health care, 2002-2010



N/A represents interventions which main focus is not health care but policy, administration, etc.

Source: Particip Inventory

Within the primary/basis health care sector, approximately 12% (€ 360 million) went to infrastructure projects.

[13] http://www.who.int/healthinfo/systems/SARA_ServiceAvailabilityIndicators.pdf

Table 15: Direct EC support to the health sector: Breakdown of the subsector 'primary health care', 2002-2010

Sector/Subsectors	Contracted amount (€)
Subsector Basic health	**3,009,926,722**
3PRDs[14]:: Malaria/TB/HIV/AIDS s	1,248,213,070
Administrative, Evaluation, Audits, TA	29,029,768
Basic health care	870,623,697
Basic nutrition	138,458,935
Essential drugs	33,528,663
Infectious disease control (IDCs)	329,390,094
Infrastructure	**360,682,494**
Subsector Health, general	887,635,832
Sexual and reproductive health	220,577,758
Total EC support to health	**4,118,140,312,58**

Source: CRIS database, Particip analysis

As the EUD survey suggests, the disadvantages of rural compared to urban areas in the availability of primary health care are fairly widespread. However, over the evaluation period this disparity has somewhat decreased – while the EUDs viewed the availability of primary care facilities as at least satisfactory level in rural areas at only 17% at the beginning of the period and 54 % at the end, for urban areas the same numbers were 46% and 71% respectively. In many cases the better progress of rural areas has been attributed to the EC support targeting the poorer and remote areas with preference. This finding is also supported by the experience of individual countries, in which the Delegations noted increased access to primary care in rural or high-poverty areas over the evaluation period, to which the EC has contributed. The most remarkable improvement in this regard was reported by EUD *Timor-Leste* that shifted two levels of the scale from "unsatisfactory" to "good" for rural areas, where the EUD also concluded that this improvement was made thanks to the EC contribution to reconstructing at least six health centres and supporting the mobile services. In *Afghanistan*, the EC contributed substantially to primary care coverage in remote areas and underserved provinces; in *Ecuador* the EC support in health access focused solely on four provinces with large indigenous populations; poor areas were also targeted in *Ghana* and the *Philippines*. This trend is also illustrated in the country specific examples in the box below.

The remaining but decreasing disparity between rural and urban areas has also shown in the MoH survey answers, where all the MoH representatives who responded to the survey assessed the availability of primary health care as unsatisfactory in 2002, with the exception of *Syria* (assessed as good). This compared to only two countries with unsatisfactory availability of primary health care in urban areas in 2002 (*Egypt* and *Afghanistan*). By the end of the evaluation period, access to primary health care in both rural and urban areas, as viewed by the MoHs, improved in most countries (*Lao, Egypt, Afghanistan, Moldova, Burkina Faso and Morocco*). The highest degree of improvement was reported from *Afghanistan* and *Egypt* in both rural and urban areas – from unsatisfactory to good. *Yemen* remains an exception, with access to primary health care remaining unsatisfactory in rural areas (satisfactory in urban). The *Syria* MoH assessed the access to primary health care as good throughout the evaluation period (both rural and urban), while at the same time noting that renovation and equipping of some PHC centres were financed by EC.

On the other hand the situation in appropriate equipment and budget for maintenance and expenditure in primary care remains quite problematic (see JC12 for more detailed discussion). According to the EUD survey a clear disparity between rural and urban areas in facilities with appropriate equipment is shown. While the ratio of countries where conditions in rural areas were considered at least satisfactory grew from 14 to 29% over the period, the same increase was 25 to 50% in urban areas. The discrepancy between the physical availability of primary care centres and their actual appropriate equipment and maintenance budget also underline the challenge of sustainability of EC interventions aimed at increased primary care availability noted by the EUDs both in the survey and in the EAMRs.

[14] This category includes support to the three poverty related diseases Malaria, TB and HIV/AIDS, either interventions that targets these three diseases together, e.g. support to the GFATM or support to one specific of the three diseases.

Box 20 Availability of primary care health facilities: Main findings from the country case studies and the EUD and MoH surveys

ACP

In *Burkina Faso,* the ratio of population to primary care facilities has remained stable, as the increase in the number of primary care health facilities has been matched by population growth. The role of health in the EC's GBS policy matrix and the fact that allocations to the social sectors have increased have probably contributed to the improvement in provision of health services, but no direct evidence has been found. However, the MoH survey reports an improvement in the situation of primary health care availability, with the number of inhabitants per one health centre decreasing from 14.000 to about 9.800 between 2002 and 2010. The MoH also attributes some of the improvement to the GBS provided by the EC in upgrading the health infrastructure.

In *DRC,* the EC interventions supported the rehabilitation of many primary health care infrastructure facilities (121 rehabilitated health care infrastructures (health centres, maternity centres and centres for the treatment of cholera) under LLRD programme and 41 health centres in the framework of PS9FED), which directly contributed to increasing the number of functioning primary care facilities. The EUD also noted the improvement in availability of primary health care for rural populations over the evaluation period.

The disaggregated data from *Ghana* on the availability of health facilities per capita show that with exemption of Upper West and Upper East the situation worsened in all regions between 2004 and 2007. According to the Ghana CSE (2005), in the early 2000s, the EC showed good performance in increasing access to and utilisation of basic health services by the rural and deprived population. Thus, EC seems to have contributed to an increase in primary health care facilities to some extent; however it is very difficult to measure the contribution.

For *Mali*, the Budget Support evaluation[15] reported that between 2002 and 2009, most indicators of health sector results showed significant progress. The GBS and SBS health have helped fund the expansion of infrastructure and the GBS contributed to financing of health personnel, which are both highly correlated with the achievement of results.

No time trend data have been found for *South Africa* on the indicator in question. The EC investment has been mainly targeted towards accessing quality services as opposed to the traditional support to rehabilitation. The only EC contribution to better geographical access to health services has been based on supporting the concept of home based care, i.e. bringing services to the people and communities and to strengthening the District Health System. The home based care concept is implemented through the Partnership for Health, which had a major role in planning of the rehabilitation of health services but did not finance capital projects, construction and provision of equipment to health infrastructure. All provinces of South Africa have been supported and no data are available specifically on rural population.

In *Zambia*, the EUD reported improvements in availability of primary care facilities in rural areas over the evaluation period. However, a major shortfall of recommended number of Health Posts to deliver the Basic Health Package continues to exist. No evidence relevant to EC contribution related to this Indicator has been found.

Asia

Afghanistan has seen a dramatic increase in primary health care facilities since 2002, including the provinces that receive EC support. The MoH HMIS office reported in 2009 around 1,500 primary care facilities in all of Afghanistan, which would amount to about 1 for every 17,000 population and a much better spread over the various regions, including the areas supported by the EC. The roll out of facilities was primarily targeted at previously underserved areas all over Afghanistan, mostly poor, rural areas. The EC has contributed to this substantial expansion of primary care facilities in the 10 provinces and has had a significant positive impact on the geographic proximity to care, although remote and mountainous regions remain a challenge. The role of the EC support in the increased access to primary health care in 10 provinces was also confirmed by the MoH survey.

In *Bangladesh,* the health care system is highly fragmented with a high degree of vertical organisation. While Bangladesh will work towards a more integrated 'Upazila health service', where

[15] ECO Consult (2011): Evaluation conjointe des opérations d'aide budgétaire au Mali de 2003 a 2009.

the various services will get a place within primary care facilities, the current system is still highly verticalised, not only in terms of the 'classical' vertical programmes, such as TB Control, Malaria, EPI or Vitamin A distribution, but also in its overall management structures, through the various Directorates. The HNPSP programme's implementation review of 2010 reported significant progress of community clinic construction and renovation in the framework of the programme.

No time trend data have been found for *Lao PDR* on the indicator in documents consulted. The state system remains underutilized, especially in the peripheral areas. Availability of facilities and trained personnel does not appear to be a major constraint at the national level, but facilities, equipment and staff are very unevenly distributed, resulting in continuing problems of access in rural and especially remote rural areas. The EC provided two primary health facilities, but the problem in Lao PDR seems to be not so much the number of facilities, but their underutilisation, worst at the hospital level, but affecting the primary level, as well. No evidence on further EC contributions could be found in the EC GBS documents.

There has been stagnation in the availability of health facilities per capita in the *Philippines*. At the primary level, the number of Barangay Health Stations per 10,000 population has declined over the last decade. The EC is supporting rural health units by increasing the number of accredited rural health units for out-patient benefits, Emergency Obstetric and Neonatal Care and Tuberculosis – Direct Observed Treatment Strategy. So far, according to the CSE Philippines, progress was slow. Furthermore, health improvement for the Internally Displaced People of Mindanao project's accomplishments helped establish some basic facilities in 18 provinces. In summary, the EC has provided direct support to increasing the number of primary health care facilities. However, loss of existing centres and population growth has prevented this from translating into an increased number of primary health care facilities per capita. Remoteness is the major issue in the Philippines and infrastructure is currently under an intense process of rationalisation in order to balance the needs with availability and the quality of infrastructure.

ENP

The constitution in *Egypt* assures access to health services to all. This includes the goal of guaranteeing universal access to primary health care for the entire population. In 2009, there were 0.7 primary health care units and centres per 10,000 population. No time-series data are available. EC support has provided primary health clinics, equipped them and supported policy reforms to improve their effectiveness and make them more affordable for the poor.

The number of primary health care units per capita in *Moldova* actually decreased over the evaluation period. Given the dense health network that existed in Moldova, a decrease in the number of primary facilities per capita is not necessarily a negative sign; this may represent rationalisation. Geographical access to a health care facility at the appropriate level is not a problem in the country and the regional distribution of hospitals is even. None of the assessed EC supported projects contributed directly to geographical access to care.

Latin America

For *Ecuador*, it is difficult to meaningfully estimate this Indicator due to the great fragmentation of the health system. The EC support to health contributed to the increased availability of primary health care facilities in the four provinces where it was implemented by building and improvement of physical infrastructure, provision of drugs, equipment and health workers training. The provinces of EC intervention were all with high proportion of indigenous populations. The EUD noted the prioritisation of the health sector by the national government as one of the main factors for better availability of primary health care over the evaluation period. In addition, a minor component of the post-earthquakes reconstruction programme PROARES contributed to remodelling of seven health units and one health centre and according to the programme's final evaluation[16], it considerably improved the condition of existing infrastructure.

The EUD in *El Salvador* rated the availability of primary health care in rural areas as fully unsatisfactory, while at the same time indicating that the EC had no projects in the health sector to improve it. The two GBS programmes in El Salvador also did not contain indicators aimed at the access to primary care or physical care facilities improvements.

[16] Cited in Ecuador CSE 2010, Vol 2, p. 166 (Annex 9)

Related to the issue of inequitable access to primary health care is also the conclusion of the evaluation of EC support to decentralisation processes[17], which found that support to decentralisation can have some impact on access to services by expanding the availability of small-scale infrastructures frequently planned and delivered by local governments (e.g. local clinics). However, improving overall quality of service provision appears to be a far more complex task.

Overall, there is evidence that the EC support to primary health care has in many cases been translated into contribution to improved access to health care facilities and in many cases disproportionately more so for poorer and disadvantaged populations. However, this is not always necessarily reflected in the improvement of the indicator of facility per capita – for instance in countries where the loss of existing centres and/or population growth offset the gains, such as in the *Philippines, India* or *Burkina Faso*. EC support to primary health care provision did not always mean just support to expanding the number of units – attention has also been paid to the rehabilitation of existing units (especially in post-conflict countries), or extending accreditation. Provision of appropriate medical equipment to increase the functionality of existing units has also increased the access to adequate health care, even though the gap between rural and urban areas in facilities with sufficient equipment and budget for maintenance and expenditure seems to be growing nevertheless.

3.1.2 I-312 Change in the proportion of rural population living in a radius of 1 hour of a primary health care facility

Service delivery access refers to the ability of a population to reach appropriate health services. As various factors can hinder the access to a health facility, including the presence of geographical and transportation barriers, for developing countries, the radius of access is often given in time rather than distance units. The physical accessibility by itself of course does not ensure effective coverage of the population in question with health care, as further factors may prevent certain segments of the population from actually receiving the health intervention needed, such as lack of financial resources or cultural barriers. While one way of addressing the spatial availability of health care is to contribute to expanding the number of health care units and their equipment in underserved areas (see also the Indicator I-311 above), access can also be tackled by investments in other types of infrastructure, such as roads improvements or provision of transport options in remote areas.

The data on this indicator is often not readily available and time trends are even more difficult to obtain. Generally, it is the case that people living in rural and remote areas are more likely to live prohibitively far from a health care facility.

Some data were provided by the MoHs in the survey with the responding seven ministries generally hinting to an increase in the proportion of population living within a radius of 1 hour from a primary care facility in some countries (*Syria, Lao, Egypt and Afghanistan*). Out of these, *Afghanistan*, *Burkina Faso* and *Morocco* attribute some improvements to the EC support and Afghanistan reported the largest improvement (from less than 20% to 50-70% of population). Other countries do not report improvements in this indicator over the evaluation period – namely *Yemen* (remaining under 20%), *Moldova* (more than 90% already at the beginning of the evaluation period) and *Morocco* (deterioration from 20-50% to less than 20% of population).

There are cases with solid evidence of successful development in this area, to which the EC contributed. In *Afghanistan* a survey showed that nearby access to primary care facility in 2006 was achieved for 65% of population, compared to 9% in 2000. The EC has contributed to this substantial increase of access in 10 provinces through contracts with NGOs, which included the obligation to expand the number of health care facilities in their area of operation. In *DRC*, where distance to health facility was a problem in accessing health care for 40% of women in 2007 and this proportion was much higher in rural areas, good improvements in access to facilities were made through the investments in road infrastructure. The EC supported the rehabilitation of roads infrastructures in the *DRC*, both in urban and rural areas, to facilitate productive activities and contribute to meet the basic needs of populations. It is thus likely that the EC intervention has contributed to reducing the time needed by the rural population to access health care facilities. Similarly, the country strategy evaluation in *Tanzania*[18] concluded that the access of the rural population to health services had been improved thanks to EC support. In three typical cases travel time to health centres has been reduced from 10 hours to 3 hours and the cost of journeys has been reduced by

[17] Particip (2012): Thematic global evaluation of the European Commission support to decentralisation processes, 2012
[18] Eureval (2006): Country Strategy Evaluation Tanzania, 2006, Vol1, p. 47

40%. Access to villages by health workers has also increased, owing to both road improvements and provision of bicycles.

In some countries, mostly the countries of the ENP region covered by the case studies – *Egypt* and *Moldova*, geographic proximity to health units is not an issue for most of the population, as physical health facilities are available in sufficient number and is not being addressed in health support. However, as other data show, the actual utilisation of the system is not equitable across income groups, governorates and gender (*Egypt*), or the quality of equipment differs between rural and urban areas (*Moldova*).

Many other countries have documented problems of populations in accessing primary care due to geographical distance (or related lack of financial resources for transportation) but aggregate country data are not available on this particular indicator or for its time trends and no findings have been documented as to potential EC contribution in alleviating the problem. The EC was in many cases addressing underserved areas with priority, as discussed in I-311 above and it could be expected that such interventions would have positive impact on this indicator as well, even if not substantiated by quantitative data. This could be the case for e.g. *Ecuador*, the *Philippines*, *Ghana* or *South Africa*.

Overall, while statistics on this particular indicator were not available for sufficient number of countries, some particular examples of EC contribution can be found (*Afghanistan, DRC*) and inference can also be made on contribution by examples of support to primary care access in underserved areas (Indicator 311 above).

3.2 JC 32 Increase in availability of secondary health care facilities

The JC of increase in the availability of secondary health care facilities was assessed based on three Indicators: change in number of hospital beds per 10,000 population, change in the proportion of population living in a radius of 2 hour of a secondary health care facility and increased number of Caesarean sections in total deliveries. The statistical data were not always readily available especially for the latter two indicators.

As discussed in JC31 above, the direct EC support to health care strongly prioritised primary care over secondary care and this is also reflected in much less evidence found of the EC contribution to the indicators in this JC.

Some examples of the EC contribution have been found nevertheless in the country cases. In the *DRC*, the EC 9th EDF health programme (PS9EDF) supported hospitals rehabilitation, which directly contributed to increasing the number of functioning secondary care facilities. It has been reported that hospitalisation rates have increased and rates of intra-hospital mortality as well as postoperative infections decreased during the programme implementation. Some countries experienced a decrease in the number of hospital beds per capita over the evaluation period, e.g. *Moldova*, *Egypt*, but it seems that quality of care or equitable access is of more concern in these countries. (I-321)

Corresponding to the trends in primary care access, secondary health facilities are less available to rural populations and while the gap between rural and urban service delivery might have become narrower according to the EUD survey, unsatisfactory scores made by EUDs were still quite high in 2010. Again, availability of appropriate equipment and adequate maintenance budgets remains an issue for secondary care units and more so for those in rural areas. (I-322)

With regards to the number of Caesarean sections, some countries have already achieved or even surpassed the levels of international clinical good practice, which may be set at 15% – e.g. *Ecuador* 26% in 2011, *Egypt* 28% in 2008, *South Africa* 20%. The contribution of the EC to increasing number of Caesarean sections has been difficult to find evidence for, partly due to the lack of time trends on the indicator and partly due to the fact that there were no interventions found that aimed at improving this particular indicator specifically. However, it is likely that some improvements might have occurred indirectly, through general support to maternal health and general quality of care. This could be the case for example in *Bangladesh* or *Afghanistan*, which both have had programmes with components on maternal health supported by the EC. Also in *Egypt*, which has seen the proportion of Caesarean deliveries rise from 7% in 1995 to 28% in 2008, the EC supported programmes to increase the use of health facilities and to reduce out-of-pocket payments, which could have contributed to increased access to obstetric care. (I-321)

Overall, only little direct evidence has been found of the EC support towards alleviating the problem of insufficient or inequitable availability of physical secondary care facilities, as most of the EC contributions favoured primary care access.

3.2.1 I-321 Change in number of hospital beds per 10,000 population (to >10 per 10,000 population)

The number of hospital beds for 10,000 population is an indicator that serves as proxy for the availability of secondary health service delivery. The indicator usually includes inpatient beds available in public, private, general and specialised hospitals and rehabilitation centres. A greater number of hospital beds suggests

greater availability of inpatient health services. However, some countries have witnessed a downward trend in hospital beds per capita as outpatient care increases.

The following table shows the sketchy data available regarding the number of hospital beds. Huge discrepancies continue to exist, especially between most ACP and ENP countries and, for sure, between fragile states and non-fragile states.

Table 16: Desk study countries: Hospital beds (per 1,000 people), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados		7.30	7.30	6.70	6.60		7.60		
Burkina Faso					0.90				
Congo, Dem. Rep.				1.10	0.80				
Ghana				0.90				0.93	
Mozambique					0.80	0.80			
Nigeria			0.53						
South Africa				2.84					
Timor-Leste									
Zambia			2.00				1.90		
Zimbabwe					3.00				
Tanzania					1.10				
Asia									
Afghanistan		0.40				0.42	0.42	0.40	
Bangladesh	0.34			0.40					
India	0.69	0.90		0.90					
Lao PDR	0.90			1.20					
Myanmar	0.63				0.60				
Philippines	0.50				0.50				
Yemen, Rep.				0.60	0.70	0.70	0.70	0.70	
Vietnam	1.40		2.80	2.60	2.66		2.87		
ENP									
Egypt, Arab Rep.		2.20		2.20	2.10	2.08		1.70	
Moldova		6.70		6.40	6.30	6.12			
Morocco	0.80		0.90		0.87	1.10		1.10	
Syrian Arab Republic		1.50	1.30		1.40	1.47	1.54	1.50	
Latin America									
Ecuador	1.50	1.70					1.50		
El Salvador				0.90	0.90	0.70	0.80	1.10	

Source: http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=

Indicator Name	Hospital beds (per 1,000 people)
Short definition	Hospital beds include inpatient beds available in public, private, general and specialized hospitals and rehabilitation centres. In most cases beds for both acute and chronic care are included.
Long definition	Hospital beds include inpatient beds available in public, private, general and specialized hospitals and rehabilitation centres. In most cases beds for both acute and chronic care are included.
Source	World Health Organisation, OECD, supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average

As discussed in JC31 above, the direct EC support to health care strongly prioritised primary care to secondary care and this is also reflected in much less evidence having been found of the EC contribution to the improvements in the number of hospital beds per capita. In addition, only few countries can provide reliable time trends of this indicator. For only two countries among the desk sample, some further evidence can be added:

- In the *DRC*, EC supported hospitals rehabilitation, which directly contributed to increase the number of functioning secondary care facilities. In the framework of the 9th EDF health programme (PS9EDF), hospitalisation rates have increased and rates of intra-hospital mortality as well as postoperative infections decreased. At the end 2008, 93 hospitals were supported by the "*Fonds pour l'achat des service de santé – medicaments essentiels génériques"* FASS MEG and 44 hospitals were specifically subsidised in the framework of the EC funded PS9FED.
- In *Afghanistan*, only around 4 beds per 10,000 population in 2009 were available, as per World Bank statistics. This is likely to be similar to the years before, with a low priority being given to the hospital sector and the need to rehabilitate existing but poorly functioning hospital prior to extending current capacity. Since 2005, the Essential Package of Hospital Services is in place, which is incorporated in the work done by the NGOs that are under contract of the EC in 10 provinces. So, in most of the areas support is being given to the basic hospitals. However, this would normally not lead to increased number of hospital beds. Secondary and tertiary hospitals are not supported by the EC.

According to the country strategy evaluation of *Vietnam*[19], the EC has supported two major project interventions in health, the Health Sector Development Programme (HSDP; 1995-2008) and Health Care Support to the Poor of the Northern Uplands and Central Highlands Project (HEMA; 2006-2010). The HSDP project concentrated on the provision of infrastructure and equipment. While there were positive impacts in terms of strengthening provincial health teams and training, the main component was widely judged to have performed poorly, with serious delays. Much of the benefit went to secondary and tertiary facilities and there was little demonstrable impact on health facility utilisation in the two target provinces.

In some countries, the number of hospital beds per capita decreased over the evaluation period, e.g. *Moldova*, *Egypt*, but inequitable access remains a larger problem in these countries.

Similarly as for primary health care facilities, there are differences in the availability of secondary health care facilities between urban and rural areas, evidenced also by the reports of MoHs in the survey. However, even the availability of secondary health care facilities seems to be improving and the differences between rural and urban areas somewhat decreasing. Most MoHs report improvement of the availability of secondary healthcare facilities in both rural and urban areas over the evaluation period (*Lao, Egypt, Afghanistan, Moldova and Morocco*). In *Syria*, the improvement was reported for rural areas, while the availability in urban areas was considered good even at the beginning of the evaluation period. In *Yemen*, the availability in rural areas remains unsatisfactory. *Afghanistan* reported the biggest improvement in this respect (availability in urban areas from unsatisfactory to good) and specifically mentions EC contribution to the support for four provincial hospitals and one regional hospital, although it is not clear that this lead to increase in hospital beds per se.

Overall, not much evidence could be found on the EC contribution to help improving the situation regarding hospital beds, which, overall, has only in few cases significantly improved over the period under evaluation. This is mostly ascribed to the priority given to the support of primary over secondary health care (e.g. *Burkina Faso, Lao PDR*), or to the rehabilitation of existing infrastructure over building additional, especially in fragile states (*Afghanistan, DRC*).

3.2.2 I-322 Change in the proportion of population living in a radius of 2 hours of a secondary health care facility

The distance to secondary health care facility is an indicator of health care delivery access. However, no statistics on this particular indicator could be obtained for any of the countries under study.[20]

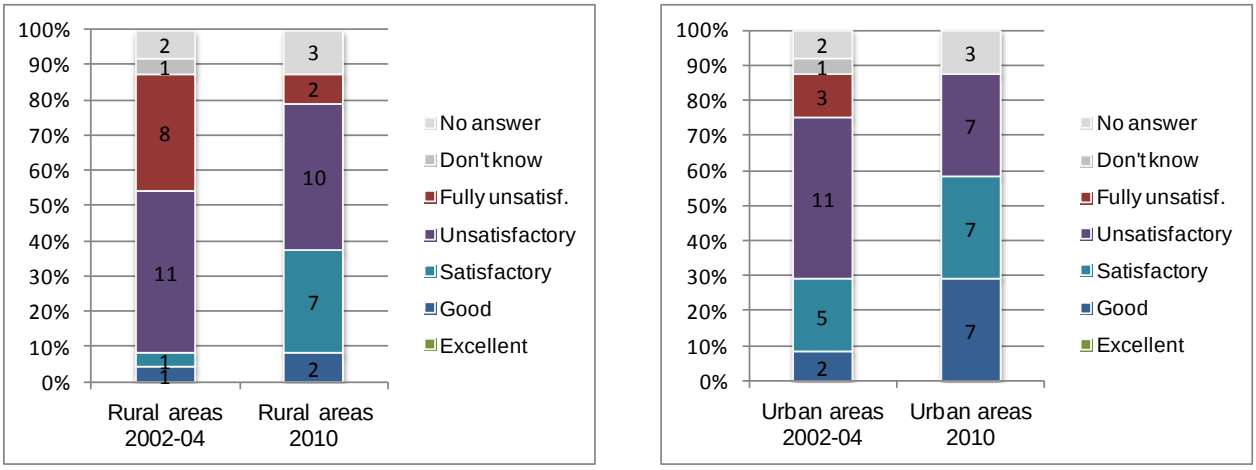
In some countries like *Egypt* and *Moldova*, geographical access to facility is not a problem, as discussed under primary care facilities in JC31 above.

In most countries, the access to secondary facilities is more difficult for rural population. The EUD survey suggests that the situation regarding the availability of secondary care has somewhat improved over the evaluation period and more so in the rural areas, but unsatisfactory rates given by the EUDs were still quite high in 2010. While at least satisfactory access in rural areas was only in 8% of countries at the beginning of the period according to the EUDs, it was already 37% at the end. For urban areas the same numbers were 29 and 58% respectively. EUD *Timor-Leste* also highlighted the EC contribution to reconstructing three

[19] Vietnam, CSE 2009, Vol1, p. 17
[20] The indicator does not seem to be broadly collected and reported on in WHO statistics or national MoH reports

district hospitals and the National referral hospital in the improvement of its grades. In general, the EUDs confirm the previous findings that the focus of EC support is on primary care level.

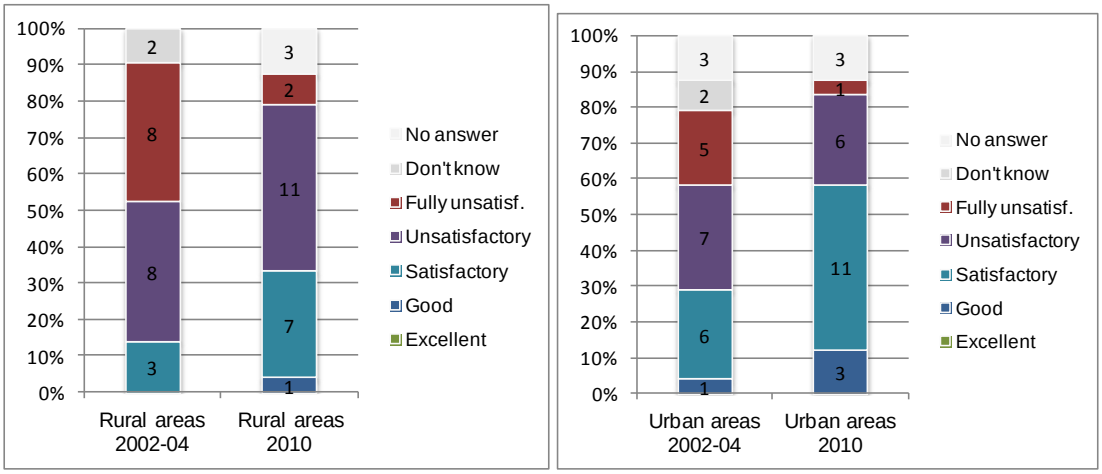
Figure 17: Results of the EUD survey: Availability of secondary health care facilities



Source: EUD Survey, 2011, Particip GmbH

Similarly as for the access to primary care facilities, in many countries the appropriate equipment and budget for maintenance and expenditure is also an issue and more so for rural hospitals. According to the EUD survey, this aspect of secondary care availability also improved for both rural and urban areas, but still remains largely unsatisfactory (over 50% of rural and almost 30% of urban secondary facilities remain unsatisfactorily equipped according to the Delegations - see JC12 for more detailed discussion of equipment in health care facilities).

Figure 18: Results of the EUD survey: Coverage with secondary health care facilities with appropriate equipment and budget for maintenance and expenditure



Source: EUD Survey, 2011, Particip GmbH

Some improvements in the indicator are reported by the MoHs in the survey across most countries, which submitted answers. Improvements were reported by *Syria*, *Egypt*, *Yemen* and *Afghanistan*. Three countries reported no change in the indicator (*Lao*, *Morocco* – both 50-70% and *Moldova* – more than 90%). Out of these, *Afghanistan* mentions EC contribution in five provinces and *Morocco* reports EC support to infrastructure development and upgrading of facilities.

Overall, access to quality secondary health care facilities remains a problem for large segments of populations in many countries and disproportionately more so for people living in rural areas. However, only little direct evidence has been found of the EC support towards alleviating this problem, as most of the EC contributions favoured access to primary health care.

3.2.3 I-323 Increased number of Caesarean Sections

The rate of Caesarean sections is an indicator of access to essential obstetric care. There is no global recommendation as to what proportion of births should be delivered by Caesarean sections. It has been a general trend that the proportion increases in countries as they become more developed, even to a point of recent discussions of the Caesareans being unnecessarily over-used in developed countries. However, very low proportions of Caesareans probably signify that not all complicated deliveries have been attended to as would have been beneficial and points to insufficient obstetric care access.

Wherever disaggregated data are available, differences are clearly seen between rural and urban areas, confirming previous findings about inequitable access to health care. Moreover, higher rates of Caesarean sections seem to correlate positively with higher educational and wealth status of women undergoing them. This has been shown for countries where disaggregated data are available, such as *Egypt*, where the rate of Caesarean deliveries peaked at 45% among women in the highest wealth quintile compared to 14% among women in the lowest quintile, or *Bangladesh*, where more than one-quarter of women who have completed secondary or higher education and women in the highest wealth quintile delivered by caesarean section, compared with less than 2 percent of women with no education and women in the lowest wealth quintile.

No evidence of direct contribution of the EC support to increasing the number of Caesarean sections has been found in the sources consulted. However, country case studies hint to some indirect contribution through support to maternal health or general quality of care cannot be ruled out. This could be the case e.g. in *Bangladesh*, where the number of Caesarean sections increased from 3.5% in 2004 to 7.5% under the Health, Nutrition and Population Sector Programme and the various projects explicitly addressing maternal health. Similarly, it could be inferred that some contribution towards this indicator was provided in *Afghanistan* (still very low rate of 3.5% given by WHO with no time trend), where emphasis was given to maternal care within the Basic Package of Health Services / Essential Package of Hospital Services, which was specifically supported by the EC through its contracts with the NGOs in 10 provinces. Also in *Egypt*, where the rate was at 28% in 2008 (up from 7% in 1995), the EC programmes aiming at increasing accreditation of health facilities, increase of facility use (also for the poor), reduction of out of pocket payments, health insurance coverage increase and others, might result in a further increase in Caesarean sections, but which will also depend in the future on birth attendance recommendations by insurances and the MoHP.

Some countries have already achieved the levels of international clinical good practice related to this indicator on average – e.g. *Ecuador* 26% in 2011, *Egypt* 28% in 2008, *South Africa* 20%. However, it is likely that the access to obstetric care is not equitable and the numbers do not apply in all areas and all wealth segments of population equally.

Overall, no direct evidence of the EC contribution to this indicator has been found. It can be expected that some of other EC support in health care accessibility, health infrastructure, maternal health and quality of care (discussed in more detail under other indicators) could all have had some positive impact on this indicator.

4 EQ4- To what extent has EC support to health contributed to improving health service utilisation related to MNCH?

4.1 JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC

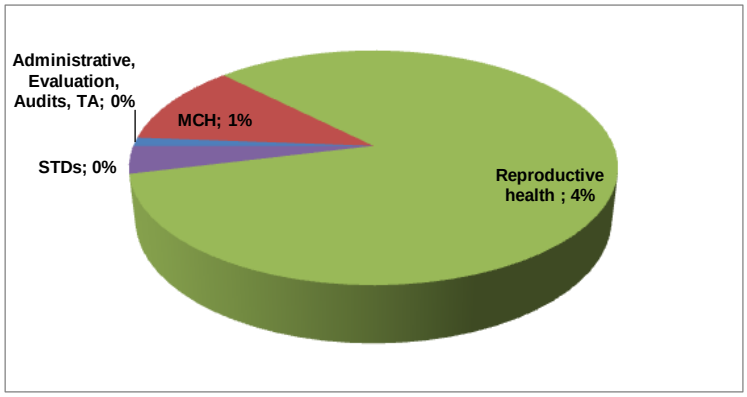
MDG5 on maternal health is the most off track of all MDGs. With the exception of North Africa and some parts of Asia, overall progress in this area has been relatively slow. Although more and more women have access to modern family planning, receive ante-natal care during their pregnancy and deliver attended by skilled personnel, millions remain unprotected due to a lack of access to high-quality care.

The EC's commitment to sexual and reproductive health (SRH) has been continuously strong since the 1990s, as set out in the 1994 ICPD Program of Action (PoA),[21] the EC Regulation of 2003 on 'Aid for policies and actions on reproductive and sexual health and rights in developing countries'[22], the EU Agenda for Action on MDGs (2008), the 'Investing in People' action programme 2007-2013[23] and in the 2010 Council conclusions on the EU Role in Global Health[24].

In contrast to these political commitments, SRH does not figure prominently in the strategic planning of the EC, which is translated through the CSPs, as the analysis of the 25 sample CSPs shows. For example in Sub-Saharan-Africa, where maternal health is worst, none of the CSPs under the 10th EDF have chosen SRH as a focal s or prioritised sector.

Looking at the effective EC support to SRH during the evaluation period, the inventory shows that the sector sexual and reproductive health - which includes maternal and child health interventions - has received the smallest share of direct EC support, amounting to only 5% or EUR 219 million of the total direct support during the period under evaluation. As can be seen in the figure below, the majority of funds within this subsector (84% of the funds of the SRH-sector) target reproductive health.

Figure 19: Direct EC support to the heath sector: Sub-sector reproductive health breakdown, as a proportion of the total direct support to health sector, 2002-2010



Source: CRIS database, analysis Particip

[21] UN (1994): United Nations International Conference on Population and Development (ICPD). http://www.iisd.ca/cairo.html
[22] Official Journal of the European Union (2003): Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on reproductive and sexual health and rights in developing countries.
[23] European Commission: Investing in People. Strategy Paper for the Thematic Programme 2007-2013
[24] Council of the European Union (2010) Council conclusions on the EU role in Global Health

Table 17: Direct EC support to the heath sector: Sub-sector reproductive health breakdown, 2002-2010 (in EUR million and %)

Sector categorisation	*Contracted amount (EUR million)*	*% of the subsector SRH*
Evaluation, Audits, TA	3	1%
MCH	25	11%
Reproductive health	185	84%
STDs	8	4%
Total SRH	*221*	
Total EC support during the period	4'118	

Source: CRIS database, Particip GmbH analysis

However, as pointed out in the Inventory analysis, only those SRH interventions are detected which are primarily and solely aiming at reproductive health activities. It would be a mistake to judge the EC's contribution in the area of maternal and child health purely on the amount of direct support clearly labelled in the inventory as MNCH interventions, as they represent only part of actual amounts contracted on RH.25 MNCH is often integrated in primary health care programmes, funded under big sector interventions (e.g. Provision of Basic Health Care Services or Sector Budget Support) or GBS programmes. Through these sector interventions, aiming at providing basic health care, access or quality of health care, the EC has certainly provided additional support for the improvement of maternal health, resources, although not directly quantifiable, that must be added to the direct support to SRH.

The JC has been assessed using three indicators: increased proportion of deliveries supervised by a skilled attendant; increased percentage of women receiving 4 or more ante-natal check-ups; and increase in the use of modern family planning methods.

The EC's primary impact on the indicators related to utilisation of maternal health care services must be considered in the framework of its support to health sector reforms and health care delivery approaches that have been beneficial to improve access to basic services, including emergency obstetric services. Basic health care delivery usual includes many interventions related to reproductive health (such as antenatal and postnatal care and care during child birth). Good examples are EC basic health provision programmes in *Egypt* and *Afghanistan,* which seem to have been very successful to improve maternal health, according to documentation review, EUD and MoH interviews (I-411, I-412). Policy dialogue under sector support in Egypt was credited by the EUD as being the main factor behind the increasingly primary health care orientation of MoH policy, with strongly beneficial implications for mother and child health.

GBS programmes often include performance indicators related to MNCH, such as the MDG indicator *"Proportion of births attended by skilled health personnel"*. In the reviewed GBS programmes in ACP countries (*Ghana, Burkina Faso*), supervised deliveries has been included as a performance indicator in the GBS triggers. The review of the tranche assessments show an overall good performance and a fulfilment of the indicator's targets, although a slight trends toward a worsening of the situation can be seen towards the end of the evaluation period (I-411).

A specificity of EC support to the SRH sub-sector is the high percentage of regional projects or worldwide call for proposals.

- 71% of all SRH projects are directed to more than one country.
- 35% of SRH funds go to the ACP region, followed by Asian countries (25%), while 35% of funds are worldwide interventions. Examples of regional programmes are the *ACP* programme "*Sexual and Reproductive Health EC/ACP/UNFPRA/IPPF Joint Programme"* or, in *Asia,* the *"Reproductive health initiative for youth in Asia (RHIYA)"*, both with a component targeting ante-natal care, safe deliveries and, to some extent, also family planning.
- A EUR 23.5 million worldwide call for proposal *"Implementation of Cairo agenda on reproductive health"* has been launched at the very end of the evaluation period, an assessment of its results is difficult at this stage

[25] For further explanation see Annex 2 (inventory).

Furthermore, it is interesting to note that 95% of EC support geared towards MNCH is channelled through individual projects, usually with rather small budget (less than EUR 2 million).[26] In most cases MNCH support is implemented by MNCH-specialised NGOs or multilateral organisations (e.g. UNFPA, IPPF, Marie Stopes International, or UNICEF). (I-411, 412, 413)

Country case studies show that most of the individual MNCH projects target rural and remote area or conflict zones and aim at poor, underprivileged or indigenous population (e.g. *Laos, Bangladesh*). Bigger interventions, providing substantial support to maternal and child health, even financed through SBS, often show a similar pattern, as they target prioritised regions only (e.g. PASSE programme in *Ecuador*; SBS to the Mindanao province, *Philippines;* HSPSP II in *Egypt*). The assessment of all three indicators of this JC shows that considerable MNCH support of the EC is targeted towards rural, remote and conflict areas and underprivileged communities. The gap between rural and urban areas is still pronounced, as evidenced by the national statistics and confirmed in by the responses of the MoH survey. In the intervention areas, the assessment shows that results have been achieved in relation to more frequent use of health facilities and services by women and children, resulting in an increase of almost all indicators assessed in this evaluation related to MNCH. In this sense, EC support to MNCH seems to have been highly relevant when specifically addressing geographical areas for which MNCH indicators were worse than the national average. (I-411, I-412, I-413)

An increase of ante-natal visits of pregnant women is closely correlated with the availability and the quality of health care facilities and services. Statistics showing increasing ANC of pregnant women draw an encouraging picture. The EC interventions, including e.g. the increase of female health workers in health care centres in *Afghanistan*, the provision of home based care focusing mainly on antenatal care in *South Africa* or the primary health care programme in rural areas in *Egypt* as well as the MNCH support in Burkina Faso have its share in this positive development I-412)

In addition, GFATM programmes, although targeting primarily HIV, TB and Malaria, often include components aiming at improving maternal health in relation to these three diseases. The EC is one of GFATM's biggest contributors. The GFATM interventions are likely to have some indirect impact on increasing the proportion of women using modern family planning through, for instance, awareness rising campaigns and condom distribution or through the new Health System Strengthening (HSS) component (I-413).

Overall, EC supported to maternal health in most of the countries and this support has contributed to an amelioration of all three indicators – supervised deliveries, ante-natal-care visits and use of family planning, as shown in the country case studies. Maternal health has been supported by the EC in two different ways, thus allowing to targeting different country contexts and issues (e.g. neo-natal care, sexual rights and family planning, HIV/AIDS) adequately:

- **Support targeting in priority remote, underserved and conflict area and underprivileged populations:** Targeting has been made either through low-budget NGO interventions or through large regional programmes implemented by specialised multi-lateral organisations. Both types of interventions have yielded the expected results related to the improvement of maternal health. While regional support has achieved its targets, it must however been noted that problems related to the co-operation and administrative procedures between implementing partner organisations and the EC were frequent. Individual projects also have contributed to improved maternal health, although, due to their limited scope, the benefit of these projects can mainly be found in the awareness raising of women and communities on health behaviour related specifically to health behaviour during pregnancy and neo-natal care as well as sexual health rights. So the EC contributed locally to reduce the - still huge gap - between rural/poor/badly educated areas and the urban/wealthier and educated areas.
- **Support of basic health care and/or health system strengthening programmes**, which often included rather substantial targeting of maternal health, e.g. in sector programmes, SBS and, to some extent, also GBS. EC financing of basic health care packages (*Afghanistan*, *Egypt*) or support to primary health (*Ecuador*, *South Africa*, *Philippines*) has been most successful in improving maternal health (supervised deliveries as well as ANC visits) and family planning. Also in countries were the EC provided support via GBS (*Burkina Faso*, *Ghana*), the situation related to maternal health indicators, especially related to supervised deliveries, has improved. It must however be

[26] With the exception of the component "Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction" of the Support to the national Health, Nutrition and Population Sector Programme in Bangladesh

noted that indicators are again declining towards the end of the evaluation period, which might also be related to an increased population growth and a declining ratio in health facilities and health workers per inhabitant.

4.1.1 I-411 Increase in proportion of deliveries supervised by a skilled attendant

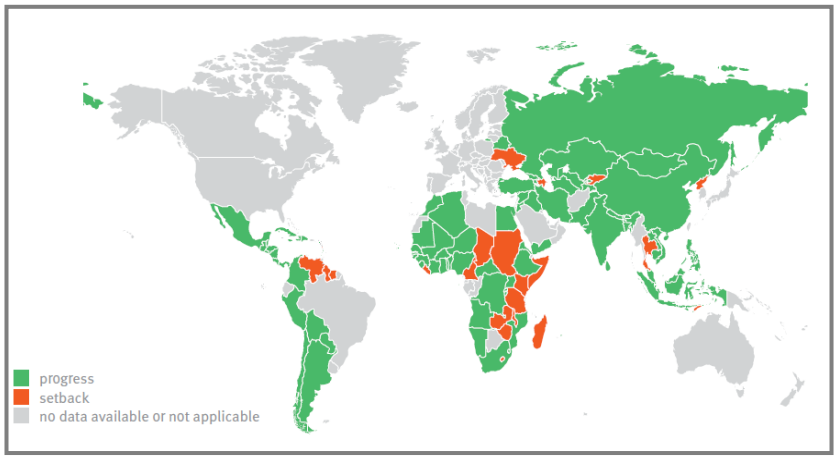
The presence of a trained health-care worker during delivery is crucial in reducing maternal mortality (MDG5 Target A). A skilled health professional can administer interventions to prevent and manage life-threatening complications, such as heavy bleeding, or refer the patient to a higher level of care when needed. Over half a million women die every year in childbirth or from pregnancy-related causes. Virtually all (99%) of these maternal deaths occur in low-income countries. The lifetime risk of maternal death is 1 in 30,000 in Northern Europe as compared to a high of 1 in 6 in the poorest countries.[27] MDG5 is the most off track of all MDGs, especially in fragile states. Data are scattered and high quality time-series are sporadic, although more data are now available in the international series for the assessment of trends for all MDGs. For instance, the number of countries with two or more data points on contraceptive prevalence increased from 50 in the period 1986-1994 to 94 in 1995-2004.

According to the MDG Report 2011, the proportion of deliveries attended by skilled health personnel rose overall in developing regions from 55% in 1990 to 65% in 2009. Despite dramatic progress in many regions, coverage remains low in sub-Saharan Africa and some countries in South Asia, where the majority of maternal deaths occur.[28] About one-third of developing countries (35 out of 107) have succeeded in providing universal access to skilled birth attendants and nearly 20% of countries (20 out of 107) have achieved universal access. High levels of coverage (above 90%) have been achieved in almost all countries in the Caribbean and the CIS, in the majority of Latin American countries and in some parts of Asia. Birth attendance by skilled professionals is lowest in a number of Sub-Saharan African countries and in some parts of South and South-East Asia. With the exception of North Africa and some parts of Asia, overall progress in this area has been relatively slow, with the average coverage ratio improving by only 0.6 percentage points per annum.[29] Although more and more women deliver attended by skilled personnel, millions remain unprotected because they lack access to high-quality care.

In 22 countries, coverage has declined (see following figure). The most striking decline has been in Sudan, where coverage fell from 86% to 49% between 1991 and 2006. Countries with the highest rate of relative progress are in regions which have already achieved high coverage rates (the Caribbean, the CIS and Asia), suggesting that it is relatively harder to achieve the MDG5 target in countries with low initial levels than in countries with higher initial levels. Top performers in absolute progress terms come from a broader set of regions and include a number of African countries that have increased their coverage by more than 2% annually (compared with 0.6% for all countries in the dataset).[30]

[27] S. Paruzzolo, R. Mehra, A. Kes, C. Ashbaugh. 20101. Targeting poverty and gender inequality to improve maternal health. Executive Summary, p.1
[28] UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations, p.30.
[29] Overseas Development Institute, 2010. Millennium Development Goals Report Card. Measuring Progress Across Countries, p.55
[30] Ibid, p.55

Figure 20: Progress on the proportion of birth attended by skilled health personnel (various years)



Source: Overseas Development Institute, 2010. Millennium Development Goals Report Card. Measuring Progress Across Countries, p.54

The following table shows data related to skilled birth attendance for the desk study countries. The trends highlighted in the ODI study presented above are not so clearly visible in the countries of the desk sample. Between 2002/2003 and 2008, there have been significant increases in almost all of these countries where the initial proportion was low (exception: *Zimbabwe and Myanmar*).

Table 18: Births attended by skilled health staff (% of total), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados		100.0	100.0	100.0	100.0	100.0			
Burkina Faso		37.8		53.5	53.5				
Congo. Dem. Rep.						74.0			74
Ghana		47.1			49.7	55.2	57.1		
Mozambique		47.7					55.3		
Nigeria		35.2					38.9		
South Africa		91.2							
Tanzania				43.4					50.6
Timor-Leste	23.7	18.4							29.3
Zambia	43.4					46.5			
Zimbabwe					68.5			60.2	
Asia									
Afghanistan		14.3			18.9		24.0		
Bangladesh		14.0	13.2		20.1	18.0		24.4	
India					46.6		52.7		
Lao PDR					20.3				
Myanmar		67.5				63.9			
Philippines		59.8					62.2		
Vietnam	85.0		90.0		87.7				
Yemen. Rep.		26.8			35.7				
ENP									
Egypt. Arab Rep.		69.4		74.2			78.9		
Moldova				99.5					
Morocco			62.6						
Syrian Arab Republic			89.7		93.0				
Latin America									
Ecuador			98.2						
El Salvador		92.4					95.5		

Source: http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=

Indicator Name	Births attended by skilled health staff (% of total)
Definition	Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period; to conduct deliveries on their own; and to care for newborns.
Source	UNICEF, State of the World's Children, Childinfo and Demographic and Health Surveys by Macro International.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average

Evidence concerning direct EC contributions to progress on this indicator is very diverse as shown in the country case studies (see box below) and in the interviews with EUDs and MoHs. There are countries with no intervention (e.g. *Moldova, Zambia, South Africa*), indirect support through projects covering broader basic health interventions (e.g. Basic Package of Health Services (BPHS) in *Afghanistan* and *Egypt*, *DRC* or through GBS) as well as direct interventions of very different scale such as individual projects or SBS/big sector support programme, e.g. *Bangladesh, the Philippines, Laos, Ecuador*.

The following box summarises EC interventions related to the indicator "supervised deliveries" in selected desk study countries reflecting the diversity of EC support.

Box 21: Findings from the Country Case Studies: Supervised deliveries: Selected examples from the country case studies

Support mainly through GBS in ACP countries

Burkina Faso: A survey in 2003 showed that about 38% of births were assisted by skilled birth attendants, which increased to 73.4% in 2010 according to data from the Ministry of health sector review 2010. A large disparity in access to skilled care was reported between urban and rural areas. EC support contributed to improve basic public services in the health sector. GBS programmes, in particular ABRP2 2005-2008 and the MDG contract 2009-2014, included performance indicators for the health sector such as the "rate of birth supervised by skilled attendant. The disbursement notes of the variables tranches (2007, 2008 and 2010) indicates that this performance indictor increased between 2008 and 2010 and that the objectives had been achieved in 2008, 2009 and 2010. From the interview with the EUD it appears that the EU has, in the last decade, paid particular attention to this topic both politically and financially. The EC was also cofounder of the Regional Conference on Family Planning held in Burkina Faso in 2011.

Ghana: The proportion of births attended by a skilled medical professional rose from 42% to 59%, according to the 2003 and 2008 DHSs. Geographical, economic and educational differentials are significant. The EC formulated triggers and targets for evaluations in the PRBS relevant to this indicator for all PRSB between 2004 and 2008 and the MDG contract starting 2009. The tranche release assessments note that the indicator on supervised delivery was fulfilled yearly until 2008 and increased slowly but permanently. According to the EUD, PBRS 2 funds were fully released for 2004, but not for 2005 and 2006.

Sector wide basic health care interventions

Afghanistan: The Afghanistan Health Survey 2010 report found an increase of women giving birth under skilled supervision up to 34% in 2010 compared to 14% in 2003. This shows the influence of the introduction of the Basic Package of Health Services (BPHS). Still, a huge gap remains between rural and urban areas. While in 2010, 71% (35% in 2003) of women give birth under skilled assistance, only 26% (7% in 2003) of women do so in rural areas. There has clearly been a significant EC contribution to improvement in this indicator through the roll out of BPHS to all Afghans. The EC covers ten provinces with projects contracted-out to NGOs. The ROM report of 2010, reported the observation of following changes: a) increased use of the facilities b) falling of barriers previously preventing women and children access to the services which has directly led to reduced maternal/child mortality and morbidity c) increased presence of female staff/midwives has led to an increase in the number of safe deliveries d) better understanding of the referral system e) increased acceptance of family planning f) increased services in remote areas g) increased understanding of the need to vaccinate and much better coverage of vaccinations.

Bangladesh: The BMMS report shows a doubling in deliveries attended by a skilled birth attendant from 12.2% in 2001 to 26.5% in 2010; more pronounced is the increased use of private sector health facilities by the wealthier quintile Under HNPSP the EC has directly contributed to these achievements with the EUR 10 million project *"Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction"*. However, the marked increase in supervised deliveries still does not match HNPSP target for 2010; 85% of women still deliver at home. The programmes have tried to access these women by increasing the number of community skilled birth attendant (CSBAs). Only about 43% of the estimated requirement of 15,000 CSBA has been trained. According to the annual progress report of 2010, a major problem affecting maternal health care is the attrition of human resources. Trained personnel in emergency obstetric care facilities are difficult to retain. In order to stimulate the demand side, a new 'maternal and neonatal health voucher scheme, should give an incentive to use health services more

frequently[31].
Egypt: According to the Egypt NDHS 2008, births attended by skilled health personnel increased constantly from 35% in 1988 to 46% in 1995, 69% in 2003 and to 79% in 2008. It can safely been stated that the Basic Benefit Package with a strong emphasis on maternal health has contributed to the increase in the proportion of birth attended by skilled health personnel. The EC supported the elaboration of this Package and improved reproductive health is one of the expected results of HSPSP-II.
Philippines: The DHS 2008 shows a slight increase to 62% compared to 60% in 2003. The skilled birth attendance in the Philippines is marked by a huge rural-urban gap and by education and wealth status. The EC has contributed significantly to the availability of skilled birth supervision in disadvantaged areas. The development of Health Service Delivery (HSD) models and Behavioural Change Communication (BCC) strategies under the Mindanao HSPSP in support of the reduction of maternal and neonatal mortality and morbidity and most-at risk and vulnerable population groups constitutes the third key result under the health service delivery pillar. At an aggregated level, however, improvement in the proportion of births attended by skilled professionals has increased only modestly.

In contrast to large scale basic health interventions or GBS, individual and geographically-targeted maternal health projects benefited mostly rural areas and underprivileged communities. This specific focus can also be found in regional ACP programmes such as the co-financed EC-WHO programme "Partnership on Health MDG", which targeted eight ACP countries[32]; all with alarming maternal mortality rates and a high percentage of people living in rural areas. Also, the ACP regional project "Sexual and Reproductive Health", an EC/UNFPA/IPPF Joint Programme, targets the most excluded population in order to deliver a basic package of reproductive health services. Responses of the MoH survey results confirmed the gap between rural and urban areas in relation to supervised delivery (with the exception of *Moldova* and *Yemen*) and stress the relevance of the EC strategy to target its support towards rural areas and underprivileged communities.

Most GBS countries included supervised births as one of their performance indicators, especially in ACP countries with MDG-contract (*Burkina Faso, Ghana*). In both aforementioned countries, the assessments of the tranche releases indicate that the indicator on safe delivery has been fulfilled and is, in both countries, rising. Especially in *Burkina Faso*, the EUD has given particular attention to maternal health, according to the interview with the EUD (see box below).

Where EC supported maternal health through Basic Health Packages (especially in *Afghanistan* and *Egypt*), it seems that the EC was very successful, according to documentation review and both EUD and MoH interviews.

In summary, national statistics show an increased number of women giving birth under skilled supervision and EC support has contributed to this positive development. Where EC supported maternal health through Basic Heath Packages (especially in *Afghanistan* and *Egypt*) or through large primary health sector support (*Bangladesh and Philippines*), the assessment reveals that EC was very successful in increasing the number of supervised deliveries, with the exception of *Bangladesh*. In countries where EC provided GBS, examples (*Ghana* and *Burkina Faso*) show an annual achievement of the performance indicator "supervised deliveries".

4.1.2 I-412 Increased percentage of women receiving 4 or more ante-natal check-ups

According to WHO and UNICEF recommendations, women should receive antenatal care from a trained health-care practitioner at least four times during the course of their pregnancies. However, less than half of pregnant women in developing countries and only a third of rural women receive the recommended four visits. Among rural women in South Asia the share is only 25%.[33]

The MDG Report 2011 concludes that in all regions, progress is being made in providing pregnant women with antenatal care at least once. Remarkable gains were recorded in Northern Africa and in Southern and Western Asia, where the share of women who saw a skilled health worker at least once during pregnancy increased by up to 30 percentage points between 1990 and 2008. The lowest indicators are found in South Asia, with only 70% of women having at least one visit during their pregnancy (figures of 2008). Also in sub-Saharan Africa almost one-third of women do not receive any antenatal care at all in 2008.[34]

[31] APR 2010
[32] Angola, Burkina Faso, Kenya, Malawi, Niger, Tanzania, Guyana and Haiti
[33] *UN (2011): The Millennium Development Goals Report 2011. New York: United Nations, p.34*
[34] UN 2011. The Millennium Development Goals Report 2011. New York: United Nations, p.30

Disparities in the share of women receiving antenatal care by wealth are striking, particularly in South Asia, North Africa and sub-Saharan Africa. Large disparities also exist between women living in rural and urban areas, although the gap narrowed between 1990 and 2008. In sub-Saharan Africa, the proportion of urban women receiving antenatal care at least once increased from 84% in 1990 to 89% in 2008. The corresponding proportions for rural women are 55% to 66%, indicating that coverage has improved at a faster pace among rural women.[35]

Nine countries have suffered setbacks of 7% or more. Setbacks have taken place in almost all regions, including those with high levels of coverage such as the Caribbean and the CIS. The worst performer is Azerbaijan, where coverage declined from 98% to 77% between 1997 and 2006.[36]

The following table shows the state and/or development of the proportion of women receiving at least one ANC visits (Table 19) and at least four ANC visits (Table 20) in the desk studies countries of this evaluation.

Table 19: Pregnant women receiving prenatal care of at least one visit (% of pregnant women), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	100			100	100	100	100	100	
Burkina Faso				73.4			85		
Congo. Dem. Rep.		68.2						85.3	
Ghana				91.9			92.1	96.1	90.1
Mozambique				84.5					92.3
Nigeria	56.5			58					57.7
South Africa				91.9					
Timor-Leste			42.5	60.5					
Zambia			93.4					93.7	
Zimbabwe							94.2		
Tanzania						78.2			75.8
Asia									
Afghanistan				16.1					36
Bangladesh		39.8		39.7	48.7		47.7	51.2	
India							74.2		75.2
Lao PDR		26.5					35.1		
Myanmar		75.6						79.8	
Philippines				87.6					91.1
Yemen. Rep.				41.4			47		
Vietnam		86.4					90.8		
ENP									
Egypt. Arab Rep.				68.7		69.6			73.6
Moldova						98			
Morocco					67.8				
Syrian Arab Republic							84		
Latin America									
Ecuador					84.2				
El Salvador				86					94

Source: UN site for MDG indicators: http://mdgs.un.org/unsd/mdg/Data.aspx

[35] UN 2011. The Millennium Development Goals Report 2011. New York: United Nations, p.33.
[36] Overseas Development Institute, 2010. Millennium Development Goals Report Card. Measuring Progress Across Countries, p.59

Table 20: Pregnant women receiving prenatal care of at least four visits (% of pregnant women), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso				17.6					
Congo. Dem. Rep.								46.7	
Ghana				69.4				76.7	78.2
Mozambique				53.1					
Nigeria	52			47.4					44.8
South Africa				56.1					
Timor-Leste				29.6					
Zambia			71.6					60.3	
Zimbabwe							71.1		
Tanzania						61.5			
Asia									
Afghanistan									
Bangladesh		11.6			15.9			20.6	
India							37		51.1
Lao PDR									
Myanmar		65.9						73.4	
Philippines				70.4					77.8
Yemen. Rep.				13.9					
Vietnam			29.3						
ENP									
Egypt. Arab Rep.				55.6		58.5			66
Moldova						88.8			
Morocco					30.5				
Syrian Arab Republic									
Latin America									
Ecuador					57.5				
El Salvador				71.2					78.3

Source: UN site for MDG indicators: http://mdgs.un.org/unsd/mdg/Data.aspx

As indicated in the JC summary, sexual and reproductive health is often integrated in primary health care programmes. The EC is most likely to have contributed to the improvement of this indicator through projects aiming at providing basic health care packages or access to health facilities resulting in higher service usage, like it is the case in the country case studies of *Afghanistan* and *Egypt*, *Ecuador* and *South Africa*:

- In *Afghanistan,* only 16.1% of pregnant women had received at least one ANC visit in 2005[37], but this represents a steep increase from 4.6% in 2003 according to a MICS figure. The figure further increased during the evaluation period and reached 36% of women in 2010. The roll-out of BPHS with a strong emphasis on maternal health and increasing the number of facilities offering ANC clearly backed the overall positive development in the ten regions that were covered by the EC. Furthermore, the EC has been successful in ensuring the availability of at least one female health worker at all clinics supported. The MoH reports that shortages of female health workers remain a serious constraint.
- Also in *Egypt,* the number of women receiving ante-natal-care rose during the evaluation period: 66% had at least four ante natal checks in 2008 compared to 36.7 in 2000. Regional disparities are still high, e.g. only 40% of women in rural Upper Egypt had four ante-natal check-ups in 2008. With its contribution to the HSPSP II, aiming at strengthening primary health care in rural areas, the EC has improved maternal health.

[37] MDG report Afghanistan 2005.

- In *Ecuador,* the EC is likely to have contributed to the increase of the indicator through the PASSE programme which aimed at expanding primary health care availability in rural areas.
- In *South Africa*, with the PDPHCP the EC focused on the provision of home based care (HBC) which addressed the needs of maternal and child health care and focusing mainly on antenatal care.
- In *Bangladesh,* one component of the HNPSP, the project *"Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction"* explicitly targeted maternal health. Results are not yet completely satisfactory as is described more in detail in Box 21, in indicator I-411.

Beside country-specific interventions, ante-natal care, especially linked to HIV-AIDS**,** is also addressed through regional programmes, such the ACP regional joint- EC/UNFPA/IPPF programme "Sexual and Reproductive Health". This programme aimed at providing a basic package of reproductive health services and increasing geographical coverage of ANC, especially in underserved areas and towards excluded population. According to the Mid-term review of the programme[38], there has been an increase in service utilisation (building and renovating of health facilities and provision of mobile facilities) and an improvement in the quality of services also in remote areas. Mobile facilities could still be better and more extensively used in rural areas, according to the assessment of the European Court of Auditors.[39]

The remaining gap between urban and rural areas is confirmed by the MoH staff responding to the survey. Although an increase of ANC-visits is seen in all countries answering the survey, a systematic gap between rural and urban areas is highlighted. Among the countries answering, *Syrian Arab Republic* and *Morocco* indicate improvements in both urban and rural areas, *Laos* only for urban areas.

The EC helped to close this gap in some countries through very specific and small interventions, such as the project *"SRH services and information in Shariatpur, Bhola and Barisal"*[40] in *Bangladesh*. According to the project's ROM report of 2009, better health during the pregnancy and professional assistance for deliveries can be seen as an outcome of the project. Also in *Lao*, where the gap between rural and urban, respectively between wealthy/high educated women and poor women is striking, the *"Better Health project in Attrapeu Province"* and the regional project *"Health for Youth in Asia"* have locally contributed to more service utilisation during pregnancy.

Unlike the indicator *"Increase in proportion of deliveries supervised by a skilled attendant"*, the indicator on ante-natal-check-ups does not figure prominently in GBS performance matrices. How successful GBS has been to improve this indicator is therefore not clearly assessable.

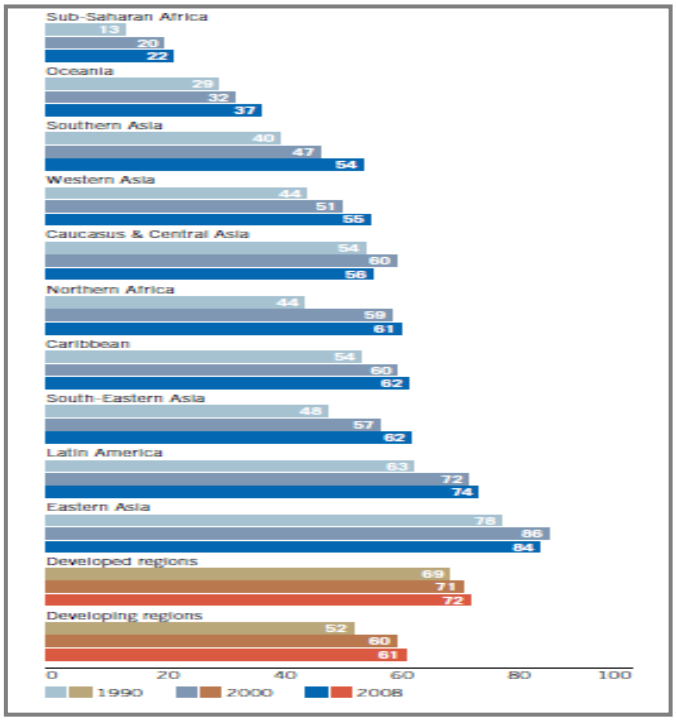
In summary, the EC supported ante-natal care of pregnant women through its support of basic health care packages or access to health facilities. The review of case studies shows that the support has resulted in higher service usage by women (e.g. basic health care packages in *Afghanistan* and *Egypt*, sector support to primary health in *Ecuador* and *South Africa*). Furthermore, regional programmes in the ACP regions resulted in increased service utilisation of pregnant women, especially in remote and underserved areas. Small individual projects in *Asia* contributed to improve locally the situation on ANC check-ups in remote areas. Although still huge gaps between rural and urban areas remain, EC support has locally helped to addressing the gap between rural and urban areas and between wealthy/high educated women and poor/non-educated women.

4.1.3 I-413 Increased proportion of women using modern family planning

By 2008, more than half of all women aged 15 to 49 who were married or in a union were using some form of contraception in all but two regions - sub-Saharan Africa and Oceania. However, progress slowed from 2000 to 2008 in almost all regions. Women in sub-Saharan Africa continue to have the lowest level of contraceptive prevalence (22%), with little progress reported since 2000 (see the following figure).

[38] European Commission (2006) Mid-term review sexual and reproductive health EC/ACP/UNPFA/IPPF Joint Programme.
[39] European Court of Auditors (2008): ECA Special Report No 10 2008: EC Development Assistance to Health Services in Sub-Saharan Africa
[40] Full project name *"Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal"*

Figure 21: Proportion of women who are using any method of contraception among women aged 15-49, married or in a union, 1990, 2000 and 2008 (percentage)



Source: UN 2011. The Millennium Development Goals Report 2011. New York: United Nations, p.32

Unmet need for family planning has remained at the same moderate to high level in most regions since 2000, but is highest in sub-Saharan Africa and the Caribbean. In those regions, respectively, at least one in four women of childbearing age who are married or in a union have an unmet need for contraception. The rates of contraceptive prevalence are lowest in the low income countries (35.2%) compared to 70.8% in high income countries in 2005 (WHO). Use of contraception is lowest among the poorest women and those with no education.

Trends in the proportion of women using modern contraception in the desk study countries of this evaluation are given in the following table and document significant, sometimes striking increases in many countries. Exceptions are *DRC, Ghana* and *Bangladesh*, where the indicator is falling[41].

Table 21: Proportion of women using modern family planning (contraceptive prevalence rate / UNFPA: contraceptive prevalence rate - modern methods), 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso				13.8			17.4		
DRC		31.4						20.6	
Ghana				25.2			24.2		23.5
Mozambique					16.5				
Nigeria				12.6				14.7	14.6
South Africa					59.9				
Tanzania					28.2	26.4			
Timor-Leste		8		10				19.8	
Zambia			34.2					40.8	
Zimbabwe							60.2		

[41] See Annex 27 for further data on unmet need for contraception for these 25 countries.

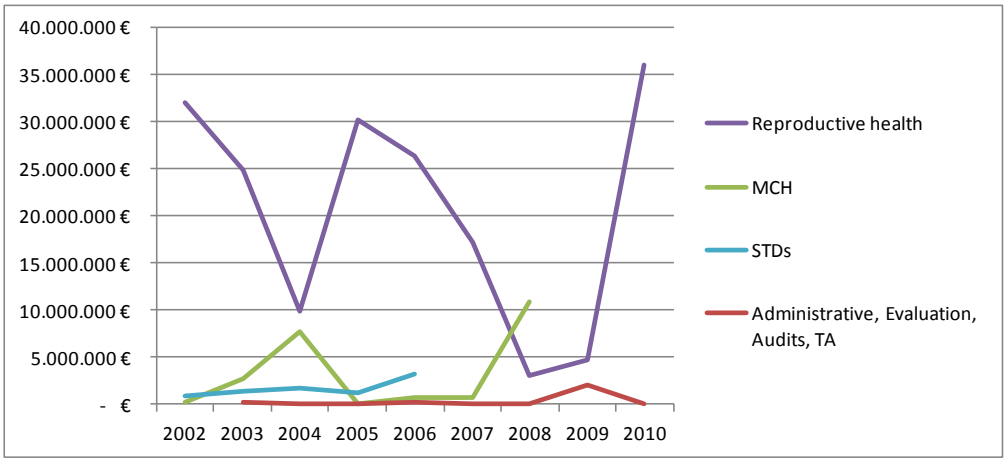
Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Asia									
Afghanistan	4.9			10.3		13.6	18.6		22.8
Bangladesh	53.8				58.1			55.8	
India	46.9				53		56.3		
Lao PDR	32.2					38			
Myanmar		37						41	
Philippines	47	49.5	48.8	48.9	49.3	49.3	50.6		50.7
Vietnam	74.2	73.9	78.5	75.3	75.7	76.8	81.7	79	79.5
Yemen				23.1			27.7		
ENP									
Egypt	56.1			60		59.2			60.3
Moldova	62.4					67.8			
Morocco					63				
Syria		46.6					58.3		
Latin America									
Ecuador					72.7				
El Salvador				67.3					72.5

Source: UN site for MDG indicators: http://mdgs.un.org/unsd/mdg/Data.aspx

The EC and the EU Member States have strong policy commitments towards the support of reproductive health and family planning (RH/FP) in developing countries and have been historically very significant donors for population assistance. Family planning was highlighted as priority area in the 1990s and beginning of the 21st century.[42]

The inventory shows that within the sub-sector "sexual and reproductive health", the "reproductive health" component is the one receiving most of the funds, with 84% (see also Table 17.). However, this figure must be interpreted with caution, as interventions pooled in this category can also tackle e.g. child health. Funds to the reproductive health sectors have especially been committed between 2002 and 2007, before achieving a peak again in 2010, as is visualised in the figure below.

Figure 22: EC support to health: Committed funds for the SRH-subsector between 2002-2010



Source: CRIS database, Particip analysis

[42] See, for instance, the SEC(92) 2002 'Demography, family planning and co-operation with developing countries' (Communication by the Commission to the Council and the European Parliament) and the European Parliament legislative resolution on the proposal for a European Parliament and Council regulation 'On aid for policies and actions on reproductive and sexual health and rights in developing countries' (COM(2002) 120) which outline the importance of RH in relation to poverty reduction and safe motherhood and child's health. (see: http://aei.pitt.edu/4303/ and http://eur-lex.europa.eu/Result.do?T1=V5&T2=2002&T3=120&RechType=RECH_naturel&Submit=Search

For the desk study countries, an overall increase in contraceptive prevalence can be reported (see Table 21 above), however at different speed with stagnation to be observed e.g. in *South Africa* and a slight decline in *Ghana* over the last years. These trends have also been confirmed by the responses of the MoH survey. Among the countries answering, *Syrian Arab Republic, Morocco*, *Afghanistan* and *Lao* indicate improvements in both urban and rural areas, *Yemen and Egypt* only for urban areas.

The country case studies show a variety of means and ways in relation to the EC increasing women using modern family planning which also confirms that EC support has contributed to increase the number of women using family planning. EC support has been delivered through individual projects (e.g. *Philippines, Bangladesh, Burkina Faso*, *South Africa, Moldova*) and through bigger and less-MNCH specific health sector programme (*Afghanistan, Egypt*). A project prior to the evaluation period in Upper Egypt contributed significantly to an increase in the utilisation of modern family planning. The box below illustrates some findings related to EC support to family planning for the desk study countries. SRH is a topic which is culturally highly sensitive in some countries and one has to bear in mind that changes in national indicators will only move slowly. In some countries (*Burkina Faso*, *Philippines*), the EC has put the topic on the policy dialogue agenda, thus trying to exert influence the policy agenda. According the EUD in the *Philippines*, as of this writing family planning legislation is still stalled in the legislative process.

Box 22: Findings from the Country Case Studies: Examples of EC interventions related to family planning

Afghanistan: "Basic package of health services"

Contraceptive prevalence increased from 5% in 2002 to 13% in 2007 and reached almost 23% in 2010.

This increase can be attributed in large part to the roll-out of BPHS financed by the EC in ten regions contracted-out to NGOs which includes expansion of facilities where Family Planning (FP) is being offered. Family planning services are in place in all facilities. There is a good co-operation among health professionals, CHWs and even health Shura in promoting child spacing and family planning, e.g. in Kunduz province. Nevertheless, in some areas the environment may still not be so favourable to talk freely about FP and child spacing, according to the evaluation of BPHS in Kunduz.[43]

Bangladesh: Individual projects, implemented by, NGOs

Throughout the evaluation period, the EC has supported sexual and reproductive health with EUR 10 million, which is the highest amount in the SRH-subsector for an individual country.[44] Most of the funds are committed to the project "Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction" within the Support to the national health, nutrition and population sector. Furthermore, family planning is addressed with several individual projects, such as

- "Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts", "
- "Primary Health Care Project, Cox's Bazaar Bangladesh",
- "Adolescents and Women's Reproductive and Sexual Health Initiative (ARSHI)".

The first project combines service delivery with a strong awareness raising and service promoting strategy and with strong linkages with Government structures and other organisations involved in SRH and Essential Services Package (ESP).

Also the ARSHI first of all awareness raising and prevention towards the issue of maternal mortality and morbidity in the Sunamgoni district. The project has been successful in generating knowledge and awareness within the community to break down many of the socio-cultural barriers that prevent women and adolescents from accessing maternal, family planning and sexual reproductive health (SRH) services. Moreover, the remoteness of the area justified the intervention of ARSHI, according to the ROM report (2008). However, the ROM report noted also that even though the information and advocacy objective of the project has been fulfilled, changes of behaviours will be long-lasting. Due to the remoteness and isolation of the areas covered by the project, the government, in charge of health service provision, often failed to reach these areas. This led, according to the ROM to a gap between raised expectations and unavailability of health service provisions or facilities. [45] In close relation to the

[43] External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

[44] Only Yemen receives a similarly high EC support for SRH through the "Yemen Reproductive Health & Population Programme" (MED/2005/017-088). As the first funds were committed in 2010, no information on results is yet available.

[45] MR 113040.01 (20/11/2008)

fact of lacking health facilities, the project aim of reducing maternal morbidity, is therefore not quantifiable, as stated by the Mid-term-review.[46] In its concluding remarks, the MTR highlights that the ARSHI project could serve as a model for reaching remote areas. "*As a start-up, projects of a catalyst type are required. ARSHI has many of those characteristics to make isolated areas as self-sufficient as possible in driving their own development process*."[47]

Philippines Individual project, implemented by NGOs

Related to family planning issues, the Philippines are characterised by strong resistance from the Catholic church and low access to family planning. However, since 2002, the contraception prevalence has been raising constantly since 2002, but only slowly (47% in 2002 to 50.7% in 2010).

EC projects financed during the evaluation period were:

- "Accelerating community-based responses to reproductive and sexual health. HIV/AIDS and STDs concerns of Filipino youth" (EMPHASIS-RH).
- Asia-Urbs project "Improving health services offered to marginalised mothers and young children".

The EC financed family planning through NGO projects with moderate success only, not showing significant results and hampered by external, cultural factors. Especially in rural areas severe deficiencies still remain related to the availability and, where existing, the use of reproductive health services, which explains the slow improvement of national figures related to the number of women using modern family planning. However, in the last years the EC as well as other donors have repeatedly raised these issues in high-level policy dialogue. Although hoped, this investment has so far not yet paid off under the new Government, according to the EUD. Furthermore, sexual rights and the link to economic growth and poverty reduction is a topic of attention of the EUD and also of other donors, which have repeatedly raised the issue in high level-policy meetings (see below)

The EC support through the GFATM or regional projects are worth mentioning, although their primary aim is the fight against HIV/AIDS.

- **GFATM** is encouraging condom use and condom distribution in all HIV/AIDS prone countries, though family planning is not on their agenda, but may improve the overall situation regarding sexual and reproductive health rights.
- Better access and use of family planning is also an indirect outcome of **regional projects** aiming at sexual and reproductive health and rights, especially, but not solely, linked to HIV/AIDS prevention and treatment. This is the case of the regional ACP programme "Sexual and reproductive health", jointly financed between the EC, UNFPA and IPPF or different projects in Southern Africa, such as "Soul city" and projects implemented by Marie Stopes International in Western Africa (e.g. "PASSAGE – Proposed Approach to reproductive Health Solidarity" "Prevention and treatment of ST/HIV/AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfore and Po") or in Asia "Reproductive Health Initiative for Youth in Asia, RHIYA.". It must be highlighted that EC projects tackling RH are mostly implemented by international partners specialised in the area, such as UNPFA or IPPF.

  In relation to the project RHIYA, the ROM report (2004)[48] highlighted that the project in Bangladesh had been working very closely with the government and that the national Health Nutrition and Population Sector Programme (started in 2005) has taken over many issues tackled in the RHIYA. This is a good example on how small and innovative projects can help introducing high priority issues in national policies and programmes, thus having a considerable leverage effect.

Besides the financial support to this subsector, the importance of policy dialogue related to sexual and reproductive rights can be highlighted. Interviews with EUDs in *Burkina Faso* and the *Philippines* confirmed that attention and importance is giving to sexual and reproductive rights.

In *Lao* and *Bangladesh*, however, policy dialogue on sexual and reproductive health was not on the policy agenda, as the focus was more put on the achievement of MDGs targets.

To conclude, it appears from the research that family planning was mainly tackled through small projects, often targeting different countries of a region or all countries at the same time (e.g. through the annual call for proposal on reproductive health). Only few examples of large scale (financially and geographically speaking) reproductive health programmes have been implemented during the evaluation period, such as the Yemen

[46] International Consulting (2007) Mid-term-review of the Thematic project Sante/2006/120021; "Adolescents and Women's Reproductive Health Initiative."
[47] EC (2007): Aide memoire to the MTR "Adolescents and Women's Reproductive Health Initiative."
[48] ROM report MR -20226.01; 21/10/04.

Reproductive Health & Population Programme, which started in 2008. Furthermore EC supported regional project in the ACP region and Asia as well as the activities of the HIV/AIDS component of the GFATM. From the evidence available it appears that the EC was successful in raising awareness on sexual and reproductive health issues (e.g. *Bangladesh* and to some lesser extent in *Afghanistan* and *Philippines*) and on increasing availability and eventually use of family planning and sexual and reproductive health services (e.g. Afghanistan, Egypt).

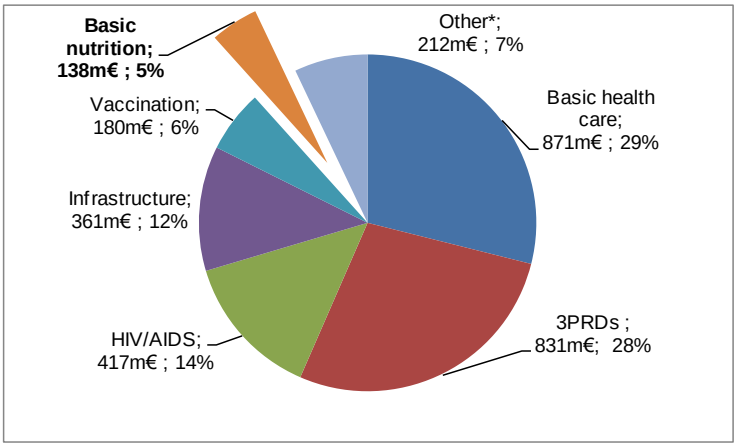
4.2 JC 42 Increased use of services and facilities to support health care for children supported by the EC

The assessment of this Judgment Criterion on increased use of services and facilities to support care for children is based on two indicators: percentage of children under 5 receiving regular growth monitoring and the child immunisation rate.

Only very limited statistical figures are accessible for the first indicator on growth monitoring of children under-five. Therefore, the nutritional status of children has been used as a proxy. Globally, malnutrition is the most important risk factor for illness and death, contributing to more than half of children's deaths worldwide. The prevalence rate of children under five severely underweight is one indicator to measure the MDG target 1C *"Halve, between 1990 and 2015, the proportion of people who suffer from hunger"*, therefore the reliable data availability is better.

As shown by the CSP analysis, nutrition is rarely included as a particular focus within the CSPs. Only for *Bangladesh*, the *Philippines* and *Barbados* evidence could be found for the CSP period for 2002-2006. From the inventory, it is not possible to extract the exact financial amounts allocated to children's growth and nutrition, as those interventions will often be included in the basic health sector. However, 3% (EUR 138 million) of the total support health during the evaluation period went to interventions clearly labelled as "basic nutrition", as can be seen in the figure below.

Figure 23: Breakdown of EC committed funds within the Sector "Basic health" (contracts between 2002-2010)



Source: CRIS database, Particip analysis

With the exception of Bangladesh where the EC supported child nutrition explicitly through the "Support to the national Health, Nutrition and Population Sector Programme," none of the case study countries benefited from substantial interventions aimed specifically at child nutrition. Only small projects related to food security and child nutrition can be found in *DRC, Zimbabwe, Afghanistan, Myanmar, Vietnam* and *Yemen*.

Literature confirms that increased health service utilisation of children under the age of five has positive impacts on children's growth monitoring. The evaluation's analysis reveals encouraging records for *Afghanistan* (increases in child attendance to BPHS centres, especially an increase in girls' attendance), *Bangladesh* (improved children's nutrition status), *Lao PDR* (increased number of women consulting medical personnel with their children) and *Ecuador* (increased number of children receiving annual check-ups in EC supported rural provinces; see Box 23). In *Egypt*, as well, the promotion of the family health model through EC sector policy support has promoted primary health care, although child nutrition trends are discouraging (I-421).

According to the inventory the EC has supported vaccination interventions with EUR 180 million, which represents 4% of the total EC support to the health sector during the evaluation period. The majority of funds (EUR 100 million) went to global initiatives, such as GAVI (EUR 39.4 million)) and the Polio Eradication

Campaign, implemented by the WHO (EUR 60 million). Remaining funds went to large scale country vaccination interventions in *Nigeria* and *Ethiopia*. However, evaluations of both global initiatives show a mitigated picture concerning the results of routine immunisation campaigns (funded by GAVI) or specific campaigns tackling measles (GAVI) or polio (WHO). While some significant progress related to the vaccination coverage of children has been made in a number of countries related to polio and measles vaccination, shortfalls in vaccines, delayed vaccination activities or poor implementation of the immunisation campaigns have led to new outbreaks and failure to reach initial targets. Moreover, large donor-funded vaccination campaign, especially when it comes to routine vaccination, also implies a certain risk to substitute the government's own activity. However and despite some negative points, it can be concluded that EC financed country wide immunisation programmes, helped considerably to raise awareness for the importance of children's immunisation and made a concrete contribution towards higher immunisation rates.

In addition to direct and identifiable support to vaccination initiatives, the EC has contributed to progress related to immunisation of children through its support to basic health care and general health systems strengthening, as evidence from country case study confirms. In GBS and health sector support programmes, immunisation rates (DPT 3 and measles) were a frequent performance indicator and the evaluation's assessment of a selection of GBS programmes showed that the targets were reached in most of the cases. In countries where the EC financed health facilities and basic health care, which would include *Afghanistan, DRC, Egypt, Lao PDR and Ecuador*, the EC contributed to improved immunisation of children. Health sector programmes focusing essentially on pro-poor health, such as in *Bangladesh* and *South Africa*, contributed to an increased number of children receiving vaccination. These same programmes as well as more specific immunisation interventions contributed to strengthening national capacities to further develop their own national (routine) immunisation programme (e.g. *Nigeria, Burkina Faso, Bangladesh, South Africa*).

To conclude, information on EC support to a better monitoring of children's growth and nutrition status is scarce, although some positive developments in the numbers of children being regularly growth monitored (*Afghanistan, Bangladesh, Ecuador*) can be seen in a selection of EC financed interventions which aim at increasing service utilisation by children and at the same time having an impact on growth monitoring of children. Discouragingly, in one country where the EC contributed substantially to primary health care through sector support, Egypt, child nutrition continues to be a major and worsening public health problem. In contrast to the first indicator, EC support to immunisation is much more pronounced and identifiable, either through contribution to large regional/worldwide vaccination campaigns such as GAVI and polio eradication or targeted country interventions (e.g. *Nigeria*, *Ethiopia*). In the majority of EC supported countries results in terms of increased child vaccination coverage are good. Furthermore, the EC also contributed, through its immunisation programmes, to an increased awareness on the importance and use of children's immunisation.

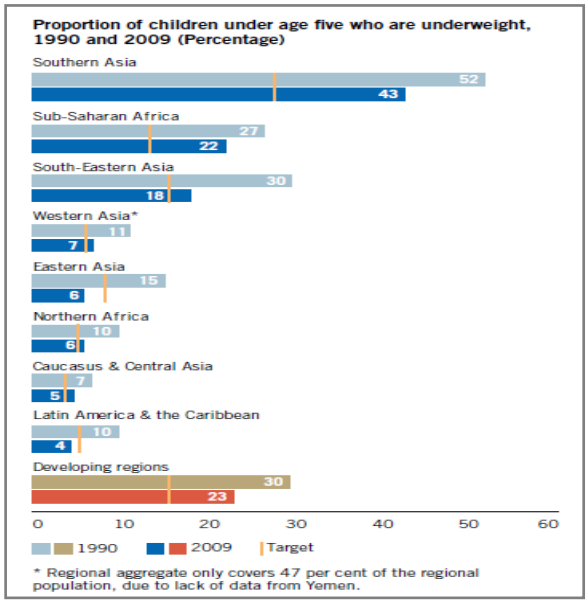
4.2.1 I-421 Percentage of children under 5 receiving regular growth monitoring

Growth references are among the most valuable and widely used tools to measure how to fulfil children's basic physical needs. Furthermore, they best define the health and nutritional status of children while serving as a useful indirect measurement of a population's overall socioeconomic status. However, accessing growth monitoring data is difficult and available data are quite often of bad quality and include only weight-for-age information. Additionally, data on the proportion of children being monitored is more or less not publicly available. Even though growth monitoring exists universally, data on proportion of children who are monitored are not available.

A proxy to the indicator of growth monitoring is the nutritional status of children. Malnutrition is globally the most important risk factor for illness and death, contributing to more than half of deaths in children worldwide and the prevalence rate of children under five severely underweight is taken as one indicator to measure the MDG target 1C *"Halve, between 1990 and 2015, the proportion of people who suffer from hunger"*.

Between 1990 and 2009 the proportion of children under the age of five who are underweight has globally decreased. However, only in Eastern Asia and Latin America have the targets been achieved (see Figure 24) and children across Southern and Central Asia as well as in Sub-Saharan Africa continue to suffer very high levels of malnutrition.

Figure 24: Percentage of children under age five who are underweight, 1990 and 2009



Source: UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations. pp.13

Considering that the MDG4 on child mortality, just as the MDG5 on maternal health (discussion in JC 41) is a target off track in most countries, one could conclude that children's health is ranked top on donors' agenda. However, this is not particularly well reflected in the EC's strategic planning at country level, with only *Bangladesh*, the *Philippines* and *Barbados* including the aspect of nutrition as a focal sector in their CSPs for the period 2002-2006; none of the CSPs for 2007-2013 dealt directly with this aspect. How much the EC spend in financial terms towards child growth monitoring and nutrition cannot be identified unambiguously in the inventory of this evaluation, as interventions aiming at children's health and nutrition are often included in general basic health interventions.[49] Interventions that could be clearly labelled as "nutrition" interventions represent 3% of the total support to the health in the evaluation period, as can be seen in Figure 23. As for the EC support to maternal health (see discussion in JC 41), the rather negative picture has to be balanced and it can be assumed that important shifts in accessibility and quality assurance of health care centres/units and higher utilisation rates of health facilities have improved the situation.

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Where time series are available, statistics show that the percentage of underweight children under five is decreasing in the countries of the desk study sample, exceptions being *Ghana* and *Egypt*, in which figures went slightly up. In the EU Delegation interview, EUD Egypt highlighted poor child nutrition as a key health problem in the country. The worst figures are found in Asia (*Bangladesh, India* and *Yemen*) as well as in the ACP region (*Burkina Faso, DRC, Nigeria and Timor Leste*).

Table 22: Prevalence of underweight children under-five years of age 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso			35.2			37.4			26
Congo. Dem. Rep.	33.6						28.2		
Ghana			18.8			13.9		14.3	
Mozambique			21.2						

[49] Furthermore, the general aspects of food security, including specific nutrition aspects, have not been included in the scope of this evaluation. It is thus likely that more EC funds have been committed to this topic between 2002 and 2010.

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Nigeria			27.2					26.7	
South Africa									
Timor-Leste		40.6	41.5						
Zambia	23.3						14.9		
Zimbabwe					14				
Tanzania				16.7					
Asia									
Afghanistan				32.9					
Bangladesh				42.7			41.3		
India					43.5				
Lao PDR						31.6			
Myanmar			29.6						
Philippines			20.7						
Yemen. Rep.			43.1						
Vietnam						20.2			
ENP									
Egypt. Arab Rep.			8.7		5.4			6.8	
Moldova					3.2				
Morocco			9.9						
Syrian Arab Republic	11.1					10			
Latin America									
Ecuador				6.2					
El Salvador		6.1							

Source: UN site for MDG indicators: http://mdgs.un.org/unsd/mdg/Data.aspx

An increase in children receiving growth monitoring is reflected in the assessments of the MoH-survey, but the answers also show a discrepancy between rural and urban areas for *Syria*, *Laos*, *Egypt*, *Yemen*, *Afghanistan and Morocco*. Only the MoH *Moldova* stated that more than 90% of children under five receive growth monitoring equally in rural and urban areas. The MoH of Lao, Yemen, Afghanistan and Morocco indicated the lowest growth monitoring rates (between 50-70%) for urban areas and under 50% for rural areas in 2010, but only the MoH in Afghanistan stated clearly that the EC contributed to children's growth monitoring.

With the exception of Bangladesh where the EC supported child nutrition explicitly through the "Support to the national Health, Nutrition and Population Sector Programme", none of the desk study countries have a substantial intervention aiming at child health and nutrition of children aged under-five. Small projects related to food security and child nutrition are also found in *DRC, Zimbabwe, Afghanistan, Myanmar, Vietnam* and *Yemen*.

In *Bangladesh*, the results of the HNPSPS related to nutrition indicate still some severe shortages and structural problems to overcome. The annual performance report of the MoH 2010 highlights that the targets of reducing children's malnutrition are reached, however some important improvements have still to be made to reach the final programme target in 2011. The action to be taken for the future, as highlighted by the annual progress report of 2010 are: (i) mainstreaming nutritional activities in all health facilities, (ii) opening special centres to treat acute malnutrition cases and (iii) gradual merging of nutrition activities undertaken by NNP, IPHN, ICDDR under the overall co-ordination and guidance by the MOHFW, iv) long term contracts with NGOs to avoid interruption of services.[50] What exactly of these evolutions can be connected to the EC support to the overall HNPSPS, it is difficult to say.

Concerning increased service utilisation of children under the age of five, encouraging records can be mentioned for *Afghanistan*, *Bangladesh, Lao PDR and Ecuador*:

In *Afghanistan,* increases in child attendance at BPHS centres, especially of girls, have improved child nutritional monitoring. In *Bangladesh*, the ROM report of the project "Improving Health, Nutrition& Population in the Chittagong Hill Tracts" mentions positive results related to children's nutrition status. In *Lao PDR*, the "Better Health project in Attrepeu province" indicated an increase in the number of women consulting medical

[50] APR 2009 and APR 2010.

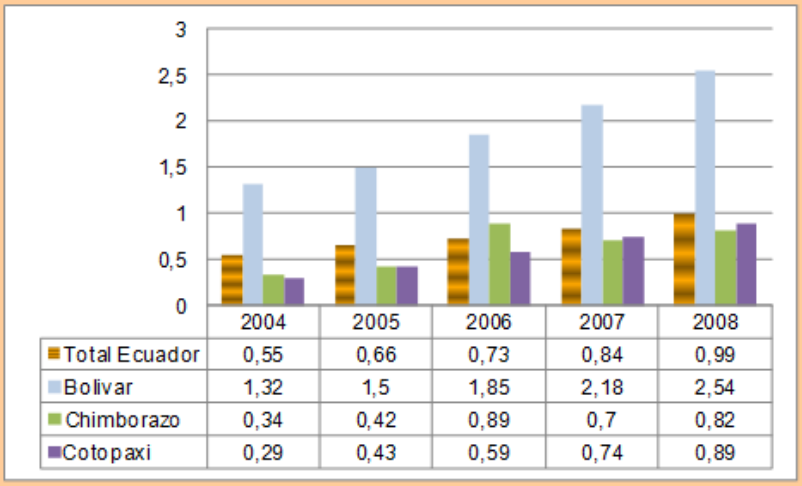
personnel with their children, with the result that the number of seriousness of diseases has dropped since the beginning of the project. In *Ecuador*, the EC funded PASSE project contributed to the increased access to health care in the three provinces of implementation with a raising number of children receiving annual check-ups.

Box 23: Findings from the Country Case Studies: Example of the EC project PASSE in Ecuador

The situation in Ecuador highlights very well the relation between children's health status and the population's overall socioeconomic status. Countrywide, 6.2% of children under-five were underweight in 2005. This figure is significantly higher for children of indigenous women (47%), for children of mothers with lower educational levels (38% in children of mothers with no education) and among the population living in the Sierra (32%) and rural areas (31%).

The EC support within the PASSE project aimed at increasing the access to health care in three rural provinces. As can be seen in the evaluation reports of PASSE, the EC has likely contributed to the increased use of services and facilities by children and this situation translated into an increased number of children between 1 and 4 years receiving annual check-ups. The following graphics shows the ratio of annual check-ups of children between one and four years compared to the total of children in this age category in the three provinces of the PASSE implementation in the period 2004 to 2008.

Figure 25: Change in number of annual consultation per region for children aging between 1 and 4 years. (Ecuador)



	2004	2005	2006	2007	2008
Total Ecuador	0,55	0,66	0,73	0,84	0,99
Bolivar	1,32	1,5	1,85	2,18	2,54
Chimborazo	0,34	0,42	0,89	0,7	0,82
Cotopaxi	0,29	0,43	0,59	0,74	0,89

The number of annual check-ups for children between 1 and 4 years in the three provinces covered by the project shows a growing pattern, similar to the entire country. Notably, coverage in the province of Bolivar remains nearly four times that of the national average and the other two provinces. These data tend to suggest that the EC supported project had a positive impact on this indicator, at least during the mid-to-late years of the evaluation period.

Source: Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, Final Report, 09/2010

In conclusion, the lack of available information from desk research makes it difficult to assess the EC contribution to improving child growth monitoring and nutrition. However, some encouraging records of increased health service utilisation of children can be reported from a number of country cases, such as *Afghanistan, Bangladesh, Laos and Ecuador* which resulted in a higher number of young children receiving a growth and nutrition monitoring. Overall, however, the aspect of child monitoring has not prominently figured on the agenda of EC support.

4.2.2 I-422 Immunisation rate

In 1974, the WHO started the Expanded Programme on Immunisation (EPI), which widened the range of vaccines routinely provided from smallpox, BCG and DTP to include polio and measles, as well as new and more recent vaccines. It set out to increase coverage in line with the international commitment to achieve the child immunisation goal of 80% coverage in every country.

The table below shows that the immunisation rate for DTP3 developed positively during the evaluation period in the majority of desk study countries. Almost all countries with an initially very low immunisation percentage

(under 50%), such as *DRC, Nigeria and Afghanistan* doubled their immunisation rate. A small amount of countries experienced a decline of the rate from 2005 on *(Zambia, Zimbabwe, Laos and Myanmar*).

Overall, the countries analysed in the desk phase sample have relatively high immunisation levels, generally around 80%, with exceptions of *Nigeria* and *Laos* which were, in 2009, at 42%, respectively 57%[51]. Remarkable increases in immunisation coverage during the evaluation period have been achieved in *DRC, Timor Leste and Afghanistan* and, to some extent, in *Nigeria* and *South Africa,* which had universal coverage in the 1990s, showed an alarming decline down to 70% in 2002 and stagnation since then. What is not shown in these national figures is the fact that the target populations are increasingly concentrated in hard to reach areas, often in conflict zones. For this reason, progress is getting harder and harder and progressively more expensive.

Table 23: Immunisation, DPT (% of children ages 12-23 months, 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	87	89	93	92	84	93	85	93	
Burkina Faso	61	68	75	82	82	82	82	82	
Congo, Dem. Rep.	38	41	54	60	62	72	68	77	
Ghana	80	80	80	84	84	94	87	94	
Mozambique	76	76	76	76	76	76	76	76	
Nigeria	25	29	33	36	40	42	42	42	
South Africa	70	69	69	69	69	69	69	69	
Timor-Leste	54	55	57	55	67	70	79	72	
Zambia	84	83	83	82	81	81	81	81	
Zimbabwe	73	70	68	65	68	72	75	73	
Tanzania	89	95	95	90	90	83	86	85	
Asia									
Afghanistan	48	54	66	76	77	83	85	83	
Bangladesh	86	87	99	93	94	94	94	94	
India	58	61	64	67	66	66	66	66	
Lao PDR	53	49	45	49	57	57	57	57	
Myanmar	79	78	82	73	82	86	85	90	
Philippines	79	84	88	89	88	87	91	87	
Yemen, Rep.	53	48	59	65	65	67	67	66	
Vietnam	75	99	96	95	94	92	93	96	
ENP									
Egypt, Arab Rep.	97	98	97	98	98	98	97	97	
Moldova	97	98	98	98	97	96	95	85	
Morocco	94	91	97	98	97	95	99	99	
Syrian Arab Republic	83	82	81	80	80	80	80	80	
Latin America									
Ecuador	76	75	75	75	75	75	75	75	
El Salvador	81	94	90	89	96	99	98	91	

Source: http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=

Indicator Name	Immunisation, DPT (% of children ages 12-23 months)
Short definition	Child immunisation measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunised against diphtheria, pertussis (or whooping cough) and tetanus (DPT) after receiving three doses of vaccine.
Long definition	Child immunisation measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunised against diphtheria, pertussis (or whooping cough) and tetanus (DPT) after receiving three doses of vaccine.
Source	WHO and UNICEF (http://www.who.int/immunisation_monitoring/routine/en/).
Topic	Health: Disease prevention

[51] According to MoH-EPI, 2011, the DTP3 immunisation rate has considerably raised, to reach amazing 73% in 2011.

Periodicity	Annual
Aggregation method	Weighted average

The MDG4 on Child Health includes the indicator of proportion of 1-year-olds immunised against measles. The MDG Report 2011 summarises that though important gains have been made, the poorest, most marginalised children, especially in hard-to-reach areas, have been left behind. In countries with lower coverage, immunisation campaigns have been effective in vaccinating children who are beyond the reach of existing health services. Between 2000 and 2008, the combination of improved immunisation coverage and the opportunity for a second dose led to a 78% drop in measles deaths worldwide.[52]

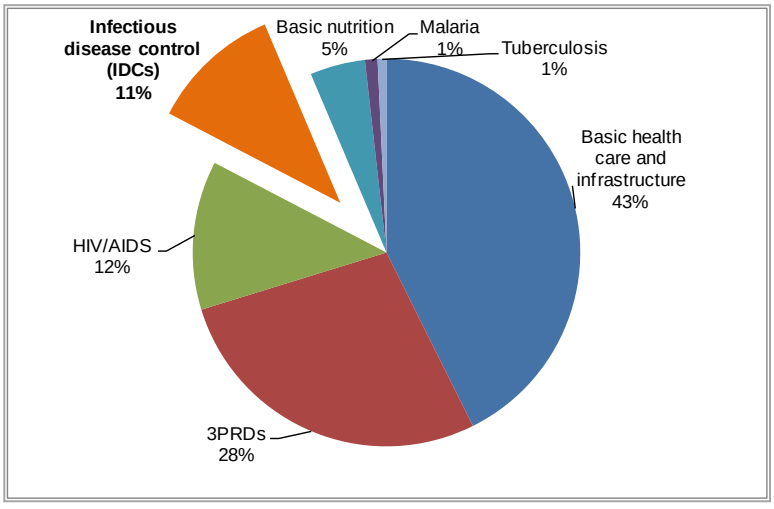
The EC has supported the aim of increasing immunisation rates of children in four main ways:

- Through direct support to GAVI and the Polio Eradication Campaign;
- Through its own bilateral support, e.g. for polio vaccination in countries such as Ethiopia and Nigeria;
- Through the delivery of basic health care service and health sector strengthening, especially in rural and remote areas (e.g. Basic health care package provisions).
- Through SPSP and SBS where it strengthened health care delivery and through GBS, where immunisation has figured in policy matrices.

Further support for vaccination has been provided through research and development activities. The criticism has been made that vertical health programmes supported by the EC and other donors, e.g. GFATM projects, weakened vaccination campaigns by siphoning human resources out of the public health sector. However, in response, GFATM has strengthened the sector-wide strengthening aspects of its programmes.

Regarding the inventory, EC's bilateral support to help increasing immunisation rates, the EC contracted 11% of its total support to the health sector to diseases control (IDC) (11%) – see figure below.

Figure 26: EC funds committed to infectious disease control- IDC" (contracts between 2002-2010): Inventory



Source: CRIS database, Particip analysis

The table below shows the breakdown within the infectious disease control interventions, indicating that vaccination makes up a share of more than 55% of the funded interventions in this subcategory. Seen in relation to the total EC support to the health sector, support to vaccination represented 4% of the total direct support to the health sector during the evaluation period.[53]

[52] UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations.
Detailed immunisation for measles coverage rate in the 25 desk study countries can be found in Annex 27.
[53] Inventory of EC support to the health sector, p.6

Table 24: Direct EC support to the heath sector: Breakdown of support to infectious diseases control, contracts (EUR million), 2002-2010

Sector categories	Contracted amount 2002-2010 (EUR million)
Vaccination	180
Human/Pandemic Influenza	103
General IDCs	41
EPI training and surveillance	5
Evaluation, Audits, TA	0,6
Total support to IDC	**330**
% of support to IDC to total support to the health sector	**8%**

Source: Particip inventory

Looking at the funding channels, the inventory reveals that out of the EUR 180 million for vaccinations, EUR 100 million were contracted to global initiatives, such as GAVI (EUR 39.4 million) and the Polio Eradication Campaign, implemented by the WHO (EUR 60 million).

As discussed under Indicator 242, a significant amount of vaccination progress can be attributed to the EC's strong support of the Global Alliance for Vaccines and Immunisation (GAVI), as well as more focused support for efforts dealing with polio, malaria and tuberculosis. WHO estimates that the impact of GAVI's vaccine support, one of the major alliances of vaccination programs and heavily funded by the EC has been to avert 3.4 million future deaths caused by pertussis, Haemophilus influenzae type B (Hib) or Hepatitis B (HepB) as at the end of 2008 and nearly 4 million future deaths prevented projected to the end of 2009.[54] Another estimate (see Indicator 2.4.2) is that GAVI was responsible for immunising 346 million children and averting 5 million deaths in the period 2000-2010.

In total, GAVI has committed USD 7.2 billion since 2000 and 80% have been committed towards the purchase of vaccines. The EC is one of its major financers. GAVI's work that is financially supported by the EC strongly underwrites continuation of the WHO EPI programme. Total EC contribution between 2002 and 2010 amounted to EUR 39.4 million.[55]

Despite progress, a number of priority countries are facing shortfalls in resources for both routine immunisations and special immunisation campaigns such as against measles. As a result, outbreaks of the disease are on the rise. [56] The evaluation report of the year 2007 analyses the impact of the first five years' of GAVI's Immunisation Services Support (ISS) funding. The study found that total immunisation funding increased in all but three of 27 countries, with a median increase of 11%. Excluding new vaccine expenditures and ISS funding, however, they found that expenditures decreased in 20 of 27 countries. According to the evaluation report, data from the in-depth study countries strongly support the finding that ISS was used to fill gaps. Given this set of mixed results, the report urges future attention to this issue.[57]

Also of relevance are activities of the European and Developing Countries Clinical Trial Partnership (EDCTP). The EDCTP supports large-scale clinical trials for development of new vaccines and drugs against HIV/AIDS, malaria and tuberculosis in a number of sub-Saharan African countries. Other research and development activities relevant to vaccines are described in the global public goods thematic case study and alluded to in Indicator 242.

Between 2004 and 2009, the EC contributed EUR 60 million to the programme "Polio Eradication Initiative"[58], led since 1988 by the WHO, through the regional programme "Polio Eradication in 13 ACP countries"[59]. The main purpose of the project is "to reach over 90% of children under five in the 14 ACP countries with oral polio vaccine (OPV) multiple times through intensified and high quality Supplementary Immunisation

[54] Second GAVI Evaluation Report, September 2010, p.8
[55] Source: inventory.
[56] UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations
[57] G. Chee, N. His, K. Carlson, S. Chankova and P. Taylor. Evaluation of the First Five Years of GAVI Immunisation Services Support Funding, September 2007
[58] Particip Inventory
[59] Participating countries are: Angola, Benin, Burkina Faso, Cameroon, Chad, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Ghana, Niger, Nigeria, Somalia, Sudan and Togo

Activities (SIAs)".[46] Data on performance of the EC co-financed initiative are scarce, with only some progress reports of the first years of the campaign being available. According to the 2008 ECA report on sub-Saharan Health[60], new outbreaks follow periods of reduced outbreaks due to importation into formerly polio-free areas (data of 2006).

According to the ECA report (2008), the performance of the programme should be qualified as sub-optimal, especially in *Nigeria* and *Ethiopia*. Reasons for the failure to reach targets were: 1) children being absent from home at the time of the vaccination rounds; 2) vaccination team did not reach all families, 3) delays in the arrival of vaccination; 4) delayed start of activities or 5) poor implementation of the house-to-house strategy by vaccination teams. Corrective measures have been implemented, especially focusing on the re-training of vaccination teams and a stronger supervision by consultants, especially in poor performing areas. The ECA report concluded that consistent high quality rounds of supplementary polio immunisation will need to be conducted in the endemic areas to close the immunity gap and restrict transmission. [61]

Another regional immunisation programme covering Western Africa is the ARIVA project "Appui au renforcement de l'immunisation vaccinale en Afrique". This programme has shown good results when it comes to improved vaccine coverage and diminution of the prevalence of the diseases as well as good advocacy to secure budget lines to purchase vaccines, linked with a good relation set up between Ministries of Health and Ministries of Finance. However, according to the final evaluation report of the project[62], the long term impact is seen as limited, as the advocacy efforts did not have significant effects on increasing the national budgets for immunisation and thus limited the introduction of new, more expensive vaccines. The aim of one of the ARIVA components to strengthen national capacities for routine vaccination has sometimes run contrary to the activities already conducted by donors and approved by the partner government. The importance of EC support to introduce routine immunisation as opposed to one-shot immunisation campaigns is also highlighted in the EC immunisation intervention in Nigeria (see Box 24 below).

The EC financed large scale country vaccination interventions in Nigeria and Ethiopia.

- In *Ethiopia,* the EC support consisted of an emergency intervention for a polio outbreak through a contribution agreement to the WHO.
- In *Nigeria*, one of the EC's focal sectors consisted of supporting immunisation through the "PRIME - Partnership to Reinforce Immunisation Efficiency" programme. The PRIME programme aimed at 1) support the National Immunisation Day as well as the Polio Eradication Initiative and 2) revitalise a system of Routine Immunisation (RI) spell-out-services in six focal states. According to the CSP (2010) *"the achievements of EU-PRIME are best assessed in terms of software development (capacity-building) and hardware (equipment) contribution"* and *"EC support has contributed to the greater immunisation coverage of the population. PRIME is rightly considered as a success programme of EU assistance in Nigeria".*

Box 24: Findings from the Country Case Studies: EC support to immunisation: The Nigerian EC-PRIME programme as an example

Initial situation regarding immunisation in the country

Before the inception of the EU-PRIME programme, the general state of primary health care and immunisation was very poor. "Cold chain" functionality and availability as well as distribution of vaccines covered only about 10% of requirements and there was poor mobilisation of communities as well as poor funding of immunisation programmes at all levels, especially the Local Government level. Against this background it is not surprising that only 13% of children in the country were fully immunised. There was also a widespread misconception in the public that polio vaccination was they vaccination needed and no further routine immunisation was necessary.

The EC-PRIME project

The PRIME project was implemented from 2001 to 2009. Its primary aim was to facilitating change and behaviour regarding immunisation. The "Change agent programme" therefore exposed committed individuals to countries that had excelled in their immunisation programmes and Primary Health Care.

Achievements of the PRIME project

PRIME supported eight international study tours to Tanzania, Zambia, Egypt and Malaysia. Results of these study tours can be exemplarily shown through the study tour to Egypt involving religious and traditional leaders from the Northern part of Nigeria. This study trip helped to resolve the polio rejection controversy in the country, as religious and traditional leaders publicly announced their support for Polio immunisation as a means of preventing

[60] ECA (2008), EC support to health in Sub-Saharan Africa.
[61] Ibid.
[62] Ecorys (2006): Final evaluation of ARIVA project.

serious diseases and withdrew previous statements that immunisation would be in conflict with Islamic law.
The identification of targeted change agents or champions within government at all levels has institutionalised the commitment to Routine Immunisation (RI) as opposed to an emphasis on campaigns, national immunisation days (NIDs) or other one-off efforts to raise the level of immunisation coverage. These important achievements of EU-PRIME have enhanced the potential for sustained government-managed-and-financed RI activities beyond the lifetime of the project. There seems to be a general agreement by all stakeholders that the EC support has contributed to the greater immunisation coverage of the population. PRIME is considered as a success programme of EU assistance in Nigeria.
At regional level within Nigeria, the EC-has supported six focal states. In those states, DPT 3 coverage (Diphtheria–Pertussis–Tetanus) has risen to 75% (national average just over 50%). After overcoming (to some degree at least) perceptions of fear, lack of confidence and trust and confusion in some areas, there are increasing percentages of child immunisation, according to the CSE. Cold chain systems have been in place in 2010 and services continued even after the termination of PRIME in June 2009. However, only a few activities could be supported in the 17 additional States from 2008 onwards. The State-specific routine immunisation project "Support to Routine Immunisation in Kano State" (SRIK) has not yet materialised, although it would be needed, as Kano State is a hotspot for wild polio spread and WHO/UNICEF polio eradication campaigns rely on improved SRIK services. The EC has supported the WHO Polio campaign with EUR 78.4 million but its objective of polio eradication has not yet been reached. Despite advances, Nigeria continues to have one of the worst immunisation coverage records in the world (and significantly worse than neighbouring countries in West Africa). The links between PHC and good health are not clearly understood and failures of good practice noted elsewhere can easily fuel such confusion. There has been and still is also fear of a covert agenda to immunisation programmes whether expressed as a religious statement or otherwise.
Problematic aspects of the PRIME project
There is the impression that PRIME was a substitute for the Government of Nigeria rather than a change facilitator. This impression, according to the CSE, is evident both in government circles and also among other donors operating within the immunisation sector.
There is, however, recognition that the project itself has adopted a resource mobilisation approach at level to encourage Government to put into practice mechanisms for supporting RI and also some evidence that certain States are beginning to adopt a resource mobilisation approach at LGA level.
At state level, cost sharing between the Federal level, State and LGA levels remains problematic. As disease prevention is a public good, which benefits to the whole nation (and beyond, as in the case of polio eradication as a global goal), the increased reliance on individual federated states to prioritise routine immunisation cannot be considered a viable approach, so the conclusion of the CSE.

Source: Country Strategy Evaluation (2010)

Further to specific immunisation interventions, EC activities in this area are embedded in its support to the health sector as a whole. The EC has contributed to progress related to immunisation of children through general health systems strengthening and health systems strengthening support of GAVI and the GFATM, including strengthening that can be attributed to GBS and SBS. Immunisation coverage, e.g. of DPT3 or Measles, is included among the budget support indicators selected to monitor sector performance and improved health outcomes, such as in the subsequent GBS agreements covering the evaluation period, including the MDG contracts in *Burkina Faso, Ghana* and *Zambia*. The annual performance assessments for Burkina Faso show that the indicator "immunisation rate measles" has been achieved; the targets for 2008 and 2010 (100% coverage) have not completely been achieved, however, the tranche was released.

Much of the challenge in conducting successful immunisation campaigns lies not in the supply of vaccines itself, but in the cold chain cycle, transport and human resources needed for a successful vaccination. Since target populations are increasingly located in hard-to-reach places, the EC's work to deliver basic health care in remote areas and/or conflicted affected areas in countries, such as *Lao PDR, the Philippines (Mindanao province), DRC and Ecuador* is likely to have contributed to improving immunisation rates. The long-standing complaint that donor-supported vertical health campaigns (e.g. through GFATM or GAVI) attract health professionals out of the public health sector has been to some extent addressed by the increased attention of such programmes to general health system strengthening.

Where the EC supported the delivery of basic health care packages and increased access to health facilities, such as in *Afghanistan*, it can also be concluded that higher service utilisation has contributed to improved immunisation coverage of children:

- In the Afghan province of Kunduz, the evaluation of EC-BPHS showed an increased utilisation of primary health care centres and an increasing EPI coverage of children. In order to improve the quality of health care services of children, an 'Integrated Management of Childhood Illnesses' (IMCI) training of health personnel started from December 2007 and the IMCI approach was introduced in Kunduz in all the Merlin-CAF run health facilities. However, it was recognised that the introduction of IMCI via one initial training is not sufficient in order to ensure the familiarity of health workers with

IMCI and other quality approaches. A close follow up is usually needed and Merlin-CAF is planning to recruit a focal point for IMCI in order to reinforce IMCI services.[63]

- EC support to governmental sector programmes, such as the HNSPSP in *Bangladesh* or Sector Budget Support to the MoH in *South Africa*, is likely to have supported immunisation indirectly, as in both countries governmental programmes included immunisation.

Laudable as these efforts are, it should not be forgotten that donor-support for regular immunisation can lead to substitution effects and a lack of additionality. As highlighted in the CSE of Nigeria (2010), even though the EC aimed at strengthening national capacities and adopt a "facilitating" approach, the EC-PRIME project was perceived as substituting the Government. The same observation was highlighted in the Five Years Evaluation of GAVI.[64]

In sum, the EC supported improved immunisation rates in many ways. It was a major supporter of GAVI and participated in vaccine initiatives related to malaria and tuberculosis. It supported the Global Initiative to Eradicate Polio and also funded country-specific immunisation campaigns (e.g. *Nigeria*). In GBS and health sector support programmes, immunisation rates (DPT 3 and measles) were a frequent performance indicator; an indicator which was, in the majority of GBS programmes assessed, fulfilled. Most of these programmes showed good results in terms of increased vaccination coverage, as can also be seen in the trend towards a higher immunisation rate of children in most of the countries (Table 23). Furthermore, EC-financed country-wide immunisation programmes helped to raise awareness for the importance of children's immunisation. Also in countries where the EC financed health facilities and basic health care (*Afghanistan, DRC, Lao PDR and Ecuador)*, EC support contributed to the increased immunisation rate of children. Moreover, general health sector programmes as well as specific immunisation interventions contributed to strengthening national capacities to further develop their own national (routine) immunisation programme (e.g. *Nigeria, Burkina Faso, Bangladesh, South Africa*).

4.3 JC 43 Children better protected from key health threats as a result of EC support

Thousands of child deaths could be averted through a combined prevention and treatment strategy implemented at household level – interventions such as improved mother and child nutrition; Oral Rehydration Therapy (ORT); new low-osmolarity formulations of ORS; zinc supplementation during diarrhoea episodes and improved personal and domestic hygiene, including keeping food and water clean and washing hands before touching food and micronutrients.

We assessed this Judgment Criterion on child health based on three indicators: Increased proportion of children sleeping under a bednet and reduction in rate of child deaths from diarrhoeal diseases and, closely related, an improved household management of diarrhoea based on oral rehydration salts (ORS).

International statistics indicate that over the evaluation period there has been a substantial increase in the proportion of children sleeping under insecticide-treated bednets (ITNs). Especially in the malaria risk zones of sub-Saharan Africa, data for 2009-2010 show that ITN coverage increased and, further, disparities in the use of bednets among population groups reduced[65]. This is largely due to nationwide campaigns aiming at the distribution of free nets with a specific focus on poor, rural areas as well as pregnant women and children, to which the EC has indirectly contributed through its GBS support , e.g. in *Ghana* and *Burkina Faso*.

The GFATM, of which the EC is one of the largest supporters, is the biggest distributor of bednets in the developing world. The figures (Table 25) show that GFATM activities, financed by the EC, have contributed to considerably increase bednet coverage for children especially in high-risk zones and countries such as West- and Southern Africa (*Ghana, Burkina Faso, Zambia*), where figures increased from almost no use at of bednets for small children at the beginning of the evaluation period to a coverage of around 40% in 2009-2010. Furthermore evidence from the country case studies shows that the EC financed small self-standing projects in *Afghanistan, Bangladesh* and *Laos* which have resulted in an increased availability of ITNs as

[63] Source: External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF:
[64] Chee, N. His, K. Carlson, S. Chankova and P. Taylor. Evaluation of the First Five Years of GAVI Immunisation Services Support Funding, September 2007
[65] UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations

well as awareness raising on its use, especially for children and pregnant women. Two EC initiated projects on bednet distribution in *Afghanistan* and *Laos* (the latter in the context of a regional project which also covered Vietnam and Cambodia) have been continued by the GFATM after the project end. These examples, as well as the rather small amounts of EC funds directly targeting child health, highlight that the EC has chosen to channel its main support related to malaria-control activities through other than bilateral support, i.e. mainly through the GFATM, as it has greater expertise and influence in this area. (I-431)

According to UNICEF and WHO, diarrhoea remains the second leading cause of death among children under five globally. Nearly one in five child deaths is due to diarrhoea. Diarrhoea is more prevalent in the developing world, in large parts due to the lack of safe drinking water, sanitation and hygiene, as well as poorer overall health and nutritional status. Diarrhoea deaths are concentrated in two regions (Africa 46% and South Asia 38%).[66] The use of oral rehydration salt (ORS) therapy and continued feeding is an effective way to children to save children from death caused by diarrhoea and can be directly applied by the families.

The evaluation did not find evidence, neither in the inventory nor in the country case studies, of single EC interventions specifically targeting the treatment of children affected by diarrhoea. The biggest impact of the EC on this indicator must to be seen in EC-financed primary health care interventions, which also target children's health and are particularly effective in combating diarrhoeal diseases. Through increased availability of primary health care facilities, awareness and the treatment of diarrhoeal diseases have improved in countries such as *DRC, Afghanistan or Bangladesh*. General sector strengthening support, be it through GBS or support to sector wide programmes, had an impact on treatment of diarrhoeal diseases, such as in *Ghana (GBS) or Bangladesh* (HNSPSP). Furthermore, individual NGO-implemented projects operating in remote areas or targeting vulnerable people, have locally have increased knowledge and awareness on the origin of diarrhoeal diseases and contributed to the promotion of better prevention and treatment of diarrhoeal disease of young children *(Laos, Philippines*). (I-432; I-433)

In sum, no direct interventions to both indicators could be found. However, the EC contributed indirectly to increased availability of ITN through GBS and its impressive contribution to the GFATM activities. Concerning the treatment of diarrhoea through ORS, the EC has through its support to primary health care, in some countries, contributed to reducing child mortality due to diarrhoea diseases, e.g. by financing of basic health care packages in *Afghanistan and DRC*. Small projects have helped to spread the knowledge on water-borne diseases and increase the use of ORS, especially in remote and rural areas.

It must however be noted that the fight against diarrhoea is closely linked to the water and sanitation sector, which was not included in the scope of the present evaluation. Through its support to the water and sanitation sector, the EC has certainly also further contributed to fighting diarrhoea.

4.3.1 I-431 Increased proportion of children sleeping under a bednet

Data from household surveys indicate a marked increase in both ownership of bednets and their use among children. Between 2008 and 2010, 290 million nets were distributed in Sub-Saharan Africa. How effectively they were used is, of course, not captured by distribution statistics. Most African countries with data for 2009-2010 show ITN coverage increase and reduced disparities among various population groups - largely due to nationwide campaigns for the distribution of free nets that focused on poor, rural areas targeting pregnant women and children in priority.[67]

For the countries of the desk study sample, the figures are as follows.

Table 25: Proportion of children under 5 sleeping under insecticide-treated bednets, 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		1,6			9,6				
Congo, Dem. Rep.						5,8			38,1
Ghana		3,5			21,8		28,2		
Mozambique						6,7	22,8		
Nigeria		1,2					5,5		
South Africa									

[66] UNICEF and WHO. 2009. Diarrhoea: Why children are still dying and what can be done, p.7
[67] UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Timor-Leste	8,3								42
Zambia	6,5				22,8	28,5	41,1		49,9
Zimbabwe					2,9			17,3	
Tanzania				16			25,7		63,8
Asia									
Lao PDR					40,5				
Vietnam				13					

Source: UN site for MDG indicators: http://mdgs.un.org/unsd/mdg/Data.aspx

The EC has supported the aim of increasing the proportion of children sleeping under a bednet in two indirect ways:

- Through support to GFATM, especially its malaria component as well as health system strengthening component (HSS) of HIV/TB or malaria;
- Through general health system strengthening, e.g. through SBS, GBS or provision of Basic Health Care Packages.

The Global Fund pays for 76% of all the ITNs distributed around the world and distributed nearly 200 million ITNs to prevent malaria.[68] As described in the thematic case study on EC support to the GFATM, the EC should be apportioned a significant share of the impact which the GFATM has achieved in progress against the three diseases of poverty[69]. Over the period 2002–2010, the EC disbursed EUR 803 million, from which EUR 420 million went to the ACP region. The document review reports bed-net distribution activities by the GFATM in the following desk study countries: *Burkina Faso, Ghana, Zambia, Afghanistan, Laos and Philippines*.

- In *Ghana* and *Burkina Faso,* the MoH included the free-distribution of ITNs, especially to pregnant women and children under five, in their national health plans. Through its GBS support to both countries, the EC might have indirectly contributed to and the financing of the aforementioned bednet distribution and awareness raising campaigns.
- The analysis of the case study countries provides evidence that the EC financed interventions aiming at bednets distribution and community awareness-raising on this issue in *Zambia, Afghanistan* and *Bangladesh*. Preceding the evaluation period, the EC had financed a regional malaria control programme in *Laos*, Vietnam and Cambodia, which was continued by the GFATM. According to the CSE Laos (2008), the EC had made a highly significant contribution to the fight against malaria with the distribution of impregnated bed nets. Also in *Afghanistan*, the EC initiated projects related to malaria control, which increased the coverage with bednets. One of the reasons for this increase was the fact that free bednets were distributed to pregnant women for her first prenatal visit and many women went to different health facilities in order to get bednets. The project was continued after the end of EC funding in 2003 by the GFATM. Looking at these two examples could led to the conclusion that the EC plays a role of initiator for specific topics, but once the projects are running, leaves its further development to more specialised stakeholders in the field, as is the GFATM in relation to the fight against PRDs.

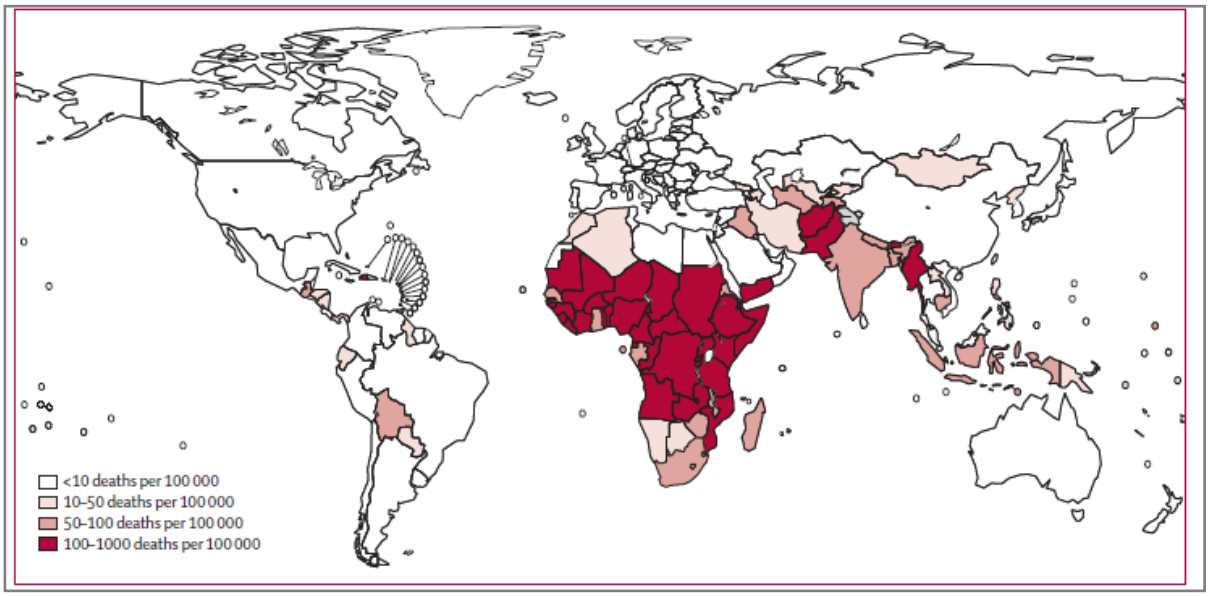
Overall, the EC financed only very few individual and rather small projects directly targeting the use of bednets of children (*Zambia*, *Bangladesh*, *Laos, Afghanistan*). These projects aimed at the distribution of bednets to pregnant women or women with small children and awareness-raising action, which, as a result, helped increasing the coverage with bednets among these two target groups in the project area. From the case study it appears that the most substantial EC contribution in the area was provided through supporting GFATM activities as one of the global players in the fight against malaria. This support has contributed to considerably increase bednet coverage for children especially in high-risk zones and countries such as West- and Southern Africa (Ghana, Burkina Faso, Zambia), where figures raised from almost no use of bednets for small children at the beginning of the evaluation period to a coverage of around 40% in 2009-2010.

[68] The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria. September 19, 2011
[69] The full thematic case study can be found in Annex 17.

4.3.2 I-432 Reduction in rate of child deaths from diarrhoeal disease and I-433 Improved household management of diarrhoea based on oral rehydration salts (ORS)

According to UNICEF and WHO, diarrhoea remains the second leading cause of death among children under five globally, beside pneumonia, accounting for 15% of all deaths respectively in 2008.[70]. Nearly one in five child deaths is due to diarrhoea. It kills more young children than AIDS, malaria and measles together.[71] Diarrhoea is more prevalent in the developing world, in large parts due to the lack of safe drinking water, sanitation and hygiene, as well as poorer overall health and nutritional status. Diarrhoea deaths are concentrated in two regions (Africa 46% and South Asia 38%) and nearly three quarters of child death due to diarrhoea occur in just 15 countries, in Asia: *Afghanistan, Bangladesh,* China*, India,* Pakistan; in ACP in Angola *Burkina Faso, DRC,* Ethiopia, Kenya, Mali, Niger, *Nigeria,* Uganda, *Tanzania*).[72]

Figure 27: Rotavirus mortality in children younger than 5 years



Source: JE Tate, AH Burton, C Boschi-Pinto, AD Steele J Duque, UD Parashar and the WHO-coordinated Global Rotavirus Surveillance Network. 2011. 2008 estimate of worldwide rotavirus-associated mortality in children younger than 5 years before the introduction of universal rotavirus vaccination programmes: a systematic review and meta-analysis, p.5

There is a strong link between malnourishment (I-421) and deaths from diarrhoea. Around one third of diarrhoea, measles, malaria and lower respiratory infections in childhood are attributable to underweight.73 Overall, diarrhoea is still an important issue and it is clear that, the MG4 target to reduce under-five mortality will not be reached without successfully coping with this burden of disease.

The use of ORS therapy to treat effects of diarrhoea shows important regional differences as well as differences between income groups. While in the African and Eastern Mediterranean Region, only around 40% of persons with diarrhoea receiving ORS and/or RHF, this percentage is of 67.8% in South-East Asian Region. Low income groups use ORT only to 42.1%, while 66.5% of lower-middle income households are treated with ORT.[74]

The following table shows diarrhoea treatment in the 25 desk study countries for children under-five. Where time series are available, a trend towards less use of ORS and continuous feeding is observed in a substantial number of countries (*Burkina Faso, Nigeria, Zimbabwe, Egypt*). As figures seems to fluctuate considerably – as can be seen in countries with equal or more than three data points during the evaluation period – interpretation of these figures should be done with caution.

[70] WHO. 2011. World health statistics 2011, p.14
[71] UNICEF and WHO. 2009. Diarrhoea: Why children are still dying and what can be done, p.1
[72] UNICEF and WHO. 2009. Diarrhoea: Why children are still dying and what can be done, p.7
[73] WHO. 2009. Global health risks: mortality and burden of disease attributable to selected major risks, p.13
[74] WHO. 2011. World health statistics 2011. p.101

Table 26: Diarrheal treatment (percentage of children under 5 receiving oral rehydration and continued feeding), 2002-2010

Country	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		47.3			42.4				
Congo. Dem. Rep.						42.3			
Ghana		39.9			28.6		44.6		
Mozambique		46.6					46.9		
Nigeria		27.7					24.9		
South Africa									
Tanzania				53.0					
Timor-Leste									
Zambia	47.8					56.1			
Zimbabwe					46.7			34.9	
Asia									
Afghanistan		48.1							
Bangladesh			52.5		48.9	68.0			
India					32.7				
Lao PDR					49.2				
Myanmar		65.0							
Philippines		59.6					75.8		
Vietnam	39.4				64.8				
Yemen. Rep.		18.0			47.6				
ENP									
Egypt. Arab Rep.				27.0			18.9		
Moldova				48.2					
Morocco			45.8						
Syrian Arab Republic					34.2				
Latin America									
Ecuador									
El Salvador									

Source: http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=

Indicator Name	Diarrheal treatment (% of children under 5 receiving oral rehydration and continued feeding)
Definition	Children with diarrhoea who received oral rehydration and continued feeding refer to the percentage of children under age five with diarrhoea in the two weeks prior to the survey who received either oral rehydration therapy or increased fluids, with continued feeding.
Source	UNICEF, State of the World's Children, Childinfo and Demographic and Health Surveys by Macro International.
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average

Responses of the MoH survey show an increasing use of ORS only for *Syria*, *Laos*, *Yemen* and *Afghanistan*. No change was reported for *Egypt*, *Moldova* and *Morocco*. Disparities between rural and urban areas are reported for all countries, except for Morocco. According to the MoH responses, the EC seems not to have contributed to the promotion of household management of diarrhoea.

As for other MNCH interventions, the inventory did not allow to identify specific interventions tackling diarrhoeal diseases of children. However, it can be assumed that interventions related to child diarrhoea have been financed under the sub-sector "basic health", which accounts for 21% of the total support to the health sector.

The analysis of the case studies gives some, but overall rather scarce, information on the indicator. The picture that emerges from the country case studies is that support to primary health care, aiming at increased availability of health care services, increased availability of health care workers or increased awareness on child health and at the prevention and treatment of water born and water-washed disease, is likely to have

an impact on treatment of diarrhoeal diseases. *Afghanistan* and *DRC* are examples where the EC supported the delivery of basic health care packages or *Bangladesh,* with the EC supporting the national Health, Nutrition and Population Sector Programme.

Beside large sector interventions, individual NGO-implemented projects operating in remote areas or targeting vulnerable people, have contributed locally to the promotion of better treatment of diarrhoeal disease. An example of increased awareness and proper disease management is *Laos*, where the EC financed the NGO project " *Amélioration des conditions sanitaires des populations rurales vulnérables (Province de Vientiane et de Sayabouri) par l'appropriation communautaire et le renforcement des capacités de la Croix Rouge Lao*" which, according to the ROM report[75] was also successful in providing clean water and the management and maintenance of the water infrastructure by the community, as well as hygienic behaviours (boiling water, hand washing). Women have been identified as essential actors in hygiene and family health, however reaching them, appears still to be difficult. The EC-funded water and sanitation had a major impact in the form of reduced child mortality rate due to diarrhoea diseases. While at the general level, water and sanitation interventions are outside the scope of this evaluation, they have been considered in cases where the inventory allowed establishing a clear link with the promotion of better health. For example in *Lao PDR*, NGO projects[76] and the PSIE and PASSE projects in *Ecuador* had a focus on sanitation and safe access to drinking water. However, whether they have helped decreasing child death due to diarrhoea could not be assessed for the Lao case, while, according to the beneficiaries' opinions in Ecuador, the intervention there has not helped improving the health status of children.

Overall, information on the mortality rates of children as a consequence of a diarrhoeal disease and the treatment with ORS was scarce in the sources consulted and only few direct EC-interventions could be found. The EC financed some individual projects targeting the management of water-borne diseases and health education on aspects such as water and sanitation, e.g. in *Laos and Ecuador*. These projects showed good results and have contributed to increasing knowledge and awareness on the origin and treatment of diarrhoeal diseases. However, specific data on reduced child mortality are not available or do not show a trend downwards. The highest impact of the EC on better management of child diarrhoea through ORS and reduced child mortality due to diarrhoeal diseases, must to be seen in EC-financed primary health care interventions, which also target children's health, especially diarrhoeal diseases. Through increased availability of health care facilities or health workers, awareness on and the treatment of diarrhoeal diseases have improved, in countries such as *DRC*, *Afghanistan* or *Bangladesh* out of the country sample.

It must however be noted that the fight against diarrhoea is closely linked to the water and sanitation sector, which was not included in the scope of the present evaluation. Through its support to the water and sanitation sector, the EC has certainly also further contributed to fighting child diarrhoea.

[75] Monitoring Report, MR-123062.01, 30/07/2009.
[76] "Education to health and improvement of the sanitary arrangements in Laos" and "Amélioration des conditions sanitaires des populations rurales vulnérables (Province de Vientiane et de Sayabouri) par l'appropriation communautaire et le renforcement des capacités de la Croix Rouge Lao".

5 EQ5- To what extent has EC support to health contributed to strengthening the management and governance of the health system?

5.1 JC 51 - Improved availability of policy analysis and data for health sector management and governance due to EC support

There is mixed evidence from sources (country case-studies, CSPs, interviews and the EUD survey) on the degree to which EC assistance has improved the availability of policy analysis and data to strengthen management and governance in the health sector. The EC has clearly contributed to strengthening health policy strategy processes and has incorporated key issues such as PFM, accountability and capacity into policy dialogue, but there is less evidence of these activities being sustainable. Moreover, little work has been undertaken by the EC at sub-national level.

The EC has, however, made a contribution to strengthening overall health policy strategy processes in the countries in which it works by supporting the preparation of national strategic health plans, the co-ordination of performance monitoring and preparation of indicators and has assisted in the development of sector co-ordination mechanisms. The EC not only aligns its support to these plans, but also engages in co-ordination mechanisms related to health such as policy dialogue, joint sector analysis and reviews.

Most of this support has been in the form of TA to assist in the drafting of health sector plans, MTEFs and development of indicators, while EUDs in country have been active in establishing health co-ordination mechanisms. In some instances the development of plans and health policy related processes have been included as conditions in policy matrices to provide further leverage for these mechanisms to be established. There is however little evidence given as to how successful the support given by the EC was in strengthening these processes. Also, in a few countries, the EC has not made such a large contribution in these areas, mainly when there are few donors present to coordinate with or the government is not interested in dialogue, as aid does not represent a high percentage of the government budget.

EC policy dialogue related to health in GBS/SPSP forums has incorporated PFM, accountability and capacity building measures, in the majority of countries, although it is not always clear the extent to which this dialogue has resulted in strengthened capacity in these areas. These issues were often introduced into this dialogue by the inclusion of indicators related to the three areas into policy matrices or through the EC raising specific issues. The willingness of governments to engage with the EC in these areas was an important factor in the EC achieving successful dialogue.

The EC has undertaken limited work on decentralised capacity building to strengthen health policy capabilities, but not in all countries and often the support undertaken has not been sufficient. This is probably due to the fact that most SBS/SWAps tend to focus more on upstream policy and monitoring processes, rather than the actual delivery of services. It is also notable that in the countries where decentralisation has been addressed, capacity building support was provided through projects. The activities that have been implemented ranged from TA to support and building capacity at local government level developing road maps to guide the decentralisation of health budgets, training in IFMIS systems at local level capacity building and supporting planning. It is not clear in all cases from the information analysed, what tier of local government this work was aimed at and the extent to which it was successful. This is an omission as it is pointed out by the ECA report on health services in Sub-Saharan Africa that low capacity at provincial and district level negatively affects the performance of EDF projects.

Examples of where capacity building at local level has been successful in the *Philippines*, *India, Ecuador, DRC, Afghanistan* and *South Africa* are outlined in the box 25

5.1.1 I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators)

The EC has made a contribution to strengthening the overall health policy strategy process and related documents in the majority of countries where it is giving support. It has supported the preparation of national strategic health plans (e.g. in *Barbados, DRC, Morocco, Nigeria*), the co-ordination of performance monitoring and preparation of indicators (e.g. in *India* and *Lao*), development of health policy (Ecuador) and

has assisted in the development of sector co-ordination mechanisms (*DRC*).[77] The EC not only aligns its support to these plans, but also engages in co-ordination mechanisms related to health such as policy dialogue, joint sector analysis and reviews (*Ghana, El Salvador, DRC, Philippines, Moldova, Mozambique, Syria, Timor Leste, Zambia and Burkina Faso)*[78].

Most of this support has been in the form of TA to support the drafting of health sector plans, MTEFs and development of indicators, while EUDs in country have been active in establishing health co-ordination mechanisms (see also EQ6). In some instances the development of plans and health policy related processes have been included as conditions in policy matrices to provide further leverage for these mechanisms to be established. For example, in *Moldova* the MTEF for the health sector was one of the conditionalities of the Policy Matrix for the Health Sector Budget Support Programme[79], while in *Mozambique,* due to the SBS conditionality, the monitoring of the annual work plans and budget is undertaken by the annual joint review[80].

Examples of support provided by the EC in this area are illustrated by *Timor-Leste* where the draft National Health Sector Strategic Plan (HSSP) and a Medium Term Expenditure Framework (MTEF) have been developed by the Ministry of Health with the assistance of EC TA.[81] In *Lao,* EC TA helped in drafting annual work plans for the MoH linked to the Health Master Plan and the Health Financing Strategy and identified and agreed with partners a list of indicators for 2009 – 2011.[82] Similarly, in *Moldova* the EUD commented that the EC contributed to the establishment of an MTEF for the health sector[83] and in the *Philippines* the EC co-chairs the Health Working Group of the Philippines Development Forum (PDF) and TA contributed to the enhancement of the Philippines National Health Accounts (PNHA.)[84] There were also some quite innovative examples of the EC attempting to strengthen co-ordination mechanisms. For instance in DRC, the EUD prioritised the strengthening of the Country Co-ordination System (CCM) of the Global Fund, so that the body could actually become a platform for joint decision making between the Ministry of Health, donors and civil society.[85] In the case of Ecuador there was also significant support given to the Ministry of Public Health by the EC to develop health policy. This is outlined in the box below.

Box 25: Ecuador: EC Support to the Ministry of Health to develop health sector policy

The *Programa de apoyo al sector salud en Ecuador* (PASSE was to support the Ministry of Public Health (MPH) in developing an integrated model of health care (MAIS). The initial focus on increasing public health care insurance coverage was transformed into an approach aimed at developing universal health care provision financed through the government budget. The programme supported this new approach with the provision of technical assistance to the MPH and a technical team for reform was established at the MPH as a Coordinating Office for Health Policy. The technical assistance was one of the key inputs to PASSE processes and subsequent discussions on the construction of the MAIS and proposals for the new Constitution. A MAIS proposal document prepared with funding from PASSE was considered valuable by the MPH and overall the **contribution of PASSE to the process of reform by supporting establishment of public policies and strengthening the institutional capacities of MPH for the process was significant**.

Source: Ecuador Country Case Study

Another example of EC initiatives is *Vietnam*, where, in conjunction with other donors, the EC is engaging in the strategic planning process in health, in order to have the basis to design and launch sector budget support in health[86]. Moreover, the EC/ACP/WHO Partnership on Health Millennium Development Goals (MDGSs is aiming to enhance national capacity for formulation and implementation of health policies including a strengthened engagement of the health authorities in Poverty Reduction Strategy Papers (PRSPs), Sector-wide Approaches (SWAps) and budget support processes, in order to scale up programmes to accelerate the achievement of the MDGs. The project began in and includes support to *Angola*, *Burkina*

[77] Relevant CSPs and DRC and Ecuador and Philippines Country case-study
[78] Relevant CSPs and country studies for Timor-Leste and DRC
[79] EUD Survey
[80] EUD Survey
[81] Timor-Leste country case-study
[82] Lao country case-study
[83] Moldova country case-study
[84] Philippines country case-study
[85] EAMR 1/2006
[86] Vietnam CSE, 2007

Faso, *Kenya*, *Malawi*, *Niger*, *Tanzania*, *Guyana* and *Haiti*;[87] however, there is no evidence available on how successful this particular initiative has been.

There is also evidence from the MoH Survey that some of the support given by the EC was successful in strengthening health sector processes. The survey asked 'how would you rate the availability and quality of data, analyses and guidelines facilitating policy making and implementation for 2010?'. For all eight countries that responded, this was rated as either satisfactory or good, with specific EC contributions highlighted, although in the cases of *Syria* and *Afghanistan* there were some caveats to this. The specific comments were as follows:

- In Syria, there was a minor contribution by the EC through the HSMP.
- Improvements occurred in Lao in management information systems, use of monitoring indicators and regular use of household surveys. The EC contributed to this through HSPSP II conditionalities relating to household surveys. Also, in Lao, EC support to policy development occurred through the PRSO and according to the MoH, policy became more evidence based which the EC contributed to through its health sector support programme.
- For Afghanistan, the MoH observes an EC contribution to health policy, but it was commented that out of pocket expenditure still remains an issue.
- In Moldova, the TACIS project assisted in strengthening statistical data, analytical reports and access to data.
- A health information system was supported by the EC in Burkina Faso.
- Health financing studies and consultations were the EC's contribution to policy development in Morocco.

However, in some instances, it was noted that further support in this area was still needed, such as in *DRC* where it was commented that the MoH still did not have the capacity to design policies independently.[88] In the case of *Ecuador*, the final evaluation noted that although the support provided had been important, the focus on this area detracted from results in other areas of the PASSE programme[89].

As highlighted in the EUD survey, in some countries, the EC has not made such a large contribution in these areas, mainly when there are few donors present to coordinate with or the government is not interested in dialogue, as aid does not represent a high percentage of the government budget. This was the case in *Myanmar* where there was reported to be no health sector dialogue and in *Afghanistan, Laos, Yemen, South Africa, Barbados and Nigeria*, where there was no co-ordination mechanism with the government in the health sector during the period under review, as there were few other donors to coordinate activities with[90]. For example, it was commented that in *Barbados "there are not enough donors active for co-ordination to be a priority"*[91].

In conclusion, the EC has made a contribution to overall health policy strategy processes and related documents in most countries, where it has operated, mainly through the provision of TA to support the development of health sector plans and assistance from EUD to establish co-ordination processes. When this has not occurred this has been due to a lack of interest on behalf of recipient governments or to the fact that there have not been a large amount of donors to coordinate health sector activities with.

5.1.2 I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector

EC policy dialogue related to health in GBS/SPSP forums has incorporated PFM, accountability and capacity building measures, in the majority of countries, although it is not always clear the extent to which this dialogue has resulted in strengthened capacity in these areas.

EUD survey results show the following picture: one EUD (*Ghana)* reported that PFM dialogue was excellent in their country, eight EUDs *(Egypt, Barbados, Lao PDR, India, Afghanistan, Morocco, Mozambique* and *South Africa)* reported that the incorporation of PFM in policy dialogue was "good", five EUDs (*Philippines,*

[87] European Court of Auditors, EU Development Assistance to Health Services in Sub-Saharan Africa., 2008
[88] DRC Country case study
[89] Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, Final Report, September 2010
[90] EUD Survey
[91] EUD Survey

Moldova, Burkina Faso, Vietnam, Ecuador) reported it was "satisfactory", while only two (Bangladesh and DRC) rated it as "unsatisfactory".

Examples of dialogue related to PFM in the countries surveyed are[92]:

- In *Egypt*, PFM reform benchmarks were included in all budget support operations. These benchmarks, were included in all BS operations, as a mean of enhancing policy dialogue.
  - In *Vietnam*, there is now an annual financial report for the health insurance fund, due to the pressure for more transparency in public finances. The EC contributed to this through joint dialogue with other donors on this issue.
  - In *India*, policy dialogue was enhanced due to the close relationship with government and the fact that both EUD staff, as well as government officials, have been trained on PFM issues.
  - In *South Africa,* the EC insisted on including PFM as one of the three conditions for the fixed tranche of health SBS and including one PFM related indicator in the variable tranche. This led to a more focused discussion on PFM
  - In *Moldova,* the EC contributed to the establishment of the Internal Audit Unit in the MoH through incorporating these activities into the policy matrix of the health SBS

Although both *Bangladesh* and *DRC* rated dialogue on PFM as unsatisfactory, there has still been an EC contribution to dialogue in *Banglades*h as the EC was a member of the Financial Management Task Group. Interestingly, in *Ghana* the EUD rated PFM dialogue as excellent, despite the fact that the EC does not work in the health sector in Ghana. This ranking was justified by noting that the EC keeps active in the PFM area and therefore influences the entire system including health.

In terms of **dialogue** related to accountability, five EUDs (*Barbados, Vietnam, Afghanistan, Morocco, Mozambique)* reported it to be "good", six EUDs (*Philippines, India, Moldova, DRC, Ecuador, Timor Leste*) found it "satisfactory' and one EUD (Ghana) found it "excellent", with again only two (*Lao PDR* and *Burkina Faso*) rating it as "unsatisfactory". Few countries who responded gave specific examples of how accountability was incorporated into dialogue, but the EUD in *India* noted that *"capacity and methods in accounting, better accountability, simplified expenditure positions and reporting timeliness*" are seen as major changes during the evaluation period. Frequent interaction with financial managers and seminars with beneficiary government officials by the EUD is a success factor for these changes. While in *Timor Leste* the factors which led to putting accountability onto the policy agenda included the agreement of "*partners and MoH to reduce the level of drug stock out in every level*." The EC funded SIHSIP and provided technical assistance to the national medical store and MoH.

The EUD in *Lao* rated dialogue related to accountability as unsatisfactory as *"accountability is a difficult issue," and* there is a *"need for more financial accountability"*. In *Burkina Faso,* the EUD notes that accountability has only to a small extent been included in policy dialogue as it involves a "*sensitivity of the government/minister to discuss the issue and existence of a system that measures accountability"*. The EC in this context "*raises the issue at opportune moments".* This indicates that the success that the EC has had with including accountability within policy dialogue has also been dependent on the political will of governments to engage with this issue.

EUDs reported that **capacity building** was incorporated well in policy dialogue, six EUDs (*India, Bangladesh, Afghanistan, Morocco, Mozambique* and *South Africa*) who rated policy dialogue as "good", eight EUDs (*Egypt, Lao PDR, Barbados, Philippines, Moldova, Burkina Faso, Ecuador* and *Timor Leste*) "satisfactory", with only two EUDs (*Ghana* and *DRC*) rating it as "unsatisfactory".

- In *Afghanistan*, an increased level of training was a major change due to incorporation of capacity building measures. The EC contributed to that by funding training.
- In *India*, the changes regarding incorporation of capacity measures included electronic accounting and reporting, an implementation of a financial management manual, on site reviews and hand holding.
- In *Barbados*, there were only "moderate improvements", due to an "unwillingness of government" and "very dogmatic demands" by the EC. These statements were not explained further in the survey,
- In *Moldova*, changes include "capacity building in MoH on management and budgeting issues", due to "lack of capacity" in this area. The EC contributed to these changes through "incorporating these activities into the Policy Matrix of the Health Budget Support".

[92] EUD Survey

For **accountability** only two EUDs (*Ghana* and *DRC*) rated the extent to which PFM is incorporated into the policy dialogue on SPSP/GBS as unsatisfactory. Only one EUD (DRC) provided qualitative information regarding their assessment and noted that the capabilities of the health ministry are still weak, despite the EC contributing to the overall process of accountability and transparency of the health system, in particular by supporting the national system for collecting and analysing health data[93].Also overall, in Mozambique it was noted by a range of stakeholders interviewed that although dialogue was good there was a 'strong focus of the dialogue over the past few years on the technicalities of the mechanism for SBS rather than on policy and substantive issues related to implementation and to progress. This means that dialogue remains stuck in operational issues.[94] As a result, there was less focus on PFM, accountability or capacity building. This contradicts the EC report observations noted above.

Other evidence also confirms this finding as in *Vietnam* a Working Group, including EC officials, has been formed to discuss experiences in the social sector and lessons derived from sector budget support in education to inform the new sector budget support being developed in health[95]. This has included PFM, accountability and capacity building measures likely to be needed for SBS to be successful.

In *Bangladesh*, the EC has been particularly influential by bringing issues related to health financing into the donor dialogue and through this persuading both donors and the Government of Bangladesh of the need for reform in this areas: The EC and a small group of other like-minded donors were keen to improve health financing, but this area had not been part of SWAp dialogue, which was focused more on MDG achievement. As a result the group initiated some work on the revenue allocation formula at local level which needed amending and on overall issues related to health sector financing. They brought this to the SWAp group and were able to persuade the government and other donors of the usefulness of interventions in this area. This has led to the Government of Bangladesh piloting the revenue sharing formula and engaging further work on health financing. [96]

It was also noted in the Zambia Multi-Donor Budget Support Evaluation of 2007 that there had been significant effects from policy dialogue and conditionality discussed by the health sector group, which the EC is part of that was credited with enhancing MoH ownership and responsibility for the policy process, as well as prioritisation, target setting and monitoring. Also, in *Moldova* PFM was integrated into HSPSP policy dialogue which the EC was part of, with a major achievement being a 'unified set of methodologies concerning budget formulation for all four components – state budget, state social insurance fund and mandatory health insurance fund and ATU budgets'.[97] In *Egypt*, the EC dialogue with the MoH was judged as 'excellent and transparent', with the EC as a front runner in the dialogue. This has allowed discussion of sensitive issues such as PFM and health sector insurance[98].

The EC has also implemented some good strategies for engaging in health sector dialogue. As the European Court of Auditors findings on GBS in *Lao* note, the EUD in Lao identified the need to recruit health and education experts to enable the EUD to take part in GBS dialogue related to these sectors as well as in the PFM dialogue. This increased the EUD's influence over health sector dialogue and allowed the EC to play an active role[99].

On the other hand, in other instances such as Paraguay, GBS dialogue was used purely to focus on compliance and disbursement issues, rather than sector policy or implementation issues or PFM.[100]

Results from the EUD survey and other sources indicate that there has been a good level of dialogue in health sector forums related to PFM, accountability and capacity building measures, in the majority of countries, although it is not always clear the extent to which this dialogue has resulted in strengthened capacity in these areas as a result.

Overall, EC engagement in policy dialogue related to PFM has been very good and has been helped by indicators related to PFM in health sector PAFs. This has led to a greater focus on PFM in sector dialogue. Accountability issues have also been addressed well, although, in a few instances both these areas have not

[93] DRC Country Case Study
[94] Visser-Valfrey and Umanji (2010)
[95] Vietnam CSE 2007
[96] Interview with EUD Bangladesh
[97] HSPSP PFM Final Monitoring Report
[98] Egypt CSE, 2010
[99] Court Of Auditors, Statement of Preliminary Findings related to the Mission to Laos, 2009
[100] Court of Auditors, Statement of Preliminary Findings Related to the Mission to Paraguay, 2009.

been included in dialogue due to government sensitivities. Capacity building has also been incorporated very well into dialogue.

5.1.3 I-513 EC contributed to decentralised capacity building to strengthen health policy capabilities at provincial, district and local levels

The EC has had a limited contribution to decentralised capacity building to strengthen health policy capabilities, as this has not been included in all country programmes and where it has it often has not been sufficient. Countries among the desk countries where work in the health sector has been undertaken at sub-national level were *Afghanistan*, the *Philippines, India* and *Lao PDR* in Asia, *DRC, Ghana, Zambia* and *South Africa* in ACP countries, *Egypt* and *Ecuador* in ENP respectively Latin America. This is not surprising given that a lot of the support provided to health by the EC is given through SPSPs which tend to focus more on upstream policy and monitoring processes, rather than the actual delivery of services.[101] It is notable that in the case of the *Afghanistan*, *DRC*, South Africa, *Lao PDR, India* and *Ecuador*, the capacity building support was provided through projects, only the support given by the *Philippines, Zambia* and *Egypt* was through an SPSP

The activities being implemented ranged from TA to support building capacity at local government level (*Philippines*), developing road maps to guide the decentralisation of health budgets (*Egypt*), training in IFMIS systems at local level (*Lao PDR*), capacity building (*Afghanistan, South Africa*) and supporting planning (*India, DRC, South Africa*). It is not clear in all cases from the information given what tier of local government this work was aimed at and the extent to which it was successful. However, the EUD survey did note that one of the areas where an improvement has been experienced over the evaluation period was in the decentralisation of administrative and financial function in the health systems[102].

Examples of where capacity building at local level has been successful in the *Philippines*, *India, Ecuador, DRC, Afghanistan* and *South Africa* are outlined in the box below:

Box 26: Successful examples of support to strengthening health systems at the local level: Country case studies

Afghanistan – Under the 'Health Management Training to the General Directorate of Provincial Public Health, Ministry of Public Health' (2006-2009), the EC strengthened the managerial and administrative capacity of the Afghan Ministry of Public Health for providing an efficient, accessible and equitable health services to the Afghan population at large and specifically in rural and remote areas.[103] This was undertaken through a combination of national and international TA supply contracts and training. The programme has a positive impact on the capacity of the provincial public health and as an example, other donors started to replicate the same format late in 2007.

India – The Health and Family Welfare Development Programme, 1998-2007 (HFWSD) programme's support to the decentralisation process and to the planning and implementation capacity of State and District health authorities has led to better-defined roles and responsibilities. The initiative also allowed State and District health authorities to develop various initiatives to recruit and retain staff and to increase and maintain their skills and knowledge. These initiatives range from various training programmes to incentive schemes, including renovated staff houses for health workers.[104] The HFWSD programme has also played a crucial role in the decentralisation process by providing budgets to participating Districts, based on plans developed by the District authorities in addition to the existing, rigid expenditure-based funding from State and national level.

Ecuador – The TA attached to the main health sector programme (PAPES) had four different technical support and training programmes supervised by four national institutions. This has strengthened the PFM capacity of local governments where there have been interventions.

DRC – EC support in capacity development have prioritised the decentralised level, especially targeting health facilities. The PS9FED has supported the provincial health departments by creating an expert team at provincial level, which has helped the DPS to better fulfil their new role in the context of devolution of responsibilities.[105]

Philippines - The EC programme on health provided TA to support both the local government units and the DoH in systems strengthening (planning, procurement internal control, performance-based monitoring) and improving budget credibility and budget execution. This led to an improvement local health systems due to enhanced co-ordination across local health systems, enhanced effective private-public partnership and improved national capacities to manage the health sector, in particular in the areas of PFM (e.g. procurement, finance, internal controls) and information systems.

[101] This was one of the main conclusions Williamson & Dom (2010) Sector Budget Support in Practice: Synthesis Report.
[102] EUD Survey
[103] Final Progress Report on Health Management Training to the General Directorate of Provincial Public Health, Ministry of Public Health
[104] India CSE 2007
[105] Country Case-study

South Africa - The PDPHCP I and II were successful in supporting decentralised capacity building to strengthen health policy capabilities at provincial, district and local level. The 2009 MTR[106] states that through PDPHCP II 1,264 non-profit organisations were funded to provide the primary health care packages to support the DoH in provide PHC to all communities. By 2009 the programme was operational in 40 of the 52 health districts in the country.

Source: EUD Survey (Philippines), Country Case-study Afghanistan, DRC and South Africa

However, both *India* and *Ecuador* EUDs raised concerns about the progress and sustainability of capacity building support at local level. In the case of India, it was reported that the EC developed a District Medical Officers Manual to guide on planning and plan orientation in implementation and spending and that this impetus has been further developed in the states. However, according to the EUD, no more than satisfactory progress has been made in this area[107]. The EC in Ecuador raised concerns regarding the sustainability of support at provincial level, noting that the ownership of the process by the Provincial Health Directorates is generally weak, linked to difficulties in relations between the provincial structures of the programme and those DPSs and there was little co-ordination between institutions offering TA. As a result of the above, the programme had smaller effects at the provincial level than at the central level and there was an on-going need for capacity building, so this limited support was not likely to be sustainable[108].

Decentralisation has also been a key aspect of EC programmes in *Egypt*, *Ghana* and *Zambia*, although no information is available on how successful these initiatives have been. In some instances, it has been highlighted that decentralised capacity building should have been focused on but was not. In *Vietnam*, the HSDP project was criticised in the 2002 MTR for working with different departments of the MoH in Hanoi that had overlapping policy making functions. The MTR recommended the remainder of the project focus primarily on the provincial level. On the other hand, there was some evidence that policy-making capacity and ownership had grown over time for provincial health departments in areas benefitting from the HSDP.

This lesson appears to have been learned by the EUD in Vietnam, as in 2008 a new initiative was undertaken by the EC where the EUD is engaging, together with other donors, in a capacity building project at the Ministry of Health (MoH) and in three provincial-level Health Departments designed to lay the groundwork for budget support. This acknowledges the fact that, while the EC has contributed to capacity building for service delivery through other programmes, there have been no programmes which addressed the need to enhance the capacity for policy making.

In several countries, the EC has also sought to enhance Private-Public Partnerships (PPPs) at local government level to further enhance the likelihood of improved service delivery by local governments. Positive examples include the *Philippines* (PPPs in the health sector) whereas the EC supported introduction of PPPs in *South African* local governments was less sustainable because national guidelines on PPPs were poorly suited to the needs of local governments and, to a large extent, PPPs was introduced as precondition for EC funding rather than fully appreciated by local stakeholders[109].

The findings in this section also relate to concerns regarding the sustainability and the need that capacity building initiatives are also in line with those of the EU Special Report on the Effectiveness of Technical Assistance in the Context of Capacity Development 6/2007. This report notes existing capacity is often weak and a comprehensive analysis of institutional capacity weaknesses and capacity development needs is often not undertaken. This is an omission, as it is pointed out by the ECA report on health services in Sub-Saharan Africa that low capacity at provincial and district level negatively affects the performance of EDF projects.

Overall, the EC has provided some support to decentralised capacity building, but this has not been comprehensive, as not all programmes have received this type of assistance. As noted by the ECA, the capacity building support when it has been given has often not been sufficient. The lack of capacity building is probably due to the fact that most SBS/SWAps tend to focus more on upstream policy and monitoring processes, with most capacity building support being given through projects. In more than half the cases where support was given to the local level, this was through projects. Therefore, if the EC is only providing SBS or pooled funding it will not be giving direct assistance for capacity building. Although there is not substantive evidence of how successful this type of support at the decentralised level is, provisional evidence

[106] Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&Aids Services – PDPHCP II, Mid-Term Review, September 2009
[107] EUD Survey
[108] Ecuador Country case study and CSE 2010
[109] EC/Particip (2012) Thematic global evaluation of the Commission support to decentralisation process

from other studies indicates that this type of support can result in improved access to health services, but the effects of the support on the quality of locally-provided services is limited[110].

5.2 JC 52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

The EC has made some contribution to strengthening institutional and procedural systems related to transparency and accountability in the countries in which it has implemented programmes. The majority of the EC's work has been addressing public financial management and this has been the area where there has been most success. There has been some technical and capacity building support provided by the EC to assist Ministries of Health in establishing and monitoring Annual Work Plans and budgets, but this assistance has not been comprehensive as it was only been provided to a limited number of countries. The area where there is least evidence of EC support is procurement as there appears to be little focus on this in EC health programmes.

In terms of improving transparency and accountability, much of this work has been aimed at strengthening public financial management, planning, statistical strengthening and auditing, with less evidence of support aimed at the division of roles and responsibilities between the MoH and MoF. Most of this support was through TA or through actions related to PFM in health sector policy matrices and has included work at both national and sub-national level. This has resulted in improvements in most countries where the EC had provided this support (I-521)

There has also been some technical and capacity building assistance given by the EC to assist Ministries of Health in establishing and monitoring Annual Work Plans and budgets in a limited amount of countries. This has been reasonably successful in supporting Ministries of Health in strengthening their capacity for establishing and monitoring Annual Work Plan and Budgets linked to health sector plans and budgets. This support has not been comprehensive, however and it is notable that there has not been much assistance in this area to Sub-Saharan African countries. It is not clear why this is the case, but could well be due to the fact that and other development partners may be providing support in this area so the EC does not need to fund these activities. (I-522)

EC support to the health sector has not focused very strongly on procurement reform. Where there has been support, it has mainly been in the form of (i) public financial assessments of the current system and (ii) technical assistance to the government and there is little evidence provided of improvements in accountability and transparency from these activities.

5.2.1 I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews)

The EC has made a major contribution to the strengthening processes of accountability and transparency of health systems through the support undertaken. This was mainly through strengthening public financial management, planning, statistical strengthening and auditing. Most of this support was through TA or through including actions related to PFM in health sector policy matrices. There is less evidence of support aimed at the division of roles and responsibilities between the MoH and MoF.

The main support provided by the EC was in strengthening public financial management. This was highlighted in the majority of the desk study countries (*Lao*, *Philippines*, *DRC*, *Ghana, India*, *Vietnam*, *Bangladesh*, *Nigeria*, *Burkina Faso*, *Barbados*, *Moldova*, *Zambia*, *South Africa*, *Egypt*, *Moldova* and *Syria)*. Examples of this EC support to PFM are:

- The EC in the *Philippines* provided TA to support planning, performance-based monitoring and improving budget credibility in the health sector.[111]
- In *Mozambique***,** the EC played a lead role in the drafting of the MOU for the SWAp "ProSaude II", which emphasised PFM standards[112].

[110] EC/Particip (2012) Thematic global evaluation of the Commission support to decentralisation process
[111] Country case-study
[112] Country case-study

- In *El Salvador*, the EC helped the health sector local authorities to elaborate annual and monthly financial plans[113].
- In *Egypt*, the EC supported the implementation of performance based budgeting in health and the establishment of a new actuarial department which has developed a financing model for the health sector[114].
- In *Lao*, the EC supported the implementation of an HMIS system which included financial data[115]
- In *Moldova,* the EC supported increased competencies in the MoH for establishing annual work plans and budgets, while the MTEF itself, as well as the National Health Accounts benefitted from Tacis support.[116]

Only in three countries was it reported that this support was not successful. In *Myanmar* and *Yemen*, few changes to the PFM system were reported by the EC. In *Ecuador,* a programme was specifically designed to strengthen the budgetary and financial management at the central level of MPH. However, the initial objective of 25 % of operational units in the health care system using, the system for budget and financial management (SGPF) was not met and remained at 0%.[117].

Other EC support was directed at strengthening the audit function and strengthening data collection and statistics. Examples of this are:

- In *Burkina Faso*, the EUD reported that the EC provided TA for the Court of Auditors and assisted in strengthening the national institute for statistics[118]. The main achievements of this support were the annual publication of statistical year books, which have contributed to making the statistical system of Burkina Faso one of the strongest in West Africa[119].
- The EUD in *Barbados* noted that the audit function had improved due to EC support[120].
- The EUD in *Moldova* reported that the establishment of the Internal Audit Unit was included in the policy Matrix of the EC Health Budget Support Programme.[121]
- In *DRC*, the EC intervention (PATS II and PS9FED) supported the national system for collecting and analysing health data[122]. This system has received the full support of the Ministry of Health and has been gradually extended to the whole country. It is also reported as successful[123]
- The EC in *Zambia* gave support through a project to develop the health management information system (HMIS) system. This was funded from 2006-2008 and was a € 4 million project, implemented through a project implementation unit in the MoFNP. This was complementary to the EC's health SBS as it assisted in providing the information needed on health sector[124] inputs, outputs and outcomes which underpin the indicators for SBS.
- In *Ghana,* EC TA provided to the Centre for Health Information Management assisted in strengthening MoH capacity to assess and monitor interventions and assess sector performance[125].
- In *Ethiopia*, the Protection of Basic Services Program II which the EC funded with other donors was designed to support the budgets of regional level and lower tiers of government which were responsible for basic services such as education, health and water. The programme contained strengthened reporting and accountability measures to enable verification that the services were reaching the intended beneficiaries. These measures also included the continuous audit of local government expenditure by the Auditor General combined with the necessary capacity-building support for the Auditor General's staff.[126]

[113] EUD Survey
[114] Country case-study
[115] EUD Survey
[116] Country case-study
[117] Country case-study
[118] EUD Survey
[119] EAMR 01/2011
[120] EUD Survey
[121] Country case-study
[122] Country case-study
[123] EAMR 7/2005
[124] Bartholomew (2009) Sector Budget Support in Practice: Zambia Case-study
[125] Country case-study
[126] ECA, Special report on GBS

Results from the EUD survey make clear that the quality of MoH and MoF financial planning has improved in most countries between 2002 and 2010, although it is noted that there are still major improvements to be undertaken. Despite this, EUDs observed that there has been improved co-ordination between the two institutions, improvements in the audit function, greater co-ordination across local health systems and decentralisation of administrative and financial functions[127]. It is therefore assumed that the assistance provided by the EC as noted above has contributed to this improvement.

The only country where little EC contribution was observed was in *Afghanistan*, due to the specific context in-country. However, this was because, unlike the World Bank, the EC does not channel health sector funds through the Ministry of Finance, but directly to NGOs and procurement is still undertaken by the EC. Attempts to work through the MoF/MoH have to date failed due to accountability concerns[128].

In summary, EC has contributed in most countries to increasing accountability and transparency of health systems through strengthening, planning auditing and budgeting, although there has been less emphasis on the division of roles between the MoH and MoF.

5.2.2 I-522 EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing)

There has been some technical and capacity building support provided by the EC to assist Ministries of Health in establishing and monitoring Annual Work Plans and budgets, but this assistance has not been comprehensive as it was only been provided to a limited number of countries. *Lao, Barbados, DRC, Philippines, Egypt, India, Ghana, Moldova, Mozambique, Nigeria, Morocco and Ecuador* reported giving TA support in this area,[129] but some EUDs (*Burkina Faso, South Africa* and *Zambia*) stated that there had been a very limited contribution from their programmes.[130]

This support appears in most cases to have had a positive impact on the competencies of the Ministry of Health to develop and monitor annual work plans and link these to budgets. Results from the EUD Survey indicate that there was a perception by EUDs that the capacity of the MoH to establish and monitor annual work plans linked to the health sector substantially improved between 2002-2004 and 2010**.** By 2010, more than half of the EUDs who responded changed from "unsatisfactory" scores in 2002-04 to "satisfactory" in 2010 (*Philippines, India, Vietnam, Bangladesh*, *Moldova, Morocco, Nigeria, Mozambique and Ecuador*). Only five EUDs (*Lao, Timor-Leste, DRC and Syrian Arab Republic*), out of 24, continued to report in 2010, "unsatisfactory" Ministry of Health capacities in this area, mainly due to annual plans and MTEFs not being adhered to or adapted on an annual basis. This indicates that all the countries that had EC support in this area have shown improvement, apart from *Lao*.

Examples of successful assistance in this area include:

- In *Mozambique,* the monitoring of annual work plans and budget is done by the annual joint review as part of the SBS process as a condition was included in the policy matrix for a review to take place[131].
- In *India,* the EC developed a District Officers Manual to guide planning, programme implementation and spending, which has now been replicated in a number of states[132]. However it was noted by the EC that no more than 'satisfactory' progress had been made in this area.
- In *Lao* EC support assisted in drafting Annual Work plans linked to the Health Master Plan and the Health Financing Strategy[133]. The EC reported that significant progress has been made with implementing activities related to this.
- In the *Philippines,* the EC programme on health has contributed to establishing performance based assessments and has a result been successful in building the capacity of the DoH.[134]

[127] EUD Survey
[128] Interview with the EUD Afghanistan
[129] EUD Survey
[130] They not give any explanation as to why or if they were actually providing assistance in this area.
[131] EUD Survey
[132] EUD Survey
[133] Country case-study
[134] EUD Survey

- In *Moldova,* the EUD commented that the EC largely contributed to the establishment of an MTEF for the health sector since it was one of the conditionalities of the Policy Matrix for the Health Sector Budget Support Programme[135].
- For *Ecuador,* the EC commented that the EC technical support to the local health units has helped to develop, follow up and monitor annual health plans and budget expenditure[136].
- The health SWAp in *Ghana* which the EC participates in has helped create a more coherent framework for sector policy and planning. This was through dialogue and technical support provided by donors.[137]

- In *Zambia*, the EC contributed to annual health sector planning exercise and funded the plan for the Retention of health Workers.[138]

Overall, the evidence above indicates that the EC has had some success in supporting Ministries of Health in strengthening their capacity for establishing and monitoring Annual Work Plan and Budgets linked to health sector plans and budgets. This support has not been comprehensive however and it is notable that there has not been much assistance in this area to Sub-Saharan African countries. It is not clear why this is the case, but could well be due to the fact that other development partners may be providing support in this area so the EC does not need to fund these activities. It is also worth highlighting that apart from the case of *Mozambique*, the successful examples above come from programmes that just the EC is supporting.

5.2.3 I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

There has not been comprehensive EC support to procurement reform over the period evaluated. Support has mainly been in the form of (i) public financial assessments of the current system and (ii) technical assistance to the government. There were PFM assessments with recommendations on procurement cited in the cases of *India*, *Vietnam*, *Barbados* and *DRC*, while technical assistance and capacity building support in the area of procurement were given by the EC in *Timor-Leste*, *Lao*, *Afghanistan*, *Moldova*, *Philippines* and *Nigeria*[139].

The most substantial support related to procurement was in the cases of *Moldova*, the *Philippines* and *Lao*.

- In *Moldova*, it was reported that the EC had assisted in procurement reform through secondary legislation, guidelines on public procurement on health and training for health care providers[140].
- In the *Philippines,* EC support coordinated a project procurement management plan for goods and services needs of the provinces with the Bureau of local Health Development (BLHD) and gave TA to develop the local government annual procurement plan and annual procurement and forecasting needs tools.[141] Support was given to help local governments adopt Good Procurement Practices in Pharmaceuticals (GPPP), but the HSPSP MTR team noted inadequacies in the design and implementation of this support which limited effectiveness.[142]
- In *Lao*, the EC supported through GBS the development of procurement regulations of the MoF[143].

There is no evidence in any of these cases, however, of the extent to which the reforms resulted in enhanced accountability, transparency and lower incidences of mis-procurement. What evidence there is comes from the EUD survey, where the EUD in the *Philippines* reported that there had been no reform in procurement during the evaluation period, whereas in *Lao* the EC reported the procurement had been reformed. In *Lao*, *Afghanistan*, *Barbados*, *Nigeria* it was noted that the procurement system had increased accountability and transparency and it was now sufficient, while in *Timor-Leste* the reform had helped to large extent to enhance accountability and transparency. In some instances, e.g. for *Zambia*, it was specifically mentioned that there was no donor support to procurement reform[144].

[135] Country case-study
[136] EUD Survey
[137] ODI & CDD Joint Evaluation of Multi-Donor budget Support, 2007
[138] DIE/AOB, Evaluation of Budget Support in Zambia
[139] EUD Survey
[140] HSPSP Report Review 2009
[141] Philippines country case-study
[142] HSPSP Mid-term Review
[143] Lao country case-study
[144] Bartholomew (2009) Sector Budget Support in Practice: Zambia Case-study

This finding is corroborated by the MoH survey where, as the following table indicates, as far as responding MoH interviewees are concerned, the EC has played no role in procurement reform. While in a number of the eight responding MoHs (*Syrian Arab Republic, Lao, Afghanistan, Moldova, Burkina Faso* and *Morocco*) reforms have been started in the 2000s and the extent to which these reforms have helped enhancing accountability and transparency is judged "modest" or "high", only the Burkina Faso MoH sees a good contribution of EC to the reform, through sector policy dialogue at national level. Although in *Lao* the EC has been engaged, but, as this has been through GBS, the MoH has not been aware of individual donor support.

The EC lack of support to procurement reform is not necessarily an issue if this area is being supported by other donors. For instance the World Bank is often heavily engaged in this area, which means there is no need for other donors to participate. This was noted in the example of Bangladesh, where although the EC used to have support to procurement this is now being undertaken by other donors.[145]

In summary, EC support to the health sector has not focused very strongly on procurement reform and in the few cases where it has done, there is little evidence provided of improvements in accountability and transparency from these activities.

[145] Interview with EUD Bangladesh

6 EQ 6: To what extent and how has the EC contributed to strengthening government-led co-ordination, complementarity and synergies with Member States and other donors in the health sector, in line with the Paris Declaration? (national, regional and global levels)

6.1 JC 61 Level of health sector-related co-ordination in place with active role/contribution of the EC

Overall donor co-ordination in the health sector was judged by the EUDs as rather positive in 2010 and communication and co-ordination between the Development Partners has considerably improved between 2002 and 2010. As for co-ordination between donors and related to EC support to the health sector, including the EU MS, findings reveal a rather positive picture. Since 2003, there is a general trend towards more formal co-ordination, specific to the health sector, involving all donors working in the health sector and engaging the governments in the co-ordination tasks for the health sector. Specifically related to EU MS co-ordination, the EC has played a key role, has chaired these groups and thus provided added value. The main types of co-ordination mechanisms related to the health sector that the evaluation team could identify, from numerous sources like the EUD survey, the Paris Declaration evaluation, CSEs and sector evaluations, is depicted in Figure 28.

According to the EUD survey, most EUDs have been involved in one or several formal sector working groups. The EC participated actively in sector co-ordination and only few EUDs (mostly when GBS was provided) reported no participation at all of the EC in sector-related co-ordination groups. However, EUDs chaired only few co-ordination mechanisms including donors only and thus provided much less value added as compared to EU MS co-ordination. The tool "Delegated Partnership Agreements" may, in the future, help to further simplify co-ordination among donors, just by reducing the number of players involved in these processes, while at the same time ensuring that EC has adequate access to relevant information. (*I-611*)

The move towards more and more sector support requires closer co-ordination between MoH and DPs, especially when programme implementation is not as smooth as hoped for (e.g. *Bangladesh).* EC also played a key role in a good number of countries in the health sector, e.g. by being increasingly involved in forms of sector support, including SWAp and channelling funds via common baskets (e.g. *Zambia)*. Health sector working groups (HSWG) in which governments usually participate, are more technical in nature and rather focus on operational (rather than strategic) information sharing. HSWG are sometimes underpinned by Task Forces or specialised sub-groups (e.g. *Bangladesh*), or specialised sub-groups work e.g. on Maternal Health (e.g. *Morocco)*, HIV (e.g. *Moldova*), Tuberculosis and vaccination (e.g. *Burkina Faso*).

Co-ordination mechanisms including partner governments have been an important ingredient of co-ordination during both periods under evaluation. Overall, the EC was active in this type of co-ordination mechanism, with almost two thirds of the EUDs participating actively and regularly or at least on specific occasion. Among the EUDs not participating in sector co-ordination groups, were, not surprisingly, GBS-countries (*Ghana*) and SBS-countries (*South Africa*). On the other hand, this pattern cannot be generalised, as EUDs in *Laos, Mozambique* and *Vietnam* claim to have participated actively or occasionally in technical health working groups gathering donors and partner governments.

The increasing role of partner governments in donor-government co-ordination mechanisms clearly demonstrates the improving capacity of governments to steer and coordinate donor assistance. However, evidence on EC support in the health sector affecting government's capacity to steer and coordinate donor assistance has only been found in *Afghanistan* so far. Increased government leadership is often a result of an emerging sector approach, federating donor and government around the same strategy or objectives (e.g. *Philippines*, *Tanzania*). A tool that was made available at the end of the evaluation period is joint assessment of national health strategies (JANS) in the framework of the International Health Partnership Initiative (IHP+). The EC is an active promoter of this initiative and EUDs highlight the positive contribution of the use of JANS in the overall co-ordination process for the health sector. (*I-612*)

The use of parallel Project Implementation Units (PIUs) related to health has decreased during the evaluation period and a clear will to phase out during these parallel units can be seen, thus showing progress of EC support to health in achieving Paris Declaration indicators. According to more general findings of the survey on monitoring the Paris Declaration, most countries of the desk phase sample for which data was available even achieved to have no parallel PIU in 2010 (*Afghanistan, Bangladesh, Ecuador, Moldova, Morocco, Mozambique, Philippines, Timor-Leste, Viet Nam, Zambia*). Different interpretation of the concept of PIU leaves some room for interpretation of the actual number of PIU still running today in the desk

sample countries. It should be noted that, where parallel PIUs in the framework of EC support in the health sector have existed over the evaluation period, problems such as creating parallel power structures, distortion of salaries and diversion of staff and difficulties in achieving sustainability tend to occur (e.g. *Afghanistan*). (*I-613*)

6.1.1 I-611 Evidence of EC participation and value added in functioning co-ordination mechanisms between donors

The EUD survey reveals a very positive perception of overall donor co-ordination in the health sector in 2010 by the EUDs , with 83 % of all respondents rating the overall donor co-ordination in 2010 either "Excellent", "Good" or "Satisfactory"[146]. The eight rrespondents to the MoH survey are slightly less positive about overall donor co-ordination in the health sector with only three countries rating it as good (*Lao, Egypt, Moldova*), two rating it as satisfactory (*Afghanistan, Morocco*) and three countries considering it as unsatisfactory (*Syrian Arab Republic, Yemen, Burkina Faso*), i.e. an overall ratio of 62.5% being at least satisfied – although care should be taken over-interpreting the figure given the small sample in that case.

The EUDs pointed out five major changes related to health sector co-ordination during the period under evaluation (2002 to 2010, 21 EUDs):

1. enhanced communication among donors;
2. set up of health sector review processes;
3. improved co-ordination between the Development Partners;
4. increased leadership of the MoH in the co-ordination and partnership mechanism;
5. development / revision of health sector policies.

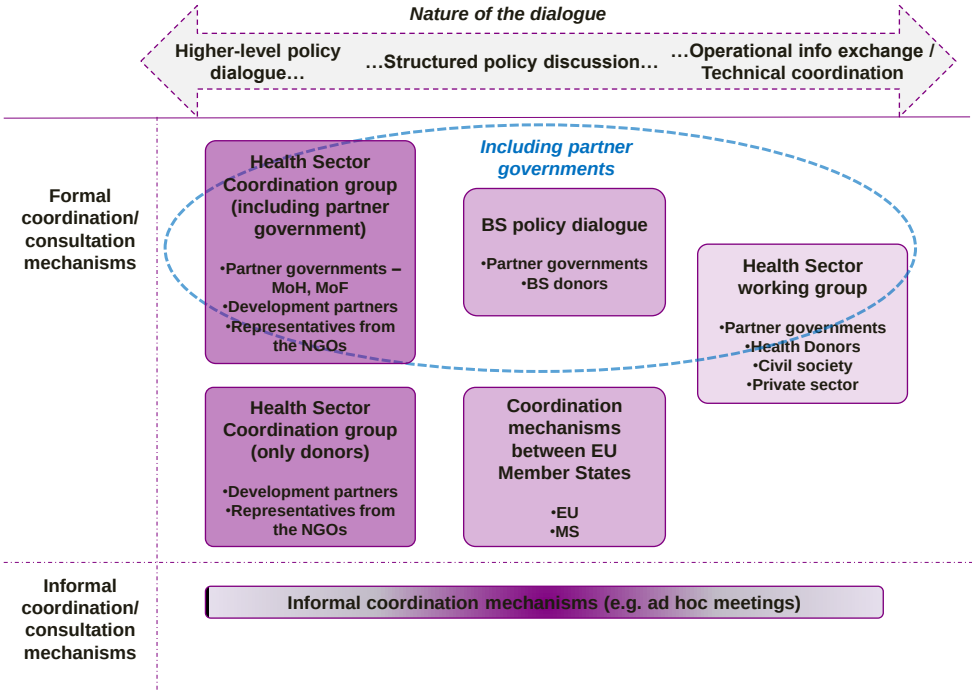
The CSP analysis confirmed that co-ordination mechanisms with other donors existed for most of the reviewed countries already in the first CSP.

Six kinds of co-ordination mechanisms have been identified with the following tasks (from the most formal co-ordination/higher level dialogue to the most technical dialogue/less formal) and represented in Figure 28:

- **Sector co-ordination groups (including partner government)** dealing with overall donor co-ordination in the health sector and, among other, issues related to alignment on donor priorities with national priorities;
- **Sector co-ordination groups (only donors)** that deal with the same issues;
- **Co-ordination mechanisms between EU Member States** that often tend to focus on the Division of Labour between the MS
- **BS policy dialogue**: Overall BS donors co-ordination in the health sector (mostly discussed in EQ7)
- **Health sector working groups** with multiple aims, among which: i) Information sharing on on-going and future projects/ programmes, ii) Progress in implementation of the health- related programmes, iii) Technical discussions on specific issues
- **Informal co-ordination mechanisms,** i.e. ad hoc meetings on specific topics.

[146] EUDs *Philippines, Myanmar, Bangladesh, Afghanistan, Moldova, Syrian Arab Republic, Ghana and South Africa, Lao, Vietnam, Timor-Leste, Morocco, Egypt, Mozambique, Zimbabwe, Burkina Faso, Nigeria, Zambia* and *Barbados*.

Figure 28: Co-ordination mechanisms in the health sector



Source: Particip analysis

Sector co-ordination groups and Health sector working groups in which only donors participate

Sector co-ordination groups in which only donors participate was one of the co-ordination mechanism used by EUDs during both periods 2003/2006 and 2007/2011. They take various forms:

- They can either be a **general health sector co-ordination group** like in *DRC* or *Mozambique,* or in *Bangladesh* (Health, Nutrition and Population Consortium); or
- They **focus on specific topics** like in *Nigeria* (Development partner group on HIV/AIDS (DPG HIV/AIDS), or in *South Africa* (Aids and Health Development Partners Forum (AHDPF)[147], or in *Zimbabwe (*Health Development Partners Co-ordination Group), or in *Afghanistan* (Health Donors Co-ordination Forum); or
- They even create **sub-groups on specific topics**, such as reproductive health and HIV/AIDS in *Vietnam.*

Many EUDs describe different kind of donor fora, which involve the main donors[148]. Some working groups gathering donors only were focused on specific technical issues. For instance in *South Africa*, three working groups were listed by the EUD in various sub-sectors: i) Health Systems WG, ii) Maternal and Child Health WG, iii) HIV and TB WG.

According to the EUD survey, the EC participated actively and on a regular basis in sector co-ordination. Only few EUDs reported no participation at all of the EC in the co-ordination groups - *Ecuador* and *Ghana.* This is understandable as EC support was mainly provided through GBS in *Ghana*[149]*,* but unclear why for the SBS in *Ecuador*. The survey revealed that the EUDs of *Bangladesh, DRC and Zimbabwe* chaired sector co-ordination groups including only donors in 2011. However, no further information has been found so far on how the chair was used, what were the problems encountered etc.

Specifically related to the role of the EUD in EU MS co-ordination mechanisms (see sub-section below), the survey underlines that the EC has played a key role and has chaired these co-ordination groups in 12 out of

[147] Before 2011 it was called: EU+ working group on HIV and Health, which was chaired by Sweden. In 2011, it was co-chaired by Germany and WHO, it meets every two months, with bilateral donors and UN agencies, while DOH and NAC are observers.
[148] EUD *Afghanistan, India, DRC, Ghana, Nigeria, Egypt, Moldova, Syria, Ecuador*
[149] In Ghana, the EC is not supporting the health sector anymore and has signed a delegated partnership

17 countries (in ACP - *DRC, Mozambique, Nigeria, Timor-Leste, Zimbabwe*, Asia - *Afghanistan, Bangladesh, Philippines, Vietnam,* ENP - *Egypt, Morocco, Syrian Arab Republic*). This leads to the assumption that within the EU MS community the EC has an active and influencing role in the health sector. In *South Africa,* the core role of the EC in the health sector has been underlined in the evaluation of the Implementation of the Paris Declaration and Accra Agenda for Action in South Africa. Harmonisation appeared there to be mainly a result of the efforts of the European Commission's EU+ Working Group (including global funds such as PEPFAR and USAID).[150]

In *Vietnam*, the EU was leading discussions on division of labour, as well preparing the ground for SBS in the health sector. The EU had a Working Groups on health. It published an annual Blue Book, indicating where the MS were active and addressing policy issues like the development of new aid modalities. [151]

The example of EC added value in *Bangladesh* can in particular be underlined. The EC has been very active in donor co-ordination and has been Chair and Vice-chair of the donor group twice. The EUD has been active in the dialogue itself and has often brought lessons learned from EC projects into the dialogue. This has been helpful as these lessons have then been incorporated into the next health sector strategy. According to the case study, examples of EC value added in this country are in the area of health financing which the EC has championed with a group of other like-minded donors. This has led to the development of a revenue allocation formula for budget allocations to the local level which is now being piloted by the GoB and a health financing strategy. Also lessons from an EC project which focused on planning and budgeting at local level have now been integrated into national planning and budgeting processes.

As for health sector co-ordination between donors, including the EU MS, survey results show a rather positive picture. 42% corresponding to ten EUDs[152] perceive co-ordination as "good" and an additional ten EUDs out of 24 that provided an answer rated it "satisfactory"[153], for 2010. It is interesting to notice that five countries receiving SBS rated the co-ordination as "good", only three countries receiving SBS rated "satisfactory".

This picture changed when looking at countries which received, either individually or combined SBS and GBS: here only one GBS-receiving country[154] rated the co-ordination as good, compared to four countries[155] rating "satisfactory" or even "unsatisfactory", as it is the case of *Mozambique*. The "good" ranking of *Ghana* must also be seen vis-à-vis the role of the EUD Ghana in the health sector. Since 2003, the EUD Ghana has concluded a delegated partnership for the health sector and relied completely on EU MS for the steering and co-ordination of the health sector. It appears as if, health sector related donor co-ordination within GBS is less effective than when other modalities are used. The fact that room for improvement exists has also been emphasised by the EUDs *Laos* and *Burkina Faso*.

Only three EUDs in ACP and Asia (*Timor-Leste, Mozambique and Yemen*) found the co-ordination was "unsatisfactory". All three EUDs complained about the lack of a clear and jointly agreed sector strategy.

EU MS co-ordination mechanisms

The EUD survey reveals that, before 2003, only informal co-ordination mechanisms and EU MS co-ordination were existing. It also shows, since 2003, a general trend towards more formal co-ordination, specific to the health sector, such as health working group or sector co-ordination, involving all donors working in the health sector and engaging the governments in the co-ordination tasks for the health sector. A few layers of co-ordination with MS can be identified:

- EUD Development Counsellors Meeting such as in *Afghanistan, India, Philippines, Mozambique, Morocco*, or ENPI Management Committees (*Egypt*);
- EU MS technical staff meetings, such as in *Vietnam, Timor Leste, Zimbabwe, Yemen, South Africa and Ecuador*.

The latter type of meetings can take place:

[150] Phase Two evaluation of the Implementation of the Paris Declaration and Accra Agenda for Action in South Africa, Final Country Evaluation Report, February 2011
[151] Paris declaration/ Hanoi Core Statement Phase 2 Evaluation, Vietnam Country Evaluation, January 2011
[152] *Afghanistan, Bangladesh, Ghana, India, Moldova, Morocco, Myanmar, Philippines, South Africa* and *Syrian Arab Republic*
[153] *Barbados, Burkina Faso, DRC, Ecuador, Egypt, Lao, Nigeria, Vietnam, Zambia and Zimbabwe*
[154] Ghana
[155] Burkina Faso, Zambia, Laos, Vietnam,

- ad hoc (*DRC*) or on a regular bases (e.g. in *South Africa* a EU MS health counsellors meeting was set up in 2010 and meets four times a year at least, to prepare joint EU positions if needed, chaired by EU Delegation);
- around a health round table of EU MS (in *Ecuador*, not any more operational) or to prepare in an informal manner sector meetings (e.g. in *Yemen* where meetings are usually held prior to the monthly sector meetings in order to consolidate positions prior to the meeting itself).[156]

It should be added that, in addition to formal mechanisms, EUD staff also uses ad hoc exchanges on specific issues in their day to day information management (email/phone) with other donors.

Delegated Partnership Agreements

A specific and rather new mechanism of co-ordination between EU Member States is Delegated Partnership Agreements (DPA). According to the EU toolkit on complementarity, a DPA implies the following: *"Delegated co-operation when one fund managing donor acts with the authority on behalf of one or more other donors, while using the fund managing donor's rules & procedures. EU donors may enter into a delegated co-operation/partnership arrangement with another EU donor and thereby delegate authority to the other EU donor to act on its behalf in terms of administration of funds and/or sector policy dialogue with the partner government. The legal basis for the delegation of co-operation from the Commission to other donors are financial and implementation regulations of the Community Budget and of the EDF*.[157]

According to an EC mandated study on DPA in the health sector[158] of June 2011, the only DPA to date can be found in Tanzania.

Box 27: Tanzania: Example of DCP between EUD and EU MS in the health sector

The German Embassy - through its bilateral co-operation (GIZ) – and the European Union Delegation in Tanzania decided to cooperate strategically for development assistance in the health sector of the Republic of Tanzania, in the spirit of greater donor co-operation and harmonisation. In accordance with the *EU Code of Conduct of Complementarity and Division of Labour in Development Policy* and the subsequent Division of Labour agreements in Tanzania, the EC under the 10th EDF is no longer involved in the health sector. However, the EC is still following the developments in the sector, notably in the context of the MDG contract which includes a number of health indicators. In consultation with HQ, the Delegation has therefore signed a formal MoU empowering the German Embassy as the coordinator of the German Development Co-operation in Tanzania – which is an active partner in the health sector – to engage strategically on health policy related matters on behalf of the EC. This arrangement should ensure to the EC access to health-related information required to inform the preparation of budget support payment files. The documents signed between the two parties - on the 15th of December 2009 – detail the: (i) Scope and representation of the agreement; (ii) Responsibilities of the Lead and Silent partners and (iii) Monitoring, evaluation and reporting.

Source: Study on DPAs in the health sector, 2011, EUD presentation workshop in Brussels 27-29th June 2011

In sum, overall donor co-ordination in the health sector was judged by the EUDs as rather positive in 2010 and communication and co-ordination between the Development Partners has considerably improved between 2002 and 2010. As for co-ordination between donors and related to EC support to the health sector, including the EU MS, survey results show a rather positive picture. Since 2003, there is a general trend towards more formal co-ordination, specific to the health sector, involving all donors working in the health sector and engaging the governments in the co-ordination tasks for the health sector. Specifically related to EU MS co-ordination, the EC has played a key role, has chaired these groups and thus provided added value.

Equally, co-ordination between donors in the health sector has considerably improved over the evaluation period. Most EUDs have been involved in one or several formal sector working groups. The EC participated actively in sector co-ordination and only few EUDs (mostly when GBS was provided) reported no participation at all of the EC in co-ordination groups. However, EUDs chaired only few co-ordination mechanisms including donors only and thus provided much less value added as compared to EU MS co-ordination.

[156] There is also interestingly co-ordination with GFATM, as for example in Zimbabwe where the EUD reported of GFATM-CCM co-ordination.

[157] EU toolkit complementarity p. 22

[158] Donelli, Eric (2011) Delegated Co-operation Partnerships (DCP) in the Health Sector for Health Sector Performance Monitoring (HSPM) and Health Sector Policy Dialogue (HSPD).

The tool "Delegated Partnership Agreements" may, in the future, help to further simplify co-ordination among donors, just by reducing the number of players involved in these processes, while at the same time ensuring that EC has adequate access to relevant information.

6.1.2 I-612 Evidence of partner government leadership and EC value added in functioning co-ordination mechanisms between government and donors

Sector co-ordination groups including partner governments

Sector co-ordination groups which include partner governments have been an important ingredient of co-ordination during both periods under evaluation. Most of these groups meet on a regular basis; the frequency of meetings varies from monthly to bi-annual. Often, meetings of sector co-ordination groups are linked to sector performance reviews as for example in *Timor-Leste*.

Generally, the move towards more and more sector support requires closer co-ordination at a high level between MoH and DPs, especially when programme implementation is not as smooth as hoped for (for example in *Bangladesh* as noted by a programme review[159]). The field mission to *Zambia* undertaken in 2008 by the preceding evaluation also stated that EC has played a key role in the health sector being strongly involved in the SWAp and in channelling funds through the common SWAp basket. The EC was considered as a leader in the Monitoring and Evaluation process and in the Monitoring and Evaluation Sub-Committee. In *Mozambique*, the EC also participated actively in the policy dialogue of the SWAp. During 2007, the EC was appointed as focal donor of the SWAp, meaning that it is responsible for co-chairing, planning and preparing the co-ordination committee meetings and that it can represent other donor agencies in these meetings.[160] A specific donor forum to be highlighted is the Country Co-ordination Mechanism (CCM) of the Global Fund, specifically indicated by the EUDs *Myanmar, Burkina Faso, Moldova* and to the *Syrian* Arab Republic. The role of the EUD in GFATM co-ordination mechanisms is further analysed in I-623. This mechanism includes a broad range of stakeholders: representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, NGOs, academic institutions and civil society.

In the same line of co-ordination mechanisms important to the health sector, the International Heath Partnership Initiative (IHP+) must be named. Launched in 2007 and brings together developing partner and partner countries and has today (May 2012) 56 signature to the Global Compact. The aim of IHP+ is to provide support to strong and comprehensive country and government-led national health plans in a well-coordinated way. EC has been a signature of the initiative since the beginning and is still a great supporter of its core goal to increase aid effectiveness and results in the health sector through better alignment on a single national health strategy, as the following quote illustrates: "*The economic crisis increases the argument in favour of aid effectiveness. Lack of effective aid is costly. The EC considers IHP+ to be the aid effectiveness framework for health and feels it is gathering momentum. We have the instruments and now we have to make them work.*[161] Following the recommendation of the ECA report on the health in SSA, the EC co-signed the IHP+ agreement with the government of Ethiopia and Mozambique. One core feature of the IHP+ is the Joint Assessment of National Strategies (JANS). The use of a JANS has been mentioned by the EUDs in Nigeria, Vietnam, Burkina Faso and Zambia. According to those EUDs changes in the health sector co-ordination are clearly to be attributed to such joint actions, including JANS (most of the IHP signatures have taken place in the course of 2010.

Although the EC is usually actively participating in co-ordination mechanisms, the survey revealed that in 2011 the EC chaired only one sector co-ordination group including partner government (*Morocco*). This low number of groups chaired by the EC can be explained by the high number of donor-government co-ordination mechanisms are chaired by the government in 2011, as fully explained below as well as through the fact that this number is a snapshot for 2011 and the chair usually rotate very regularly between donors.

Only few EUDs reported no participation at all of the EC in the donor-partner government sector co-ordination groups (*Ghana and Ecuador*). As discussed above, the EUD Ghana has retired from the active participation health sector (delegated partnership); and in *Ecuador*, no sector co-ordination mechanisms exists any more.

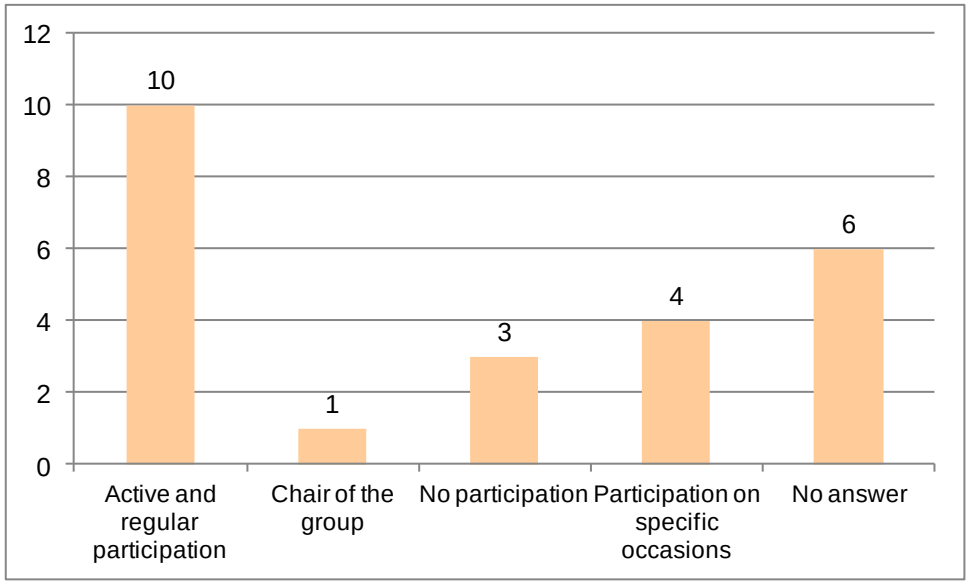
[159] Health Nutrition and Population Sector Program, Second Annual Program Review, March - April, 2007, p. 17
[160] Mozambique, CSE 2007; Vol 2, p. 105
[161] IHP+ website, Luis Riera, European Commission, http://www.internationalhealthpartnership.net/en/audiences/development-partners/ (July 2012)

Health sector working groups

Health sector working groups (HSWG) are usually more technical in nature and rather focus on operational (rather than strategic) information sharing.

According to the EUD survey, health sector working groups (in which governments often participates) have been in existence and used as co-ordination mechanism during both periods, i.e. between 2003 and 2006 and between 2007 and 2011. The EC was very active in this type of co-ordination mechanism, with almost two thirds of the EUDs participating actively and regularly (11 EUDs[162]) or at least on specific occasion (four EUDs[163]). The EUDs not participating in sector co-ordination groups, were, not surprisingly the GBS-countries with no operational EUD involvement in the sector - *Ghana* - and furthermore *South Africa*.

Figure 29: Results of survey to EUDs: Role of the EC in health sector working groups in 2010



Source: EUD Survey, 2011, Particip GmbH

Even though allocating its funding through GBS, the EUDs in *Laos, Mozambique* and *Vietnam*, participated actively or occasionally in such mixed technical health working groups.

Across all regions, HSWG are sometimes underpinned by Task Forces or specialised sub-groups. For instance, in *Bangladesh*, a programme review highlighted that several task groups had been set up, in which MOHFW and DP representatives work together to address critical urgent issues[164]. In the ACP and ENP regions, specialised sub-groups work e.g. on Maternal Health (e.g. *Morocco)*, HIV (as for example in the framework of the CCM in *Moldova*), Tuberculosis and vaccination (e.g. *Burkina Faso*), etc. In *Nigeria*, thematic Working Groups are operative and the Training Working Group has been chaired by EU-PRIME (Partnership to Reinforce Immunisation Efficiency).[165] In *Egypt*, there is harmonisation in the health sector mainly as a result of the efforts of the EC's EU+ Working Group (including global funds, such as PEPFAR and USAID).

Leadership of partner governments in co-ordination mechanisms

While the capacity of governments to steer and coordinate donor assistance is clearly evident from their apparently increasing role in HSWGs and other co-ordination mechanisms bringing together donor and partner government, desk research could only yield one example of EC financed project to improving government's capacity to steer and coordinate donor assistance has been found during for *Afghanistan*, which is presented in the following box.

[162] Morocco (chair of the group in 2010), Bangladesh, Barbados, DRC, India, Mozambique, Philippines, Syria, Timor-Leste, Vietnam and Zimbabwe.
[163] Afghanistan, Ecuador, Laos, Nigeria
[164] Health Nutrition and Population Sector Program, Second Annual Program Review, March - April, 2007, p. 17
[165] Nigeria, CSE 2010, Vol 1, p. 38

Box 28: Afghanistan: Capacity Building Groups in core ministries

In *Afghanistan*, co-ordination between the inputs of different donors and NGOs was still low in 2002 and **government capacity was lacking**, thus giving way to unproductive overlaps as well as to neglected areas. An EC funded project aimed at tackling this problem in a joint MoH/NGO cluster/district health systems approach, i.e. public-private partnership aiming at combining strengths and defining responsibilities among MOH, HNI and other stakeholders including the community itself.[166]

In the framework of the EC funded second reconstruction programme from 2002, it was planned to establish Capacity Building Groups (CBG) and keep them operational in core ministries and provinces. Project management staff would coordinate **donor and Government projects** to ensure effective and efficient implementation. In this regard, CBGs staff would provide a central point of contact within the Ministry for information on the government and donor programs within the Minister's portfolio. The CBG Coordinator would hold regular meetings with the Afghan Assistance Co-ordination Authority (AACA), Ministries of Finance, Planning and Reconstruction, donors, other relevant Ministries. The CBGs staff would also contribute regular reports for AACA to collate, publish and distribute as part of its donor co-ordination and information functions.

Eighteen ministries had agreed to install CBGs in their ministries. At the moment of the FA (in 2002), six such CBGs were operational. The funds aimed at ensuring that the remaining twelve ministries had their CBGs set up and operational plus including other ministries if budgets permit and if those ministries agree to the CBG agenda[167]

Source: Decision 2002/004847/ contract 76120 and TAP Decision 2002/003-024, p. 4, 5

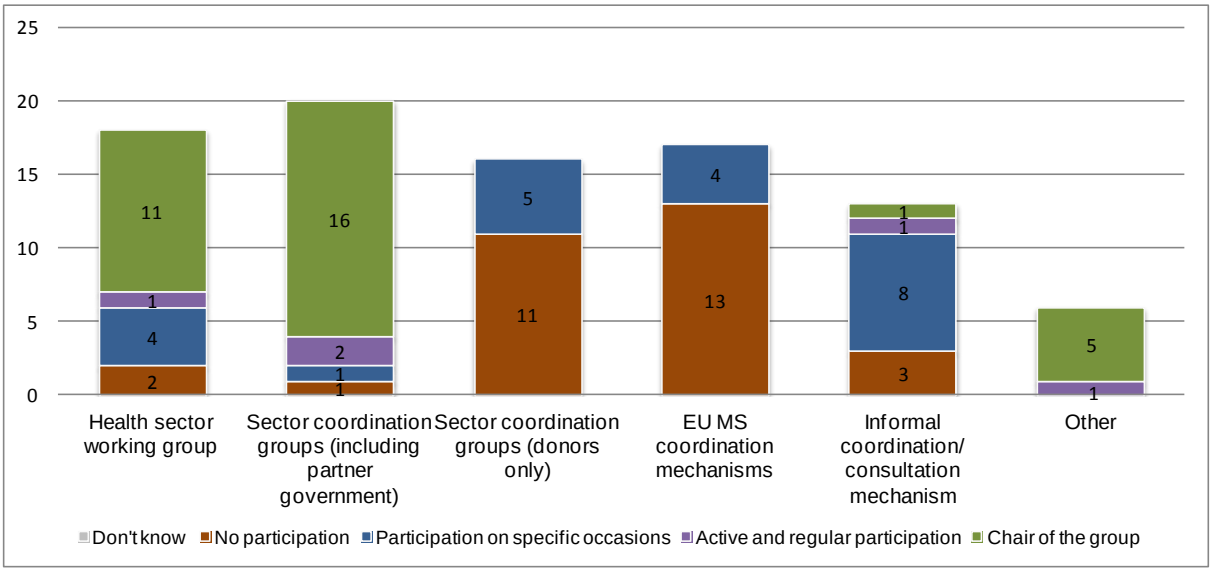
For *Bangladesh*, the case study highlighted that the EC has been active in supporting more Government leadership. A Joint Co-operation Strategy was signed in 2011 by the GoB and donors. The Government now chairs the HSWG, with a donor acting as vice-chair and the EC as key member of the group.

The CSP analysis confirmed that the leadership of partner governments in health sector co-ordination mechanisms has increased in the past years. In some countries the enhanced active role is explicitly mentioned (CSP II, *Burkina Faso, Tanzania, Timor Leste, Philippines*). Increased government leadership is often a result of an emerging sector approach, federating donor and government around the same strategy or objectives. This has for example been the case in the *Philippines* where the increased ownership is a result through the Support of the Health Sector Reform Agenda, a SWAp in which the EC participated, according to the CSP II, as well as in *Tanzania* (CSP II) in which *"coordinated Government and DP support under a single Government-led-framework"* has resulted in the lead-taking of the Government for the definition of the sector strategy. In *Tanzania*, the EC also supported the development of countries' INAPs (Integrated National Action Plans), providing a longer (three-year) financing framework. The plans have been key to mobilising resources and ensuring partner co-ordination and quick identification of gaps and needs, thus helping to assuring ownership, coherence and synergy and avoiding wastage and overlapping of resources for improved cost-efficiency and cost-effectiveness.[168]

The increasingly active role of national governments in co-ordination in the health sector has been confirmed by the survey to EUDs. According to a vast majority of EUDs[169], national governments played a considerable role in the co-ordination existent mechanisms as shown in the following figure. The majority of partner-governments chaired the mixed co-ordination groups (bar 1[170], 2[171] and 6).

[166] Decision 2002/004847, contract 76120
[167] TAP Decision 2002/003-024, p. 4, 5
[168] European Commission (2010): Outcome and Impact Assessment of the Global Response to the Avian Influenza Crisis. Final Report – August 2010
[169] 21 out 24 that answered this question
[170] *Lao, Barbados, Vietnam, Bangladesh, Afghanistan, Timor-Leste, Philippines, Nigeria, Burkina Faso and Ghana*
[171] *Bangladesh, Philippines, Myanmar. Afghanistan, Timor-Leste, Moldova, Yemen, Syrian Arab Republic, Egypt, Barbados Burkina Faso, Ghana, DRC, Zimbabwe and Mozambique*

Figure 30: Result of survey to EUDs: Role of the government in different co-ordination mechanisms



Source: EUD Survey, 2011, Particip GmbH

In addition the governments' increasing role may also be exemplified by the fact that of being the chair so-called "other" co-ordination mechanisms which mainly include:

- country co-ordination mechanism (CCM) of the Global Fund for AIDS, Tuberculosis and Malaria for instance in *Laos, India and DRC;*
- the Inter-agency coordinating committee (ICC) on Immunisation in *Nigeria*. The ICC that has been created by the Ministry of Health provides a forum for regular information sharing and networking among the major stakeholders in order to ensure synergy and complementarity of programme implementation;
- the supervision committee of medical provision (CAMEG) in *Burkina Faso;*
- the Pandemic Preparedness Mechanism in *Myanmar*.

Respondents to the MoH survey identified the difference in priorities, procurement policies and rules among donors as one of the main problems encountered in these co-ordination mechanisms (e.g. in *Syrian Arab Republic, Yemen, Afghanistan and Morocco*). Weak capacity of MoH and low government leadership were also indicated both by *Yemen* and *Morocco*.

To summarise, the move towards more and more sector support requires closer co-ordination between MoH and DPs. EC also played a key role in a good number of countries in the health sector, e.g. by being increasingly involved forms of sector support, including SWAps and channelling funds via common basket (e.g. *Zambia)*.

Health sector working groups (HSWG) in which governments usually participate, are more technical in nature and rather focus on operational (rather than strategic) information sharing. HSWG are sometimes underpinned by Task Forces or specialised sub-groups (e.g. *Bangladesh*), or specialised sub-groups work e.g. on Maternal Health (e.g. *Morocco)*, HIV (e.g. *Moldova*), Tuberculosis and vaccination (e.g. *Burkina Faso*), etc. No information has been found on EC specific role in these Task Forces and specialised sub-groups.

Co-ordination mechanisms including partner governments have been an important ingredient of co-ordination during both periods under evaluation. Overall, the EC was active in this type of co-ordination mechanism, with almost two thirds of the EUDs participating actively and regularly or at least on specific occasion. Among the EUDs not participating in sector co-ordination groups, were, not surprisingly GBS-countries (*Ghana*, *South Africa*). On the other hand, this pattern cannot be generalised, as EUDs in *Laos, Mozambique* and *Vietnam* participated actively or occasionally in mixed technical health working groups.

The increasing role of partner governments in donor-government co-ordination mechanisms clearly demonstrates the improving capacity of governments to steer and coordinate donor assistance. However, evidence on EC support in the health sector affecting government's capacity to steer and coordinate donor assistance has only been found in *Afghanistan* so far. Increased government leadership is often a result of an emerging sector approach, federating donor and government around the same strategy or objectives (e.g.

Philippines, *Tanzania*). The main problems identified in these co-ordination mechanisms are the difference in priorities, procurement policies and rules among donors. Weak capacity of MoH and low government leadership were also indicated by some respondents of the MoH survey.

6.1.3 I-613 Change in number of project implementation units running parallel to government institutions within the health sector

Even though the concept of PIU has a DAC definition, the concept remains blurred for a lot of stakeholders, including the EUDs, as a 2008 study for the EC[172] has shown. The DAC definition of PIU and the closely linked concepts of Technical Co-operation/Coordinated Technical Co-operation) and Capacity Development are presented in below.

Box 29: DAC definitions of TC, PIUs and Capacity Development

Technical Co-operation

Technical co-operation (also referred to as technical assistance) is the provision of know-how in the form of personnel, training and research and associated costs. (*OECD DAC Statistical Reporting Directives 40-44*). It comprises donor-financed:

- Activities that augment the level of knowledge, skills, technical know-how or productive aptitudes of people in developing countries; and
- Services such as consultancy, technical support or the provision of know-how that contribute to the execution of a capital project.

The DAC survey of the Paris Declaration uses this definition and adds that 'TC should include both free-standing TC and TC that is embedded in investment programmes, or included in Programme based approaches.'

Coordinated technical co-operation

Coordinated technical co-operation means free-standing and embedded technical co-operation that respects the following principles. *Ownership* – Partner countries exercise effective leadership over their capacity development programmes. *Alignment* – Technical co-operation in support of capacity development is aligned with countries' development objectives and strategies. *Harmonisation* – Where more than one donor is involved in supporting partner-led capacity development, donors coordinate their activities and contributions. Donors are invited to review all their development activities with a view to determining how much technical co-operation was disbursed through coordinated programmes that meet *BOTH criteria* below:

1. Have relevant country authorities (government or non-government) communicated clear capacity development objectives as part of broader national or sector strategies? (Y/N).
2. Is the technical co-operation aligned with the countries' capacity development objectives? (Y/N). *AND at least ONE* of the criteria below:
3. Do relevant country authorities (government or non-government) have control over the technical co-operation? (Y/N).
4. If more than one donor is involved in supporting country programmes, are there arrangements involving the country authorities in place for coordinating the technical co-operation provided by different donors? (Y/N).

Project Implementation Units

When providing development assistance in a country, some donors establish Project Implementation Units. (They are also commonly referred to as project management units, project management consultants, project management offices, project co-ordination offices, etc.) These are dedicated management units designed to support the implementation and administration of projects or programmes. PIUs typically share the following key features:

- PIUs are TYPICALLY required to perform subsidiary (rather than principal) tasks with regard to the implementation of a project or programme: monitoring and reporting on technical and/or financial progress, accounting, procurement of works, goods and services, drawing-up terms of reference, contract supervision, detailed design or equipment specification.
- PIUs are often established at the request of a donor following the inception of a project or programme.
- The staff of PIUs varies considerably in size and composition. Staff size can vary from 1 to as many as 200 but most count less than 10 professional staff. Although a significant number of PIUs make use of government staff, most PIUs rely on staff recruited outside the civil service (e.g. long-term local consultants).

A distinction is made here between a PIU and technical advice provided directly to national administrations.

Parallel PIU

A PIU is parallel when it is created and operates outside existing country institutional and administrative structures at the behest of a donor. In practice, there is a continuum between parallel and integrated PIUs. The criteria below have been designed to help donors and partner authorities draw a line within this continuum and identify with greater certainty

[172] Particip (2008): Results-Oriented Monitoring of EC External Assistance Findings on issues regarding TC/TA and PIUs to support the new TC strategy.

parallel PIUs.
Donors are invited to review all their development activities with a view to determining how many PIUs are parallel. For the purpose of this survey, PIUs are said to be parallel when there are three or more 'Yes' to the four questions below (anything less counts as integrated):

1. Are the PIUs accountable to the external funding agencies/donors rather than to the country implementing agencies (ministries, departments, agencies etc.)? (Y/N).
2. Are the terms of reference for externally appointed staff determined by the donor (rather than by the country implementing agencies)? (Y/N).
3. Is most of the professional staff appointed by the donor (rather than the country implementing agencies)? (Y/N).
4. Is the salary structure of national staff (including benefits) higher than those of civil service personnel? (Y/N).

Capacity Development
The processes whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.

Source: Reforming Technical Co-operation and Project Implementation Units for External Aid provided by the European Commission, A Backbone Strategy, July 2008

However, according to various ECA reports, implementation arrangements are not yet fully favourable to local ownership.

Box 30: Implementation arrangements and local ownership

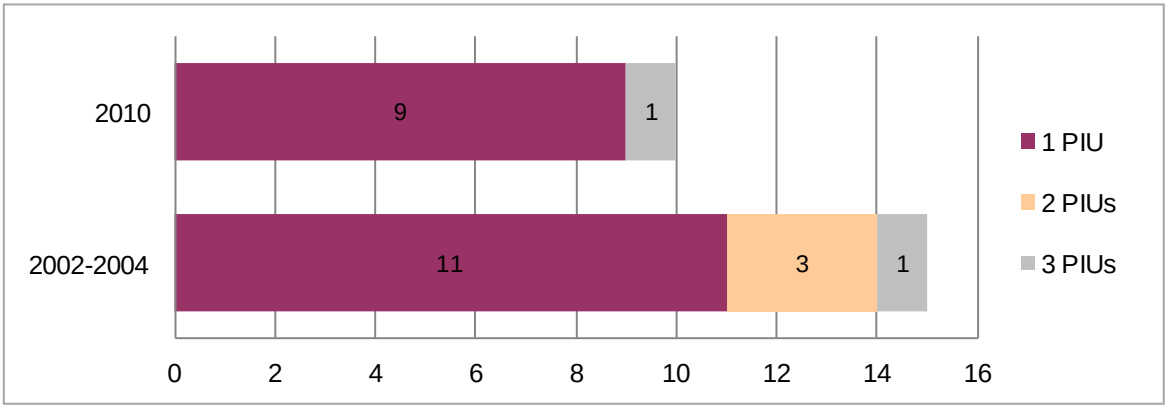
Project Implementation Units (or Project Support Units) are still set up in most countries as temporary structures, for the duration of a project and in parallel to the existing national administration; although in several cases they are already more integrated within the regular institutional structure of the beneficiary administration. In none of the countries concerned was the procurement of and payment for, Commission-financed technical assistance being managed through national systems and procedures, as the Commission considered these to be unreliable and lacking transparency. However, several of these countries (i.e. Benin, Chad, Morocco, Sierra Leone, Uganda and Vietnam) are recipients of Commission-financed budget aid, whereby expenditure of the funds is, by definition, subject to the national financial procedures. This illustrates incoherence in the Commission's approach regarding the use of the beneficiary countries' public financial management and procurement systems under its different aid instruments.
In the context of the Paris Declaration donors have undertaken a number of commitments to align their support with partner countries' development strategies, institutions and procedures. Several of these commitments are directly related to the issue of capacity development. In this context the European Union formulated in three areas even stricter targets for itself, i.e. to provide all capacity-building assistance through coordinated programmes with an increasing use of multi-donor arrangements; to channel 50 % of government to government assistance through country systems; and to avoid the establishment of any new Project Implementation Units. Given the design of most current capacity development projects, the Commission's task to meet its commitments under the Paris Declaration is a challenging one.

Source: ECA reports on 1) Technical assistance and institutional capacity building (2007) and 2) NSA support (2009)

According to the EUD survey, a trend towards reducing parallel PIUs occurred during the course of the evaluation period, showing somewhat towards achieving Paris Declaration indicators.

Figure 31 shows the number of project implementation units running parallel to government institutions within the health sector in the first reference period (from 2002 to 2004) and in the second reference year (in 2010). In the health sector, the number of parallel units decreased over the evaluation period, from 0.7 in average for the first period of the evaluation, to an average of 0.4 for the second period.

Figure 31: Results of survey to EUDs: Number of PIUs using PIUs in 2002-2004 and 2010 running parallel to government institutions within the health sector in the country



Source: EUD Survey, 2011, Particip GmbH

For the period **from 2002 to 2004**, one EUD indicated that there were three parallel project implementation units - PIU (*Timor-Leste*), three out of 24 EUDs indicated that two parallel PIU (*Moldova, Mozambique, Ecuador*) existed in their country in the health sector. Eleven EUDs (corresponding to 45%), indicated that one PIU was running in their country at the beginning of the evaluation period.

The EUD survey revealed that the picture had changed considerably for **2010**. Although still one country (EUD *Bangladesh*, no information for 2002-04) stated that three PIU were running in parallel to the government institution, the number of countries which had in 2002-04 one or two PIU has been considerably reduced in 2010, as only nine countries[173] stated having one PIU running in their country (instead of eleven in 2002). This means that nine countries have reduced the number of PIUs or completely abandoned the parallel management structures.[174]

General findings of the survey on monitoring the Paris Declaration (see Table 27) confirm this evolution in the number of parallel PIUs between 2005 and 2010, for the countries of the desk phase sample. It clearly shows that the number of parallel PIUs tended to decrease between 2005 and 2010, according to Paris Declaration's objectives. Most countries of the sample for which data was available even achieved to have no parallel PIU in 2010 (*Afghanistan, Bangladesh, Burkina Faso, Ecuador, El Salvador, Ghana, Moldova, Morocco, Mozambique, Philippines, Timor-Leste, Viet Nam, Zambia*). The only countries where an increase in the number of parallel PIUs has been noted are *DRC* (from 5 in 2005 to 6 in 2010) and *South Africa* (from 0 in 2005 to 10 in 2010).

Table 27: Survey on Monitoring the Paris Declaration: Parallel PIUs

Partner country	QD13: Parallel PIUs (Raw data / Partner country-Donor)			Evolution between 2005-2010
	2005	2007	2010	
Afghanistan	0	0	0	↔
Bangladesh	3	1	0	↓
Burkina Faso	9	0	0	↓
Congo Dem.Republic	5	4	6	↑
Ecuador	n.a.	n.a.	0	n.a.
Egypt	14	7	6	↓
El Salvador	n.a.	n.a.	0	n.a.
Ghana	4	8	0	↓
Laos	n.a.	2	1	↓

[173] Afghanistan, Moldova, Morocco, Myanmar, Nigeria, Syrian Arab Republic, Timor-Leste, Vietnam, Yemen.
[174] Moldova and Timor Leste reduced their PIU to one; DRC, Ecuador, Egypt, India, Mozambique, Zimbabwe did not use any more PIUs,

Partner country	*QD13: Parallel PIUs (Raw data / Partner country-Donor)*			*Evolution between 2005-2010*
	2005	*2007*	*2010*	
Moldova	n.a.	10	0	↓
Morocco	n.a.	1	0	↓
Mozambique	0	0	0	↔
Nigeria	n.a.	9	1	↓
Philippines	n.a.	2	0	↓
South Africa	0	n.a.	10	↑
Tanzania	2	2	1	↓
Timor-Leste	n.a.	n.a.	0	n.a.
Viet Nam	1	1	0	↓
Yemen	8	7	n.a.	↓
Zambia	3	1	0	↓

Source: Survey on Monitoring the Paris Declaration, OECD database

It should, however, be noted that information on PIU is difficult to obtain (and therefore not always reliable), especially because of the difference in interpreting whether PIU is parallel or not, as underlined by the evaluation of the implementation of the Paris Declaration in *South Africa*. The EC noted that they were "*definitely not creating parallel Project Implementing Units (PIUs)*". While this was supported by the 2006 Survey on Monitoring the Paris Declaration reporting that the EU has no PIU, several government departments in South Africa, such as the SAPS, reported they have EC funded PIU. This Evaluation speaks of a difference in interpreting whether the PIU is parallel or not and highlights the need for a common locally adjusted definition of PIUs in *South Africa*.[175]

The Study of EC Technical Co-operation and PIUs confirmed that very limited information was available in the documentation on how the PIUs are managed and to whom they are accountable and that in some cases the information available is too limited to make a judgment whether the PIU was "parallel" or "integrated". Box 31 presents the results of this study and in particular the findings on PIUs.

[175] First Phase of the Evaluation of the Implementation of the Paris Declaration Country Level Evaluations, Final Report, South Africa, April 2008

Box 31: How PIUs work: Some cases from the Study of EC Technical Co-operation and PIUs

*In the Study of EC Technical Co-operation and PIUs, ECDPM (2008) reviewed 25 cases spread across more than 20 countries and some eight sectors: **health**, education, trade, decentralisation, transport, governance, institutional reform and social assistance (all national). The review was based on a variety of sources, including: (i) various project/ programme documentation collected from EC staff at Headquarters and in the Delegations; (ii) the AIDCO database of procurement contracts; (iii) the Court of Auditors' report on TA; (iv) EC's internet sites.*

14 of the 25 cases reviewed had PIUs. However, for most of these only very limited information was available in the documentation on how the PIUs are managed and to whom they are accountable.

The ACP cases in the review had a relatively low number of PIUs compared to the cases in the other regions, probably at least in part a result of the fact that most ACP countries tend to have at least one EU assistance - related PIU, the EU -PMUs which support the NAO offices.

From the material available, three cases could be classified as "parallel" and nine as "integrated" , while for two cases the information available is too limited to make a judgement. "Integrated" can be defined as where the PIU is formally part of an existing institutional structure and where at least three of the four DAC criteria are fulfilled [Q1: PIU accountable to the PG; Q2: TOR of staff drafted by the PG; Q3: Staff appointed by the PG; Q4: Salary structure similar to that of the national civil service].

At least in one case where a PIU is "parallel" and managed by a TA (EFCC Nigeria), its integration into the PG's institutional structure is foreseen in due course.

Information related to the 4 DAC criteria in the cases:

Q1- PIU accountable to the PG: In the case of the three "parallel" PIUs, reporting and accountability is to a joint donor/ PG steering committee in two of the cases and to the PG and the EC Delegation in one. For the "integrated" PIUs, the PIU managers are accountable to the PGs, but also to steering committees in which the EC and other donors (e.g. the WB) retain at least "observer status". In at least one case, accountability is also to the EC directly (NAO support office PNG).

Q2- TOR of staff drafted by the PG: In most of the PIU cases (whether we've classed them as integrated or as parallel) , it is unclear who drafted the TORs for the PIU staff and to what extent the PG took the lead (…or even participated in making decisions on the establishment of a PIU)

Q3- Staff appointed by the PG: As regards the question who appoints the staff working in a PIU, the situation varies from case to case. There are cases where the PG appoints staff (with the consent of the EC); for others, the EC takes the lead in procuring international TA on behalf of the PG; in other cases both the PG and the EC take a joint decision. Appointees can be a mix of national and international staff. An interesting (but specific) case is the Moldova NCU, which is run by national officials, with support provided by international short -term experts when required.

Q4- Salary structure similar to that of the national civil service: Information on the salary structures of PIU staff was very limited. However, from the cases reviewed by the ECA in Vietnam, it is clear that national staff working in the respective PIUs are paid more than other civil service personnel and benefit from bonuses or other forms of "topping -up".

Source: Study of EC Technical Co-operation and PIUs - Review of case documentation, Final Version, ECDPM, 11 February 2008, p.7

The existence of parallel PIUs in the framework of EC support in the health sector has been found in various countries over the evaluation period:

- In the *Philippines*, the Evaluation of the Implementation of the Paris Declaration highlighted the existence of multiple Program Monitoring Units (PMUs) in the health sector, from developmental partners and from Department of Health (DoH). Each of these individual PMUs has their own reporting systems. A unified PMU has been created under the DOH Bureau of International Health Co-operation (BHIC) to spearhead monitoring and evaluation. Under the umbrella of BHIC, matters of repetition and discord on monitoring and evaluation performance indicators as well as discrepancies in salaries between the different PMU personnel of each of the donor agencies are being resolved. The UN and EU have already aligned with this effort, while some donor agencies still prefer to have their own PMUs, like JICA and the German Agency for TC.[176]
- The *Afghanista*n CSE of 2007 highlights in an exemplary manner a number of problems related to having working PIUs in parallel in the health sector (see following box), problems occurring in other sectors as well:
    - Creation of parallel power structures;
    - Distortion of salaries and diversion of staff;
    - Difficulties in achieving sustainability;

[176] First Phase of the Evaluation of the Implementation of the Paris Declaration, Country Level Evaluation, Philippines

- Coping with the challenge of progressing as fast as possible and at the same time improving national capacities.

Box 32: Afghanistan: GCMU as separate PIU

One issue of particular significance is the role of the Grants and Contract Management Unit (GCMU) as the central liaison between the MoPH, the three main health donors and the implementing NGOs and its effect on the management and administrative capacity of the MoPH overall. The central question is if it is preferable for the EC to work through the GCMU as a separate PIU or if, in the long run, it is better to work directly with the MoPH. One key concern is that the GCMU is being built up as a "ministry within the ministry" and thereby effectively hinders the build-up of capacity in the wider Ministry. It is feared that this development could eventually limit the sustainability of those interventions that currently are being managed by the GCMU. The substantial volume of funds managed by the GCMU, the better working conditions and higher salaries in the unit also have created tension within the MoPH and have limited the willingness of other departments to accept GCMU's input. The Unit has responded to these dynamics by engaging in a capacity building strategy within MoPH and by seconding advisors to other MoPH departments. One challenge is, however, that these advisors receive an income that is many times higher than that of the department heads they are assisting and to whom they are reporting. Both GCMU and MoPH recognise this, but neither side has found a solution yet. A separate issue is the debate on the best approach for the EC to organise and manage its contracts with the NGOs. In principle, the choice of the EC to work as much as possible through existing institutions is coherent with its intention to build capacity in the MoPH and at the same time to expand the delivery of health services. In practice, however, the EC has yet to follow through with its commitment to decentralisation. At the time of the evaluation, it had not yet decentralised the implementation and contracting of NGOs to the MoPH.

Source: CSE Afghanistan, November 2007, p.465-468

Qualitative comments from EUDs mentioned that, in most countries, PIUs were not running anymore in 2011[177]. However, this statement should be interpreted with caution, given the difference in interpreting whether the PIU is parallel or not.

In sum, the use of parallel project implementation units (PIUs) has been phasing out during the course of the evaluation period, which shows a progress of EC support to health towards achieving Paris Declaration indicators. General findings of the survey on monitoring the Paris Declaration confirm this evolution. It has shown that most countries of the desk phase sample for which data was available even achieved to have no parallel PIU in 2010 (*Afghanistan, Bangladesh, Burkina Faso, Ecuador, El Salvador, Ghana, Moldova, Morocco, Mozambique, Philippines, Timor-Leste, Viet Nam, Zambia*). It should, however, be noted that information on PIU is difficult to obtain (and therefore not always reliable), especially because of the difference in interpreting whether PIU is parallel or not.

It should be noted that, where parallel PIUs in the framework of EC support in the health sector have existed over the evaluation period, problems such as creating parallel power structures, distortion of salaries and diversion of staff and difficulties in achieving sustainability tend to occur (e.g. *Afghanistan*).

6.2 JC 62 Increased complementarity of EC support and between EC support and support of other donors

According to the EU toolkit, "*complementarity is a result of an optimal division of labour (DoL) between various actors in order to achieve optimum use of human and financial resources for enhanced aid effectiveness, i.e. to attain country strategy objectives and achieve better results in poverty reduction*."

Co-ordination can help achieving complementarity. In EC support, one of the steps is ensuring, when drafting the CSPs that complementarity of support with the support of other donors is researched. The fact that donor matrices detailing donor interventions in all sectors, including health, have been produced in most CSPs reviewed is a first indication of reflection on the issue. Overall and especially for the second programming period under review, there is further evidence of co-ordination of the programming process with other donors, thus allowing for and, as e.g. in *Bangladesh*, leading to, synergies. In this context, an enhanced Division of Labour, at least in the EC programming process, among EU MS becomes apparent for this second period. (*I-621*)

The Paris Declaration of 2005 has put significant pressure on both donors and governments to further strengthening their joint efforts, which had already partly started in the first period under evaluation. Evidence of joint efforts has been found ranging from a fully-fledged joint assistance strategies to punctual joint donor

[177] The only exception was EUD *Vietnam* that reported a new PIU established for health sector capacity building project.

efforts (i.e. joint field mission or shared analytical work) has been found. It also appeared that joint efforts have helped enhancing co-ordination over the period under evaluation and improved co-ordination then has helped launching further joint efforts.

A number of Joint Assistance Strategies (JAS) have been developed during the evaluation period. However, they are not necessarily complete nor applied in all areas of support, as indicated by several EUDs. Moreover, too many separate strategies and initiatives are a major area of concern. The JAS may complement CSP, their aim being to provide a joint response to the partner countries needs and priorities, each donor focusing on specific sectors where it has a comparative advantage.

Progress has also been made in increasing the number of joint field missions and shared analytical work. The driving forces to start using joint actions during the evaluation period are the improved capacity of the MoH, taking the lead on the sector approach (*Ecuador*, *Philippines*) or the introduction of a new sector-wide intervention (e.g. *Vietnam*, *Bangladesh*). (*I-622*)

EC contribution to global trust funds, including global initiatives, amounts to € 900.6 million for the evaluation period. Most of this amount was directed to the GFATM, the Avian Influenza Preparedness and GAVI. With its funds to global trust funds, the EC provides an important contribution to the realisation of Global Public Goods for Health.

Moreover, the EC finances and is actively involved in several (multi-donor) trust funds at country level. Most of them can be found in Asian and ACP countries. They either support the entire health sector in fragile states (*Timor Leste, Philippines-Mindanao province, Occupied Palestinian Territory, Angola*) or actions related to specific diseases (*Myanmar, Nigeria, Ethiopia*). This hints to the fact that trust funds at national level can take many forms when it comes to the geographical coverage (national level vs. provincial level), thematic focus (entire health sector, or specific areas, like immunisation, PRD, health workers). In some countries TF are national level have been used as a pre-step towards a full SWAp and possible SBS (*Afghanistan*); in one occasion they were purely used as a tool to speed up implementation (*DRC*).

By their very nature trust funds can be a vehicle to enhancing complementarity in the health sector, as they bring together different donors and usually have a certain financial impact on the sector. This has been confirmed by the EUD survey giving clear indication that trust funds increase harmonisation and co-ordination efforts between donors (*Vietnam, Bangladesh*) and can facilitate the implementation of joint actions, such as joint needs assessments (*Vietnam, Philippines*) or a common and aligned donor-government strategy (*Timor Leste, Zimbabwe*). The majority of TF participants ranked them as satisfactory, the main issues of concerns being related to the day-to-day management, especially different donor procedures (*Bangladesh, Philippines, Vietnam*) and the lack of visibility of EC action within the trust funds (*Vietnam, Zimbabwe*). In most cases, the trust fund administrator at country level is the World Bank, with a total amount of € 129 million being trusted during the evaluation period. Not surprisingly, the main factor of success in the implementation phase of multi-donor trust funds is a regular and transparent dialogue between the donor partners and the government and the active participation of the EUD in the steering and co-ordination committees. (*I-623*)

6.2.1 I-621 EC programming and planning process related to health has been co-ordinated with other (EU) donors (as e.g. evidenced by EC programming documents such as CSPs, NIPs)

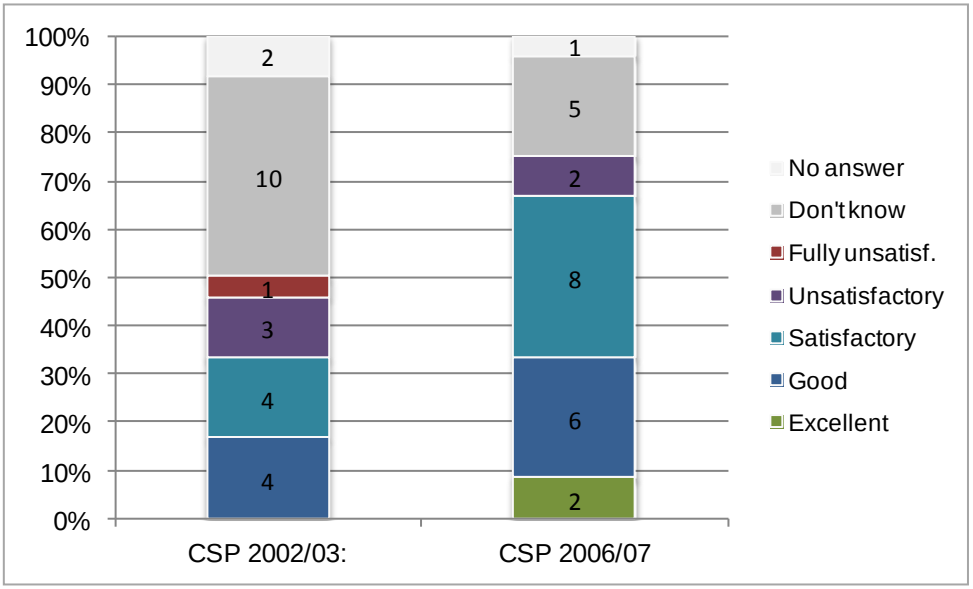
In order to arrive at coordinated and best harmonised support to health, one major building block consists of a programming process that clearly identifies how support is intended to fit and work together.

In that regard, donor matrices are a step towards complementarity and co-ordination of programming processes related to health. The existence of donor matrixes has been mentioned in most of CSPs reviewed. For *Tanzania*, *Afghanistan, Bangladesh, Burkina Faso* and *DRC,* they detail donor interventions in all sectors, including health.

However, a donor matrix does not imply donor co-ordination *per se*, as pointed out, among others in the CSP II of El Salvador: "*The level of political dialogue and co-ordination between the Commission departments on one side and the Government of El Salvador, EU Member States and non-EU donors on the other needs to be increased and consolidated."* The following reasons for weak aid co-ordination are mentioned: *"limits to the capability of the Ministry of Foreign Affairs to ensure adequate and timely counterpart funding, provide adequate project staffing and deal with other matters critical to effective programme and project implementation"*. However, the CSP does not give any indication on how this problem should be tackled.

The EUD survey gives some indication how complementarity to other EC/donor interventions has be sought during the programming stage. The following figure depicts the perception of EUD staff on the issue of co-ordination of the EU programming process related to health sector support.

Figure 32: Results of the survey to EUDs: Co-ordination of EC programming process with other donors in general in the country



Source: EUD Survey, 2011, Particip GmbH

According to the EUDs, overall, co-ordination, with the donor community and during the EC programming process, has improved between the two rounds of CSPs in the countries reviewed. While no EUD stated that donor co-ordination had worsened, a shift towards better co-ordination is pointed out by the following EUDs: *Morocco*, *Nigeria* (from unsatisfactory to satisfactory), *Philippines* and *Vietnam* (from satisfactory to good) and *Myanmar* and *Timor Leste* (from good to excellent). All other changes in the graphic above are related to the fact that almost half of the EUDs[178] did not know whether the EU programming process related to health sector support had been coordinated with other donor activities in the beginning of the evaluation period. This is understandable, to a certain extent, as EUDs have undergone considerable staff rotation since this period.[179]

Independently of the type of support given, be it projects, SBS or even GBS, all EUDs pointing out a shift towards more co-ordination, state that wider consultations had been done in 2006/2007, with the participation of all DPs working in the health sector, but also relevant civil society players. In *Morocco*, only at this time, donor co-operation emerged. In *Nigeria*, the shift towards enhanced donor co-operation seems to be due to a poorly managed basket fund (Prime-Partnership to Reinforce Immunisation Efficiency, Polio Eradication) and the necessity to channel funds to the WHO while at the same time building capacity building at the MoH. The case study for *Bangladesh* indicates that all EC programmes are joint with other donors. They provide funding to the HNPSP through a World Bank Trust Fund and work through the SWAp which has been developed. The four EC projects are implemented by UN agencies[180]. In the *Philippines*, MHSPSP has also undertaken conjoint planning for the 2009 period with two USAID projects.[181]

Co-ordination of EC programming process with EU MS

On the question on how co-ordination specifically with EU MS has changed during the evaluation period, the picture is almost the same as for co-ordination with the entire donor community. An exception is *Nigeria*, which did not rate up co-ordination between EU MS as: *"there has been no significant change in the co-operation, although his is foreseen to significantly improve with the current emphasis on use of Delegated Co-operation Instruments in the 10th EDF, according to the EUD[182]".* A positive example can be found in *Ecuador*, where the EUD improved its scoring from "fully unsatisfactory" in 2002 to "satisfactory" in 2010,

[178] Barbados, DRC, Mozambique, Zambia, Afghanistan, Bangladesh, Lao, Yemen, Moldova, Syria.-
[179] This number reduced to five in 2010: Mozambique, Bangladesh, Yemen, Moldova, Syria.
[180] Information from the interviews contained in the country case study
[181] Final Report to the Delegation of the European Commission in the Philippines, Technical Assistance to the Mindanao Health Sector Policy Support Programme, Six Month Report January 2009 & 2009 Annual Work Plan
[182] EUD survey

indicating that *"since 2006 there was more co-ordination with EC and EU members especially as the Delegation in Ecuador started implementing budget support modality".*

While the EUD *Bangladesh* did not provide any ranking, the CSP II explicitly discusses the synergies and complementarities of EC work and that of certain Member States such as Germany and DfID. Co-operation has taken place with most of the donors in the social sectors - health and education. "*Like the EC, DFID has been involved in the design and funding of the first health and education sector programmes (HPSP and PEPDII). Germany is the third largest EU donor, following DFID and the EC (and) has also a strong focus on the social sector (.). This has allowed the EC and German programmes to achieve a fair amount of synergies, notably in the health and trade sector programmes.*

The same situation as in Bangladesh has been found in *Mozambique*, where the CSP states that interaction with other donors, including EU Member States, is intensive and comprehensive. Furthermore, the CSP emphasises that *"the continuing presence of the EC in the same traditional focal sectors has influenced the current division of labour between development partners, especially EU Member States, ensuring complementarity"*.

In particular, the EU Code of Conduct and the Nordic Plus Initiative have contributed to limiting overlaps in EU donors' sector support in partner countries. Individual bilateral donors have also taken the initiative to rationalise sector engagement. For example in *Mali*, in response to the EU Code of Conduct, some donors (e.g. France and Belgium) are progressively withdrawing from the health sector, while others (e.g. Sweden and Spain), are adopting silent partnerships. Another example is *Mozambique*, where Norway and Finland have withdrawn from the health sector and Ireland represents the Clinton Foundation through a silent partnership. Within the framework of the EU Code of Conduct, a Joint Action Plan has been agreed and a donor task force has established the comparative advantage of donors and proposed that some donors exit some sectors. However, there has been little progress in sector rationalisation. Some donors characterise certain sectors as "non-focal" and hence not an area of engagement, despite still being present.[183]

It should also be mentioned that EU joint programming has been initiated in some countries, such as *South Africa, Somalia* and *Haiti* as underlined by the EU toolkit complementarity. The key objective of EU joint programming (through drafting multi-annual Country Strategy Papers, as envisaged by the Common Framework for Country Strategy Papers is to improve aid effectiveness through a more focussed and collaborative approach to EU strategy programme thus reducing transaction costs for the government.

In sum, co-ordination can help achieving complementarity. In EC support, one of the steps is ensuring, when drafting the CSPs that complementarity of support with the support of other donors is researched. The fact that donor matrices detailing donor interventions in all sectors, including health, have been produced in most CSPs reviewed is a first indication of reflection on the issue. Overall and especially for the second programming period under review, there is further evidence of co-ordination of the programming process with other donors, thus allowing for and, as e.g. in *Bangladesh*, leading to synergies. In this context, an enhanced Division of Labour among EU MS became clear for this second period, most of the time in the EC programming process but also in implementation,. In particular, the EU Code of Conduct and the Nordic Plus Initiative have contributed to limiting overlaps in EU donors' sector support in partner countries. Within this framework, a Joint Action Plan has been agreed and a donor task force has established the comparative advantage of donors, in order to enhance Division of Labour in the implementation among EU donors.

6.2.2 I-622 Evidence of joint activities enhancing complementarity

This indicator includes various types of joint activities enhancing complementarity such as: i) Joint and harmonised health assistance strategies, ii) Existence of joint field missions and shared analytical work. The issue of delegated co-operation has already been discussed above.

The documentation reviewed provides evidence of joint efforts going from a fully-fledged joint assistance strategy to punctual joint donor efforts like joint field mission or joint assessments and evaluation. These joint donor efforts aim at enhancing co-operation and efficiency.

1) Joint and harmonised (health) assistance strategies

[183] OECD (2011): Progress and Challenges in Aid Effectiveness. What can we learn from the Health Sector? 4th High Level Forum on Aid Effectiveness (29.11-01.12.2011); Busuan, Korea.

According to the EU toolkit on complementarity[184], donor wide Joint Assistance Strategies (JAS) aim at providing a joint response to the partner countries needs and priorities, each focusing on specific sectors where it has a comparative advantage.

Some JAS where the EC and MS participate include: *Kenya* (KJAS), *Mali* ("Stratégie Commune d'Assistance Pays"), *Uganda* (UJAS); and countries receiving GBS: *Ghana* (GJAS), *Tanzania* (JAST/Development Partners Joint Programming Document), *Vietnam, Zambia* (JASZ) including the EC, EU MS but also other donors.

Other joint strategies are still more restricted in their scope can be found for instance in *Sierra Leone,* where the EC and DFID have joined forces and are aiming at expanding. *Zambia* may serve as an example to highlight the need for such strategies:

Box 33: Zambia: Joint Assistance Strategy for Zambia (JASZ)

The *Zambia* Joint Assistance Strategy for Zambia (JASZ)[185] is a national medium-term framework (2007 - 2010) which has been developed by the Co-operating Partners to manage their development co-operation with the Government of the Republic of Zambia (GRZ) in alignment with the Fifth National Development Plan. The JASZ seeks to rationalise and coordinate interventions by cooperating partners within the framework of the national development strategy (FNDP) and to establish a Division of Labour (agreed by the Government and cooperating partners in June 2006) for "de-congesting" sectors that were oversubscribed, with a reduced number of lead partners in each sector, to act under agreed terms of reference. Interestingly, the CSP II is states that *"The selection of leading donors has been done not only examining the amount of resources committed but also the sector technical capacities of the possible leading donor."*

This document signed by twelve bilateral donors together with the International Financing Institutions (IFIs), the European Commission (EC) and the United Nations (UN) system is a new step for the signatories (including the EC) to confirm their willingness to strengthen their alignment to Zambia's policies, systems and procedures, including health policies, systems and procedures. [186]

There is also a web-based Aid Co-ordination and Management system[187] for tracking all economic technical and funded assistance in Zambia.

Source: Zambia (CSP II), Field mission to Zambia, Particip (2008) and web research from Particip

While JAS and CSP are not meant to be two competing systems but processes that can mutually reinforce each other, these processes may not be synchronised in time. The EUD survey found that 67% of the EUDs confirm the existence of a joint and harmonised donor health assistance strategy during the evaluation period[188]. However, despite signature of such documents, according to a considerable number of EUDs these documents are often only partial and not applied in all the areas. For instance, EUD *India* commented that although a joint strategy occurs in some health areas like HIV/TB/Malaria and RCH, certain sections of society, CSO, feel excluded from the joint exercise.

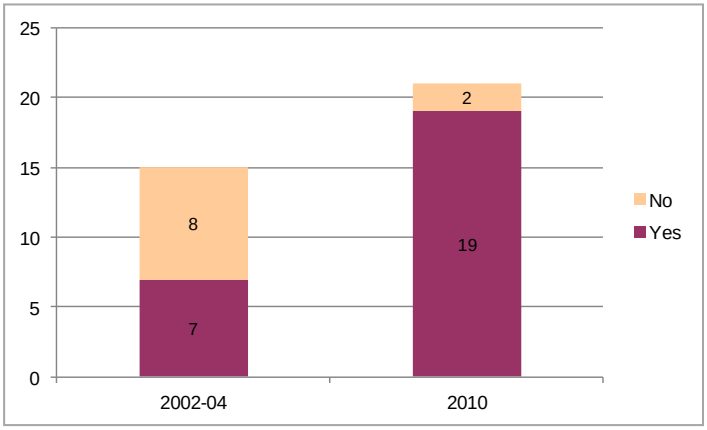
Moreover, the impact of joint assistance strategies is questioned by most of the EUDs (10 out of 16 EUDs): still considerable fragmentation of aid continues to exist, with too many separate strategies and initiatives. For example, EUD Mozambique specifically criticized that "*more than half of all donors' contributions go to bilateral projects or programmes undermining the impact of the joint strategy".* And the EUD *Zambia* highlights that despite a good quality MoU in the health sector outlining the SWAp, the legality of such sector strategies are debated particularly in the context of bilateral agreements.

2) Evidence of joint field missions and shared analytical work

The EUD survey found that progress has been made on increasing the number of joint field missions and shared analytical work.

[184] European Union (2009): EU Toolkit for the implementation of complementarity and division of labour in development policy
[185] See e.g. http://www.synisys.com/zambia/index.jsp?sid=1&id=19&pid=1
[186] Field mission to Zambia, Particip (2008)
[187] The Zambia Development and Assistance Database (ZDAD): http://www.synisys.com/zambia/index.jsp?sid=1&id=19&pid=1
[188] *Bangladesh, Burkina Faso, DRC, Ecuador, Egypt, Ghana, Lao, Mozambique, Myanmar, Morocco, Nigeria, Philippines, South Africa, Zambia and Timor-Leste*)

Figure 33: Results of survey to EUDs: Joint field mission (government or development partner) and shared analytical work taking place



Note: not shown in the graphic: answer category "don't know: 7 for 2002-04 and 1 for 2010; no answer to the question: 2 for 2002-04 and 2010

Source: EUD Survey, 2011, Particip GmbH

For the first reference period, 2002-04, 29% of EUDs (*Lao, India, Bangladesh, Afghanistan, Nigeria and Zimbabwe*) indicated that joint field missions and analytical work took place in their countries.

In 2010, 79 %[189] of the respondents confirmed that joint action related to the health sector took place in their countries. Only two EUDs, *South Africa,* remained on "no", while Zimbabwe changed from "yes" to "no", which might be explained through the political crises.

The driving forces to start using joint actions during the evaluation period are, according to the EUDs[190]:

- the improved capacity of the MoH, taking the lead on the sector approach, aiming at better harmonisation and alignment (*Ecuador*, *Philippines*); or
- the introduction of a new sector-wide intervention (e.g. HEMA project in *Vietnam*, HNPSP in *Bangladesh*).

The following elements emerge from survey, CSP analysis and analysis of financial agreements and of MTRs:

- **Annual Reviews** of the various health programmes, where provided in forms of sector support, often form the cornerstone of the joint exercises. As also in *Afghanistan*, these serve to discuss lessons learned and fine-tune the collaboration between government and the international community,[191] and to inform the policy debate, as e.g. in *Zambia*. In *Vietnam*, the EC has been heavily involved in co-ordination in the health sector through chairing the EU donor's group, which produces the Joint Annual Health Review. It is seen as a precursor to a sector plan and coordinates a European position prior to meetings of the Partnership Group in health.[192]
- **Participation** in such reviews is usually wide, including, in *Zambia*, MoH, Health Cooperating Partners, Civil Society Groups and Regulatory bodies (Health Professionals Council, Nursing Council, Pharmaceutical Regulatory Body) and DPs. In *Afghanistan*, the EC fully participates in joint reviews and is in particular seen as the donor who actively promotes a SWAp approach, according to the interviews with donors.
- The creation of **joint committees** also contributes to these joint activities, as for example in the *Philippines*, where the EU supports the DOH's (Department of Health) Sector Development Approach for Health (SDAH) and is an active member in the Joint Appraisal Committee (JAC) and the Joint Assessment and Planning Initiative (JAPI). Both the HSPSP and MHSPSP support the

[189] Afghanistan, Bangladesh, Barbados, Burkina Faso, Congo (Kinshasa), Ecuador, Ghana India, Lao, Morocco, Mozambique, Myanmar, Nigeria, Philippines, Syrian Arab Republic, Timor-Leste, Vietnam, Yemen, Zambia
[190] DRC, Ecuador, Philippines, Vietnam, Bangladesh, Morocco answered "no" in 2002 and "yes" in 2010.
[191] *Support to the AF Health sector (DEC 2006/018-370), financial proposal p. 2-3*
[192] Vietnam, CSE 2009, Vol 1, p. 17

SDAH, its governance structures and have as objectives the strengthening of core systems under the four pillars of F1 for Health.[193]

- Further **joint missions** often revolve around the annual reviews, as in the case of *Bangladesh* and related to the health sector programme HNPSP, but may take place up to three times per year, in addition possibly focusing, as in *Burkina Faso,* on very specific technical topic: (i) PNDS annual field missions; (ii) Joint Mission for results based financing; (iii) Financing sessions 2010 for central directions, hospitals and (iii) financing sessions for health districts. Here, according to the EUD the factors ensuring success were: adequate notification and realistic duration.

All these efforts together tend to paint a picture where joint efforts helped enhancing co-ordination over the period under evaluation and improved co-ordination then has helped launching further joint efforts. The observations made by the EUD *Bangladesh* in the EUD survey may help illustrating this: "*The co-ordination among all the donors in the health sector has been improved to a very large extent over the past years. It has resulted in coordinated and joint reviews of the sector as well as alignment of programming for the future support in the health. Joint assessments of the new health strategy along with joint policy dialogues are some of the outcome of this better co-ordination during 2010*."

As illustrated by the above figure as well as the analysis of two CSP periods, we tend to believe that the Paris Declaration of 2005 has put significant pressure on both donors and governments to further strengthening their joint efforts during the second part of the period under evaluation that, partly, had already started in the earlier part of the period under evaluation.

In sum, the Paris Declaration of 2005 has put significant pressure on both donors and governments to further strengthening their joint efforts, which had already partly started in the first period under evaluation. Evidence of joint efforts has been found ranging from a fully-fledged joint assistance strategies to punctual joint donor efforts (i.e. joint field mission or shared analytical work) has been found. It also appeared that joint efforts have helped enhancing co-ordination over the period under evaluation and improved co-ordination then has helped launching further joint efforts.

A number of Joint Assistance Strategies (JAS) have been developed during the evaluation period. However, they are not necessarily complete nor applied in all areas of support, as indicated by several EUDs. Moreover, too many separate strategies and initiatives are a major area of concern. The JAS may complement to the CSP, their aim being to provide a joint response to the partner countries needs and priorities, each donor focusing on specific sectors where it has a comparative advantage.

Progress has also been made in increasing the number of joint field missions and shared analytical work. The driving forces to start using joint actions during the evaluation period are the improved capacity of the MoH, taking the lead on the sector approach (*Ecuador*, *Philippines*) or the introduction of a new sector-wide intervention (e.g. *Vietnam*, *Bangladesh*).

6.2.3 I-623 Degree of complementarity of EU supported health-specific global and country-level trust funds with other EC support to the health sector in the country

EC support to health via trust funds is characterised by two types of funds:

- global trust funds/global initiatives to the health sector, such as the GFATM or other initiatives as GAVI);
- trust funds at the level of the partner countries, mostly in the form of common pooled/basket funds managed by the World Bank or UN Bodies (e.g. UNDP/UNFPA/UNOPS).

1) Global trust funds

Over the evaluation period the EC contributed with a total of € 856 million to health-related global trust funds; this represents 21% of the total EC funds to the health sector. As such, aid delivery through global trust funds is the second largest aid modality used by the EC in the health sector, ranking after support through individual projects (45% of total EC support). The overwhelming majority of financial contributions to global trust funds, 94%, went to the GFATM, while the remaining 6% went to the Avian Influenza and Human

[193] Mindanao Health Sector Policy Support, Programme (MHSPSP) Mid-Term Review, Final evaluation report, Philippines, November 2010

Influenza Pandemic Preparedness Fund. Furthermore, the EC financed global initiatives, such as the GAVI Alliance and the International Partnership for Microbicides.

The table below gives an overview of funds channelled through global trust funds and global initiatives.

Table 28: Overview of EC funds to global trust funds and initiatives between 2002 and 2010

Name	Contracted amount in €
GFATM	803.140.722
Avian influenza and human influenza pandemic preparedness	52.430.000
Migration of Physicians within and from Sub-Saharan Africa: Internal, Regional and International Movements	620.761
Total Global Trust Funds	*856.191.483*
The GAVI fund non-profit corporation	39.400.000
International Partnership for Microbicides	5.070.000
Total Global Initiatives	*44.470.000*
Total EC funds to global trust funds/global initiatives	**900.661.483**

Source: CRIS database, Particip GmbH

1a) GFATM and the EC[194]

Not least as a result of the considerable financial amounts, the GFATM has to be recognised as an important donor and development-partner in a lot of countries. With approximately € 100 million per year, the EC is the fourth biggest contributor to the GFATM on a worldwide level. According to the ECA report on EC Development Assistance to Health Services in Sub Saharan Africa[195], the EC headquarter has played an important role in setting up the GFATM and increasing the agenda setting on HIV/AIDS, tuberculosis and malaria issues.

On country level, the involvement in and co-ordination with GFATM activities of the EC has been less positively assessed, which is probable to have a direct effect on the complementarity of interventions. According to the same ECA report, the EUDs have not been sufficiently encouraged to support GFATM contribution in their countries. As a result, a survey undertaken by ECA found that in 2008, only 35% of EUDs which were actively participating in the national country co-ordination mechanisms (CCM) set up by the GFATM and only 8% of EUDs that report regularly to EC headquarter about the GFATM functioning and its activities in their countries.

Box 34: The role of EC and EUDs in the GFATM

The significant role played by the Commission headquarters in the setting up of the Global Fund, as well as the considerable resources it has allocated to it, are in contrast to the limited role played in relation to the Global Fund by most EUDs. Guidance notes issued by Commission headquarters did not instruct but only 'encouraged' delegations to support Global Fund operations. In none of the three main areas earmarked by Commission headquarters for delegations' involvement have they played an active role.

- actively participating in Global Fund country coordinating mechanisms (CCM) and help strengthen them: according to the Court's survey, only 35 % of delegations participate in the CCMs. The most common reasons given for not attending were insufficient staff in the delegations and the fact that the health sector was not a focal sector for the Commission;
- reporting on aspects of the Global Fund functioning in country: according to the Court's survey, just 8 % of delegations reported regularly to Commission headquarters, 59 % reported occasion- ally while one third had never reported. While the Commission is on the Global Fund board, its lack of feedback on Global Fund operations from delegations has reduced its capacity to act at this level to improve the effectiveness of operations;
- providing technical assistance for developing grant proposals and assisting implementation: in the face of the lack of capacity of national bodies to draw up grant proposals and then implement them, the Global Fund has particularly stressed the need for the international community to provide technical assistance in sub-Saharan Africa to address this problem, but the Commission has not responded to this need.

Source: EC development assistance to health services in Sub Saharan Africa, European Court of Auditors, Special Report No 10, 2008

[194] The detailed analysis of EC contribution to GFATM can be found in the thematic case study in Annex 17.
[195] European Court of Auditors (2008) "Special Report 10: "The EC Development Assistance to Health Services in Sub Saharan Africa".

Without being explicitly asked, in the EUD survey, seven out of 24 EUDs (*Laos, India, Myanmar, Burkina Faso, DRC, Timor Leste, Zimbabwe* and *Syria)* mention the CCM as one of the important co-ordination mechanisms in the health sector. Moreover, in the countries where the EC actively takes into account GFATM activities, evidence found shows that complementarity is quite good and even possible synergies are exploited.

Box 35: Examples of EC interaction with the GFATM at country level

Bangladesh: According to the field visit reports, the GFATM is complementary to the activities of the SWAp, to which the EC also contributes. From a strategy point of view, GFATM and EC activities are in line and follow the same objectives in the field of PRDs. But the report also highlighted that the co-ordination between GFATM activities and those of the SWAp needs improvement. On an implementation level, the EUD participated only ad-hoc and on invitation in GFATM meetings. Concerning the CCM, the EUD does not participate as such, but is represented through a Member State.[196]

Timor-Leste: The EUD indicates that EC programmes (including national trust funds) have been coordinated with the activities of global initiatives, such as the GFATM and GAVI, the later both being managed by the MoH-PRs.

Syria: In Syria, the EC represents the donor community within the CCM. The EUD reports in the survey that the CCM organises every year four to five joint field missions, in which the EC plays an active role.

Laos: The CSE Laos (2009) highlights the complementarity of GFTAM activities and other activities in the country and goes even further by attributing to the EC the credit for the design of the GFATM intervention: *"One of the one of the strongest points of the GFATM performance has been the fact that it very effectively built on the foundation that had been put in place by the EC regional malaria programme. This is a good example of a smooth strategic progression in a major public health area in Lao PDR"*[197].

1b) Other global trust funds

Classified as global goods for health, the following two initiatives are an example of the work towards complementarity between different EC budget lines and between different Directorates General of the EC (mostly DG Research and Health and Consumers).

Box 36: Avian influenza and human influenza pandemic preparedness: The role of the EC

The EC played a leading role in responding to the highly pathogenic avian influenza (HPAI) crisis and policy preparations to combat a potential pandemic influenza outbreak. The European Union, together with key partners like the USA, Japan, Canada, Australia, the United Nations Influenza Co-ordination, UN agencies, the World Organisation for Animal Health (OIE) and the World Bank, has been a leader of various initiatives and of the international co-ordination process generated. At the Beijing conference in 2006, the EC pledged € 100 million to combat the avian influenza and to prepare for a possible outbreak. € 20 million was spent on scientific research projects via the FP6 and the remaining € 80 million to assist projects outside the EU.[198]

The European Union (EC and EU Member States) was the second largest global donor with a contribution of € 413 million.

EC funds under the FP Research programmes

For more than 10 years the EC has been supporting research on influenza in both humans and animals. Already under the 5th Framework Programme for Research (1998-2002, FP5) about € 6 million was spent in 22 institutions and national reference laboratories across 8 European countries. In FP6 (2002-2006) activities were extended and reinforced with a set of new projects launched with an almost tenfold increase in funding (more than € 50 million plus share in several larger projects dedicated to influenza as well as to other viral infections). In the FP7 (2007-2013) the pandemic influenza is addressed in the 'Co-operation Programme', Theme 1 'Health' under the sub-heading 'Emerging (Infectious) Epidemics' and avian influenza in animals is dealt within the Theme 2 'Food, Agriculture and Biotechnology Research'.[199]

The Avian and Human Influenza Facility (AHIF)[200]

The Avian and Human Influenza Facility (AHIF) is a multi-donor financing mechanism administered by the World Bank that helps developing countries to minimize the risk and socio-economic impact of avian influenza (H5N1) and other zoonoses and of possible human pandemic influenza), created following the Beijing conference. AHIF complements the World Bank supported Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI) which has as its objective "to minimize the threat posed to humans by highly pathogenic avian influenza (HPAI)

[196] Particip (2008) Evaluation of EC support to the health sector. Field visit report Bangladesh.
[197] Particip (2009) Evaluation of the EC country strategy with Laos.
[198] http://ec.europa.eu/world/avian_influenza/
[199] http://ec.europa.eu/world/avian_influenza/. A catalog of funded projects on avian influenza of the period 2001-2007 is at: http://ec.europa.eu/research/health/poverty-diseases/doc/influenza-research_en.pdf; FP7 projects are at http://ec.europa.eu/research/health/infectious-diseases/emerging-epidemics/fp7projects_en.html
[200] For an evaluation of the Global Response to the Avian Influenza Crisis see: HTSPE (2010): Outcome and Impact Assessment of the Global Response to the Avian Influenza Crisis. Final Report – August 2010

infection and other zoonoses to prepare for, control and respond to influenza pandemics and other infectious disease emergencies in humans".[201]

The AHIF is currently supported by ten donor agencies, led by the EC, which have collectively pledged more than US$ 127 million. The EC is the largest donor to AHIF with total contribution of US$ 80.73 million since inception to 2010 (figure below). EC funds are earmarked for East and South Asia, the Mediterranean, Central Asia and Eastern Europe. The other nine donors - Australia, China, Estonia, Iceland, India, Korea, the Russian Federation, Slovenia and the United Kingdom – contributed to AHIF which is not geographically restricted and can be used, notably, to assist countries in Africa and Latin America and the Caribbean regions.[202]

Source: Thematic case study on Global Public Goods for Health, Annex 19

Box 37: GAVI and the EC

The EC has been one of the major donors to the Global Alliance for Vaccines and Immunisation (GAVI) since 2003, supporting GAVI through direct contributions. From a cumulative US$ 5.8 billion of funding received from 2003-2010, the EC accounted for US$ 57 million (€ 39.4 million, 1.2% of direct funding). EU Member States contributed another US$ 1.2 billion in the same period.[203] The EC contribution comes in part from the Development Co-operation Instrument and in part from the intra-ACP envelope of the European Development Fund. In October 2010, the EC pledged € 20 million to GAVI.

At the most recent pledging conference in June 2011, the EC committed an additional € 10 million to GAVI.[204] By the end of 2010, GAVI had supported the immunisation of 326 million additional children, who might not otherwise have had access to vaccines and prevented over five million future deaths.[205] As highlighted by the thematic case study on global public goods for health (Annex 19), by financing vaccination and the development of them, the EC finances a public good, which is not an attractive line of business for the international pharmaceutical industry.

Source: Thematic case study on Global Public Goods for Health, Annex 19

2) Trust funds at country level

The inventory does not allow identifying pooled funding on country level in a systematic way and as thus hints to the fact that trust funds at country level take many forms: different thematic focus - e.g. targeting the whole health sector as in the Support to the national Health, Nutrition and Population Sector Programme, *Bangladesh* versus a specific sub-sector focus as the Three Disease Fund in *Myanmar* - different geographical coverage - the overall country in *Bangladesh*, the Mindanao province in the *Philippines* - or different financial amounts provided by the EC.

Such trust funds are by nature opportune to enhancing complementarity in the health sector, as they bring together different donors and have a certain financial impact on the sector. The following table provides examples of country level trust funds in the 25 desk study countries, thus exemplifying the EC's considerable involvement in such multi-donor legal frameworks. To note that such trust fund mechanisms are mainly used in Asian and ACP countries, particularly, in both regions, to support the entire health sector in fragile states, or to support actions related to specific diseases.

Table 29: Examples of EC financial contribution to trust funds at country level

Country/Name of the trust fund	*Contracted amount in Euro*	*Main contracting party/ Amounts in Euro*
BANGLADESH	105.107.887	
EC- Support to the national Health, Nutrition and Population Sector Programme		WB: 76 million FAO: 7 million UNDP: 9 million UNFPA: 10 million WHO: 1.4 million
MYANMAR	18.082.229	UNOPS: 18 million
Three Diseases Fund		

[201] AHI Facility, Avian & Human Influenza: A Partnership for Results. http://ec.europa.eu/europeaid/where/asia/regional-co-operation/animal-human-health/documents/ahif_results_report.pdf
[202] Ibid.
[203] http://www.gavialliance.org/funding/donor-contributions-pledges/ , Particip inventory.
[204] http://www.gavialliance.org/funding/donor-profiles/ec/
[205] http://www.gavialliance.org/about/mission/impact/

Country/Name of the trust fund	*Contracted amount in Euro*	*Main contracting party/ Amounts in Euro*
PHILIPPINES	22.581.976	
Mindanao Health Sector Policy Support Programme (MHSPSP)		WB: 13.450 million UNDP: 4 million
TIMOR-LESTE	16.689.978	
Health Sector Rehabilitation and Development Programme (HSRDP II)		WB: 16.5 million
Support to the Implementation of the Health Sector Investment Programme		Not yet in CRIS
VIETNAM	17.595.548	
Health Care Support to the Poor of the Northern Uplands and Central Highlands		WB: 11.6million
ANGOLA		
Support To The Development Of Human Resource For Health Inpalop	6.843.423	WB: 1,3 million
ETHIOPIA		
EC Support for Polio Eradication Outbreak Response Activities in Ethiopia	13.000.000	WHO: 13 million
NIGERIA		
Prime-Partnership To Reinforce Immunisation Efficiency	20.000.000	WHO: 20 million
ZAMBIA		
Health Sector Supp. Progr. (Contrib. To Pooled Donor Funds) Support Of District Basket (Basket Fund)	2.099.468	
PALESTINIAN TERRITORY, OCCUPIED		
Emergency Assistance to the Palestinian Ministry of Health	10.000.000	WB: 10 million
Total	**236.6 million**	

Source: CRIS database; Particip analysis

It should be noted that the reasons for putting in place trust funds vary considerably, thus showing the range of flexibility they may be used by the EC:

- In some countries, they are seen as a step towards broader SWAps/sector support, as soon as the conditions for these are better fulfilled, as for instance indicated by the CSP II Afghanistan: *"For the medium term, multilateral trust funds may continue to be a necessary vehicle for channelling substantial budgetary support. As and when the capacity of government departments increases, there could be more scope to provide funding directly through government channels."*[206]
- In the *DRC*, the reason was purely to speed up implementation due to administrative constraints: *"Après l'exécution du PATS II en 2005, Il était prévu un démarrage rapide du PS9FED qui devait prendre sa suite, mais la rédaction de la proposition de financement a été finalisée avec retard par rapport au timing initial. Pour éviter l'arrêt ou le ralentissement des activités soutenues par le PATS II, un Trust fund a été mis en place à partir de mai 2005, avec une dotation de 1,7 M€. Il a ainsi été possible de financer les primes d'un certain nombre d'agents…".*[207]

For a few countries (*Vietnam*, *Philippines*, *Afghanistan*, *Laos* and *Timor Leste*), the CSP analysis shows that complementarity between EC supported trust funds and other EC/donor interventions has been a reason for opting for this way of support.

Further, the EUDs rated **complementarity of EC funded trust funds with other EC support** as overall rather positive, with all seven respondents either rating complementarity as "good" (four EUDs) or "satisfactory" (three EUDs). Good complementarity is, according to the EUDs, a result of an increased harmonisation and co-ordination efforts between donors in the health sector due to the trust fund

[206] CSP I Afghanistan, referring specifically to the Afghanistan Reconstruction Fund, which has a social sector component.
[207] Sofreco (2005) Evaluation de la stratégie de coopération de la Commission européenne avec la République démocratique du Congo

agreements (*Vietnam*, *Bangladesh*). Such increased harmonisation can lead to further joint actions, such as joint needs assessments (*Vietnam*, *Philippines*) or to a common and aligned donor-government strategy and single programming objectives and matrices (*Timor Leste*, *Zimbabwe*). Moreover, the usefulness and potential of trust funds to help building joint donor strategy has also been emphasised in some CSPs (CSP I *Philippines*, CSP II *Vietnam*, CSP I *Timor Leste*).

An example of complementarity between different donors within national trust funds is given in the CSE Philippines related to the HEMA project. There it is stated: *"An example of exploiting complementarities is the HEMA project, which focuses on the commune and district levels while a sister World Bank health project focuses on the provincial and district levels"*[208] The HEMA trust fund is part of the huge programme "Health Care Support to the Poor of the Northern Uplands and Central Highlands". The HEMA trust fund is managed by the WB and EC pledges a total of € 17,6 million in it

The following box shows the case of the Three Diseases Fund in Myanmar, which replaced the GFATM for a certain period in the country and to which the EC contributed substantially. It is a good example of how donors may effectively work together and the support of trust fund being an appropriate way to jointly tackle challenges and reach specific aims. In the words of the EUD Myanmar, the Three Disease Fund in Myanmar is: *"Good quality of partnership, efficiency, effectiveness, impacts, co-ordination."*

Box 38: Myanmar - The Three Diseases Fund (where the EC and EC MS, plus other donors, substitute the GFATM in Myanmar): A special case

The Three-Diseases Fund (3DF) is a multi-donor consortium, which raised an initial US$ 100 million to assist Myanmar in the control of three diseases over a five year period 2006-2011/12. It was set up with the donations of six countries and organisations -- the EC, DFID, AusAID, SIDA, the Netherlands and Norway. The United Nations Office for Project Services (UNOPS) is the Fund Manager on behalf of the Donor Consortium. In 2009, Denmark also joined the consortium.

The core aim is to provide a simple and transparent instrument to finance a nationwide programme of activities to reduce the transmission of HIV and AIDS, TB and malaria and enhance care and treatment through access to essential drugs and related services. The target beneficiaries are the most vulnerable and under-served populations, especially those living in remote and inaccessible areas and those most at risk.

By the end of 2010, 3DF had effectively supported 28 HIV projects, nine TB projects, ten malaria projects and four integrated projects. In addition, as part of its identified priorities, the 3DF has provided gap-filling support to the GFATM PRs until their programmes are fully-functioning.

The 3DF portfolio grew in 2009. DFID pledged an additional GBP 10 million (approximately US$ 15.5 million), the Netherlands increased its contribution by EUR 1.0 million (approximately US$ 1.48 million) and Sweden by SEK 10 million (or approximately US$ 1,280,000). In late 2009, Denmark committed DKK 30 million (approximately US$ 5.87 million) bringing the total pledges for the 3DF until 2012 to approximately US$ 125 million, before additional MARC funds.

In terms of contributions received between 2006 and 2009, the breakdown is as follows:

Table 30: Three-Diseases Fund (3DF): Donor contributions 2006-2009 (In US$)

	2006	2007	2008	2009	Total
AusAid	786,600	2,146,550	2,678,600	1,707,317	7,319,067
DFID	2,661,540	8,985,990	8,518,050	15,029,375	35,194,955
EC		7,067,555	5,471,295	6,344,625	18,883,475
The Netherlands		1,362,400	1,314,600	2,993,000	5,670,000
Norway	754,152	1,735,898	1,972,355	1,545,563	6,007,968
SIDA		5,738,187	6,883,625	3,699,790	16,321,602
Danida				1,950,116	1,950,116
Total US$	**4,202,292**	**27,036,580**	**26,838,525**	**33,269,786**	**91,347,183**

Source: Three Disease Fund Annual Report 2008

The EC contributed € 18 million in the evaluation period, which is approximately 21% of the overall envelope over the five years period. If EU member states are considered the financial contribution to the fund exceed 80% of the total budget.

The Mid Term Review finalised October 2009 concludes that the fund has performed well and has made significant

[208] Particip (2011), Vol II, 161.

contribution to the containment of the three diseases epidemics. Major achievements and examples of impact achieved: The 3DF MTR report concluded that the fund has been successful in adverting deaths and reducing illness due to the diseases. It notes that fund performance shows that 5-10% of needs met by services provided with Fund support. The Fund has contributed 30-50% of achievement towards the identified national targets and possibility even greater contribution to nationwide outputs. It noted that the level of effect is significant in the Myanmar context, especially given the level of need compared to available resources. The Fund has helped contain but unlikely, on its own, to have contributed to reduced mortality and morbidity nationally. Among the indirect impacts of the 3DF it notes that the Fund has demonstrated that it is possible to successfully provide health services to vulnerable groups in Myanmar.
Longer term plans for 3DF are being reconsidered given the announced return of the GFTAM. It should start operations in 2011. One option would be to widen the scope of the Fund to include mother and child health (MDG 4 and 5). A scoping mission (FWC financed by the EC), to define various options to take place in March 2010. The EC is among the lead donors.

Source: Thematic case study: The European Commission and the Global Fund, External Assistance Management Report n°17, 04.02.2010; External Assistance Management Report n°19, 31.01.2011

Co-ordination among the contributors to country level trust funds was ranked slightly less positive than complementarity by the EUDs participating in such trust funds, with a majority of EUDs opting for "satisfactory" rather than "good". The main issues of concerns were related to the day-to-day management, especially the different donor procedures (*Bangladesh, Philippines, Vietnam*) and the lack of visibility of EC action within the trust funds (*Vietnam, Zimbabwe*).

The issue of lack of visibility of EC contribution to country-level trust funds is recurrent and is also highlighted in the CSE Philippines[209] and in the CSE Laos, in the latter case in relation to the contribution to the GFATM: *"Officials interviewed were aware of, for example, the fact that the EC is a major source of funding for the Global Fund and the role of the EC in financing multi-donor trust funds such as those related to public sector financial management and trade. However, there do not appear to have been any special efforts made to promote EC visibility within the GF."*[210] It is rather natural that the fund manager will usually play the role as main communicator between the Government and the Funders, thus with only a limited role and reduced visibility remaining for EC, as e.g. in *Bangladesh*, where the EUD survey noted that the partner government perceived the World Bank as the only lead partner in the policy dialogue.

In most cases, the trust fund administrator at country level is the World Bank, with a total amount of approximately € 129 million being trusted during the evaluation period. In this context, it should also be mentioned that the differences in administrative procedures of the Bank, which are applicable to loan projects and that need to delay releases of fund to the recipient agencies are causes of concern for a good number of those EUDs dealing with such trust funds (cited by EUD *Philippines and Vietnam),* as is*,.* e.g. in *Timor Leste*, the difficult communication situation, due to remote management.

Not surprisingly, the main factor of success in the implementation phase of multi-donor trust funds is a regular and transparent dialogue between the donor partners and the government and the active participation of the EUD in the steering and co-ordination committees. For *Bangladesh*, the field visit report highlights the negotiations efforts of the EUD in order to influence the trust fund steering committee and to introduce innovative modalities of using the trust fund (e.g. financing alternative health care options or collaborate closer with actors of the non-governmental sector. According to the field visit report, the EUD was not successful, at this time. Answers to the EUD survey as well as the field visit report to Bangladesh clearly indicate the importance of qualified and experienced staff within the EUD to exert sufficient influence.

Overall, the EC has provided considerable financial contribution to global trust funds as well as trust funds at country level. While, across the board, complementarity of these funds with other EC support at country level can be assessed as rather good, co-ordination at country level between the participants of the trust funds has shown to be sometimes problematic (e.g. different administrative procedures, different objectives and strategic goals). The main factor of success identified in the implementation phase of multi-donor trust funds are a regular and transparent dialogue between donors and partner governments, as well as an active participation of EUDs in the steering and co-ordination committees. With its funds to global trust funds, the EC provides an important contribution to Global Public Goods for Health. In the case of GFATM, the significant role of EC headquarter is in contrast to the limited role played by most EUD.

[209] Particip (2011), Vol II, 91.
[210] Particip (2009), Vol II, p. 116

7 EQ7 To what extent have the various financing modalities (GBS, SBS, other sector support, projects), funding channels and instruments and their combinations, been appropriate, thus contributing to improving access to, equity of and policy-based resource allocation in health?

7.1 JC71: Aid delivery methods (incl. modalities and channels) adapted to national context

The selection of aid modalities and channels was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities. EC aid delivery modalities were adapted well to the national context in recipient countries and this trend has improved over the evaluation period and was accompanied by an increasingly thorough analysis of the different dimensions of the health sector in partner countries. In terms of delivery modalities, this evolution has corresponded to an increasing use of budget support especially sector budget support. (I-7.1.1, I-7.1.2) The growth in SBS is perhaps the most notable increasing trend over the evaluation period. The amounts contracted through SBS increased from about € 2 million in 2002 to € 200 million in 2009 and € 185 million in 2010 (inventory). This progress was quite consistent over the years and accelerated from 2008. This rapid switch to a major use of SBS coincided with the signature of the last CSPs for the period 2008-2013 and resonates with the EC's commitment in the context of aid effectiveness to make increased use of sector approaches. However, compared to other social sectors such as Education, the EC made relatively little use of Sector Budget Support to directly assist the health sector. Only 16% of the total funds contracted to support the health sector were contracted for SBS operations, while for the education sector (basic and secondary education), SBS accounted for 47% during the period 2000 to 2007.[211] This is mainly due to the fact that the health sector in recipient countries is often more fragmented than the education sector, which means that there is not always a coherent sector strategy to support, which is an EC eligibility criteria for SBS, while donor support is not harmonised due to multiple funding channels used, such as vertical funds, which make it difficult to pool health financing. The EC supported also health sector policy programmes of beneficiary countries that are not delivered through SBS. This modality represented 15% of the total amount contracted by the EC. So overall, roughly a third of EC support to health has been given in various forms of support to the sector.

This relatively small and late shift by the EC from a project approach to a sector approach has been in response to the preference stated by the EC for using budget support where possible, in acknowledgement of commitments made by the EC under the Paris Declaration (2005) and Accra Agenda for Action (2008)[212]. This shift can be clearly seen over the evaluation period, with an increase in sector and budget support and the design and choice of these aid modalities benefitting from previous EC as well as other development partners experience in the sector. (I-7.1.1)

This means that most analysis in documentation is focused on the suitability of moving towards a budget support approach or explaining why budget support has not been chosen. In nearly all cases, the discussion regarding alternative aid modalities is extremely limited. For example in financial proposals where there is the most discussion of this issue, the focus is mainly on why a particular aid modality was chosen rather than an assessment of alternatives. (I-7.1.1)

Support provided by the EU has become more aligned with national systems and procedures, given the shift from projects towards sector approaches and GBS, although this is not as large as it could have been, as there is still a considerable amount of EC support to the health sector which is not aligned. Despite this, the EU is still using fewer parallel aid delivery methods and making more use of national systems by channelling funds through national systems and supporting recipient government plans and strategies in the health sector. However, there are still countries where the EC had not been aligned with national systems and procurement is controlled by the EC, but this is due to concerns regarding the strength of government systems and fiduciary risk. (I-7.1.3)

Aid delivery methods were reasonably well tailored to the capacity of implementing partners and the methods selected were generally appropriate to the context. Evidence of the EUD survey, CSPs and programme reviews in desk study countries shows that the capacity of organisations to implement programmes was

[211] See, Particip GmbH (2010): Evaluation of the EC support to the education sector 2000-2007.
[212] EC (2007) Support to Sector Programmes, p.7

often assessed with stakeholder institutional capacity assessments to analysis partner readiness, capacity and potential structures for implementing health programmes. (I-7.1.2)

7.1.1 I-711 Alternative aid modalities and channels explicitly considered/analysed during the project formulation stage

Overall, there has been a general preference stated by the EC for using budget support where possible, in acknowledgement of commitments made by the EC under the Paris Declaration (2005) and Accra Agenda for Action (2008)[213]. This means that most analysis in documentation is focused on the suitability of moving towards a budget support approach or explaining why budget support has not been chosen. In nearly all cases analysed, the discussion regarding alternative aid modalities is extremely limited.

Only half of the CSPs analysed discuss the choice of aid delivery methods (*Afghanistan, Bangladesh, Barbados, Burkina Faso, El Salvador, Egypt, India, Laos, Mozambique, Philippines, Timor Leste, Vietnam, Zambia)*. This discussion was mostly focused on the evolution from a project approach towards a sector wide approach and the best combination between these two approaches. In *Afghanistan*, it was noted that SBS in health will be explored if government capacity increased over the period[214], whereas in the *Lao* CSP I there was a discussion on the evolution of modalities in the context of a reduction in support to health, with an implied shift to budget support[215]. In *El Salvador*, as in many other countries, it was stated that sector-wide approaches and SBS will be the preferred means of implementation and in *Bangladesh* it was noted that, if the pilot SWAp in health and population was successful, then this would serve as a model for other potential interventions in the health sector[216].

Financial agreements provide quite a lot analysis of why particular aid modalities have been chosen, but not a significant assessment of other aid modalities that could have been used, although all explain why budget support has not been used. In the financial agreement for the *Philippines* for the Mindanao Health Sector Policy Support Programme it was stated that as there were weaknesses in institutional capacity the use of budget support is precluded so funds were channelled through a World Bank managed Trust Fund instead[217]. In *Bangladesh*, it was noted that due to the Ministry of Health's capacity constraints a combination of pooled funds, project funding through UN agencies and direct procurement of services was chosen[218].

In some instances, studies were undertaken to assess the feasibility of moving to a new aid modality. In *Moldova*, in 2007, a "Sector Policy Support Study" was conducted to evaluate the feasibility of the shift of project support to budget support programme. Similarly, in the *Philippines* the EC and WB financed a diagnostic study on the potential aid modalities for health sector support and concluded that a mix of budget support and a trust fund should be used[219].

There are also some cases where it was reported that little analysis had been undertaken. This was highlighted in the case of *Ghana* where it was noted that '*there is no real analysis accompanying the switch in instrument from a SWAp to budget support that took place under the 9th EDF*'[220].

In addition, when budget support was used there has tended to be little analysis by the EUD or explanation given as to why a specific amount was allocated to this modality. This is also confirmed in the ECA 2010 report which notes the fact that '*the rationale followed by the Commission to set the amount of funds to be allocated is not clear'.*[221] This is also highlighted in the case of Vietnam which the ECA comments that there was no discussion of what the minimum amount necessary to be able to sit at the policy table was and to what extent going beyond a minimum amount will increase the Commission's influence in the policy dialogue.

Another issue is that SBS has tended to be under-used by the EC in health. Why SBS was not considered is not always clear in EC documentation, but might be related to the fact that in the EC Guidelines on SBS and GBS it is often not clear the different contexts when each should be used. In terms of discussing why trust

[213] EC (2007) Support to Sector Programmes, p.7
[214] Afghanistan CSP II
[215] Lao CSP I
[216] Bangladesh CSP I
[217] Financial Agreement Mindanao Health Sector Policy Support Programme
[218] Bangladesh Financing Agreement
[219] Philippines CSE, 2010
[220] Ghana, 2005
[221] ECA, The Commission's Management of General Budget Support in ACP, Latin American and Asian Countries, 2010.

funds, NGOs or other agencies are being used for programme implementation, there is no discussion of why a particular channel was chosen over and above another one.

There has been little analysis of alternative aid modalities and channels that could be used by the EC, as most discussion is directed at explaining why a particular aid modality has been chosen and the assumption is that either SBS or GBS is the preferred aid modality and these instruments are what the EC should be moving towards using.

7.1.2 I-712 Appropriateness of aid delivery methods used with regard to capacities of implementing partners

Aid delivery methods were on the whole tailored well to the capacity of implementing partners and the methods selected were generally appropriate to the context. Results from the EUD Survey indicate that the capacity of organisations to implement programmes was thoroughly assessed with stakeholder institutional capacity assessments to analyse partner readiness, capacity and potential structures for implementing health programmes. These assessments were reported to have been undertaken in the *Philippines, India, Vietnam, Myanmar, Moldova, Zimbabwe, Nigeria and Egypt,* while in the *DRC* and *Ecuador* the EC field experience was taken into account when making decisions on partner capacity and aid modalities[222].The EUD Survey also confirms that EUDs considered that the choice of aid delivery methods was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities. For the first programming period (CSP 2002/2003), two EU Delegations rated the selection of aid modalities and channels as "excellent" (*South Africa*, *Bangladesh*), while five (*Ghana, Zimbabwe, Mozambique, Afghanistan and Morocco*) said it was "good", with only one (*Yemen)* rating them as "unsatisfactory"[223].

This improved over the evaluation period, as in the second period (CSP 2006/2007) six EUDs (*India, Afghanistan, Myanmar, Morocco, Mozambique, South Africa*) reported the selection of aid modalities and channels as "excellent" and ten out of 20 EUDs (*Lao, Philippines, Timor-Leste, Bangladesh, Vietnam, Moldova, Syrian Arab Republic, Ghana, DRC and Zimbabwe*) commented that the EC selection of aid modalities was "good". Only two EUDs (*Yemen* and *Burkina Faso*) reported "unsatisfactory" scores.[224]

This improvement was reported to be a result of increased availability of relevant data (*Lao, Barbados, Afghanistan*). An improved consultation process and better reporting and information exchange (*Philippines, Timor-Leste, Egypt, Burkina Faso and Morocco*) and increased experience from the EC side because of continuous support to the health sector (*Bangladesh and Syria*). In the case of *Ecuador*, there was not adequate EC support in the first CSP period as there was not an EU mission, but by the second period one was established, which allowed closer co-operation with the government and other organisations which ensured their needs where defined.

The MOH survey confirms these findings, as when respondents were asked how suitable aid channels for health had been in contributing to improving health system performance and health outcomes in their country, they noted that, on the whole, most used were satisfactory. In most countries responding to the survey the channels used impacted positively on health services. Of the eight countries that responded to the survey six rated the government as a good channel for delivery, apart from in *Yemen* and *Burkina Faso* where the government was perceived to be an unsatisfactory channel. In Yemen, private companies were highlighted as the only satisfactory channel, whereas in Burkina Faso NGOs/civil society, development banks, research institutions and UN bodies were seen as appropriate. In *Syria*, the government and research institutions were seen as satisfactory channels for aid delivery, whereas in *Morocco* government, development banks and UN bodies were rated as satisfactory institutions to delivery aid.

Also, when asked if financing modalities (GBS, SBS, project) and channels (government, NGO, multi-donor trust funds, etc.) used by the EC were the right one for the health sector, five MoH agreed (*Syria, Egypt, Moldova, Burkina Faso* and *Morocco*). *Egypt* and *Afghanistan* stated that they did not know, with only the MoH of Yemen commenting that the aid modalities and channelled used were not the right one for the health sector .

[222] EUD Survey
[223] EUD Survey
[224] EUD Survey

Evaluations of country programmes support the view that aid modalities were well matched to country capacities. For example, the *Lao* CSE notes that '*If the question is whether interventions considered capacity constraints and included capacity building, then the answer is yes'*[225].

On the other hand, there have been some instances where the analysis of implementing partners' capacity was not sufficient, but this tended mainly to be in the earlier years of the evaluation period with lessons then learned from this experience. For example the *Barbados* CSP II notes, *"a fundamental lesson to be drawn from the 2002-2006 strategy is the low absorption capacity of GoB institutions, as a result of which disbursement levels have been rather low. The latter was particularly true for the first health sector programme (HPSP), for which the EC was forced to de-commit half of its € 66 million contribution."* Similarly, in the *Philippines,* for HSPSP both implementation and disbursement was delayed due to a lack of capacity of partner organisations to implement the programme[226], whereas in the case of *Burkina Faso*, the EUD reported that an MDG contract was the choice of modality for 2009-2014. According to the Delegation, this mechanism did not take adequately into account elements such as the dominance of common basket fund for health policy. However, despite these examples, the majority of aid modalities used by the EC were appropriate to the capacities of implementing partners.

There have been some concerns raised as to the appropriateness of SWAps/SBS due to capacity weaknesses in recipient countries that hinder the effectiveness of this support.

- For *Mozambique*, the CSE of 2007 highlights that crucial weaknesses were not been addressed by the SWAp, with the major one relating to weak human resource capacity, as insufficient capacity building support had been given by donors.
- In *Vietnam*, problems in the health sector derived from low capacity of health agencies to make policy, prioritise goals and estimate resource needs. While the EC contributed to capacity building for service delivery through both HSDP and HEMA, a critical mass of capacity for policy making was not achieved[227]. The lesson from this was learned by the EUD in Vietnam as later in the programme it was recognised that health sector weaknesses would restrict the effectiveness of planned SBS. As a result the EUD and other donors assisted in strengthening key capacities as a pre-requisite for SBS.[228]
- Problems with the capacity of partner countries/agencies arose in the case of EC support to the Avian Influenza crisis. The MDTF/AHIF established was intended to complement, not substitute for, existing financial arrangements. However, when countries received AHIF financing they contracted UN agencies (WHO and FAO) to implement. This resulted in lengthy delays in sub-contract signing and project implementation in several countries.[229]
- A similar concern was raised in the case of *Bangladesh* where the EUD commented that projects were implemented by UN agencies were subject to considerable delay in comparison to funding that was channelled through a World Bank MDTF (see below).[230]

Trust funds have also been used by the EC quite successfully. In *Bangladesh* for example, a large MDTF managed by the World Bank co-finances the government's Health, Nutrition and Population Support Program along with an equivalent amount of funding from IDA. Donors used the MDTF vehicle as a way to provide substantial funding for the program rather than providing direct budget support due to concerns about weak financial management and the potential for misuse of funds. This is appropriate given the context in Bangladesh[231].

In summary, the aid delivery methods used by the EC were appropriate to the capacity of implementing partners, with that the choice of aid delivery methods made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities in most cases, with evidence that this process improved over the evaluation period.

[225] Lao CSE 2010

[226] EC, HSPSP Mid-Term Review, December 2008.

[227] Vietnam CSE 2009

[228] Vietnam CSE, 2009

[229] European Commission (2010): Outcome and Impact Assessment of the Global Response to the Avian Influenza Crisis. Final Report – August 2010

[230] Interview with EUD Bangladesh

[231] World Bank (2011) Trust Fund Support for Development. An Evaluation of the World Bank's Trust Fund Portfolio

7.1.3 I-713 Evidence that aid delivery methods were aligned to national systems and procedures and adjusted to evolving contexts

Support provided by the EC has been more aligned with national systems and procedures, with a small shift from projects towards sector approaches and GBS, although this has not been as large as observed in other sectors such as education. This means that the EU is now using fewer parallel aid delivery methods and making more use of national systems by channelling funds through national systems and supporting recipient government plans and strategies in the health sector, although a significant amount of support is still remains outside of government systems.

Sector wide approaches (SWAps) in health have been established in nearly all countries that the EC supports and in most cases the EC funds through this framework to align support with national health plans. A typical example of this is in *Moldova* where in 2002, all EC funds were provided via a project approach, whereas by 2010, the major part of the EC funds was provided through the framework of the Health Budget Support Programme. Also, *South Africa* moved from a project approach in 2006 to provision of SBS in order to align support more closely with national systems. Further evidence of alignment with national government strategic plans in health is presented in a high number of CSPs (*Ghana, DRC, Bangladesh, India, South Africa, Philippines, Mozambique, Vietnam*).

There are also examples of the EC leading the way among donors in promoting alignment. This is noted in the case of the *Philippines* where the Paris Declaration review reports that the *Philippines* Sector Development Approach in Health (SWAP) as "very good practice", with progress achieved attributed to the Department of Health, the World Bank, the ADB, the EC and GIZ. In *Vietnam*, the EC has also been leading the way in preparing a sector budget support operation in health, which is important, as donor support to health is ad hoc in this country.

The EUD survey confirms the strong alignment of EC sector support programmes with national systems. One EUD (*Ghana*) said sector support programmes in health were "excellent" for strengthening alignment, eight EUDs (*Egypt*, *Philippines*, *Moldova*, *Bangladesh*, *Afghanistan*, *Timor Leste*, *Morocco*, *Mozambique*, *South Africa*) rated it as "good" and two (*Ecuador*, *India*) as "satisfactory". In relation to alignment through GBS, one EUD (*Ghana*) said GBS was "excellent" for strengthening alignment, eight EUDs (*Egypt*, *Philippines*, *Moldova*, *Bangladesh*, *Afghanistan*, *Timor Leste*, *Morocco*, *Mozambique*, *South Africa*) rated GBS as "good" and two EUDs (*Ecuador*, *India*) as "satisfactory".

There is also evidence of EC flexibility in using different aid delivery methods to respond to changing contexts. In *Lao*, there was a rapid response by the EC to avian influenza with a regional co-operation programme in the form of a cross-border project to strengthen veterinary and epidemiological services.[232] In *Nigeria*, in relation to support to polio eradication, there was a change in modality and channel from basket funds managed by the Government to a contribution agreement with the WHO, to have a more efficient disbursement of funds and stronger fiduciary management[233]. In the *DRC*, the EC support moved from implementation by NGOs, to being channelled through the Ministry Health for similar reasons[234].

There are still some countries where the EC had not been aligned with national systems due to concerns regarding the strength of government systems and fiduciary risk and in some instances procurement is controlled centrally by the EC[235]. In *Afghanistan*, the EC manages procurement themselves and does not fund through BPHS/EPHS budget through *Afghanistan* Reconstruction Trust Fund (ARTF), due to concerns regarding weak government systems. As a result, the EC was perceived as the least flexible donor with slow and bureaucratic procedures[236]. In the *Philippines*, it was also noted that EU procurement procedures, have caused delays in health programmes, while the EC still had some PMUs in health[237].

Despite the move towards more aligned approaches in health, the EC has emphasised the need to increase its support for implementation of national health strategies through country systems and to channel 80% of its health ODA using country procurement and public financial management systems (EC, 2010). This will mean more SBS, but to date this has been at a relatively low level as SBS in health has often only been used when health is a focal sector and eligibility criteria states that a well-defined sector policy must be in place which is often not the case.

[232] CSP 2007
[233] EUD Survey
[234] EUD Survey
[235] Joint Evaluation of the Paris Declaration Phase 2: Islamic Republic of Afghanistan. 2010
[236] CSP 2007
[237] Philippines CSE 2010

Overall, although aid delivery methods have become more aligned to national systems and procedures through the development of sector approaches, which represents a positive trend, a significant amount of EC health support is not channelled through government systems. This is mainly due to concerns regarding fiduciary risk, SBS eligibility criteria and also the capacity of recipient governments to use this financing effectively.

7.2 JC72: Contribution of EC GBS and SBS to policy based resource allocations and inclusive objectives in the health sector

Findings reveal that, although the EC, both on its own and in conjunction with other donors, has made a contribution through GBS and SBS to inclusive objectives in the health sector, this does not seem to have been translated into improved policy based resource allocations. There is no strong evidence from sources (interviews with EUDs, EC monitoring reports, Commission on Audit (CoA) report 2008, on GBS and evaluations of GBS for Ghana and Zambia) on a significant positive impact of budget support on national health expenditures and on budget processes at both central and decentralised levels.

It is clear that during the period assessed, the EC in nearly all countries analysed have had reasonably ambitious indicators for both SBS and GBS programmes, although there are exceptions. Most programmes have used outcome indicators focused on improving standards of health, which are linked to the health MDGs.

There are also indicators in most programmes, aimed at improving the allocation of resources to health, either through GBS which tends to be focused on improving budgeting and planning at Ministry of Finance level or SBS strengthening public financial management at the level of the Ministry of Health (MoH).

In most cases, the indicators addressed well the core issues in the health sectors in the specific countries where the EC was giving support. Analysis of the country context in programme and other documents showed that the indicators chosen in nearly all cases were appropriate to the country context, although GBS variable tranche indicators have often proved to be over-ambitious. Another problem was that often there was not sufficient data available to judge progress on these indicators. Evidence from the Court of Auditors Report, Special Report, No 10, 2008 tends to suggest that the achievement of indicators used by the EC varies, showing that not all are achievable. Those related to GBS EC health performance tranches were least successful, with on average 50% achieved, whereas overall GBS indicators were achieved 70% of the time.

There were also increased levels of capacity building support normally being given as a result of health SBS, although support for health capacity building was not normally part of the GBS package. In SBS, capacity building was more frequently included as the aim of sector support programmes and was often focused on strengthening institutional capacity.

Given this, it would be expected that as the design of programmes was appropriate, with indicators focusing on the right issues and significant capacity building components in the case of SBS that this would result in improved health sector policies, processes and resource allocations.

There is, evidence (Interviews, EC programme reviews and EUD survey) that GBS and SBS were able to enhance the framework for dialogue, particularly on PFM and capacity building issues. Also that good policy dialogue on health issues is more likely to result from SBS than GBS, which is logical given that financial support to the health ministry gives a good entry point and incentive for strengthening discussions.

An assessment of the documentation indicated that neither SBS nor GBS led to comprehensive improvements in budgeting and policy processes, although there has been a contribution from EC and joint donor programmes of support. Where there have been achievements, the development of medium-term expenditure frameworks (MTEFs) and sector strategies are the most common, but there is mixed evidence of consistent results in strengthening of policy processes or enhancing public financial management (PFM). Health sectors by their nature tend to be fragmented which makes it difficult to implement sector wide plans and processes. Additionally, political will to undertake reforms was lacking in some cases.

Another area that was not successfully addressed was improved policy based resource allocations, despite being tackled through both GBS and SBS indicators in many countries. There was only evidence from *Ghana* and *Zambia* of budget allocations to health improving, while in *Bangladesh* funding to the sector increased, but not as a percentage of the total budget. [238] This is probably as this is also an issue that needs to be tackled by the Ministry of Finance and as a result is out of the control of health ministries. However,

[238] Interview EUD.

there is the possibility to use GBS to try and enhance budget processes, but this does not appear to have been successful in most of the countries assessed.

7.2.1 I-721 Evidence that indicators of SBS/GBS related to health have been ambitious, achievable and helped address core issues related to the health sector in partner countries (design)

During the period assessed evidence indicates that the EC in nearly all countries analysed had reasonably ambitious health-related indicators for both SBS and GBS programmes. Most programmes used outcome indicators focused on improving standards of health, which are linked to the health MDGs, but there was evidence of weak indicators used in some instances, while GBS indicators for health have often proved to be over ambitious.

There are indicators in most programmes aimed at improving the allocation of resources to health, either through GBS which tends to be focused on improving budgeting and planning at Ministry of Finance level or SBS working on planning and budgeting at the level of the MoH.

There are also some very innovative examples of using indicators to address specific issues such as in *Zambia* the EC SBS to aid the retention of health sector workers and the recent use of MDG contracts to focus countries on the achievement of the health MDGs. The former is an example of where SBS does not support a sector plan but focuses more narrowly on a specific issue. For the MDG contracts, although globally EC SBS and GBS have always had indicators related to the MDGs, this represents a more formalised and systematic approach.

In most cases the indicators were discussed and agreed with development partners and government and aligned with national and sector plans, as well as designed to complement GBS and SBS[239]. It should also be emphasised that for most SBS and GBS analysed, most indicators addressed well the core issues in health in the specific countries where the EC was giving support. Analysis of the country context in programme and other documents indicated that the indicators chosen in nearly all cases were appropriate for the country context, although the main flaw was that often there wasn't sufficient data to measure indicator progress, making it difficult to judge if indicators were met[240].

Evidence tends to suggest that the achievement of indicators used by the EC varies. Health indicators related to GBS EC were least successful, with 50% achieved, whereas overall GBS objectives related to health were achieved 70% of the time. This illustrates that not all indicators have been easily achievable.

GBS programmes have tended to have 4-5 indicators that relate to health, which the EC uses as indicators for performance based tranches, while in SBS a similar number of indicators are drawn from sector performance frameworks with a greater number of indicators.

A typical example of this is in *Zambia* (see following box) where for PRBS II there were a number of indicators related to PFM and health in the PFM performance linked tranche. In PRBS III there were four indicators included in the multi-donor GBS PAF and the MDG performance contract had three indicators related to health drawn from the PRSB PAF.

[239] EUD Survey
[240] The exceptions to this were in SBS in India and in Egypt

Box 39: Indicators in Zambia's GBS related to health[241]

In PRSB II (2004-2006) there were two variable tranches, a PFM linked tranche and a variable tranche. Indicators related to health were:

- Coherence between funding of health and its budget allocation
- Share of health funding reaching primary levels in the previous year;
- Vaccination coverage;
- Supervision of deliveries by skilled staff;
- Utilisation of primary-level health services;
- HIV/Aids (% of 15-49 years old requesting an HIV test, receiving and
- Accepting test results; and 2) % of pregnant HIV positive women receiving a complete course of ARV).

In PRBS III (2007-2008) there were four indicators related to health:

- Percentage of MoH releases at district level
- Utilisation of PHC facilities
- Percentage of institutional deliveries
- Percentage of fully immunised children under 1 year of age in the 20 worst performing districts)

The MDG contract from 2009-2014 which replaced previous GBS agreements has an annual variable performance tranche related to:

- Percentage of child immunisation
- ARV rates in pregnant women
- Percentage of institutional deliveries.

EC (2004) Financing Agreement between the European Commission and the EC, Republic of Zambia: Poverty Reduction Support II.EC (2009) Financing Agreement between the European Commission and the EC, Republic of Zambia Millennium Development Goals Contract for Zambia 2009-2014.

Zambia's health SBS had a condition for the release of the fixed tranche in 2009-2010 that the Ministry of Health's budget allocation would be respected. For the variable tranche the utilisation rate of primary health facilities, percentage of Ministry of Health releases to districts and percentage of HIV positive eligible clients accessing ARVs were indicators. These came from the GBS PAF and in 2011 the variable tranche was to be released on the basis of the percentage score of indicators met in the health sector PAF.

The design of SBS and the corresponding indicators tends to be similar among countries when the programme is just EC funded, as in *Zambia* above and differs when SBS is part of a joint pooled fund. This is illustrated in Box 40 where the *Mozambique* Health Sector Support Programme II was a pooled funding arrangement with other donors. Indicators were aimed specifically at the agreement and achievement of work plans with indicators in the sector performance framework used to monitor progress. Indicators in the health sector PAF were aimed at capacity building for the MoH and building policy dialogue and SWAP structures. In the Mozambique Health and HIV Sector Support programme, which was solely EC funded there were two indicators for disbursement that were taken from the health sector PAF.

Box 40: Indicators for the Mozambique Health Sector Support Programme II and Health and HIV Sector Support

Indicators for the Mozambique Health Sector Support Programme II:

- Agreement of the related annual work programme and budget
- Satisfactory achievements of previous work programmes and budget.

Indicators for the Health and HIV Sector Policy Support Programme - Achievement against targets for three specific indicators from the health sector PAF:

- Rate of coverage for institutional births
- Percentage of budget spent under Ministry of Health management
- Number and % of pregnant women receiving ARV in 12 months after birth.

Source: Financing Agreement between the European Commission and the Republic of Mozambique: Health and HIV Sector Policy Support Programme, 2008.

[241] EC (2004) Financing Agreement between the European Commission and the EC, Republic of Zambia: Poverty Reduction Support II.
EC (2009) Financing Agreement between the European Commission and the EC, Republic of Zambia Millennium Development Goals Contract for Zambia 2009-2014.

In most countries analysed there were reasonably ambitious indicators, as shown by the indicators outlined above. There are also some very innovative examples of using indicators to address specific issues such as in *Zambia* with the EC SBS to aid the retention of health sector workers (see below) and the recent use of MDG contracts to focus countries on the achievement of the MDGs related to health. Although EC SBS and GBS has always had indicators related to the MDGs this now represents a more formalised and systematic approach. Among the countries studied, MDG contracts were being used in *Ghana*, *Mozambique*, *Tanzania* and *Zambia*.

There are some exceptions and, in some cases, there is evidence of indicators that are not particularly ambitious and are focused on process related actions rather than concrete health outcomes. For example, the indicators used in the *India* Health Sector Support Programme were not well-specified and included actions such as increasing the budget in real terms and where process related such as development of work and business plans, rather than outcome indicators[242]. In *Lao* GBS the indicators were reported by the EU Delegation as often too ambitious and in *Burkina Faso* it was noted that there was always a pay-off between ambitious indicators and those that are achievable. For example with regard to the MDG-contract, the indicators were judged to be all achievable, but not all are ambitious[243].

Examples of weak performance indicators were found in *Benin*, where two of the four GBS indicators that relate to the health sector measured the frequency of visits to health centres. However, a government priority was preventive action against malaria, which is likely to have an adverse effect on the achievement of these indicators. As a result, the Commission had to exclude these indicators from the calculation of the variable tranche amount for the year 2006. In *Uganda*, half of the GBS targets relating to the health sector were set either below or much above the baseline without explanation. In *Laos* and *Paraguay*, a number of the targets set were not very challenging, sometimes simply being set at the same level as the baseline. In *Nicaragua*, the government acknowledged that for many targets there was no adequate accompanying budget.[244]

Overall, there has not been much change in the type or ambitiousness of indicators used over time and those used in the structural adjustment style programmes that the EC contributed to in *Ghana* and *Zambia* in the early parts of the evaluation period are very similar to indicators included in more recent MDG contracts. For example, in *Ghana* indicators for the Support to Structural Adjustment SASP VII were an increase in budget funding to primary health care, the number of out-patients department visits to district health centre and ante-natal visits clinic attendance[245]. In the recent Ghana MDG contract among the indicators taken from the GBS PAF were an increase in budget releases to the health sector and improvements in health MDGs, particularly child immunisation[246].

Related to the issue of how well indicators addressed core issues of the health sector, in most cases studied, the indicators addressed such issues well in the specific countries where the EC was giving support. Analysis of the country context in programme and other documents indicated that the indicators chosen in nearly all cases were appropriate for the country context.

A good example of the appropriateness of indicators can be seen in the case of the Poverty Reduction Budget Support (PRBS) given in *Lao PDR* by the EC where one out of 11 of the disbursement criteria related to health was that '*the government improves the timeliness of payment of salaries to teachers and health workers'*. This was raised as an issue that was important for the health sector in the Particip Evaluation of the EC Programme in *Lao PDR*[247].

Another example is the case of *Vietnam* where the Poverty Reduction Support Credit (PRSC) addressed issues specific to Vietnam, which is a country that, in relation to the rest of the region, has relatively good health outcomes. Indicators therefore focused less on health outcomes, but more on policy issues with triggers and policy actions. Examples of these for the PRBS 1 to 5 were: i) to adopt a multi-sector action programme and a HIV/AIDS strategy and ii) establish a health care for the poor programme in all provinces which was based on providing health insurance[248].

[242] The only information on the India SBS is the EC 2007 financing agreement which according to various EAMR's was not signed until 2011 as the MoH insisted that it was revised. The January 2011 EAMR noted that there were weaknesses in the design of the agreement.
[243] EUD Survey
[244] ECA 2010 Special Report
[245] EC (2002) Ghana: Monitoring Report
[246] Financing Agreement between the European Commission and the Republic of Ghana: MDG Contract 2008.
[247] Particip (2009) Evaluation of the EC Programme of Co-operation
[248] Bartholomew and Dom (2006)

Similarly, in *El Salvador* the GBS programme focused on alleviating poverty in 32 poorest municipalities. Given this, the one indicator for health that was in the EC variable tranche was appropriate as it was to establish primary level health facilities in these 32 municipalities[249].

In *Zambia*, indicators for the GBS and SBS programmes were complementary and also addressed core issues which were related to retention of health staff, lack of funding from the Government of Zambia to health and general levels of health. Another example from *Zambia* is the retention of health workers programme, which was an ambitious and innovative attempt to address key issues by the EC (see below).

Box 41: Sector Budget Support to Zambia: An example of indicators addressing core issues well

In the Retention of Human Resources for Health Programme (2006- 2008) general conditions for tranche release were that PFM is transparent and effective and there is good macroeconomic and sector strategy. Conditions for the fixed tranche came from the health sector plan and were for 2006:

- formal adoption of the national development Plan (2006-2010),
- creation in the Government of Zambia budget items related to the retention of human resources.

For 2007, they were:

- creation of a human resources(HR) database;
- M & E system for the HR plan
- agreed and formalised mechanisms for providing incentives for Staff to go to underserved areas.

For 2008 they were:

- improvement in the ratio of health professionals to populations and
- progress in the integration of the MoH payroll of staff.

Source: Financing Agreement between the European Commission and the Republic of Zambia: Retention of Human Resources for Health Programme, 2006.

This finding is confirmed by the MoH survey where of the eight MoH which responded to the evaluation survey, three had SPSPs. Of these, both *Egypt* and *Moldova* thought the health-related indicators used were realistic and achievable and addressed the core issues for improving health outcomes. *Syria* was the exception and indicated that they were not achievable. In all three countries it was judged that the SPSP addressed core issues for improving health outcomes. In the case of Moldova and Egypt HSPSP II very well, for Syria and Egypt HSPSP 1 satisfactorily.

In most cases the indicators were discussed and agreed with development partners and government and aligned with national and sector plans, as well as designed to complement GBS and SBS[250]. It should also be emphasised that for most SBS and GBS analysed, most indicators addressed well the core issues in health in the specific countries where the EC was giving support. Analysis of the country context in programme and other documents indicated that the indicators chosen in nearly all cases were appropriate for the country context[251]. This is illustrated by the case of *Egypt* where the HSPSP was designed by external expertise and the Egyptian authorities through a participative methodology. In the *Philippines* the general indicators were discussed with the Government, but specific indicators at the local level were further identified using as a basis the Local Government Scorecard on health outcomes. In *Mozambique* the indicators for the Health SPSP of the 10th EDF were chosen from the Health PAF. The MDG-GBS, indicators were more directly related to the achievement of the MDGs, complementary to the Health SBS. Conversely in the *Philippines* the EC Delegation highlights the fact that inadequate consultation was undertaken in terms of the specific indicators[252].

Exceptions are also found in *Syria* where the MoH noted that indicators were imposed by consultants and for *Egypt* in the HSPSP I where the benchmarks were unrealistic[253]. On the other hand, in *Morocco*, *Moldova* and *Egypt* HSPSP II they were agreed jointly between donors and government.

In terms of quality of the evidence base of the SBS indicators this was considered “good” by EU Delegations in *Egypt*, *Moldova*, *Morocco* and *Mozambique* and “satisfactory” in *Egypt*, *India* and *Morocco* scores, with a

[249] EC (2005) Convenio Financiacion enter La Communidad de Européo y La Republica de La Salvador: Programa de Olivio a la Probreza en el Salvador
[250] EUD Survey and MoH survey
[251] The exceptions to this were in SBS in India and in Egypt
[252] EUD Survey
[253] MoH Survey

positive trend towards a majority of good quality indicators from 2008 on. Overall the SBS indicators have been perceived as ambitious, time achievable and of good quality[254].

Although indicators were often judged as good, the main problem with indicators which was highlighted throughout documentation surveyed was a lack of accurate data to assess whether they had actually been achieved (*Lao*, *Uganda*, *Mali*, *Tanzania*, *South Africa*, *Burkina Faso* and *Paraguay*). This is due to weaknesses in statistics and data collection. This was highlighted by the ECA 2010 report which stated that the '*performance based conditions attached by the Commission to disbursement of GBS are generally relevant but are unlikely to achieve their intended incentive effect because of the way they are designed and implemented'*.[255] This was due to the fact that it is difficult to assess whether conditions have been met or not and lack of clarity on what constitutes satisfactory progress.

An example is *Tanzania* where, the variable tranche of PRBS II for 04/05 and 05/06 was not all disbursed for a variety of reasons, but mainly related to a lack of data to make a judgement on whether health indicators were met. A similar situation also occurred in *South Africa* where the Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV/AIDs Services Formulation Report notes that previous health sector SBS had problems with finding reliable data for the indicators chosen and that the targets to be used for disbursement were not always clear and realistic[256]. This issue was also highlighted in the case of GBS in *Burkina Faso* where information was not always reliable or comparable between systems and it has proved costly to establish systems for data collection. In that context, the CSE of 2010 notes that the use of trigger indicators is a recurrent problem, as the problem of producing the related information had been under-estimated in the beginning.

Performance on achievement of objectives is mixed. The ECA report on EC Assistance to the Health Sector, 2008 found that only 50% of GBS health indicator targets had been met. They suggested this may be due to the following:

- The small amounts of funding attached to each indicator do not provide sufficient incentive;
- Some indicators governments did not have sufficient control over, data used;
- Data used was not reliable and it was sometimes difficult to judge if the indicator had been met;
- Targets are sometimes under or over ambitious;
- Indicators did not sufficiently address qualitative aspects of healthcare.

It is probably also related to the fact that the health indicators used are linked to achievement of MDG targets in 2015, meaning that they are not always realistic targets in the context of country capacity.

However, overall indicators related to GBS were achieved 70% of the time. Moreover, other evidence points to good achievement of indicators in some SBS programmes. The EC SBS Retention for Human Resources in Health in *Zambia* was completed in 2010 and it was reported by the EC that it had allowed the Ministry of Health to make good progress in implementing its Human Resources for Health Strategic Plan and expand the rural retention scheme as well as implementing its national training programme[257]. In *Burkina Faso*'s second GBS operation all the indicators related to health were met, but the Country Strategy Evaluation states that *'tranches have been disbursed on the bases of a good advancement of the poverty reduction strategy, but the progression in the health sector is rather weak, especially in comparison to the education sector'* (Vol 2, p. 161). Also under the MDG target several social sector indicators were missed. Similarly, in *Morocco* it was reported by the EC that no real progress has been experienced in their SBS programme and although the programme has been extended by one year, but there was a real risk that the next tranche would not be disbursed.[258]

Moldova's Health Sector Policy Support Programme (from 2008-2010) had indicators focused on: i) health care systems reform (stewardship and monitoring, health finance and purchasing, service delivery and resource management and ii) public financial management and public administration reform (budgeting process internal financial control and audit and strengthening public procurement). This was an ambitious set of indicators, which not only addressed key issues in health, but also were also achievable as in the 2nd tranche 90.5% of indicators were met and in the 3rd tranche 83.52%[259].

[254] EUD Survey
[255] ECA, The Commission's Management of General Budget Support in ACP, Latin America and Asian Countries
[256] K&M Associates (2009)
[257] Zambia EAMR 2010
[258] Morocco *EAMR 12/2007*).
[259] Delegation Note on 2009 and 2010 Budget Support 2nd and 3rd tranches

In *Vietnam*, indicators were also successfully achieved for health by the end of the PRBS 5 cycle. The two indicators related to the infant mortality rate and the under-five mortality rate were judged as satisfactorily achieved and the indicators on health financing (the introduction of health insurance) and public health approaches to tackling HIV/AIDs were both rated as satisfactory. In fact by 2007 43% of households had health insurance as opposed to 15% in 2001[260].

Additionally, in the *Philippines* the Health Sector Support Programme was reported as making good progress in terms of achieving indicators[261]. In *Mozambique* the MDG contract was disbursed satisfactorily in 2009 and 2010 as all indicators were met, while in *Lao PDR* in the Poverty Reduction Support operation 4-7 all the triggers for health were completed.[262]

In *Egypt*, the Health Sector Policy Support Programme I, was judged to be over-ambitious and unrealistic[263]. It proved to be not possible to fulfil all the indicators in the 36 months lifespan of the programme, as there were too many indicators(48 in total), which made the programme overly complex and added to the Government of Egypt's transaction costs. Nonetheless, all indicators were achieved for the release of both the EC first and second tranches[264], although by 2009 85% of the first tranche was reported as unspent by the MoH[265].

In *Zambia*, health indicators tended to be reasonably satisfactory in early phases of the Poverty Reduction Budget Support (PRBS). However, the 2010 PRBS review of the performance of health sector indicators in the PRBS noted that they has deteriorated over time and *'the performance in 2009 has been below target and out of line with the performance in other groups*' p.151. In fact health sector indicators got a score of 12.5/100. This led to the variable tranche not being disbursed in 2010. This was less because they weren't achievable but more because of issues with the management of the sector and the suspension of health sector funds in 2009 was a major cause of the indicators being missed[266].

It was noted in the case of *Zambia* that sometimes indicators were achieved but not due to EC or PRBS donor inputs. An example given was that in 2009 UNICEF undertook a programme of immunisations funded by USAID, which contributed to the related PRBS indicator being achieved, although the USAID was not a PRBS donor[267].

Overall, most countries analysed have had ambitious health-related indicators for both SBS and GBS programmes and most indicators addressed well the core issues in health. The main issue has been finding sufficient data to judge if indicators have been achieved, while performance on achievement of health indicators has been mixed.

7.2.2 I-722 Evidence of the contribution to improved capacity building support and enhanced framework of policy dialogue in the health sector (including on PFM and accountability) (direct output)

The documentation indicates that there is a difference between the type of capacity building support found in GBS and SBS. There was often not explicit capacity building support for health as part of the GBS package and indicators were not usually aimed specifically at health capacity building measures. In SBS capacity building was more frequently included as the aim of sector support programmes was often to address this issue.

Capacity building support was specifically highlighted in SBS and GBS programme documentation related to *Moldova*, *Mozambique*, *Lao PDR*, *India*, *Egypt*, *Zambia*, *Barbados*, *South Africa*, *Morocco* and the *Philippines*. This was mainly aimed at institutional capacity building support through technical assistance.

Capacity building assistance included in GBS was normally aimed at strengthening public financial management at central government level, which it would be assumed should also have a positive impact on resource allocations to the health sector. In *Burkina Faso* and *Lao PDR* there was institutional capacity building for health included under the GBS programme, which was perceived to be successful and in *Mozambique* it was equally successful and aimed at better financial management.

[260] Bartholomew and Dom (2006)
[261] Philippines EAMR (2010)
[262] Lao EAMR (2010).
[263] Conseil Santé (2009) Formulation Report
[264] EC Compliance report for first and second tranches 2006
[265] Conseil Santé (2009)
[266] Undated EC Action Fiche
[267] DIE/AOB (2011)

Overall, there is evidence that in most cases where SBS was given this resulted in increased levels of capacity building support for health, including all EC financed SBS and in some instances GBS. However, even when capacity building support was included as part of an SBS package, it was not necessarily utilised by the recipient government. In the case of *Egypt* and *Moldova* government chose not to use the funds made available for TA support and in *Morocco* and *Barbados* the government was reluctant to launch the SBS related capacity building programme[268]. In the *Philippines*, capacity building was not particularly successful due to a lack of political will to implement capacity building measures[269].

Both GBS and SBS were able to enhance the framework for dialogue, particularly related to PFM and capacity building issues. In some instances, such as in *Mozambique*, there was already a well-established framework for donor dialogue in health and other sectors linked to the PRSP and GBS processes. Also, even in GBS where there were frameworks for policy dialogue established as part of the process and health was discussed as part of this, the dialogue itself was often reported as not being particularly useful[270]. Another example of this is *Tanzania* where the focus was more on process than results[271]. On the other hand it was reported in some countries that it tended to result in a stronger link between health sector dialogue and working groups with those related to GBS.

The evidence below indicates that good policy dialogue on health issues is more likely to result from SBS than GBS, which is logical given that financial support to the health ministry gives a good entry point and incentive for strengthening discussions. An exception is in the *Lao PDR* GBS where it was noted that good policy dialogue and EC participation in the Health Care Financing Technical Working Group was important in raising health key issues[272]. In *Ghana*, too, strengthening of dialogue structures through GBS was reported to be important for strengthening priorities and conditionality[273].

There were increased levels of capacity building support being given as a result of SBS and GBS. Health capacity building support was specifically highlighted in SBS and GBS programme documentation related to *Moldova*, *Mozambique*, *India*, *Lao PDR*, *Egypt*, *Zambia*, *Barbados*, *Morocco* and the *Philippines*. However it is not possible to tell whether this was an improved level of support, as this would have to be judged in relation to other projects and programmes and information is not available to assess this.

Examples of capacity building support related to health in GBS programmes are *Mozambique* where the contribution of donors (the EC and others) to capacity building on PFM improved the timeliness, quality and availability of budgeting and financial information in the health sector[274]. Also in *Lao PDR*, TA set-aside in the EC's provision of funds to the GBS programme supported institutional capacity building in the Ministry of Health in the context of an eventual move to a sector approach[275]. This was viewed by the Particip Report as appropriate, as they highlighted that low capacity at the Ministry is one of the main causes of poor financial management, planning and priority setting[276].

In *Burkina Faso*, the second GBS programme included a capacity building component called "appui institutionnel" which was designed to reinforce the capacities of the administration related to the implementation of policy. This was directed at: (i) sectoral institutional capacity building: health, education and PFM ii) reinforcement of statistical systems and iii) evaluation/audit. This capacity building support to the social sectors was rated as successful and in 2006 the support was extended due to demand from beneficiaries[277].

In some instances, although there was not direct capacity building support being given as part of GBS, complementary programmes were put in place to enhance capacity. In *Vietnam*, the EC funded a Health Sector Capacity Building project. The project's objectives were to strengthen the capacity of the central Ministry of Health, provincial health departments and key sectoral stakeholders in the areas of sector policy (including health financing), management and regulation of the health sector (including PFM) and delivery of quality health services. This is designed to provide the basis for future SBS.

[268] Conseil Santé (2008)
[269] GTZ (2011)
[270] Visser-Valfrey, 2010
[271] Undated EC Action Fiche
[272] Particip (2009)
[273] ODI-CDC (2007)
[274] Visser-Valfrey, 2010
[275] Undated EC Action Fiche
[276] Particip (2009)
[277] see EAMR 7/2006

As for SBS, most programmes had additional capacity building included by the EC, often through TA to build institutional capacity with indicators providing incentives to implement these activities. A typical example of the capacity building support given in SBS programmes is shown in the following box, which illustrates the design of capacity building support in *Barbados*. In this case, as in other SBS programmes, additional funds were given for technical assistance over and above the financing for budget support. This was to support institutional capacity building objectives.

Box 42: EC Capacity Building Support in the Barbados Health Programme: 2005-2008

The Barbados programme had three purposes stated in the programme documentation. One of which was 'institutional strengthening and capacity building in the context of health sector reform, increasing efficiency and improving health sector outcomes for the poor'.(programme doc). The main activities to be supported through technical assistance were:

i) Setting up a participative process to discuss health sector multi-annual and annual plans of action and related to budgets.
ii) Identification of a set of indicators to monitor sector performance.
iii) Capacity building in planning, monitoring, management and support for the redefinition of the MoH role.
iv) Strengthening of the existing health information systems
v) Development of strategies for the reorientation of a hospital centred health system towards a system based on ambulatory case and related private/public partnerships
vi) Development of protocols for cardiovascular diseases, for prevention of HIV/AID's and guidelines for harmonisation of medical equipment.

In order to implement this assistance, out of a total EC budget of € 10.5 million, there was € 1.2 million allocated for short and long term technical assistance.

Source: Financing Agreement between the European Commission and the State of Barbados, Barbados Health Programme, 2004.

Unfortunately the capacity building support to health in *Barbados* progressed slower than expected as it proved difficult to get the political support, as the Ministry of Health was not convinced that it would be useful. The TA provided was not synchronised with the financial and budgeting cycle and there was a lack of capacity in the MoH to implement advice given[278].

Similar support based on technical assistance and financed through complementary funding in addition to budget support, can be seen in SBS EC programmes in *Egypt*, *India*, *Moldova*, *Morocco*, *Philippines*, *Mozambique* (Health and HIV Sector Policy Programme), *South Africa* and *Zambia*. This aimed at strengthening institutional, legal and regulatory frameworks. An exception to this was the Mozambique Health Sector Support Programme II where there was no comprehensive capacity building support given by the EC.

Interestingly in *South Africa*'s Partnerships for Health II it was reported that use was made predominantly of South African consultants and academic institutions for implementation, with TA contracted locally from National and Provincial Health Departments. This has increased capacity by learning by doing, rather than transferring skills and knowledge from local consultants[279].

On the other hand, the inclusion of capacity building support did not mean that it was necessarily utilised by partners. In *Egypt* there was capacity building support as part of the SBS agreement, but the Ministry did not make use of any of the funding for TA, preferring to use their own training institute instead. Similarly, in *Moldova* funds for TA for capacity building were not used by the Ministry and were reallocated, which the EC review perceived as a missed opportunity[280] and in *Morocco* the government was reported by the EC as being reluctant to implement the capacity building programme[281]. This suggests that even when capacity building is available it may not be successful if governments are not willing to make use of it.

Another unsuccessful example was the *Philippines* Health Sector Policy Report Programme where capacity building did not occur due to delays in recruitment of TA. The final programme review also notes that *'capacity building without political will and clear decision lines is not enough'*.[282]

[278] Conseil Santé (2008)
[279] Paris Declaration Survey
[280] EC (2010)
[281] EAMR 7/2008
[282] GTZ, 2011, p.14)

SBS and GBS have often resulted in better coordinated capacity building support due to a variety of co-ordination mechanisms established or through the role dialogue played. However, only in the case of *Morocco* was it explicitly mentioned that the EC played a major role in coordinating this support. In the *Philippines*, co-ordination was ensured under a sector development approach for health mechanisms and also during informal development partner meetings. In *Vietnam*, dialogue associated with GBS enforced greater co-ordination between partners in heath capacity building. In *South Africa*, it was reported that *"there is now better co-ordination between development partners on the different TA provided."*[283]

On the other hand in *Barbados* it was stated "*there are not enough donors active for co-ordination to be a priority"* and in *Burkina Faso* the EC Delegation did not think co-ordination was ensured, while in *Mozambique* it was noted that the *"mapping of general TA was tried but not as successful as expected"*[284].

There is evidence that both GBS and SBS were able to enhance the framework for dialogue. The analysis indicated that good frameworks for policy dialogue for health which led to enhanced levels of dialogue were more likely to occur with SBS than GBS. This is logical given that financial support to the health ministry gives a good entry point and incentive for strengthening discussions on key health issues.

In the case of *Egypt*, EC SBS led to an enhanced process of good quality dialogue between the EC and the MoH and the EC has played a prominent role in co-ordination and harmonisation of donors in the sector[285].

In *Ghana*, as part of the multi-donor budget support, new government wide structures for policy dialogue have been created through the sector working groups' framework. The ODI-CDC report highlights that the most significant immediate effects of this support have been in relation to policy dialogue and conditionality. Important improvements were identified in terms of ownership, responsibility for the policy process, as well as in the quality of prioritisation, target setting and monitoring[286].

The Ghana EUD also notes "*SWAps allow for a policy dialogue that is sector specific while budget support generally implies a policy dialogue which is located upstream and hence more distant from the sectors targeted. The review process organised within the framework of the BS programme appears to be particularly performing in the health sector but discussions and dialogue are generally focused on financial aspects rather than on technical issues.*[287]"

The EU in *Vietnam* has a working group on health and has been instrumental in preparing the groundwork for SBS in health. This has resulted in greater dialogue between development partners in health and the MoH[288]. In *Lao PDR* the policy dialogue, especially related to public sector financial management and the budgeting of the social sector made possible by participation in the budget support operation was reported as an effective means of addressing serious weaknesses in the health sector and the EC is active in the Health Care Financing Technical Working Group[289]. There were also attempts in *Morocco* by the EC to intensify its SBS dialogue in order to overcome the problems that it was experiencing in overcoming obstacles in the health sector. However, it is not reported whether this was successful.

Also in SBS in *South Africa* there is evidence of a good policy dialogue framework, which although difficult at the beginning to develop has led to better donor co-ordination structures and established structures with government and districts.[290] Similarly, in *Zambia* the SBS to health through the Supporting Public Service Health Service delivery was reported by the EC Delegation as improving sector policy dialogue[291]

In *Mozambique*, there was already well-established framework for dialogue prior to GBS support and PRBS II and III had institutional capacity building in PFM. In terms of SBS in health it was noted in a review of health sector SBS that 'an achievement at the sector policy level has been the institutionalisation of channels for joint policy dialogue between GoM and donors, which are closely linked to the structures for national dialogue and decision making' [292]

In *Burkina Faso*, GBS policy dialogue helped to reinforce the coherence between sectoral policies and the macroeconomic framework, but it has resulted in a decrease of technical dialogue with the sectoral ministries

[283] EUD Survey
[284] EUD Survey
[285] EC Monitoring Report (2008)
[286] ODI – CDC (2007)
[287] CSP 2005
[288] Paris Declaration Survey
[289] Particip (2009)
[290] K&M Associates (2009).
[291] EAMR (2008).
[292] Visser-Valfrey & Umarji (2010) p.53.

and the donors in the sectors health and education. In order to resolve this, the EC decided to get more actively involved in the sector dialogue, notably through an involvement in annual sector reviews in the health and education sector. However the Country Strategy Evaluation of 2010 notes that the EC has little visibility in the health sector[293]. In *Zambia*, also it was noted that GBS had not resulted in a strong or effective framework for policy dialogue[294].

It should be noted that, even if there is a good framework such as in *Tanzania*, the policy dialogue might not be useful itself. It was reported that dialogue for GBS is more focused on process that substantive policy issues and there was disengagement of the EC from dialogue in both health and education in previous PRBS cycles[295].

In terms of the content of policy dialogue, the incorporation of PFM in policy dialogue was reported to be excellent by the EU Delegation in *Ghana*. *Egypt*, *Barbados*, *Lao PDR*, *India*, *Morocco*, *Mozambique* and *South Africa* stated that policy dialogue was good and in the *Philippines*, *Moldova*, *Burkina Faso* and *Vietnam*, it was said to be "satisfactory". The incorporation of capacity building measures into policy dialogue was rated "good" by the EUDs *India*, *Morocco*, *Mozambique* and *South Africa* and in *Egypt*, *Lao PDR*, *Barbados*, *Philippines*, *Moldova* and *Burkina Faso* it was "satisfactory" and unsatisfactory in *Ghana*[296].

The success of including PFM in policy dialogue was reported in the EUD Survey as being due to the degree of willingness of governments, but also recognising PFM as a priority issue by other donors to increase pressure.

Policy dialogue as a result of GBS and SBS was found to encourage sound government priority setting. In *Lao PDR*, *Ghana*, *Vietnam*, *Morocco* and *Mozambique* the EU Delegations stated that that the EC policy dialogue related to GBS had encouraged sound government's priority setting in the health sector, while only *Burkina Faso* thought that it hadn't.[297]

In terms of SBS, *Egypt*, *Barbados*, *Philippines*, *Moldova*, *Ghana*, *Vietnam*, *Morocco* and *Mozambique* stated that their support encouraged sound government priority setting in the health sector, whereas *India* and *South Africa* reported that it hadn't. In *India*, according to the EUDs, this was a result of EC policy dialogue at a higher level being too weak and in *South Africa* the EC did not play an important role, as the government was capable of setting its own priorities[298].

Despite this, the ECA report on GBS raised the concern that dialogue by the EC is not used to its full potential as EUDs often do not have a dialogue strategy and there are no EC guidelines outlining how best to use policy dialogue[299]. Another key reason they highlighted for the Commission for not having made full use of the opportunities for dialogue provided by GBS was insufficient expertise in many EUDs in the priority areas covered by the GBS programme objectives. This has mainly been related to PFM and health specialists[300]

Overall, there is evidence that in most cases where SBS was given this resulted in increased levels of capacity building support for health, including all EC financed SBS and in some instances GBS. Both GBS and SBS was able to enhance the framework for dialogue, particularly in PFM and capacity building, but good policy dialogue on health issues is more likely to result from SBS than GBS.

7.2.3 I-723 Evidence of the contribution to improved budgeting and policy processes (including policy based resource allocations, inclusive objectives in sector strategies, MTEF) (induced output)

Neither SBS nor GBS has led to comprehensive improvements in budgeting and policy processes, although, over time, evidence suggests that there have been improvements in these areas and there has been some contribution from EC support. Where there have been achievements, the development of MTEFs and sector strategies are the most common, but there is mixed evidence of consistent results in strengthening of policy processes or enhancing PFM. This is mainly due to a lack of political will to undertake reforms, but also

[293] EC CSE Burkina Faso (2010)
[294] DIE/AOB (2011)
[295] EC MDG Action Fiche (2008)
[296] EUD Survey
[297] EUD Survey
[298] EUD Survey
[299] ECA, The Commission's Management of General Budget Support in ACP, Latin American and Asian Countries, 2010.
[300] EC 2007 Annual Report on the EDF, para 33,

because health sectors by their nature tend to be fragmented, which makes it difficult to implement sector wide plans and processes.

There are some successes such as in the EC-Moldova SBS where there have been good results from the development of an MTEF, which is used for sector planning and budgeting and there have also been improvements in procurement and auditing[301]. Also, in *Zambia, Morocco, Lao, Mozambique* and *Vietnam* there was some evidence of improved sector strategies and policy processes.

There was not much success in improving policy based resource allocations, through SBS or GBS, apart from in *Zambia, Burkina Faso, Bangladesh* and *Ghana*[302]. Evidence from recent evaluations on the impact of budget support on national health expenditures varied markedly and was constrained by the lack of controls for other factors that determine government health expenditure. Also, the allocation of resources is an issue that needs to be tackled by the Ministry of Finance and as a result is out of the control of health ministries. However, there is the possibility to use GBS to try and enhance budget processes.

There are some examples of SBS and GBS leading to improved budgeting and policy processes. In *Moldova*, the EC Monitoring Report notes that *'outstanding results had been observed in the use of the MTEF for health which is used for strategic planning and well costed, budget resources are allocated on this basis'*[303]. Recommendations from the court of auditors had been followed up and internal audit units established and there had been achievements in procurement.

Similarly, the *Zambia* and *Mozambique* studies of Sector Budget Support in Practice showed that, in both countries, SBS resulted in the development of improved sector strategies and policies[304]. This led to better budgeting as sector plans were costed and used for budget preparation.

There was also some evidence in *Vietnam* of GBS helping to support the development of an MTEF in health. Although the review of PRSC 1-5 notes that this has had less impact than hoped, as there was still no agreement on an overall health strategy, as the sector is fragmented.[305] The review also highlighted that GBS has been useful in taking forward the health financing reform process, but less successful in influencing budget allocations to health. Indicators related to the revision of spending norms in favour of poorer provinces and raising health budget share were dropped from the matrix of GBS indicators when they were not achieved. However, the EU and other development partners are currently working with the MoH to assist in the development of a results-orientated and costed sectoral strategy as part of the preparation for SBS[306].

In the *Philippines*, EC TA supported the preparation of the Medium-Term Expenditure Framework (MTEF) as an important step toward budget support, but the mid-term review in 2010 commented that improvements in medium term strategic planning, annual planning and sectoral financial planning were not evident yet. In *Morocco* the Ministry of Health produced the first MTEF for 2008-2010 and in *Lao PDR*, the EC support to the technical working group helped in drafting annual work plans for the AWPs MoH. An MTEF for health was also produced as a result of GBS/SBS in *Tunisia*.

In some programmes there was no attempt to provide support to improve policy, planning and budgeting processes. In *Egypt*, for example, the second phase of EC SBS support did not address PFM, as the IMF and World Bank were undertaking this. On the other hand there was no attempt to develop a comprehensive sector strategy either, but the EC budget support, did lead to several important financing tools being developed, particularly related to performance based budgeting.

In *Ghana*, there has been little impact on PFM overall of the reforms undertaken or on policy processes in health[307]. As the EC dropped out of the Health sector direct influence to the sector is limited.

On the other hand, an analysis of trends in the capacity of the Ministry of Health to establish and monitor Annual Work Plans and Budgets linked to health sector plans and MTEF suggests that there has been a substantial improvement in this area[308]. According to the EUD survey, for 2002-04, the majority of EU Delegations thought that the capacity was either "unsatisfactory" (*Philippines*, *Vietnam*, *India*, *Morocco*, *Moldova*, *Burkina Faso* and *Mozambique*) and/or completely unsatisfactory, (*Barbados*). Only *Ghana* rated it *"satisfactory"* and *South Africa* rated it *"good".* This had improved by 2010 where over 50% of the EU

[301] EC (2010)
[302] DIE/IOB (2011)
[303] EC Monitoring Report Moldova (2009) p.3
[304] Bartholomew, 2009, Visser-Valfrey & Umarji, 2010
[305] Bartholomew & Dom, (2006).
[306] Paris Declaration Survey
[307] ODI-CDC (2007)
[308] EUD Survey

Delegations now rated MoH capacities as good or satisfactory. It is worth noting that the most impressive move *was made in Barbados that changed from "completely unsatisfactory"* in 2002-04 to "good" in 2010[309]. It is not possible to judge how much of this improvement was related to SBS or GBS but it is probable that some is related to activities in this area.

There was little evidence of GBS leading to an increase in resource allocation. In *Vietnam*, the 2006 review notes that *'the PRSC did not succeed in reorienting public spending toward health in the same way as it did for education. For some, the sector fragmentation and lack of an overall strategy prevents it from attracting adequate financing[310].'* Whereas, in the *Philippines*, despite the efforts of the EC SBS programme, a review of the programme reported that *'effective rational use of resources did not sufficiently increased despite the resources and TA put into it due to a lack of political will'*[311].

In *Zambia* the Evaluation of General Budget Support reported that '*budget increases contributed to improved service delivery, especially in the social sectors'*.[312] In *Ghana,* the health sector had experienced an increase in resources, which was also due to an increase in the government budget due to GBS[313]. However the evaluation of GBS in Ghana also notes *that 'increases in the level of health funding have yet to translate into commensurate improvements in the scale and quality of health services provided' [314]* In *Burkina Faso*, it was reported that some pressure had successfully been put on the MoF to increase support to the health sector,[315] whereas in *Bangladesh* a performance indicator related to an increased resource allocation for the sector was included in the SWAp PAF. Although the absolute level of funding for the health sector increased, the percentage of the budget allocated to health did not[316]. This is confirmed by ECA who also found that GBS did not lead to increased resources being channelled through the national health budget. They found the following country evidence[317]:

- In Burundi, while the health development national plan for 2006–10 foresaw an increase in the national budget allocated to health from 3,6 % to 15 % in 2010, the budget allocations for health in 2007 decreased to only 2 %.
- In Ethiopia, health budget allocations and expenditure remained low for the period reviewed (2002–07) leaving health services seriously underfunded. While PRBS 2 targeted an increase in the health budget from 6,8 % in 2003 to 7,3 % in 2004, in fact health's share of the budget actually fell to 6,5 %.
- In Mali, while the financing agreement for General Budget Support required the share of health in the national recurrent budget to increase from 10,5 % to 11,5 % over the period 2002–05, it did not do so and in 2005 fell to 10,2 %.
- In Kenya, the health budget allocation increased to 9 % in 2005–06 compared to 7 %–7,5 % in previous years, but expenditure in 2005–06 was just 5,7 % having declined each year since 2001–02 when it was 9 % of total government expenditure.
- In Malawi, for the first two years (2005–07) following the resumption of General Budget Support, the government prioritised paying off internal debt and the health budget was only maintained at a level of 10,7 %, lower than in some previous years.

Overall, SBS or health-related GBS leading has not led to comprehensive improvements in budgeting and policy processes, but there have been some notable contributions by the EC. Where there have been achievements, the development of MTEFs and sector strategies is the most common, but there is mixed evidence of consistent results in strengthening of policy processes or enhancing PFM. There was also limited success in improving policy based resource allocations, through SBS or GBS, apart from in *Zambia* and *Ghana*.

[309] EUD Survey
[310] Bartholomew & Dom, (2009 p.7)
[311] GTZ, (2011, p.8).
[312] DIE/AOB (2011)
[313] ODI-CDC (2007)
[314] ODI-CDC (2007) p.10
[315] Burkina Faso Case-Study
[316] EUD Interview
[317] ECA (2008) p.26

7.3 JC73 Increased cost-effectiveness and internal consistency of EC support

There has been an increase in the cost effectiveness of EC support over the evaluation period, as there has been a clear reduction in transaction costs for recipient governments due to the change in aid modalities used by the EC and implementation of Paris Declaration commitments to harmonise and align support. This resulted in a reduction in the number of parallel project implementation units, a move towards more joint missions and analytical work and the shift towards using SBS and GBS. This latter trend was highlighted in the results of the EUD survey and interviews with EUDs**,** while the reduction in transaction costs for recipient governments was reported to be the case when external evaluations were undertaken of GBS in *Egypt, Vietnam, Lao, Ghana* and the *Philippines* and in interviews with EUDs. (I-733)

On the other hand, the expected reduction in transaction costs for the EC and development partners has not always occurred, due to the time that has to be devoted to policy dialogue and co-ordination for SBS and GBS programmes and the fact the EC is still implementing projects, so two types of aid modalities need to be managed. This problem has been exacerbated by a lack of health sector and PFM expertise in some EUDs (see CoA Special Report No. 10, 2008). Also, as projects remain the dominant aid modality for the EC, transaction costs for both recipient governments and the EC are still higher than need be. This was reported to be the case in Mozambique, Vietnam, Zambia, Bangladesh, India and Barbados. Sources for this information came from interviews with EUDs, EUD survey and reviews and evaluations. (I-733)

There have been significant differences in disbursement rates over the evaluation period suggesting that some EC support is more effective at disbursing than others. The financing of trust funds has had the highest disbursement rate, with 100% disbursement on the amount committed followed by support to sector programmes (excluding SBS) at 86%, while the disbursement rate for individual projects is 69% and SBS 48%. In terms of channels for disbursement, multilateral organisations (World Bank and UN bodies, GFATM) have the highest disbursement rate (87%), while the second highest at 77% is “other channels” (private companies and development agencies) and funding for NGOs which also has a disbursement rate of 77%. Private-public partnerships (mainly GAVI) score lower with a disbursement rate of 75% and the public sector, mainly governments, scored the lowest at 63%. (I-731)

This interestingly indicates that, although SBS and GBS reduce transaction costs, SBS has the lowest disbursement rate, with the rate for projects significantly higher. This is due to the fact that indicators have to be achieved prior to disbursement for SBS, which are not always met - which means that not all funds are released. For projects this is not the case as funds are disbursed when project activities are undertaken. Similarly, disbursement through other bodies results in a high rate of disbursement, but there is evidence from interviews and EC programme reviews of dissatisfaction among EC respondents when using both the World Bank and UN funding channels (I-731)

Analysis of the internal consistency of EC support suggests that although the majority of EUDs thought that EC financial instruments to support the health sector were coherent, there were distinct problems related to thematic programmes, which indicates that they do not always add value to programmes of a geographic nature. This is mainly a result of the way that these programmes are managed and implemented, as thematic programmes are subject to general multi-country guidelines so are not always tailored to a country’s needs. There also tends to be little communication or synergies between thematic and geographic programmes as the former are managed from Brussels and the latter at programme level (I-733). Evidence was also found by the ECA of a lack of coherence between EC instruments in health, as projects tend not always to be linked or complementary to SBS or GBS, while there are no links between Global Fund operations and EUD instruments, although this did not come cross strongly in this study.

Standing a bit apart from the Indicator as stated but still relevant is the mixture of bilateral and regional geographical instruments. In a number of areas – human resources for health, sexual and reproductive health and infectious disease control – the EC used regional instruments. Specific examples from Southeast Asia include the regional malaria control programme in Vietnam, Cambodia and Lao PDR (antedating the evaluation period but extending into it), the Regional Health Initiative for Health in Asia and work related to cross-border animal health in the context of avian influenza. In Latin America and Africa, regional approaches financed by thematic instruments addressed human resource issues. In general, regional approaches were well supported by the two main aspects which call for a regional approach: either a genuine cross border or regional aspect to a problem, or the potential for sharing of experiences. Most, however, involved international agencies such as WHO, UNFPA and World Bank, with the dilution of effectiveness identified under EQ 4 above.

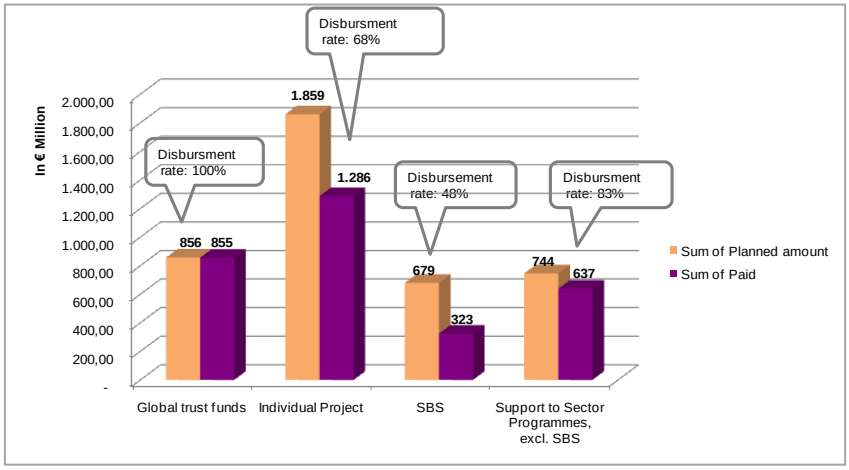
Overall the evidence on increased cost-effectiveness and internal consistency of EC support is mixed. Although there has been a move towards decreasing transaction costs for recipient governments through moving to SBS/GBS, reducing PIUs and increasing joint missions, the move to SBS/GBS has increased transaction costs for some EUDs (Egypt, Vietnam, Lao, Zambia, Ghana and the Philippines. Also as projects

still dominate EC portfolios there is still a significant burden in terms of transaction costs for recipient governments. Furthermore, the finding that SBS can reduce transaction costs is in contrast to the fact that it has a low rate of disbursement in comparison to other aid modalities such as projects, while evidence from interviews and the EUD survey on the relationship between thematic and geographic programmes suggests there is not much coherence and consistency between them.

7.3.1 I-731 Disbursement rates by aid modality and channel

There have been significant differences in disbursement rates in EC support to the health sector, both by aid modality and channel during the evaluation period, as the figure below illustrates. The financing of trust funds has had the highest disbursement rate with 100% disbursement on the amount committed followed by support to sector programmes (excluding SBS) at 86%, while the disbursement rate for individual projects is 69% and SBS 48%[318]. GBS also has a high disbursement rate with 71% of commitments disbursed under the 8th EDF and 74% under the 9th EDF[319]. Although GBS has proved to quick disbursing, predictability has been an issue. This has been due to delays in countries making eligible payment requests and problems in collecting data for performance indicators (*Burundi*, *Kenya*, *Mali*), while some countries had their GBS suspended (*Ethiopia*, *Kenya*, *Lesotho* and *Malawi*).

Figure 34: Direct EC support to the health sector: Disbursement levels by modality, health sector, 2002-2010

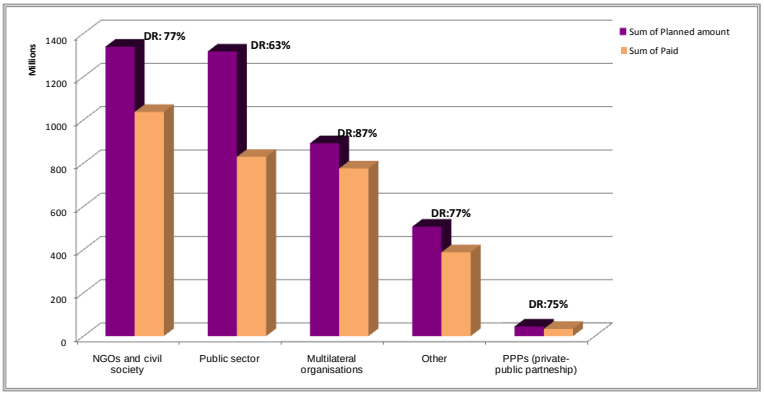


Source: CRIS database; Particip GmbH analysis

In terms of channels for disbursement, multilateral organisations (World Bank and UN bodies, GFATM) have the highest disbursement rate (87%), while the second highest at 77% is "other channels" (private companies and development agencies) and funding for NGOs which also has a disbursement rate of 77%. Private-public partnerships (mainly GAVI) score lower with a disbursement rate of 75% and the public sector, mainly governments, scored the lowest at 63% (see figure below).

[318] All the information for I-731 is drawn from the CRIS database and Particip GmbH analysis
[319] ECA, Development Assistance to Health Services in Sub-Saharan Africa, 2008.

Figure 35: Direct EC support to the health sector: Disbursement rate (DR) by channel, health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

Looking at the Global Fund compared to EDF health interventions illustrates that, although it has increased the amount of funding disbursed for HIV/AIDs, malaria and tuberculosis, its disbursement rate does not compare well to EDF disbursements. This is shown in the following table.

Table 31: Comparison of Cumulative Rate of Disbursement of Global Fund and EDF Health Interventions

	Global Fund	*EDF Health interventions*
Year 1	2 %	1%
Year 2	13%	25%
Year 3	26%	36%

Source: ECA Special Report No 10/2008

This analysis clearly has implications for the cost-effectiveness of EC support given that projects have remained the predominant aid modality for the EC in the health sector over the evaluation period, with 45% of all health sector support provided through project support, even though disbursement rates at 69% are relatively low compared to trust funds and support to sector programmes. SBS operations have 16% of total EC funding, but this has been increasing with a significant rise in the use of SBS, which increased from a total of € 2 million in 2002 to € 185 million in 2010. Despite this, disbursement rates remain low at 48%. Given this, this suggests the EC are not maximising the effectiveness of their programmes by increasing disbursement rates or making greater use of aid modalities and channels with higher rates of disbursement.

7.3.2 I-732 Evidence that the thematic programmes provide distinctive added-value from programmes of geographic nature

There is little evidence that thematic programmes provide a distinctive added value from programmes of a geographic nature. Although the EUD survey reported that, on a general level, the majority of EUDs thought that EC financial instruments to support the health sector were coherent, a variety of problems were reported related to thematic programmes[320].

This is mainly a result of the way that these programmes are managed and implemented. For instance, thematic programmes are subject to general multi-country guidelines so are not always tailored to a country's needs. This was the case in *Burkina Faso, Zambia, Bangladesh and Tanzania* where it was reported that the priorities of the country were not taken into account by thematic programmes for this reason. As they are run from Brussels rather than at country level, there also can be a disconnection between thematic and geographic programmes[321]. In *both Vietnam and Yemen* the EUDs noted that there was little communication

[320] EUD Survey
[321] CSP II Tanzania, CSP II Zambia, EUD Survey (Burkina Faso) and interview Bangladesh EUD

and sharing of information between thematic programmes and bilateral programmes, while in *Bangladesh* it was stated that thematic programmes are less likely to achieve results.[322].

There was also reported to be a lack of coherence at country level between the thematic programmes used and aid modalities for geographic programmes. In *Ghana*, where the EC moved from pooled funding/SBS to GBS the EUD pointed out that they still finance some health projects through the thematic budget line. This was perceived by the EUD as not coherent with EDF programming, while it also increased transaction costs. Similarly, the EUD in *Ecuado*r reported that they use thematic programmes (Santé and EIDHR), but they are not currently providing any support to the health sector through the CSP. The EUD in *Mozambique* commented that thematic programmes are problematic since they often have an iNGO impetus and objective, but not an overall country focus. Finally, in *Lao,* the move to thematic programme funding NGO/EIDHR projects in the health area was highlighted by the Country Strategy Evaluation team as not appearing to have been in response to strategic considerations, but rather a reaction to scarcity of budgetary resources[323].

There are few examples in the documents consulted given of the added value provided by thematic programmes. In CSPs, discussion tended to be at a general level on why different aid modalities were chosen without discussing the specific added value of thematic programmes in relation to geographic ones, meaning the evidence is not particularly persuasive. For example, in the *Philippines* it was reported that a combination of horizontal and thematic instruments has been used to engage with civil society in a variety of governance processes, thereby empowering and improving the operational capacity of civil society organisations[324]. In *Moldova* and *Syria,* EUDs indicated the usefulness of finance given for public awareness campaigns which advocated for the poor (*Moldova*) and/or to conduct preliminary studies relating the preparation of the financing system (*Syria*)[325]. Furthermore, the EUD in *Nigeria* indicated that funding of grants to CSOs and NGOs were useful, but added that compared with the size of the country, most of these were small grants[326].

Global Fund operations are also an issue. As the ECA 2010 report points out there is little coherence between these and EUD instruments, with in some instance, the EC continuing to fund EDF projects in HIV/AIDs[327]. In addition, the ECA report noted a lack of coherence between EC instruments in health, as projects tend not always to be linked or complementary to SBS or GBS.

In summary, thematic programmes in health have not provided a distinctive added value from programmes of a geographic nature. This is mainly due to the fact that thematic programmes are managed from Brussels and are subject to multi-country guidelines which means that they are not tailored to a countries needs and this also leads to a lack of coherence at country level between the thematic programmes used and aid modalities for geographic programmes.

7.3.3 I-733 Evidence that the choice of specific aid modalities has led to reduced transaction costs (both on donor and partner country side)

There has been some reduction in transaction costs for recipient governments due to the change in aid modalities used by the EC over the evaluation period. This has occurred as result of a reduction in the number of parallel project implementation units, a move towards more joint missions and analytical work and the shift towards more SBS and GBS. On the other hand, the expected reduction in transaction costs for the EC and development partners has not always occurred, due to the time that has to be devoted to policy dialogue and co-ordination for SBS and GBS programmes and the fact they are still implementing projects, so two types of aid modalities need to be managed. Overall, as projects remain the dominant aid modality for the EC, transaction costs for both recipient government and the EC are still higher than need be, as projects consistently accounted for 45% of EC health interventions between 2002 and 2010[328].

Many EC health projects are also implemented by other agencies and consistent problems are reported in projects run by UN agencies. These tend to suffer from protracted delays and large transaction costs for the

[322] CSP I Vietnam, CSP II Yemen
[323] CSE Laos, June 2009, Vol 2 P. 96
[324] Thematic Evaluation of the EC Support to Good Governance, Final Report, Volume 1, Synthesis Report, Contract Number: EVA/80-208, June 2006, P. 74.
[325] EUD Survey
[326] EUD Survey
[327] ECA Special Report 10/2008
[328] CRIS database and Particip GmbH analysis

EC. This was reported to be the case in *Bangladesh* and for the EC/ACP WHO Partnership on Health Millennium Development Goals.

For recipient governments there has been a reduction in transaction costs due to the EC reducing the number of parallel project implementation units and increasing the number of joint field missions in the health sector. Results from the EUD survey indicate a decrease in EC supported PIUs from an average of 0.7 from 2002-2004 to 0.4 in 2010. Similarly 29% of EUDs indicated that joint field missions and analytical work took place in their countries during the period 2002-04, but by 2010 this figure had risen to 79%[329] However, in some instances EUDs reported that multiple PMUs were still an issue, such as in the *Philippines* Health Sector Support Programme.[330]

There has been an increase in the amount of EC support to the health sector that has been provided as GBS/SBS or sector programmes. EC SBS increased from approximately € 2 million in 2002 to € 185 million in 2010, while GBS related to the health sector also showed an increase from 2002 to 2010[331]. SBS is still at a low level in health compared to other sectors so any decrease in transaction costs from a potential move from projects to SBS has been limited by this. However, given that one objective of budget support is to decrease transaction costs, it would be expected that transaction costs should have decreased due to this shift to budget support by the EC. This has been the case for recipient governments, but the experience of EUDs has been mixed as this has not always proved to be the case.

It was reported that SBS and GBS had reduced transaction costs for recipient governments in the case of *Egypt* where it was noted that *'SBS is appreciated (by government) because it uses national procedures so it greatly facilitates tendering'*. In *Vietnam,* GBS has led to more effective co-ordination of activities and has reduced transactions cost for government[332], while in *Lao* there was a decision made by the EC to move to GBS as it was realised that EC projects were administratively burdensome[333]. There was also evidence of lower levels of transaction costs in *Ghana* for GBS in relation to other modalities, even if was noted that transaction costs were still higher than necessary and amenable to further reductions[334]. More harmonised approaches in the *Philippines* were also reported to have reduced transaction costs, as the World Bank and the EC agreed to use common appraisal, reporting, auditing and review procedures and undertake some pooling of funds in health[335].

On the other hand, development partners expressed concerns over the high transaction costs related to GBS/SBS and using joint financing modalities. In *Mozambique*, *Vietnam* and *Zambia* the time spent on policy dialogue and harmonisation initiatives related to SBS/GBS and also the fact that rather than just implementing projects they are now managing both budget support and projects, added to transaction costs[336]. Joint financing was also reported to have increased transaction costs for development partners in *India* where *"the WB pool fund complicated the health financing system and moved away from a harmonised pooled fund approach*[337]*,*In *Barbados,* it was noted that the use of the UN channel for funding was related to *"high cost and ineffectiveness"*[338]*.*

This problem was also exacerbated by a lack of health sector expertise in EUDs. This is commented on by the ECA Report 2010, which raises concerns about the adequateness of health and PFM expertise in Delegations. Lack of health expertise in EUDs limits the extent to which there are human resources available to manage the health aspects of budget support and engage effectively in SBS. The Annual EDF survey in 2008 found that of 37 EUDs in Sub-Saharan Africa which replied to the survey, 13 EUDs had Delegations with health expertise.[339]

It should also be noted that in all countries projects are still used by the EC and managing multiple projects places a heavy burden on recipient governments. This was highlighted in the case of *Afghanistan* as the EC

[329] EUD Survey
[330] CSE Phillipines
[331] CRIS database and Particip GmbH analysis
[332] EC/ADE (2011) Joint Evaluation of the Poverty Reduction Support Credit, Final Report, July 2011
[333] Particip (2009) Evaluation of EC Co-operation with Lao PDR.
[334] ODI-CDC (2007) Joint Evaluation of Multi-donor Budget Support to Ghana.
[335] CSE Phillippines, 2011
[336] Mozambique Final Report – Paris Declaration Evaluation Phase 2, Mozambique, July 2010
[337] EUD Survey
[338] EUD Survey
[339] ECA Special Report 10/2008

is not aligned to government systems like other development partners, which caused considerable transaction costs for the government[340].

Overall, there has been some reduction in transaction costs for recipient countries, as result of a reduction in the number of parallel project implementation units, a move towards more joint missions and analytical work and a shift towards more SBS and GBS. However, this reduction in transaction costs for both the EC and development partners has not been as large as expected, due to the time that has to be devoted to policy dialogue and co-ordination and the fact that a large number of projects still remain.

[340] Afghanistan 2007