Thematic evaluation of the European Commission support to the health sector

Final Report
Volume IIb

August 2012

Evaluation for the European Commission

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This evaluation is carried out by

particip

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The evaluation is being managed by the Evaluation Unit of DG DEVCO.

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

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1 Annex 2: Inventory

1.1 Introduction

This chapter presents the inventory of the EC support to the health sector **during the period 2002 and 2010** in the countries covered by this evaluation[1].

The key elements of the inventory are presented in the following sections; the detailed methodological approach can be found in section 0. The main findings are provided in the box below.

Box 1: Key findings of the inventory

Direct support	*Indirect support (GBS referring to the health sector)*
• The EC's direct support to the health sector amounted to around € 4.1 billion during the period 2002-2010. • This € 4.1 billion represented **6%** of the **total EC aid delivered to support all sectors** over the same period • This support had a general increasing trend over the period, but with considerable year-to-year variability. Despite the increase, direct support to the health sector only amounted to six percent of total direct support to all sectors. • The direct support focused on basic health with special emphasis on support to the basic health care and infrastructure and poverty-related diseases (HIV/AIDS, TB, malaria), particularly HIV/AIDS. • The main beneficiary regions in absolute terms for direct support were the ACP states, followed by Asia and European Neighbourhood Policy-South (ENP-South). • The financing of individual projects, followed by Sector Budget Support (SBS), was the main modality used by the EC to deliver its direct support to the health sector. Other modalities used were support to sector programmes excluding SBS[2] and the financing of Trust Funds such as the GFATM.	• The EC's indirect support referring to the health sector (i.e., GBS where health is referred to), amounted to around € 5 billion over the period 2002-2010. It is not possible to estimate how much of this was actually assigned to health. • This support represents 72 % of the total GBS funds transferred to partner countries during the evaluation period. • The support concerned a total of 45 countries, out of which 39 are located in the ACP region, four in Latin America, two in Asia, but none in the European Neighbourhood Policy Instrument (ENPI) region. • The six main beneficiary countries accounted for more than 50 % of the GBS referring to health, among other sectors. • Of these GBS which have been classified as "long term objective" i.e. supporting a national poverty reduction strategy or a sustainable growth strategy, 82% have health related indicators or objectives.

The inventory is structured in the following chapters:

- Chapter 1 shows the results of the analysis of the inventory. Preliminary methodological remarks can be found in section 1.2. Section 1.3 provides the results of the inventory. It starts with a global overview and provides then the results for direct and the indirect support. Section 1.3.4 proposes a summary of the results as well as, on that basis, a list of issues to be further investigated in the next stages of the evaluation.
- The approach developed by the evaluation team to compile the inventory is presented in detail in the Appendix 1.4.
- The limits of the inventory are presented in section 1.4.4.

[1] The list of countries included in the scope of this inventory can be found in the annex.
[2] This is not an official category of EC aid delivery methods, but, as a clear categorisation of SPSPs was lacking in the CRIS database, the evaluation team used it as category for the analysis. See section Table 6 for further details.

1.2 Methodological remarks

Availability of data

The basis of any evaluation is an inventory and analysis of the actions undertaken. Financial accounting in the field of development cooperation has long been weak, and efforts for improvement in the interests of transparency and accountability have been made in recent years and at all levels (donor agencies, recipient governments, projects). Despite these, it is unavoidable that in an evaluation covering 2002-2010 ambiguities and gaps will have to be dealt with.

The primary source for identifying the EC's direct support to the health sector during 2002-2010 is the European Commission's Common RELEX Information System (CRIS). The CRIS database gathers operational data (decisions, projects, contracts descriptions) and financial data (budget lines, commitments, payments) on the EC's external assistance managed by the EuropeAid Co-operation Office (AIDCO), now DG DEVCO, and DG for External Relations of the European Commission (RELEX), now part of the newly created EEAS, and the DG for Enlargement (ENLARG). Since 15 February 2009, CRIS also encompasses data relating to the European Development Funds (previously in the On Line Accounting System - OLAS-database); in addition to data on interventions financed by the general Community budget. Therefore, as of that date CRIS is the sole systematic source for identifying EC support to the health sector (as for most other sectors).

The extraction dates from February 2011. But as the rhythm of updating the CRIS-Database may differ from project to project, not all data for 2010 might be available.

It is recognised, and explicitly stated in the Terms of Reference and Launch Note for this evaluation, that CRIS is deficient in a number of regards.[3] It is an information system that is mainly used by EC staff in Brussels and in partner countries for the day-to-day management of EC's interventions. The main limitation for conducting an inventory is that, in many cases, no Development Assistance Committee (DAC) sector code has been attributed to either interventions and individual contracts, nor to the decisions on which support is based. Mostly for this reason, the EC, evaluators, and others have recognised for years that strict logic alone is not enough when dealing with CRIS. A fuzzier, more subjective, and more innovative approach, such as that outlined below, is required, including tedious line-by-line review of interventions.

The inventory is based on CRIS data but has also been complemented and cross-checked by information obtained from other sources, such as:

- the inventory of the previous evaluation of the EC support to the health sector,
- inventories and other databases of the EC made available to the evaluation team by EC staff, e.g. the EC study "Monitoring of EU education and health expenditure in development countries (time scope 2007-2009),
- information obtained from EC staff in Brussels through interviews.

Indirect and direct support to the health sector

The evaluation team distinguishes two different types of support to the health sector:

- direct support, defined as support targeted directly and entirely to the health sector via projects or via SBS. Therefore, it can clearly be attributed to the health sector;
- indirect support, defined as support provided via General Budget Support. The evaluation team distinguishes GBS with a reference to the health sector, among other sectors, from GBS which has no reference to the health sector.

Different methodological approaches were used for each type of support and resulted in two different inventories, one for direct and one for indirect support. A detailed description of the types of aid modalities used by the EC can be found in Table 5. The detailed methodology used by the evaluation team in order to identify the EC's support to the health sector and to categorise them can be found in chapter 0.

[3] The limits inherent to CRIS for the purpose of an inventory for sectoral/thematic evaluations are described in depth the Inventory Notes for the *Evaluation of Commission's external co-operation with partner countries through the organisations of the UN family,* May 2008, for the *Evaluation of Commission's aid delivery through development banks and EIB*, November 2008, for the evaluation of *EC aid delivery through civil society organisations*, December 2008, for the evaluation of *EC support to basic and secondary education, December 2010,* all available on the EuropeAid website.

1.3 Results of the inventory

The outputs of the inventory are presented in the following sub-sections:

- 1.3.1: Global overview of EC support to the health sector
- 1.3.2: EC's "direct" support to the health sector
- 1.3.3: EC's "indirect" support to the health sector

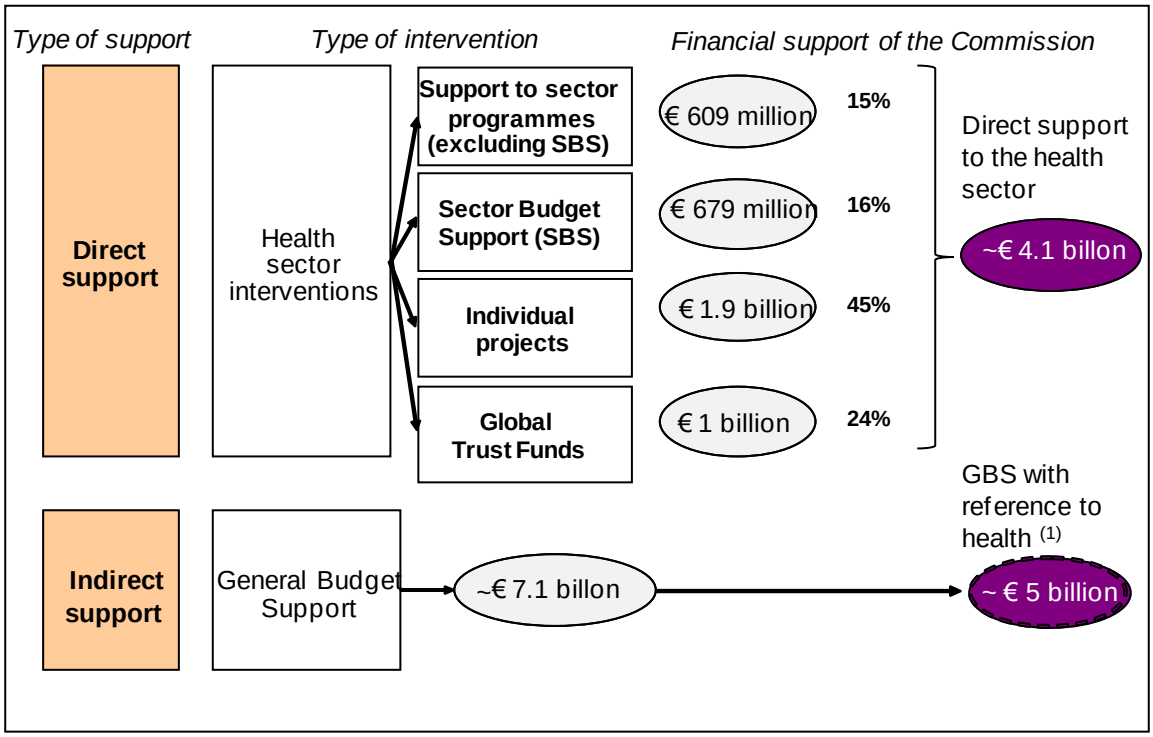
These sections are mainly descriptive, but provide also, where possible on the basis of information contained in the list of interventions extracted from using CRIS.

All figures presented below are based on data extractions from CRIS. The approach developed by the evaluation team to compile this inventory as well as the limits to take into account are presented in detail in the chapter 0 The financial figures used are all **contracted amounts**, i.e. the amounts related to the contracts signed between the EC and a specific contractor for the implementation of an intervention. Figures on the disbursements from the EC to the contractors are also provided. They concern all payments made since the signature of the contract until the date of the data extraction from CRIS (7th February 2011) by the evaluation team.[4]

1.3.1 Global overview of the EC support to the health sector

The figure below presents the global overview of all EC financial contributions to the health sector, as defined in the thematic scope of the evaluation, from 2002 to 2010.

Figure 1: Global overview of EC financial contributions to the health sector, 2002-2010



(1) This concerns GBS which refers to the health sectors among other sectors, through performance indicators or objectives stated in the financial agreements. Taking into account the nature of GBS as un-earmarked funds, no statement can be made on the share of the 5 € billion that went effectively to the health sector.

As shown, over the period 2002-2010, the EC contracted a total amount of around **€ 4.1 billion for direct support to the health sector**, using the following types of aid modalities (ordered by importance in terms of financial support):

- support to sector programmes (excluding SBS),

[4] This is the only information on disbursements available in the data extraction from CRIS. The actual disbursements from the contractors to the final beneficiary are not available in CRIS. The dates of the payments are also not available in the data extractions from CRIS. Only the sum of all payments done from the signature of the contract until the date of the data extraction from CRIS is available.

- Sector Budget Support,
- individual projects,
- financing of Global Trust Funds.

They are discussed more in-depth further on. Of this amount, around € 3.1 billion (i.e. 75% of the total amount contracted) was disbursed over the same period. In terms of weight, the € 4.1 billion contracted by the EC to deliver its direct support the health sector represented **6%** of the **total EC aid delivered to support all sectors** over the same period.

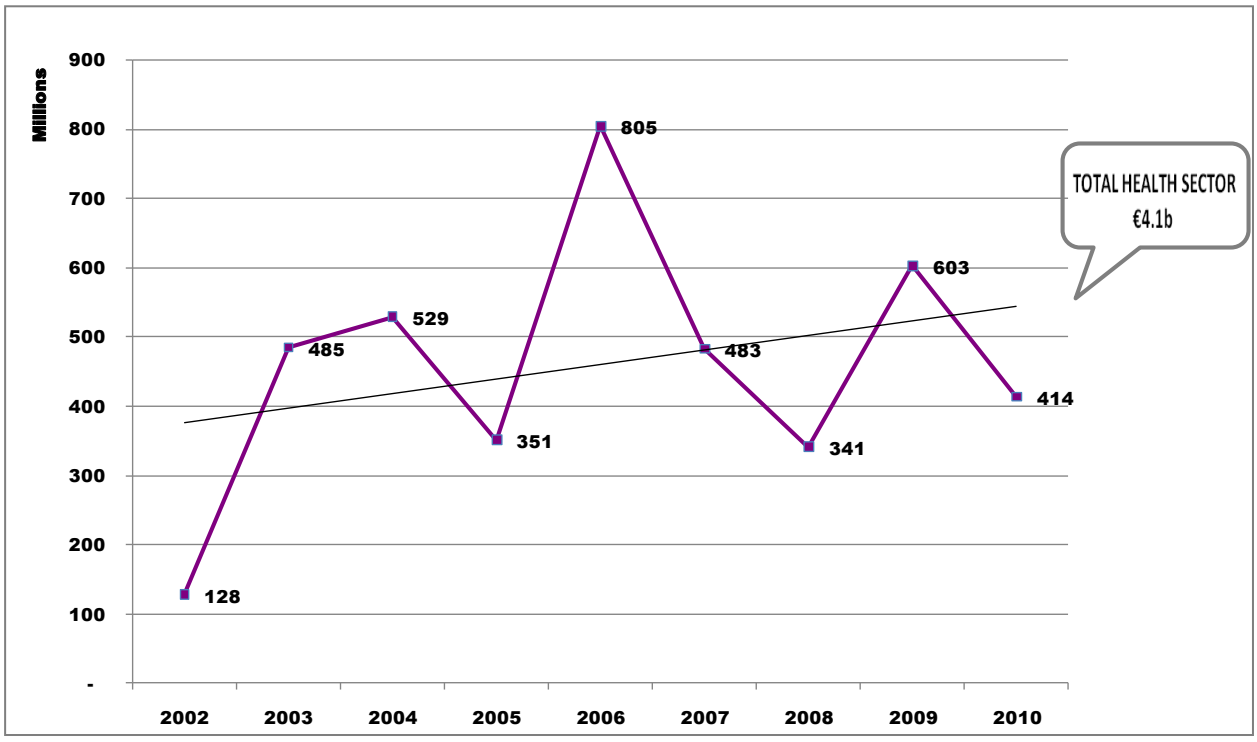
A substantial part of the GBS provided by the EC can be considered as **indirect support to the health** sector. Over the period 2002-2010, a total amount of around € 7.1 billion has been transferred to national governments of beneficiary countries under GBS operations. Out of this total amount, around **€ 5 billion** consisted of GBS for which the EC referred, among other sectors, to the health sector. The € 5 billion contracted by the EC to deliver its indirect support the health sector represented **7%** of the **total EC aid delivered** over the period 2002-2010.

1.3.2 EC's "direct" support to the health sector

1.3.2.1 Trends in the EC's funding between 2002 and 2010

The following figure shows the trend in the amounts contracted over the period 2002-2010 for the direct support to the entire health sector.

Figure 2: Direct EC support to the health sector: Trend in the amount contracted between 2002 and 2010 (€ million) for the health sector



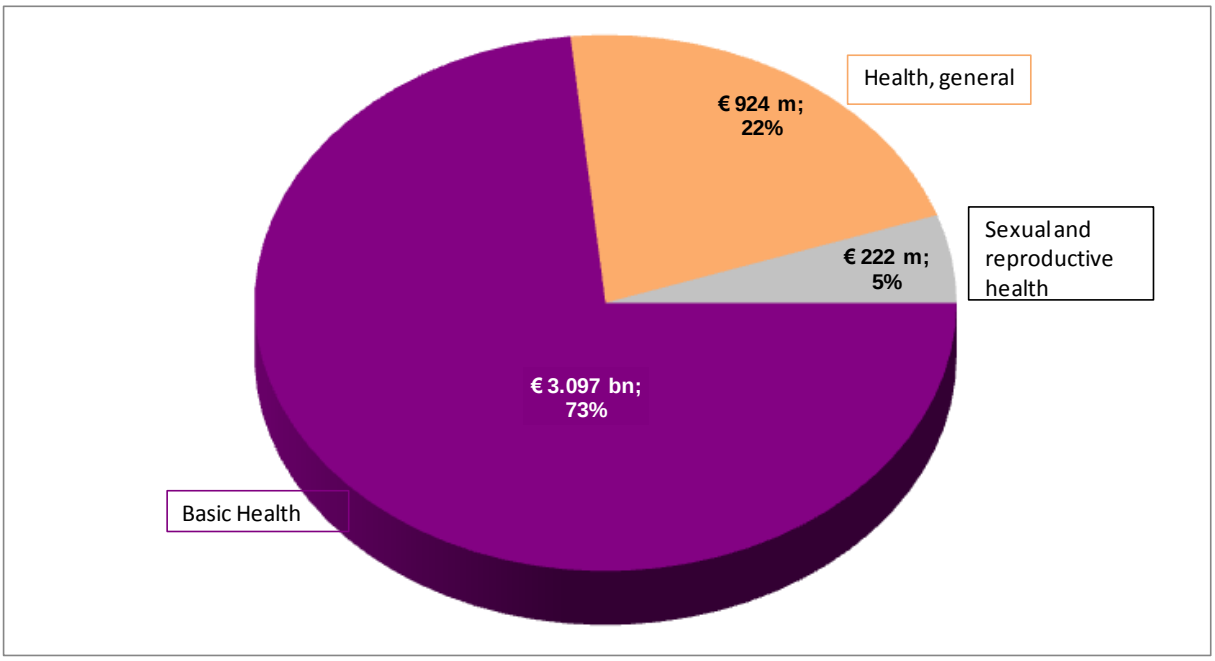
Source: CRIS and Particip GmbH analysis

Although the evolution over the whole period shows considerable year-to-year variation, there is a global upward trend of amounts contracted for the health sector. Between 2002 and 2010 the amounts evolved from € 128 million to € 414 million for the health sector. This reflects the commitment to provide increase health aid discussed in Chapter 2 of the Inception Report, such as the 2002 Communication on health and poverty.

1.3.2.2 Sector breakdown

The following figure provides a sector breakdown of the funds contracted by the EC to support the health sector. It is based on the three main sub-sectors of the Development Assistance Committee of the Organisation for Economic Co-operation & Development (OECD-DAC) sector classification: health general; basic health and sexual and reproductive health (further information of the sector classification used in this inventory is presented in the section 1.4.2.2).

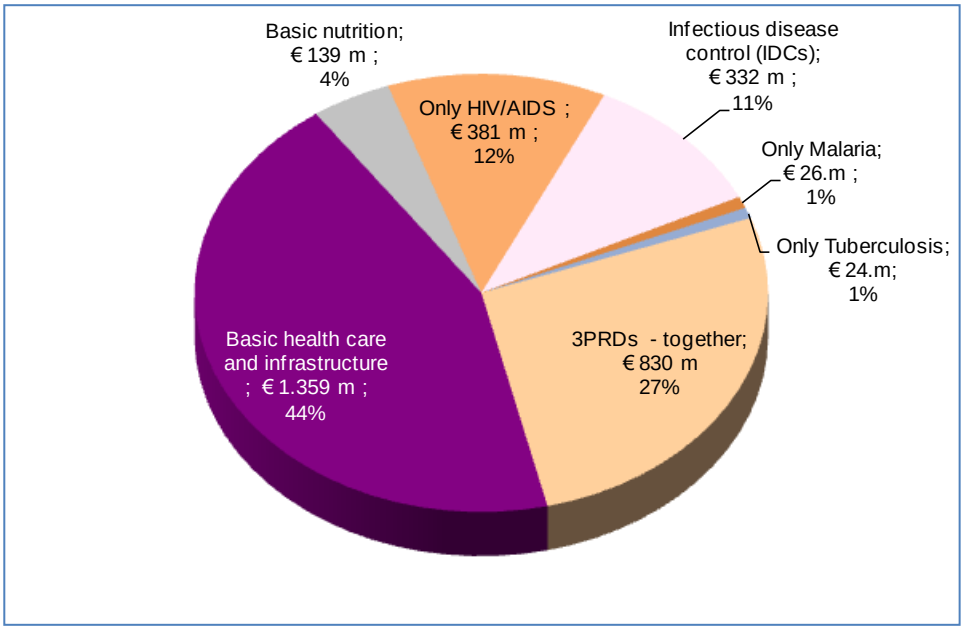
Figure 3: Direct EC support to the health sector: Sector breakdown by main health sectors, contracts (€ million), 2002-2010



Source: CRIS database; Particip GmbH analysis

The main focus over the period 2002-2010 was on **"Basic health".** The EC contracted an amount of € 3 billion which represented 73% of the total amount contracted. This sector includes (as defined by the DAC sector classification, see Appendix 1.4.2.2 interventions for basic health care and infrastructure, basic nutrition programmes and infectious diseases control including the three poverty related diseases HIV/AIDS, malaria and Tuberculosis. The next figure shows the breakdown of these sub-sectors:

Figure 4: Direct EC support to the health sector: Sub-Sector breakdown by basic health sub-sectors, contracts (€million), 2002-2010



Source: CRIS database; Particip GmbH analysis

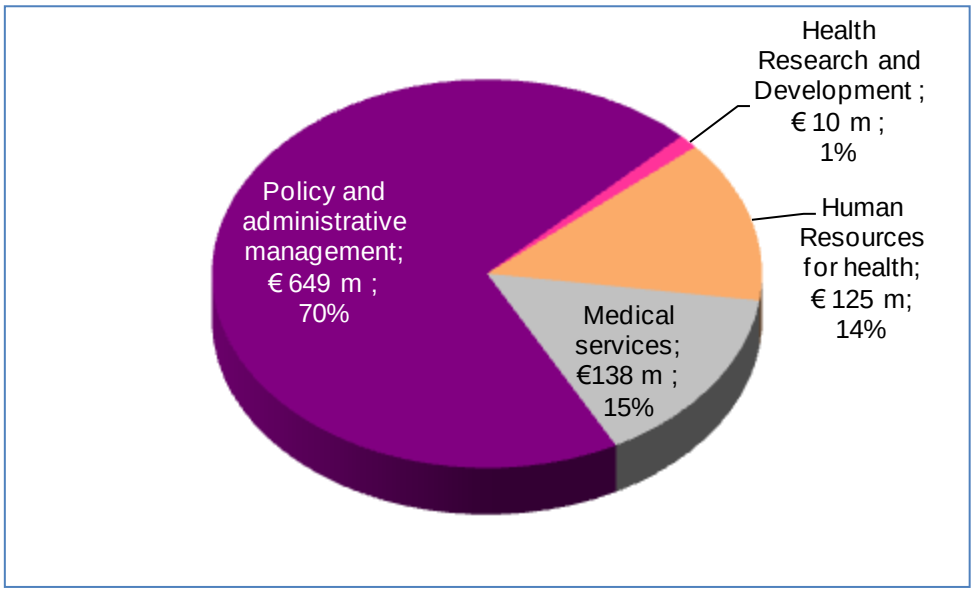
Nearly half of the total amount (43%) went to basic health care and infrastructure. Poverty related diseases (PRDs) (the funds for which consist mostly of the GFATM), represented 27% of the total funds and 12% of the total funds went to initiatives which specifically addressed HIV/AIDS. In contrast, interventions addressing malaria and TB received a much smaller amount, respectively representing 1% of the total funds. As an explanatory note, the EC deals with poverty-related diseases mainly through

contributions to the GFATM that jointly deals with the three diseases or through individual projects that specifically target each poverty-related disease separately such as the support to Lesotho HIV/AIDS response contracted in 2007 with Unicef or the development of malaria vaccines and their multi-centre trials contracted in 2003 with the African malaria network trust. The figures above showed the differences between these two approaches.

These fours sectors directly relating to the three poverty-related diseases (jointly or separately), together amounted to about 41% of all contracted amounts made over the evaluation period while interventions targeting infectious diseases control other than three disease above mentioned represented 11% . Interventions on basic nutrition represented 5% of the total funding for the sector. These figures provide a tentative indicator on the relative amount of funds committed to poverty-related diseases, and HIV/AIDS in particular in contrast to other health measures.

The second focus was on the so-called **"health general"**. The EC contracted € 895 million which represented 22% of the total contracted amount. This sector includes (as defined by the DAC sector classification, see section 0*)* interventions for the support of policy and administrative management, medical education and training, health research and development and also medical services such as mental health care or non-transmissible diseases. The figure below shows the breakdown of these sub-sectors:

Figure 5: Direct EC support to the health sector: Sub-Sector breakdown by health general sub-sectors, contracts (€million), 2002-2010

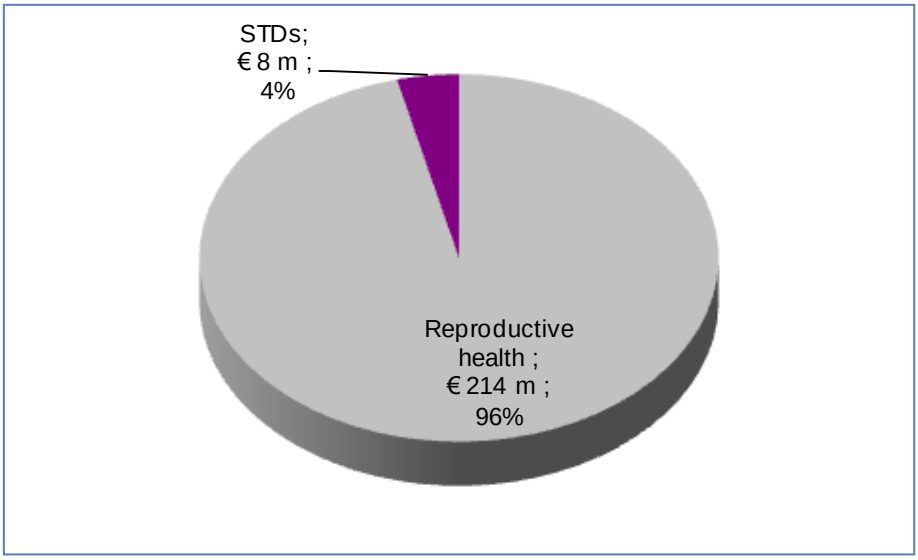


Source: CRIS database; Particip GmbH analysis

Policy and administrative management was by far the most supported category representing alone 70% of the total funding. Medical services represented 15% and 14% of the contracted amounts were specifically dedicated to human resources interventions targeting the development of health personnel in general. The lowest share went for health research and development which represented only 10% of the total amount contracted for the health general sector.

Sexual and reproductive health (SRH) has received the smallest contribution, amounting to only 5% or € 219 million of the total direct support. These data and thus Figure 3 have to be however carefully interpreted. On a country level, the EC supports health sector reform and health care delivery approaches that are beneficial for an improved access to basic services, including emergency obstetric services. Basic health care delivery, thus, usually, includes many interventions on reproductive health, such as in the case of Afghanistan where the Basic Package of Health Services (BPHS) includes maternal health programmes, including the provision of quality antenatal care, care during childbirth and post-natal care. However, due to limitations of the inventory approach, these reproductive health (RH) contracts labelled under basic health sectors could not be detected. At the end of the day only "vertical" reproductive health activities are explicitly labelled as such, they therefore represent only part of actual amounts contracted on RH

Figure 6: Direct EC support to the health sector: Sub-Sector breakdown by sexual and reproductive health sub-sectors, contracts (€million), 2002-2010



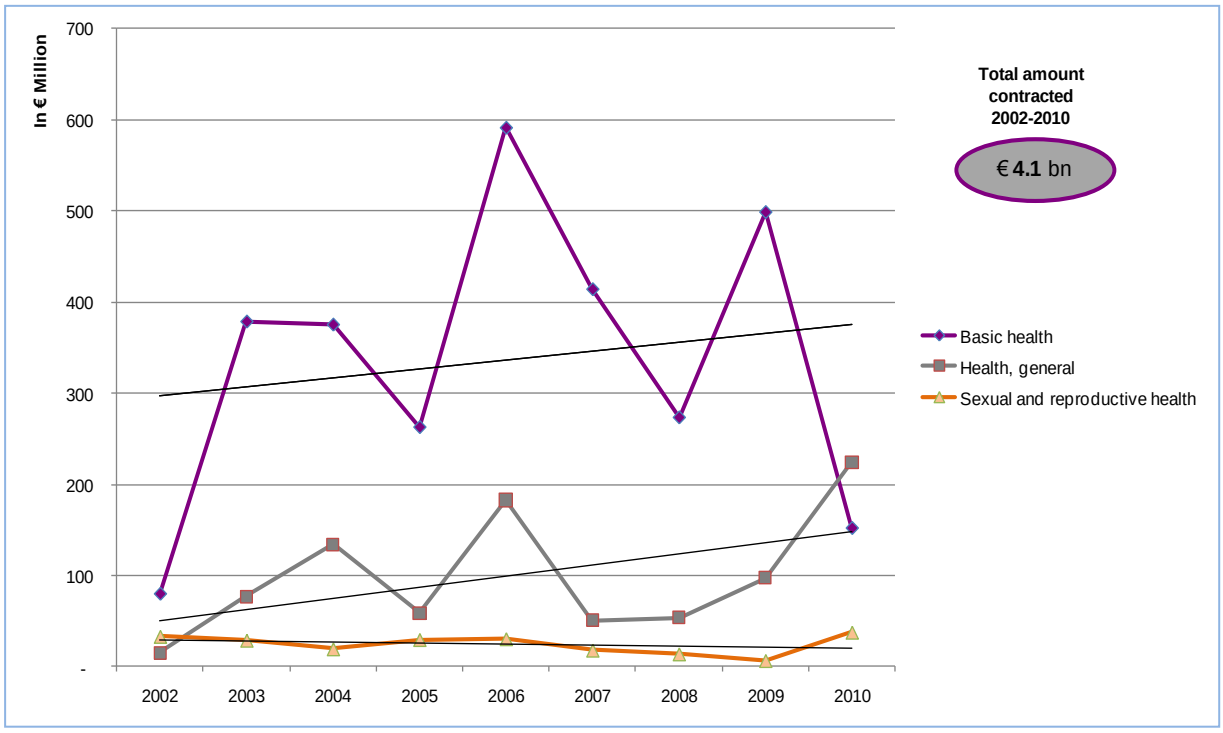
Source: CRIS database; Particip GmbH analysis

As show in the figure above, within the SRH sector, reproductive health has received by far the largest share amounting to 96% (€210m) of the total funds. In contrast, small amounts (€8'5m, 4%) were contracted to support interventions targeting sexual transmissible diseases. The EC's efforts in this area included activities related to prevention and treatment as well as sustained supply, availability and affordability of contraception and protection from sexually transmittable diseases. It must be noted that the amounts reported in the graph leave out interventions that specifically targeted HIV/AIDS. While the DAC sector codes do include HIV/AIDS in Sexually Transmitted Disease (STDs) sector, the DAC subsectors do not provide a great amount of detail, and do not differentiate the amounts going to HIV/AIDS in particular. Therefore, almost all projects classified under STDs in the inventory have the focus on STDs other than HIV/AIDS and projects that have the focus on HIV/AIDS have been classified separately.

The following figure shows the **trend in the amounts contracted over the period 2002-2010** by main health sectors.

The graph reveals that the support to "Basic health" have gradually risen from 2002, with two major peaks in 2006 and 2009 which can be explained by large amounts contracted with the World Bank in order to contribute to the GFATM and also to support the Avian Influenza and Human Influenza Pandemic Preparedness initiative in different regions of the world but most importantly in Asia.

Figure 7: Direct EC support to the health sector: Trend in the amounts contracted (€ million) between 2002 and 2010 by main health sectors



Source: CRIS database; Particip GmbH analysis

In the area of avian influenza, the inventory only accounts for interventions which explicitly mentioned human and/or global influenza in the title of the decision or the contract (e.g. Support to Avian Influenza and Human Influenza Pandemic Preparedness and Response in ACP countries or Avian Influenza and Global Influenza Pandemic Preparedness in Asia). It is not an easy task to give an exact estimate of the total number of EC financed projects in avian influenza because, as confirmed by experts of the DG DEVCO unit E3.

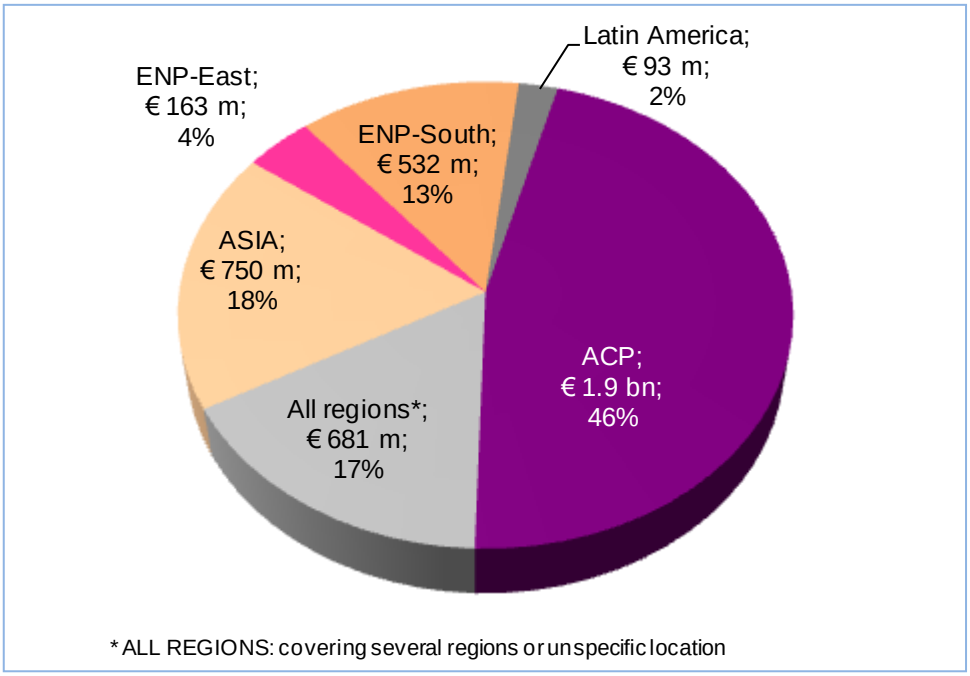
The graph above shows that the evolution of contracted amounts for the Health general sector followed the same trend. Although the amounts have greatly varied over the years, the graph shows an overall increasing trend over the evaluation period. Notable peaks were observed in 2006 and in 2009. The rationale behind this trend should be further investigated during the next phases of the evaluation. However, large contracts with national governments related to SBS operations seem to be the main reason behind. For example, in 2006, an amount of € 87 million, among others, was contracted with the government of Egypt in order to support the health sector reform. In 2009 the EC contracted € 42 million with the government of Moldova to support its Health Sector Policy Support Programme.

In contrast with the other two sectors, the trend in the evolution of the funds that went to SRH over the evaluation years remained quite steady with a slightly decreasing trend overall. It must be noted however, that, as explained before (see explanation Figure 3), given the limitations of the inventory the graph shows the evolution trend of SRH sector based on only "vertical" reproductive health activities and STDs which main focus is in STDs rather than HIV/AIDS. The trend therefore only represents the evolution of part of actual amounts contracted on RH.

1.3.2.3 Geographical breakdown

The set of diagrams below present the regional distribution of direct support for the health sector. Two types of geographical breakdown are provided here: a regional and a country breakdown. The regional breakdown of EC support the health sector is presented in the figure below.

Figure 8: Direct EC support to the health sector: Regional breakdown of support, contracts (€ million), 2002-2010



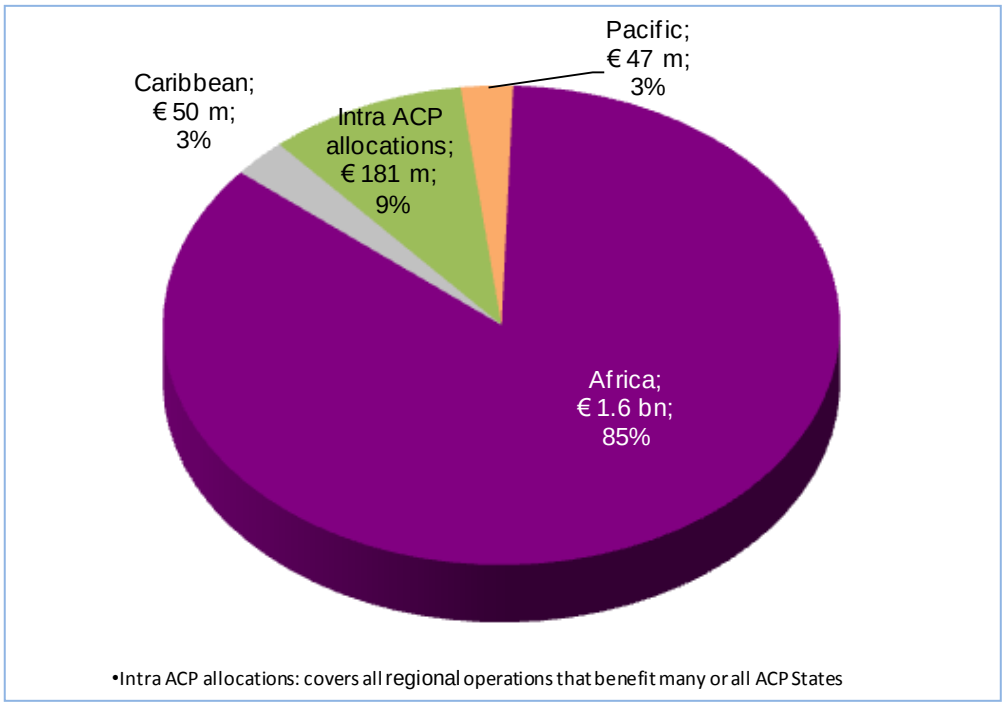
Source: CRIS database; Particip GmbH analysis

The main regional focus of the EC support to the health sector was ACP, which received 46% (or € 1.9 billion) of the contracted amounts and Asia, which received 17% (or € 715 million). Equally large is the amount contracted for the category "all regions" which received € 681 million (17%) of the total funds contracted over the period 2002-2010. It is closely followed by ENP-South (14%, € 568 million) while the other regions received relatively smaller amounts over the evaluation period: € 163 million in ENP-East and € 93 million in Latin America.

When the ACP region is further disaggregated, it becomes apparent that Sub-Saharan Africa received the largest share (€ 1.6 billion) of EC support to the health sector. The amounts contracted for the other regions with ACP and for so-called "Intra ACP allocations"[5] are relatively small compared to Africa.

[5] In accordance with the ACP-EC Partnership Agreement, intra-ACP cooperation is embedded in the regional cooperation and integration framework and covers all regional operations that benefit many or all ACP States. Such operations may transcend the concept of geographic location. Such cooperation falls into three main areas: global initiatives, "all-ACP" initiatives and pan-African initiatives.

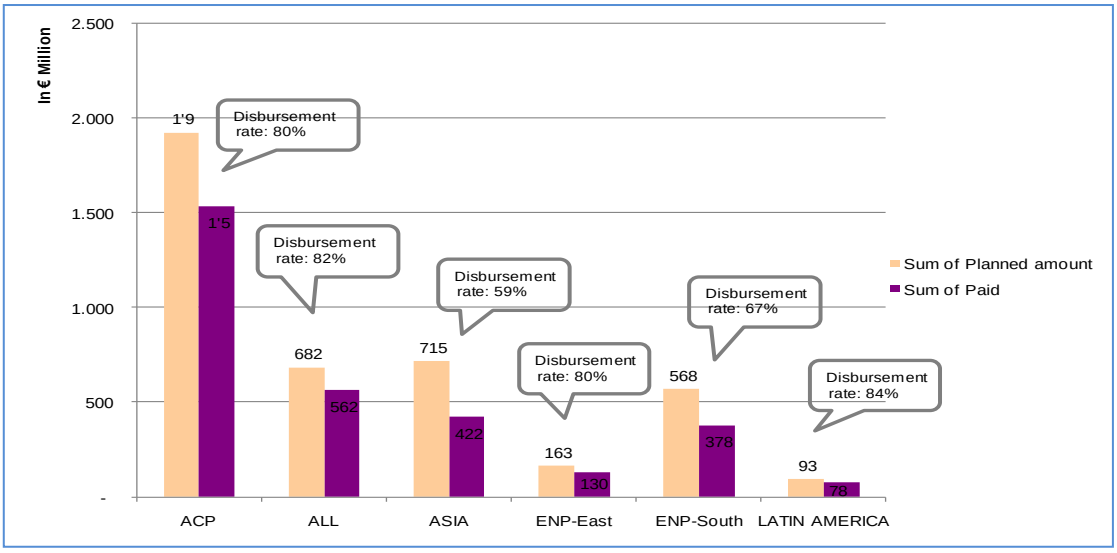
Figure 9: Direct EC support to the health sector: Regional breakdown of support towards the ACP region, contracts (€ million), 2002-2010



Source: CRIS database; Particip GmbH analysis

The disbursement[6] rates by region on the amounts contracted during the period 2002-2010 are displayed in the figure below:

Figure 10: Direct EC support to the health sector: Disbursement levels and rates by region, 2002-2010



Source: CRIS database; Particip GmbH analysis

[6] CRIS provides the sum of all payments made on the contracted amount for each intervention from the signature of the contract until the date of the data extraction by the evaluation team. The data extractions have been made by the evaluation team on 7th February 2011. Therefore the amounts of disbursement presented in the figures below are the sum of all payments made by the EC for contracts signed between 2002 and 2010 (the evaluation period) until 7th February 2011. For instance, the amount disbursed extracted from the EC database for a contract signed in 2007 would be the sum of the payments made from 2007 to 7th February 2010 and not the payments only made in 2007.

Comparably high disbursement rates of 80% or more can be observed for Latin America (84%), "All region" (82%) and for ACP and ENP-East. On the other end ENP-South and Asia scored rather low with rates of 67% and 59% respectively. The rationale behind these disbursement rates will have to be further analysed in the evaluation.

The **relative weight[7] of the amounts contracted for health interventions by region compared to the total amount** contracted for all interventions in each region depicts as follows:

- In *ACP countries*, 3% of the total EC aid contracted during the period 2002-2010 went to support the health sector through direct support modalities.
- In both *Asia* and *ENP-South,* the weight of the amounts contracted represented each 1% of the total EC aid.
- Finally, in *ENP-East* and *Latin America* the weight of the amounts contracted to support the health sector is insignificant compared to the global EC aid and together represented 1% of the total EC aid.

From this, it is clear that, despite overall increases in health aid described above, health aid remains a tiny fraction of total assistance. In terms of country breakdown, for reasons of presentation, the table below shows the 20 largest recipient countries of direct EC support to the health sector. The full list of countries (118 countries) is presented in section **1.5.6**.The table provides also the share of the amount contracted by country on the total amount contracted, the total amount disbursed by country and the disbursement rate on the amount contracted by country.

Table 1: Direct EC support to the health sector: The top-20 recipients, 2002-2010

Country	Amount contracted (in € million)	% on total amount contracted	Amount disbursed (in € million)	Disbursement rate
EGYPT	245,644,981	4%	130,924,376	53%
MOROCCO	154,528,705	3%	122,916,070	80%
AFGHANISTAN	149,373,043	3%	114,489,765	77%
SOUTH AFRICA	130,784,218	2%	116,289,602	89%
BANGLADESH	111,231,762	2%	80,046,929	72%
INDIA	110,962,276	2%	7,293,318	7%
MOZAMBIQUE	99,256,536	2%	78,350,785	79%
NIGERIA	94,747,375	2%	75,244,356	79%
DR CONGO	92,482,220	2%	65,181,672	70%
ZIMBABWE	81,286,205	1%	74,722,707	92%
BOTSWANA	70,529,222	1%	24,529,222	35%
MOLDOVA	61,559,739	1%	38,708,457	63%
PHILIPPINES	52,599,090	1%	31,794,084	60%
ZAMBIA	49,546,972	1%	24,461,034	49%
ANGOLA	47,287,992	1%	36,483,020	77%
INDONESIA	43,172,562	1%	32,342,589	75%
MYANMAR	42,866,111	1%	29,000,727	68%
TUNISIA	40,758,837	1%	40,758,837	100%

[7] In order to calculate the relative weight, the only data available were the data extracted from CRIS by the evaluation team for the elaboration of the inventory (07th February 2011). These data concern all interventions contracted by the EC between 2002 and 2010. The relative share of the EC support to the health sector by region has thus been calculated by taking the total amount contracted between 2002 and 2010 by geographical zone and the amount of the direct support of the EC to the health sector for these geographical zones as in the inventory elaborated by the evaluation team.

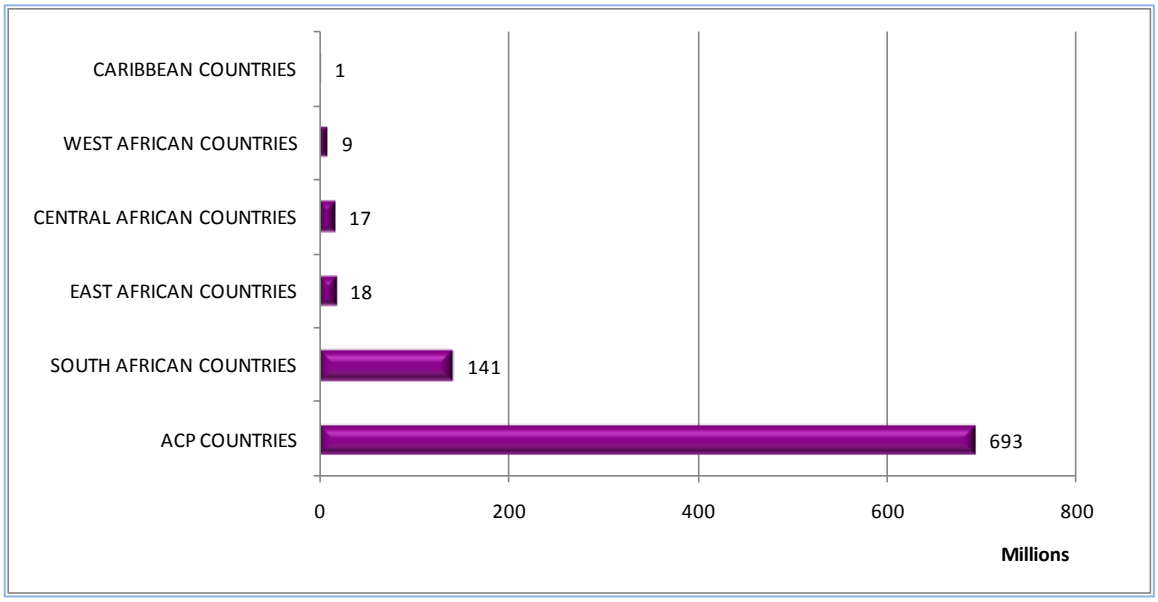
Country	Amount contracted (in € million)	% on total amount contracted	Amount disbursed (in € million)	Disbursement rate
SIERRA LEONE	38,389,689	1%	28,097,390	73%
OCCUPIED PALESTINIAN T.	36,835,603	1%	30,402,890	83%
OTHER*	4,139,546,198	0%	1,921,612,493	46%
Grand Total	**5,893,389,337**	**100%**	**3,103,650,323**	**53%**

** "Other" includes 98 countries that are presented in section* **1.5.6**
Source: CRIS database; Particip GmbH analysis

As shown, together the 20 main recipient countries (not including the regional categories and the all countries category[8]) represent almost half (42%) of the total funds contracted for the entire health sector. Among them the biggest beneficiaries were: *Egypt*, *Morocco*, *Afghanistan*, *South Africa*, *India* and *Bangladesh* accounting together for 23% of the total funding, the remaining countries receiving each between 1 to 2% of the total funding.

The next figures below show the breakdown of the regional interventions on health supported by the EC. These categories are coded as such in CRIS (see 1st column of the inventory "Zone benefitting from the action"). These categories contain interventions covering more than one country in a given region. The full list of countries and regions is presented in section **1.5.6**.

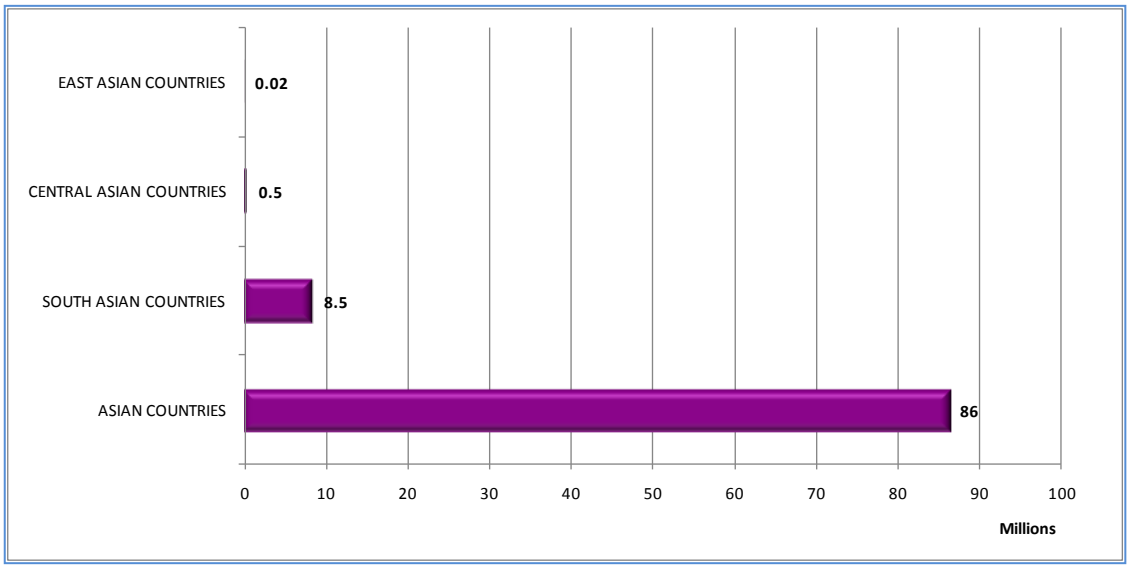
Figure 11: Direct EC support to the health sector: Breakdown of support to ACP regions, contracts, 2002-2010 (€ million)



Source: CRIS database; Particip GmbH analysis

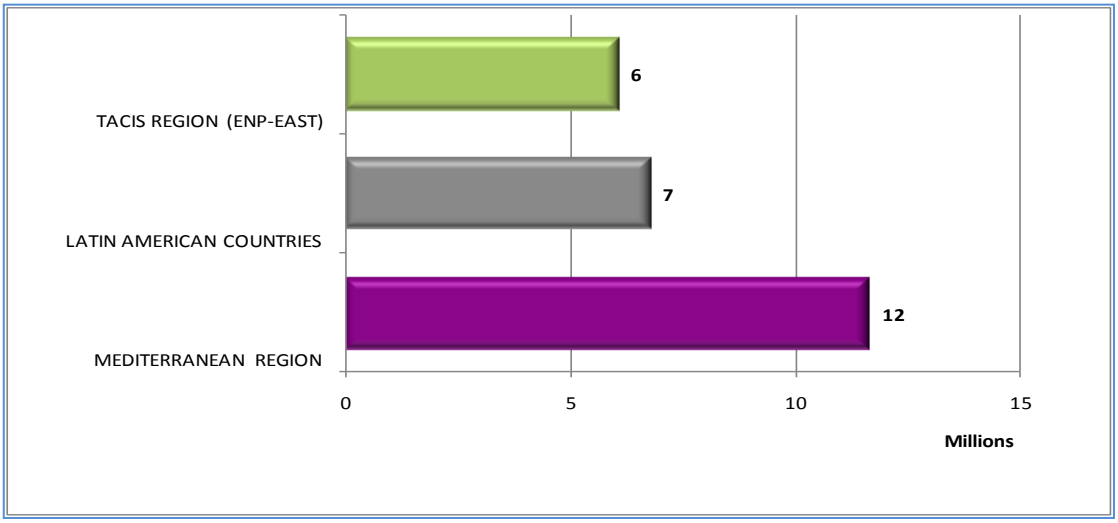
[8] The regional categories are: "ACP countries," "Asian countries," "African countries," "Latin American countries," "Caribbean countries," and "Mediterranean countries". They are defined as such in CRIS and they contain interventions covering more than one country in the region. The "all countries" category contains interventions covering more than one country without a specific regional focus or interventions with an unspecified location.

Figure 12: Direct EC support to the health sector: Breakdown of support to Asian regions, contracts, 2002-2010 (€ million)



Source: CRIS database; Particip GmbH analysis

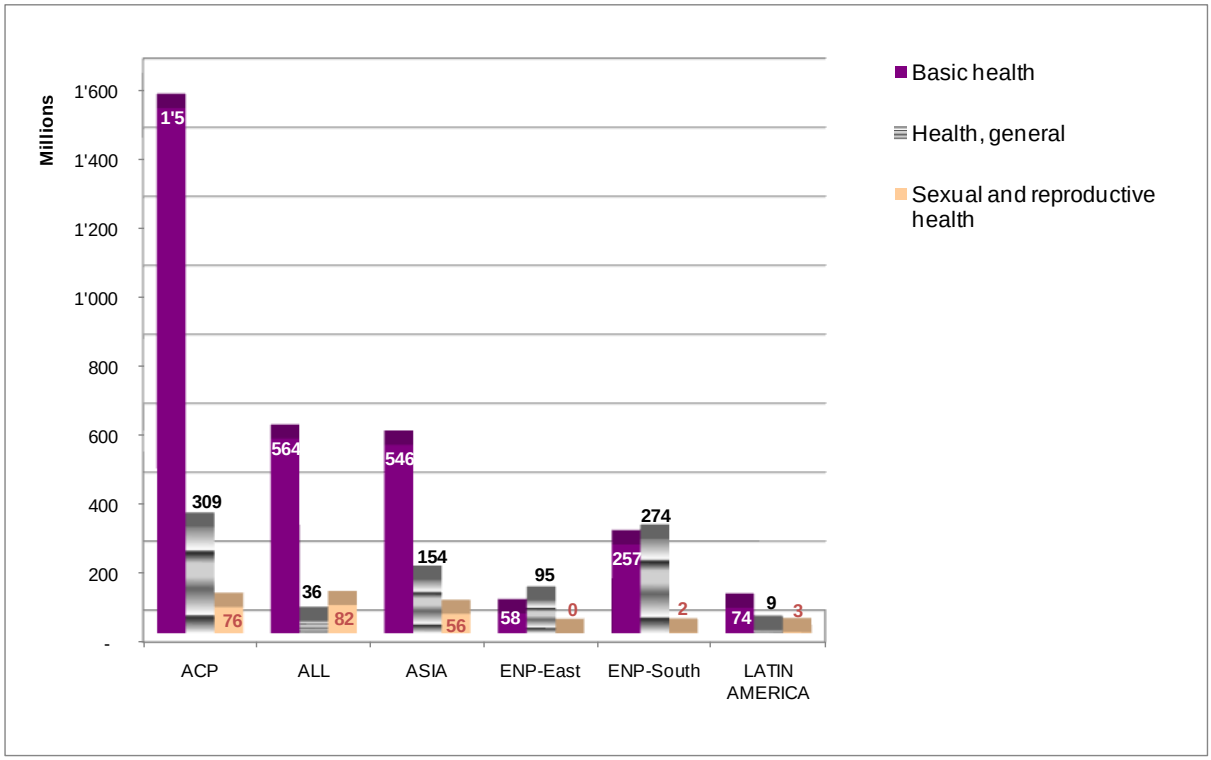
Figure 13 Direct EC support to the health sector: Breakdown of support to other region encoded as such in CRIS, contracts, 2002-2010 (€ million)



Source: CRIS database; Particip GmbH analysis

The figure below presents the regional breakdown by main health sub-sector that lies within the thematic scope of the evaluation.

Figure 14: Direct EC support to the health sector: Regional breakdown by main health sub-sector, contracts (€ million), 2002-2010



Source: CRIS database; Particip GmbH analysis

The figure shows variation in the focus of EC support by region:

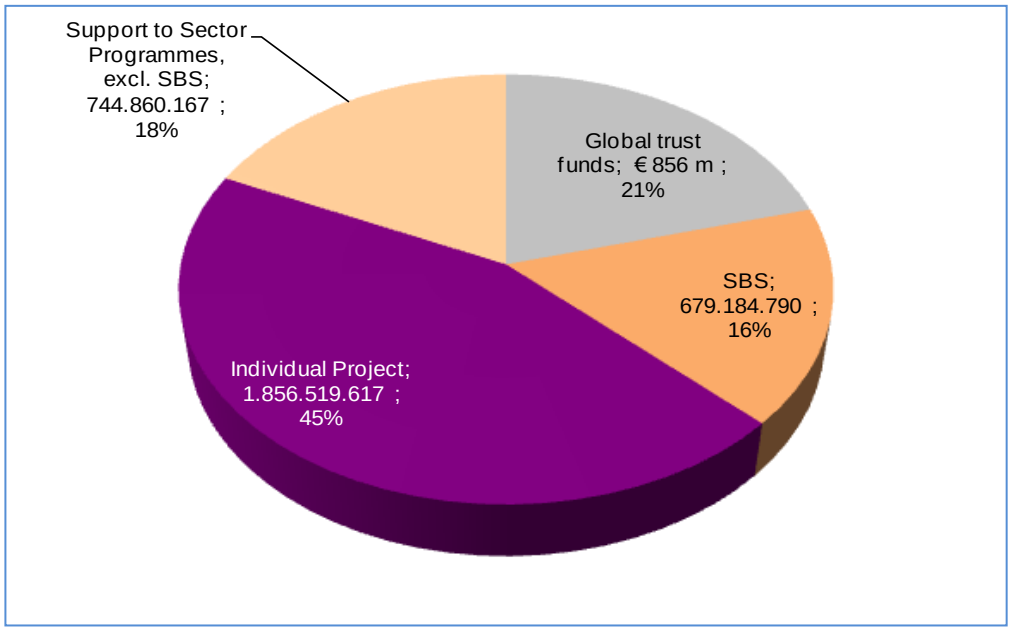
- The main focus in *ACP* was on interventions covering Basic health which represented 79% of the total amount contracted in the region. Health general was the second largest sector (17%) supported by the EC in the region, while only 4% of the total amount was used to support sexual and reproductive health sector.
- In *Asia*, the large majority of funds also went to basic health (74%) followed by "Health general" with 20%, while Sexual and reproductive health only received 6%.
- *ENP-East* received fewer funds for basic health (42%) and more support for health general which represented 58% of the total funding for the region. No contracts in Sexual and Reproductive health have been founded. Overall, however, support to this region was rather limited compared to almost all other regions
- In *ENP-South,* the situation is similar than in ENP-East. The main focus has also been on health general (51%) followed closely by basic health that received 47% of the total funds contracted in that region. Even less than for all other regions was contracted on support to Sexual and reproductive health (2%).
- In *Latin America,* 87% of the funds went for basic health and 10% for health general and 3% to sexual and reproductive health.

In the category *"all regions",* basic health was the main focus (83%), mostly covering interventions to support the fight against the three poverty related diseases. From these 83%, 57% were used to support initiatives that jointly dealt with poverty-related diseases, being represented mostly by annual contributions to the GFATM. Interventions dealing with HIV/AIDS in particular and reproductive health represented received between 10% and 20% of these funds and less than 10% went to other sectors such as basic health care and infrastructure or human resources for health.

1.3.2.4 Breakdown by modality used

As described in section 0, the EC delivered its "direct" support to the health sector through SBS, individual projects, support to sector programmes (SSP) excluding SBS, and through financing trust funds. The figure below shows the share of these four modalities of the total amount contracted to support the health sector.

Figure 15: Direct EC support to the health sector: Breakdown of modalities used, contracts (€ million), health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

It appears that:

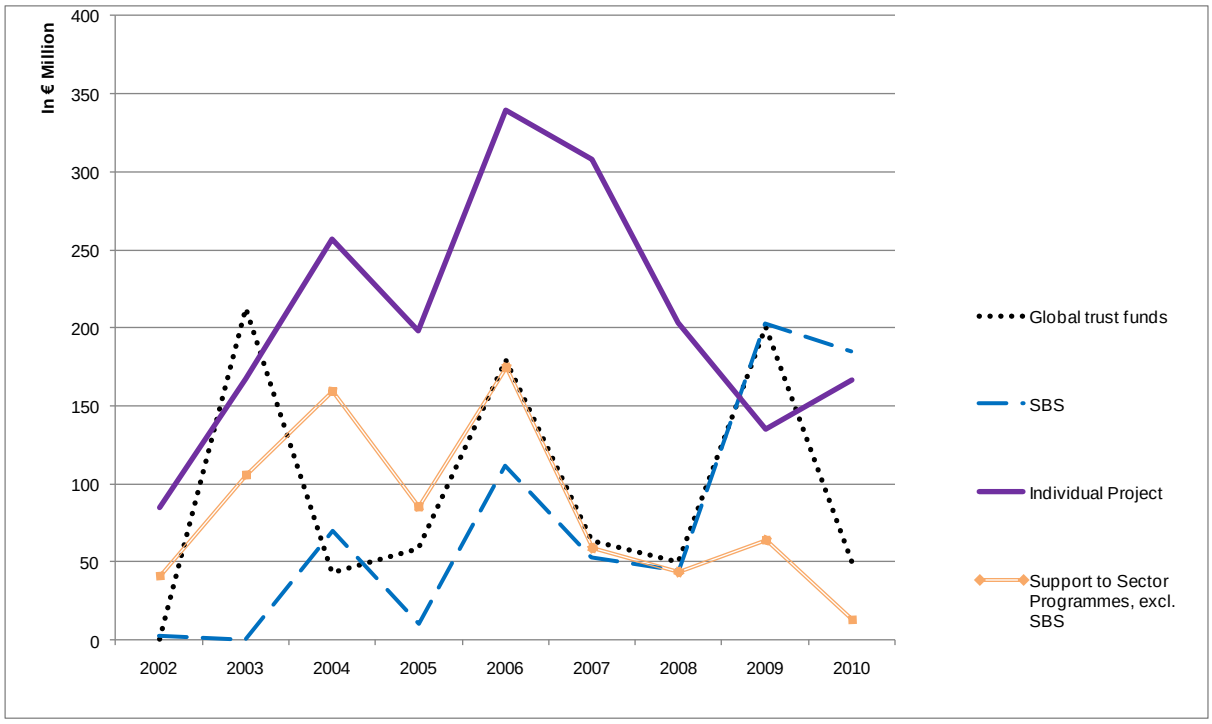
- Nearly half (46%) of EC support to the health sector was delivered through the financing of individual projects;
- Financing of global trust funds was the second largest modality used representing 21% of the total amount contracted. This mostly consisted of contracts with the World Bank to do the contributions to the GFATM (18%). Other smaller contracts (6%) were related to the Avian Influenza and Human Influenza Pandemic Preparedness and Response in various regions.
- The EC made relatively little use of Sector Budget Support to directly assist the health sector compared to other social sectors such as Education.. Only 16% of the total funds contracted to support the health sector were contracted for SBS operations. Compared to the education sector (basic and secondary education)the ratio rather is quite low where SBS accounted for 47% during the period 2000 to 2007.[9] 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.

Comparing these figures with data from the evaluation of EC support to basic and secondary education[10] reveals interesting differences between these two social sectors. For education the situation was: Individual projects represented 22% of the total amount, trust funds 10%, SBS 47% and Support to Sector Programmes 21%, i.e. 68% of the support was directed to forms of sector support, compared to only 31% in the health sector. The following phases will have to further investigate into the reasons for the prominence of some modalities compared to others.

The evolution of amounts contracted through the four modalities is presented in the figure below.

[9] See, “Evaluation of the EC support to the education sector 2000-2007”.
[10] This evaluation was finalized end of 2010, and is available on DG DEVCO website. It covers the period 2000 to 2007.

Figure 16: Direct EC support to the health sector: Trend in the amounts contracted by modality, contracts (€ million), health sector, 2002-2010

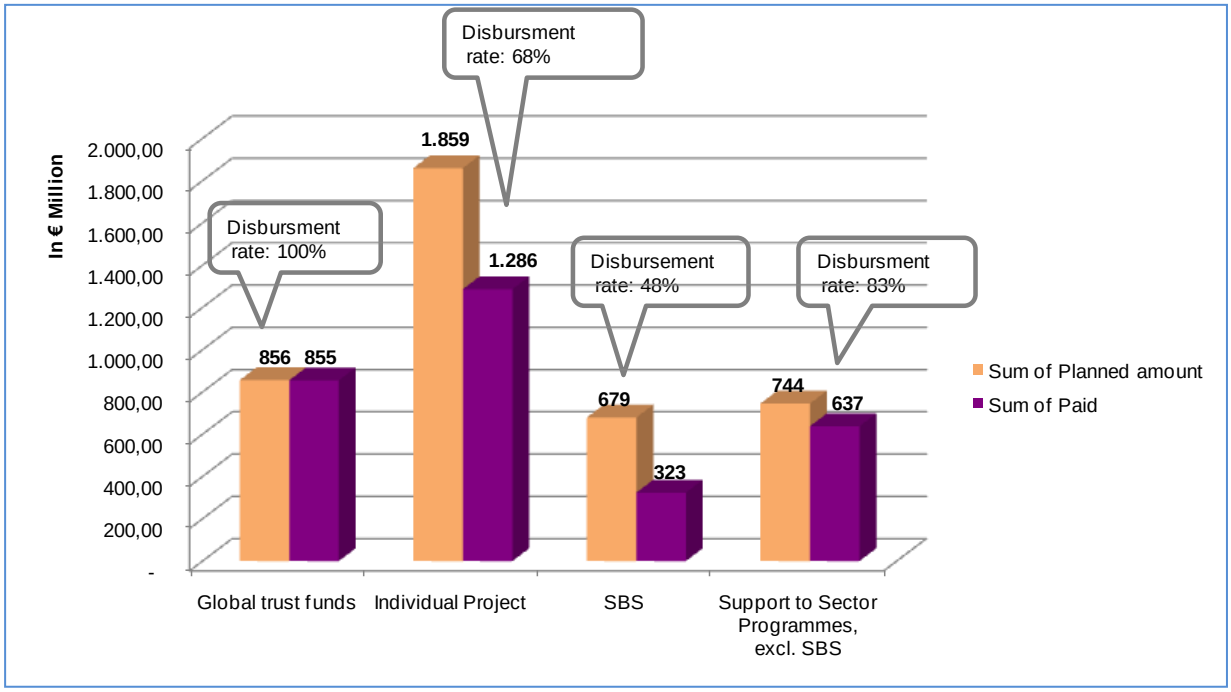


Source: CRIS database; Particip GmbH analysis

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. This progress was quite regular 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.

The levels of the EC disbursements on the amounts contracted over the period 2002-2010 per type of modality are shown in the figure below.

Figure 17: Direct EC support to the health sector: Disbursement levels by modality, health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

The financing of trust funds had the highest disbursement rate, with 100% of disbursements on the amount contracted. This is due to the fact that all contributions to the GFATM made over the period as well as the payments to the WB relating to the avian influenza and human influenza projects have been totally paid with only two minor exceptions of € 5 m and € 620,761, contracted respectively in 2006 and 2009.

While, with 86% the support to sector programmes excluding SBS scores relatively high in terms of disbursement rates, these rates are rather low for individual projects (69%) and SBS (48%). As mentioned above, disbursement levels are based on the payments done by the EC from the signature of the contract until the date of the data extraction from CRIS.

Recent project disbursement rates have been particularly low. During 2008-2010, € 503 million have been contracted through projects, while only € 151 million have been disbursed from these amounts. Some examples of these projects, among others, are the support to specialized Medical Services in Iraq with only € 5.5 million disbursed out of € 13 million contracted in 2008 or the maternal and young child malnutrition in Asia which contracted € 20 million in 2010, of which about € 4 million have been disbursed from this amount.

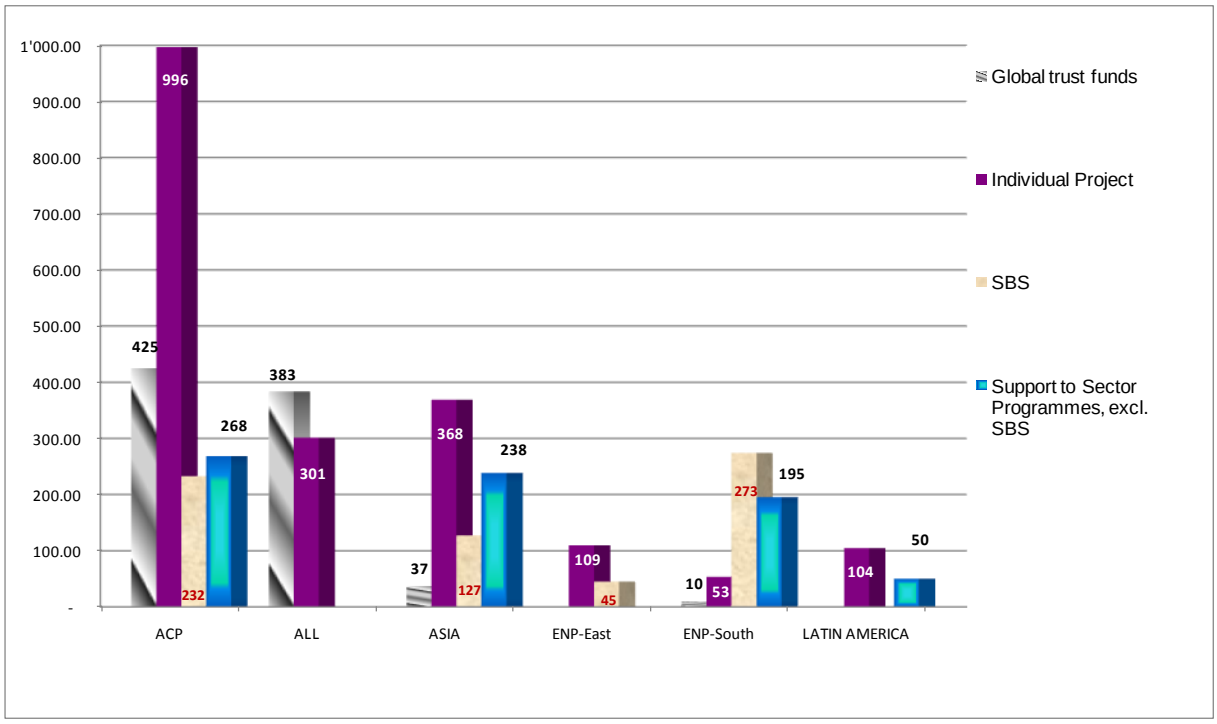
For SBS the situation is very similar. While € 432 million have been contracted during 2008-2010, only €113 million have been disbursed. Examples of these interventions are the HSPSP II-Health Sector Policy Support Programme II in Egypt which was contracted in 2010 amounting € 107 million in 2010. Only € 20 million have been disbursed. The human resource development sector policy support programme (HRD SPSP) in Botswana was also contracted in 2010 and only 14 million out of 60 million has been disbursed.

As these high amounts of funds have been contracted at the end of the evaluation period the funds might not yet have been fully disbursed at the time of the data extraction from CRIS (07th February 2011).

1.3.2.5 Breakdown by region and type of modality

The breakdown by region and type of modality of “direct” support to the health sector is presented in the following figure.

Figure 18: Direct EC support to the health sector: Regional breakdown by type of modality, contracts (€ million), health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

With some exceptions, the patterns observed at global level are confirmed throughout the regions:

- The graph shows that the preferred modalities used by the EC to support the heath sector in the category all region were regions global trust funds (38%) and individual projects (16%).
- As at the global level, "individual projects" was the main modality used in the ACP region (51%). Trust funds, constituted a major bulk of support in the region (24%). including for example contracts with the World Bank relating to avian influenza and human influenza pandemic preparedness in Asia. Programme On the other hand, sector support, be it support to sector programmes as defined by the evaluation or through SBS seems to be little used, with SSP scoring 13% and SBS scoring 12%. [11]
- It is coherent that the financing of projects were globally the main modality used by the EC to support the health sector over the period 2002-2010 given that the ACP region alone accounts for the 46% of the total funds that supports the entire health sector.
- In *Asia*, individual projects also remain the main modality used (44%), followed by SSP (20%) and trust funds and SBS who have both been equally important as modality (18%).
- Similarly to ACP and Asia, in *ENP-East,* individual projects remain the modality most used to support the health sector (66%). SBS 28%) was in second place and trust funds represented only 6% of the total amount. Interestingly, the inventory does not reveal other forms of sector support for this region over the evaluation period.
- Unlike elsewhere, in *ENP-South*, SBS was the main modality used (48%) closely followed by SSP (33%). This means that forms of sector support account for more than 80% of the support
- In *Latin America,* only projects (70%) and SSP (30%) were used during the period under evaluation.

1.3.2.6 Breakdown by channel used by the EC

The EC used different channels to implement its "direct" support to the health sector. This information is available in the EC database for most of the interventions 12 but only the name of the contracting partner

[11] For comparison: For basic and secondary education these figures amounted to 59%, out of which 35% for SBS and the remainder for SSP.

[12] The evaluation team's data extractions in CRIS for the health sector showed that out of 2,174 interventions, 103 interventions had no names of channels encoded.

(e.g. “The World Bank”, or “Republic of Botswana”, or “Save the Children Federation”) is encoded and not the category of the channel, e.g. whether it is a NGO, a public-private partnership (PPPs) or a multilateral institutions. . Therefore, the evaluation team has first encoded the category of channels based on the classification described in the CRIS-DAC form manual, version 09.03. This manual specifies that two fields must be filled out. The 'Main Channel' which is mandatory in all cases and the 'Detailed Channel' depending on whether or not related values are available to further described the channel.

Then, the inventory reports the channels according to the following categories:

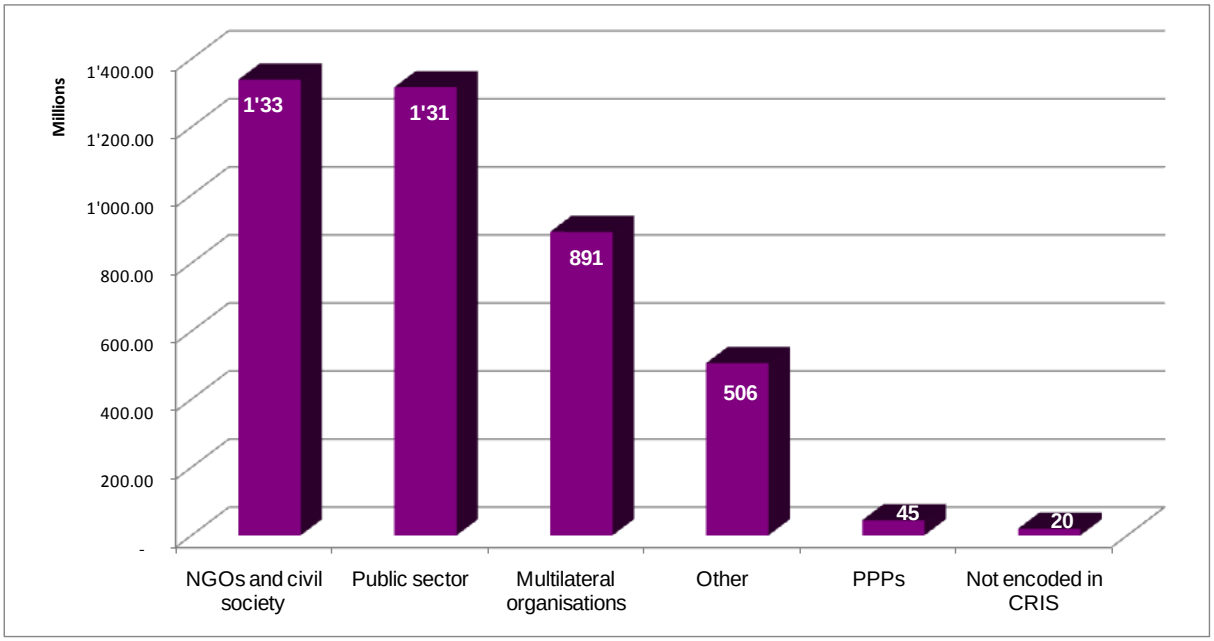
Table 2: Channel classification of EC support to the health sector, 2002-2010

Main channel	Detailed channel[13]
Public sector	Beneficiary countries’ national governments; Private companies or development agencies acting as such, contracted by governments under EDF.
NGOs and civil societies	International, national and local/regional NGOs,
Public-private partnerships (PPPs)	GAVI and the International partnership on microbicides.
Multilateral organizations	UN agencies, funds and commissions; other UN bodies refers to WHO, ILO and FAO; World Bank group; regional development banks and other multilateral such as GFATM or African Union.
Other	Private companies-development agencies and Research and educational institutions, when it is the institution implementing the action under a thematic budget line.

Source: CRIS database; Particip GmbH analysis

The figure below shows the breakdown of the amount contracted for the health sector interventions for these five categories.[14]

Figure 19: Direct EC support to the health sector: Breakdown by channel, contracts (€ million), health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

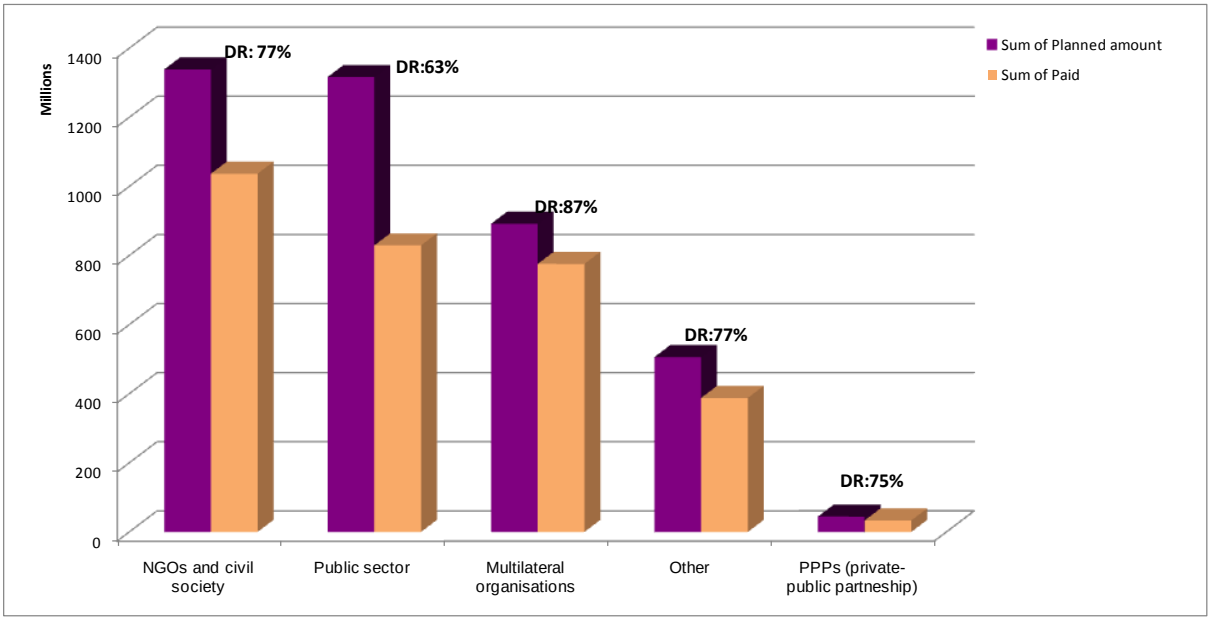
NGOs and civil society organisations as well the public sector were almost evenly distributed and accounted respectively for the 33% and 32% of the total amount contracted by the EC to support the

[13] The Annex 3 of the CRIS-DAC guideline, version 03.09, includes a comprehensive list of all agencies classified under per main channel. The detailed channel classification is based on this list.
[14] A sixth category has been defined by the evaluation team: “Not encoded in CRIS”. This category includes all interventions for which no name of channel was mentioned in CRIS. Without a name of channel, these interventions could not be classified under one of the five categories.

health sector The public sector category includes national governments that represented 74% of total funds, private companies/development agencies acting as such under the EDF that represented 24% of the funds, and research and education institutes under EDF that accounted for 2% of the funds. . The second main channel was represented by multilateral organisations and accounted for 21% of the total funds. It included the World Bank group (51%), UN bodies (28%) and other multilateral organizations (GFATM, PAHO and CARICORUM) that together accounted for 21% of the total funds. The "other" channel includes private companies and development agencies as such as well as universities that implement the action by themselves and are financed through thematic budget lines. Together, they account for 13% of the total funds, being 85% of these funds channelled through private companies and development agencies as such and 15% through universities. Public-private partnerships accounted only for 1% of the total funds and the majority of them went to GAVI. 1% of the total funds could not be classified under any channel because there was not information in CRIS about the contracting partner.

The following figure shows the disbursement rates by category of channel[15].

Figure 20: Direct EC support to the health sector: Disbursement rate (DR) by channel, health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

Multilateral organisations which mainly include the World Bank and UN bodies, GFATM, etc. show the highest disbursement rate (87%) due to the nature of the contracts concluded. The category "other channels" which mainly includes private companies and development agencies financed under budget lines form the second group with a disbursement rate of 77%, together with NGOs which also have a disbursement rate of 77%. Private-public partnership, mainly GAVI, score lower with a disbursement rate of 75%. Interestingly, the public sector, mainly governments, scored the lowest (63%). High amounts (€ 483 million) have been contracted with governments at the end of the evaluation period (2002-2010) and only 28% of this amount (€ 134 million) had been disbursed at the date of the data extraction.

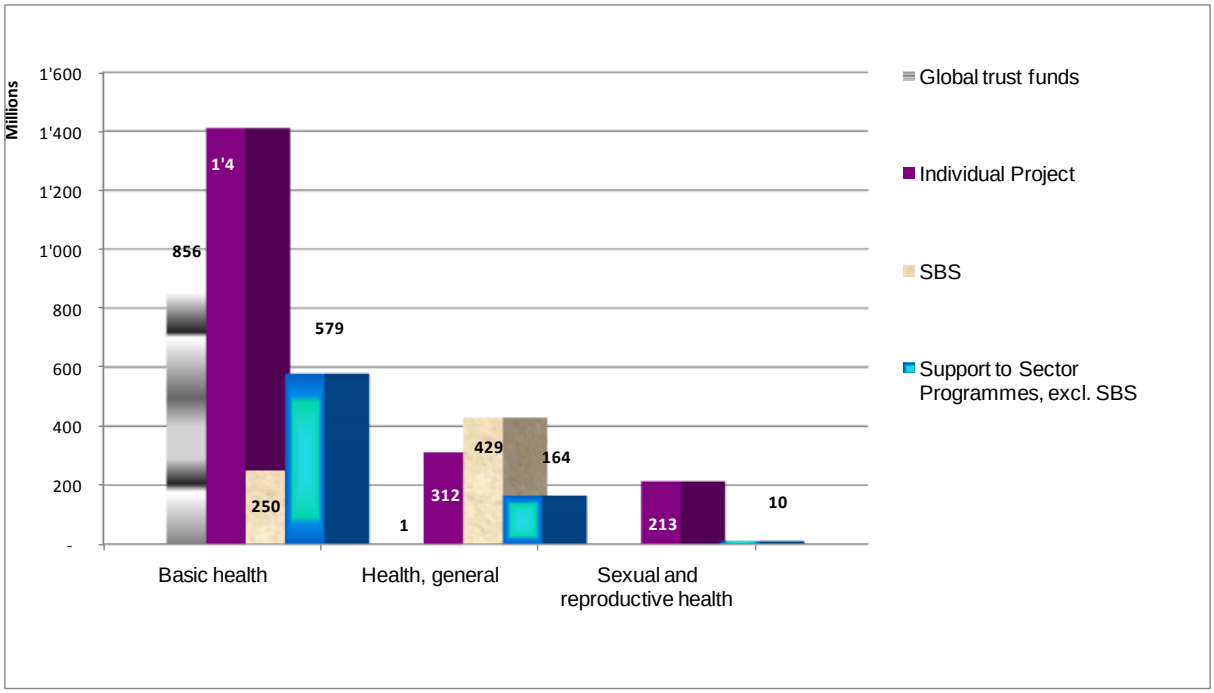
Further breakdowns using combinations of the various dimensions presented above allow a better understanding of the EC support to the health sector.

1.3.2.7 Breakdown by sector and type of modality

The following figures depict another view on the inventory data, i.e. on the breakdown of modalities by main sub-sector.

[15] This figure does not show the disbursement rate of the category of channels themselves for the implementation of the activities

Figure 21: Direct EC support to the health sector: Sectoral breakdown by type of modality, contracts (€ million), health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

To a certain extent these figures confirm the findings related to the modalities:

- EC support to Basic Health mainly used individual projects (44%) and trust funds (32%) to attain objectives set. This sector includes the delivery of health care and infrastructure as well as interventions targeting general infectious diseases and PRDs. Interestingly, here SBS was the modality least used to support the sector with only 8% of the total funds. On the other hand, SSP represented 16% of support.
- SBS was considerably used (46%) to support the health general sector, which includes mainly policy and administrative management. As per DAC definition, this sector also includes health human resources development, medical research and specialized medical services. Accordingly the inventory reveals that these sub-sectors were covered through a considerable number of individual projects (34%) that can be also classified under this category. Examples of these projects are large contracts with WHO such as the EC/ACP/WHO partnership on pharmaceutical policies contracted in 2004 or the Support to Specialised Medical Services contracted in Iraq in 2008.
- Sector support programs represented 20% of the total funds covering interventions like the Health Sector Rehabilitation and Development Programme (HSRDP II) in Timor Leste in 2003.
- As for Sexual & reproductive health, the picture is even more homogenous: EC clearly preferred to achieve objectives via individual projects (95%).

1.3.3 EC's "indirect" support to the health sector: General Budget Support

1.3.3.1 Overview

During the period 2002-2010, the EC has financed a total of **158 GBS programmes**[16] in **59 countries**[17] falling within the geographical scope of this evaluation. Overall, a total amount of €7.1 billion was actually transferred to beneficiary countries for these GBS operations.

Out of these 158 GBS programmes (one country can have several GBS programmes during the evaluation period), **93 programmes** had a reference to the **health sector** expressed by their performance indicators or by their stated objectives in the Financial Agreements. These 93 programmes with a clear reference to the health sector were implemented in **45 countries.**

The 93 health related GBS programmes represented around **€ 5 billion, i.e. 72% of the total GBS funds** transferred by the EC between 2002 and 2010.

It is important to underline that it cannot be stated that the € 5 billion actually went to the health sector; it can only be stated that the amount refers to those GBS for which the EC in one way or another pursued goals for the health sector, among other sectors.

A GBS programme provides different kind of support. There is the financial support (the "actual" GBS as being un-earmarked funds going to the national treasury of the partner government) and supplementary support to the implementation of the financial funds, such as technical assistance (TA) or other support measures (e.g. formulation missions, evaluations, audits). A detailed description on how the classification of funds has been done in the database, can be found in the methodological part referring to the indirect support, in section 1.4.3

In addition to the € 5 billion financial support transferred directly to the treasury of the partner governments, around € 90 million have been disbursed to support activities directly related to the GBS programmes with a reference to the health sector, such as technical assistance, formulation missions, evaluation and audits.

A detailed list of GBS programmes covering the period 2002 to 2010 can be found in Appendix It provides details on the receiving country, the number and title of the decision, the amounts transferred the objectives of the GBS and whether the GBS has a health reference or not.

1.3.3.2 Health related GBS – breakdown by countries and regions

The following map shows the geographical distribution of GBS distinguishing the period 2002-2006/7 and 2007/8-2010. This distinction follows the CSP periods: the GBS were regrouped from 2002 to 2007 for the ACP countries (9th EDF) and from 2008-2010 (10th EDF). For all other countries the CSP periods run from 2002-2006 and 2007-2010 (2013).[18]

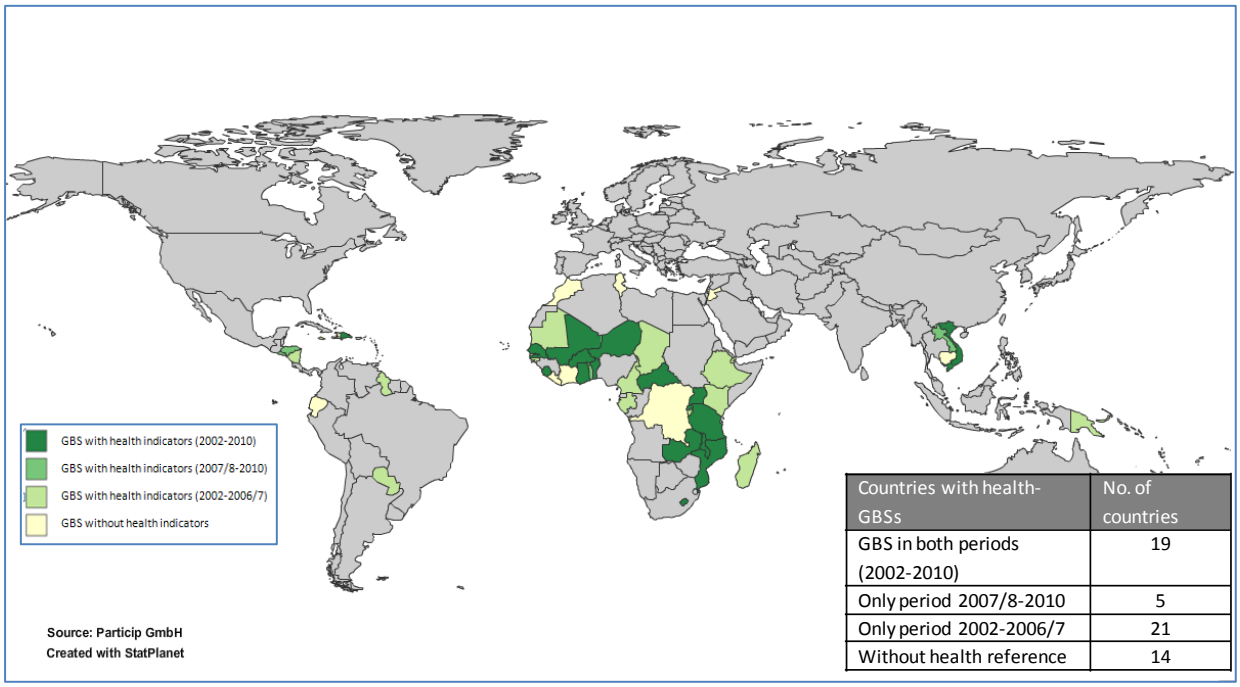
During 2002-2007/8 40 countries received GBS with a health reference, while during 2007/8-2010 only 24 countries received GBS with a health reference. Taking into account that the second period used in the analysis only accounts for two (or three years for non EDF-countries) years, the absolute number of countries receiving GBS in this period is decreasing. It is also interesting to notice that less GBS have health-related indicators in the second period of the evaluation.

[16] The term "programme" in this inventory refers to a GBS decision, as found in the CRIS-database. Under one decision there is the financial support as well as the contracts related to technical assistance or other support, such as evaluation, audits or formulation missions. A country can have several GBS decisions during the evaluation period.

[17] In some countries, more than one GBS operation has been financed.

[18] The year of the signature of the decision was taken as basis, even if the first disbursement were made later.

Figure 22: Indirect EC support to the health sector: Countries having benefited from GBS, both with and without health-related indicators (CSP periods 2002/3 to 2006 and 2007/8-2010)



Countries with health-GBSs	No. of countries
GBS in both periods (2002-2010)	19
Only period 2007/8-2010	5
Only period 2002-2006/7	21
Without health reference	14

Source: CRIS database, Particip GmbH analysis, created with StatPlanet

The following table provides an overview of health related GBS decisions in the evaluation period with the absolute amounts of GBS transferred and the relative weight of this amount of the total health-related GBS amounts transferred between 2002 and 2010.

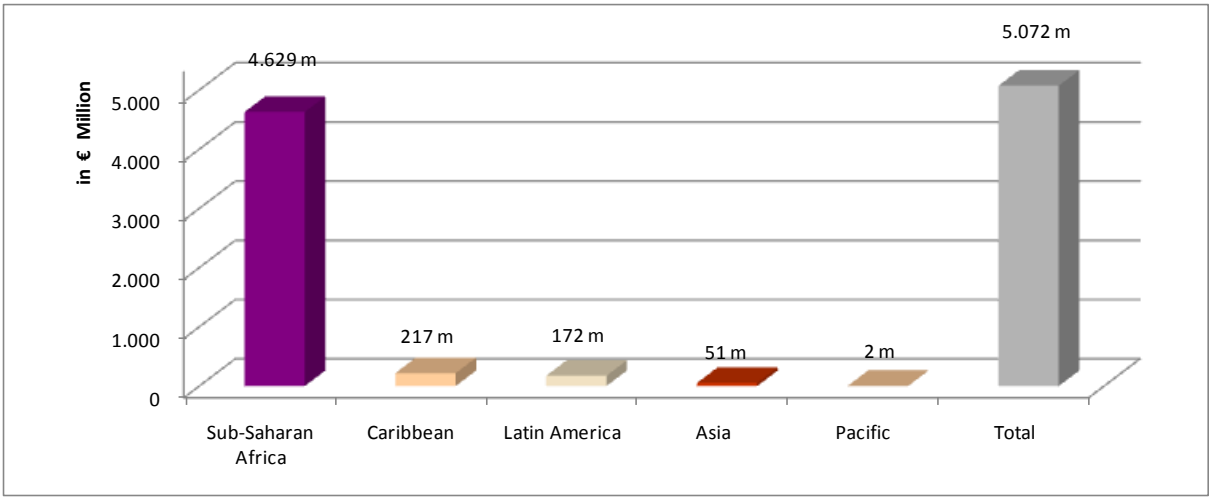
Table 3: Indirect EC support to the health sector: Financial support to countries with health related GBS (in €, 2002-2010)

Region/ Country	Number of GBS decisions per country	Financial support (incl. funds channelled through International Organisations)	% of total amounts per country (only financial support incl. International Organisations)
Sub-Saharan Africa	**72**	**4,628,538,771 €**	**65.65%**
Mozambique	4	643,640,294 €	9.13%
Burkina Faso	4	507,991,319 €	7.20%
Tanzania	4	477,252,574 €	6.77%
Zambia	4	445,190,000 €	6.31%
Mali	3	321,391,668 €	4.56%
Ghana	5	305,785,000 €	4.34%
Uganda	3	275,624,545 €	3.91%
Malawi	4	214,550,000 €	3.04%
Benin	4	186,521,360 €	2.65%
Rwanda	4	179,619,063 €	2.55%
Niger	3	162,297,000 €	2.30%
Senegal	3	145,445,300 €	2.06%
Sierra Leone	2	126,420,000 €	1.79%
Madagascar	3	123,175,000 €	1.75%
Kenya	1	120,000,000 €	1.70%
Ethiopia	2	93,626,286 €	1.33%
Lesotho	2	47,000,000 €	0.67%
Burundi	1	43,303,333 €	0.61%
Chad	2	42,452,379 €	0.60%
Central African Rep.	2	38,635,000 €	0.55%

Region/ Country	Number of GBS decisions per country	Financial support (incl. funds channelled through International Organisations)	% of total amounts per country (only financial support incl. International Organisations)
Cape Verde	2	33,000,000 €	0.47%
Togo	1	27,000,000 €	0.38%
Mauritius	1	25,980,000 €	0.37%
Cameroon	1	18,010,000 €	0.26%
Mauritania	1	10,198,496 €	0.14%
Comoros	1	7,270,000 €	0.10%
Djibouti	1	3,708,355 €	0.05%
Gabon	1	3,451,800 €	0.05%
Gambia	1	0 €*	0.00%
Guinea-Bissau	1	0 €*	.00%
São Tomé & Príncipe	1	0 €*	0.00%
Caribbean	**11**	**217,497,985 €**	**3.08%**
Dominica	1	12,044,000 €	0.17%
Dominican Republic	2	91,800,000 €	1.30%
Jamaica	4	56,144,335 €	0.80%
Guyana	1	38,959,650 €	0.55%
Saint Kitts & Nevis	2	18,550,000 €	0.26%
Turks&Caicos Islands	1	0 €*	0.00%
Pacific	**2**	**2,400,000 €**	**0.03%**
Vanuatu	1	2,400,000 €	0.03%
Papua New Guinea	1	0 €*	0.00%
Asia	**4**	**51,300,000 €**	**0.73%**
Laos	2	15,000,000 €	0.21%
Vietnam	2	36,300,000 €	0.51%
Latin America	**4**	**172,100,000 €**	**2.44%**
Nicaragua	1	68,000,000 €	0.96%
Honduras	1	59,100,000 €	0.84%
Paraguay	1	23,000,000 €	0.33%
El Salvador	1	22,000,000 €	0.31%
Total	***93***	***5,071,836,756 €***	***71.93%***

' during the evaluation period no financial support has been contracted for the GBS decision. This is the case for GBS programmes that started before 2002. The programmes are nevertheless taken into account in the inventory as some support measures have been financed in the evaluation period.*

Figure 23: Health related GBS: Funds transferred per region during 2002-2010 (in € million)

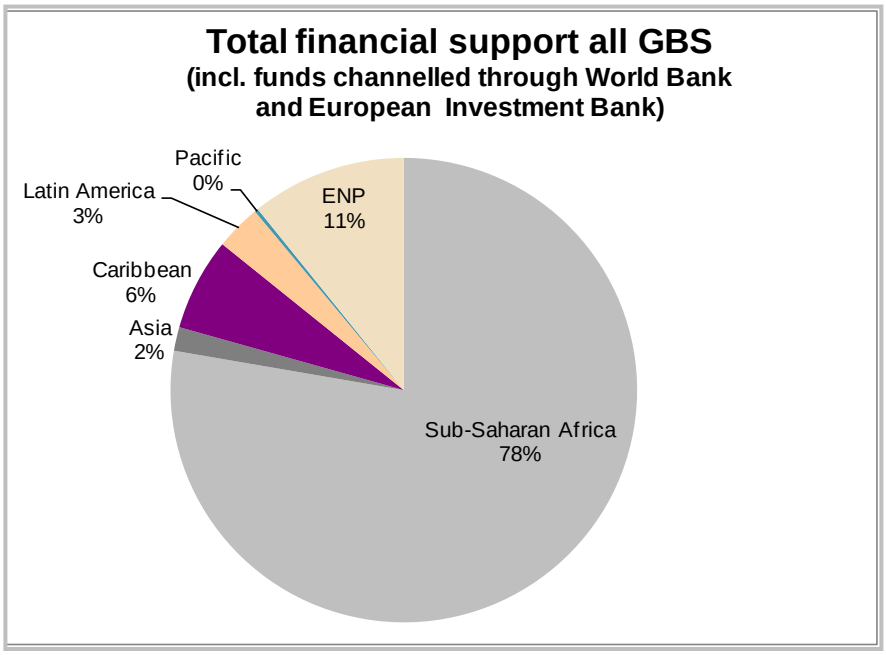


Source: CRIS database; Particip GmbH analysis

The six main beneficiary countries, all of them located in sub-Saharan Africa, accounted for 53.3% of the GBS referring to health sector. ´

As can be seen in the following figure, the great majority of the total GBS funds were transferred to ACP countries (78%), from the GBS with health related indicators, 91% of GBS went to ACP Sub-Saharan Africa.

Figure 24: Geographical distribution of all GBS funds

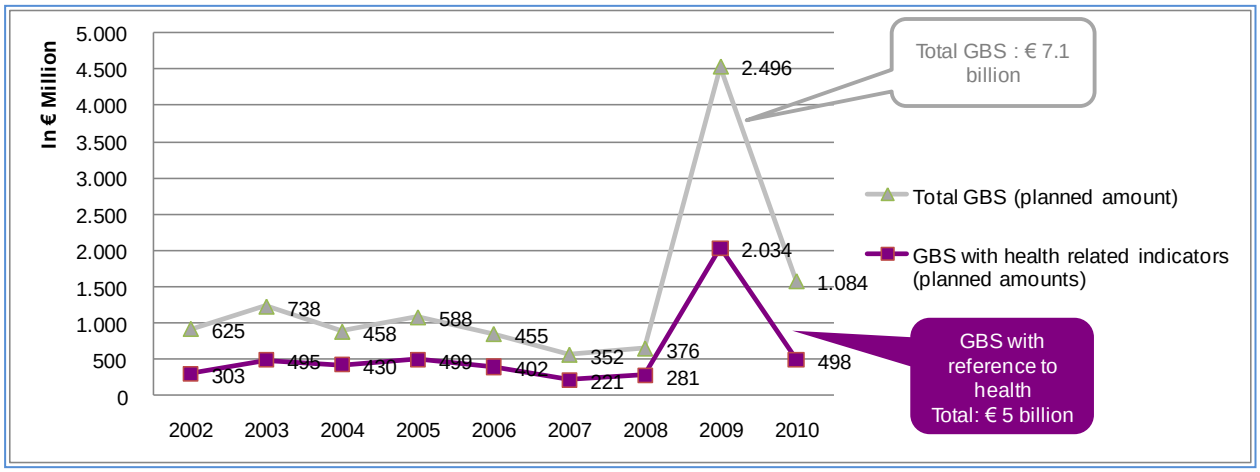


Source: CRIS data base; Particip GmbH analysis

1.3.3.3 Trends in the GBS funding modality

The figure below shows the trend in the amounts transferred through GBS between 2002 and 2010. It presents separately all GBS operations (158 for a total amount of € 7.1 billion) and those referring explicitly to the health sector (93 for a total amount of € 5 billion). Health-related GBS followed the overall trend of the GBS development which is slightly decreasing from 2002 to 2008 before reaching a disbursement peak in 2009. The considerable increase in 2009 is due to the introduction of the MDG contracts. A budget of € 1.5 billion is foreseen for this type of GBS contract and amounts to 42% of the GBS provided though the EDF.

Figure 25: Indirect EC support to the health sector: Trend in the amounts transferred through GBS (€ million), 2002-2010



Source: CRIS database; Particip GmbH analysis

1.3.3.4 GBS objectives

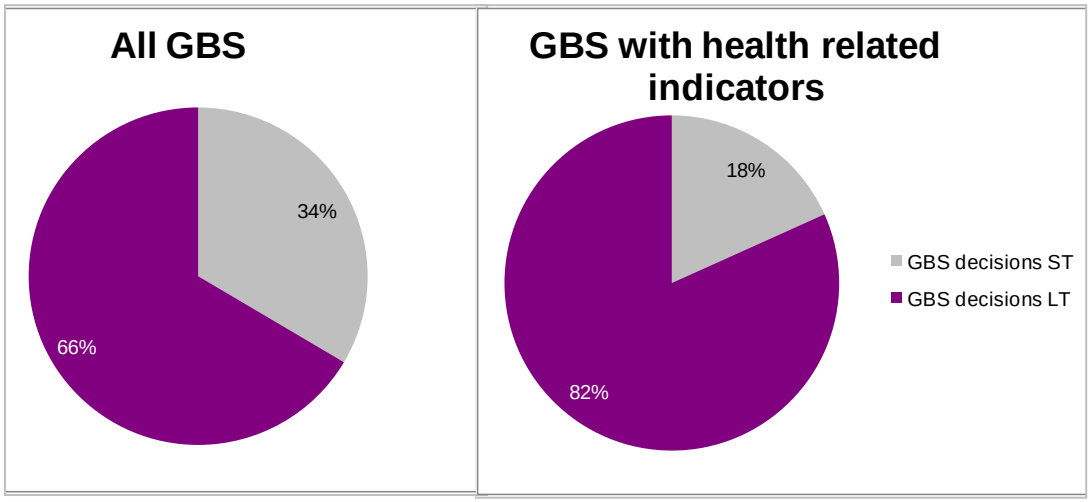
The GBS guidelines define two main categories of support to the national development or reform policy and strategy of the partner government[19]:

- **Short-term support for stabilisation and rehabilitation**[20]: This category comprises GBS for post-crisis countries, emerging from conflicts or natural disaster or GBS in order to balance fluctuation in export earnings, particularly in the agricultural or mining sectors.
- **Medium-term support to development or reform policies and strategies**[21]: This category comprises GBS to support the poverty reduction strategy or a MDG contract. For ENPI countries it supports association and economic convergence with the EU. GBS programmes may also have regional integration objectives.

The following figure shows the distribution between GBS with short and long term objectives for all GBS and in particular for those with a clear reference to the health sector. While 53 out of 158 GBS programmes have short term objectives, only 17 of the 93 GBS with a reference to the health sector belong to this category. This might be explained by the nature of short-term objectives GBS which provide funds for stabilisation or overcome of a crisis situation and not long-term development.

[19] European Commission (2007): Guidelines on the Programming, Design & Management of General Budget Support., p.16
[20] Ibid, p.16.
[21] This implies for ACP and DCI countries the support to the PRS or a MDG contract and for ENPI countries the support of association and economic convergence with the EU. All countries may also have regional integration objectives.

Figure 26: GBS with short term and long term objectives



Source: CRIS database; Particip GmbH analysis

1.3.4 Summary

This section proposes a wrap-up of the information in a schematic and detailed listing of facts and findings.

Between 2002 and 2010, the EC supported the health sector through direct and indirect support:

- Direct support to the health sector amounted to around € 4.1 billion.
- Indirect support in the form of GBS with reference to the health sector, among others, amounted to 5 € billion. This represents 72% of the total GBS transferred during the evaluation period.

The following **trends** can be observed:

- Direct support shows a serrated pattern, but with a trend towards increase (from levels of € 128 million in 2002 to € 805 million in 2006 and € 414 million in 2010);
- GBS referring to the health sector follows, in broad lines, the overall trend of GBS, i.e. a continuous increase from 2002 to 2010 and a disbursement peak in 2009. Only for 2010 the GBS related to health decreased in absolute amounts.

1) **Sectors**:

- Basic health is the sector supported most receiving 73% of the funds, of which 43% concern the delivery of basic health care and infrastructure and 27% the fight against the three PRDs.
- The second focus is on Health general (22%) out of which 70% concern the sub-sector policy and administrative management.
- SRH has received less attention representing only 5% of the total funds to support the entire health sector. The majority of these funds went to reproductive health (96%) and the remaining 4% to STDs. However as stated before in the report these figures should be interpreted with caution since only vertical RH programs have been identified in this category. Basic health contain many RH interventions that due to limitations couldn't be identified and labelled as such, Moreover, STDs exclude interventions that specifically target HIV/AIDS. These interventions have been counted under basic health. Further information about the sector classification used in the inventory can be consulted in section 0.
- Support to the basic health and health general sectors was increased significantly over the evaluation period

2) **Geographic distribution:**

- In absolute figures 63% of the direct support to the health sector went to the ACP (46%) and Asia region (17%), smaller shares went to ENP-South (14%), ENP-East (4%) and Latin America (2%).
- In relative terms, and compared to the EC's overall external assistance for each region, ACP is the main region benefiting from EC support to health (3% of the total amou**nt contracted in** this region was for health support). The EC support to health for the rest of the regions represents, in relative terms, around 1% for Asia, ENP-South and for "multi-regions". Yet, as these figures show, the overall share of direct support for health in overall direct support is very small.

- 42% of the funds went to 20 countries, nine ACP countries accounting for 17% of the funding, six Asian countries accounting for 13% of the funding, five ENP-South countries accounting for 12% and only one country from the ENP-East region accounting for 1%.
- Health-related GBS could be found in 45 countries, 39 in the ACP region, four in Latin America, and two in Asia. No GBS referring to health was implemented in the ENPI region. The six main beneficiary countries accounted for 53.3% of the GBS referring to health, among other sectors and were all located in the Africa.

3) **Aid Modalities**:

- Individual projects was by far the main modality used (45%), followed by the financing of trust funds (TFs) (24%).
- SBS operations represented 16% and SSP represented 15%, i.e. all forms of sector support together accounted for 31% of EC support to health.
- Over the period considered, the following trends in the use of each modality can be observed:
  - Support to the health sector through financing individual projects slightly increased throughout the evaluation period. The largest amount contracted through this modality occurred in 2006 and 2007, due to huge amounts contracted with WHO and other supranational organizations in order to support partnerships in relation to Health MDGs and interventions relating to Avian Influenza and Human Influenza Pandemic in ACP region An increase of more than € 200 million, from 2002 to 2006 (from € 84 million to € 327 million) followed by a progressively decrease (€ 135 million in 2009); and again a little increase in 2010 (€ 166 million).
  - TFs were quite steadily used over the evaluation period. Large contributions are observed every three years, in 2003 (€ 245 million), 2006 (€ 267 million) and in 2009 (€ 201 million). They represent 69% of the total funds financed through this modality.
  - The use of the SBS drastically increased from 2002 (€ 2 million) to 2009 (€ 203 million) and 2010 (€ 185 million), but overall this modality still occupies a modest position compared to projects.
  - For SSP, the largest contracted amounts can be observed in 2004 and in 2008, They are due to large contracts with the private sector such as “Appui à la gestion du secteur de la santé” in Morocco and with UN bodies to Support to the national health, nutrition and population Sector Programme in Bangladesh respectively.
  - For the period under evaluation, the general trend is towards a decrease. in GBS funds as well as a decrease of GBS with health related indicators.

4) **Channels**:

- 23% of the total funds went through governments, followed by 19% through private companies and development agencies.
- GFATM, NGOs and UN bodies are the second group of most important channels (respectively 17% and 13%).
- All other channels represent between 1-4% each of the totals funds.

5) **Disbursements**:

The overall disbursement level of direct support was of 75%, with disbursement rates varying by region, modality and channel. The highest disbursement rates (more than 80%) by region have been observed for Latin America (84%), “All region” (82%) and for ACP and ENP-East. ENP-South and Asia scored rather low with rates of 67% and 59% respectively. Concerning the modality, the financing of trust funds had the highest disbursement rate, with 100% of disbursements on the amount contracted. The support to sector programmes excluding SBS scores relatively high, with 86% while these rates are rather low for individual projects (69%) and SBS (48%). As regards the channel, multilateral organisations which mainly include the World Bank and UN bodies, GFATM, etc. show the highest disbursement rate (87%). The category “other channels” which mainly includes private companies and development agencies financed under budget lines, represent the group with the second highest disbursement rate of 77%, together with NGOs which scores the same. Private-public partnership, mainly GAVI, score lower with a disbursement rate of 75% and the public sector, mainly governments, scored the lowest (63%). To be noted is that high amounts (€ 483 million) have been contracted with governments at the end of the evaluation period (2002-2010) and only 28% of this amount (€ 134 million) had been disbursed at the date of the data extraction.

1.4 Appendix 1: Methodology applied for the inventory

1.4.1 The key challenges for constructing the inventory

Three key challenges had to be tackled for constructing this inventory.

- The **first challenge** is common to all mapping exercises for thematic evaluations and relates to the information source on which they are based. As mentioned in section 1.2, the main source for identifying interventions of the EC in the health sector is the EC's CRIS. The main limit to an inventory on the basis of CRIS is that the database does not offer the possibility to obtain a readily available list of all the EC financial contributions to the health sector. For instance, in many cases **no sector code** has been attributed to the interventions by EC staff.[22]
- A **second challenge** is related both to the use of CRIS and to the nature of the aid modalities used in the health sector. It is **not** possible to automatically identify in CRIS whether the EC's funds have been delivered through **SBS or using for instance a project approach**. Information on the type of modality used by the EC to deliver the aid is not encoded as such.
- The **third challenge** relates more specifically to the need to tackle GBS in the inventory. GBS, per se, are un-earmarked funds transferred to the national treasury of the beneficiary country to support its national development strategy. These funds are used by the country in accordance with its public financial management system. The funds provided by the EC through GBS are thus not directly supporting a particular sector. They might nevertheless be indirectly linked to a certain sector.

With a view to tackle these three key challenges, the evaluation team developed an approach which allowed to:

- Identify the relevant interventions in terms of EC's support to the health sector;
- Categorise these interventions by type of modality used;
- Identify those GBS that are relevant to the health sector.

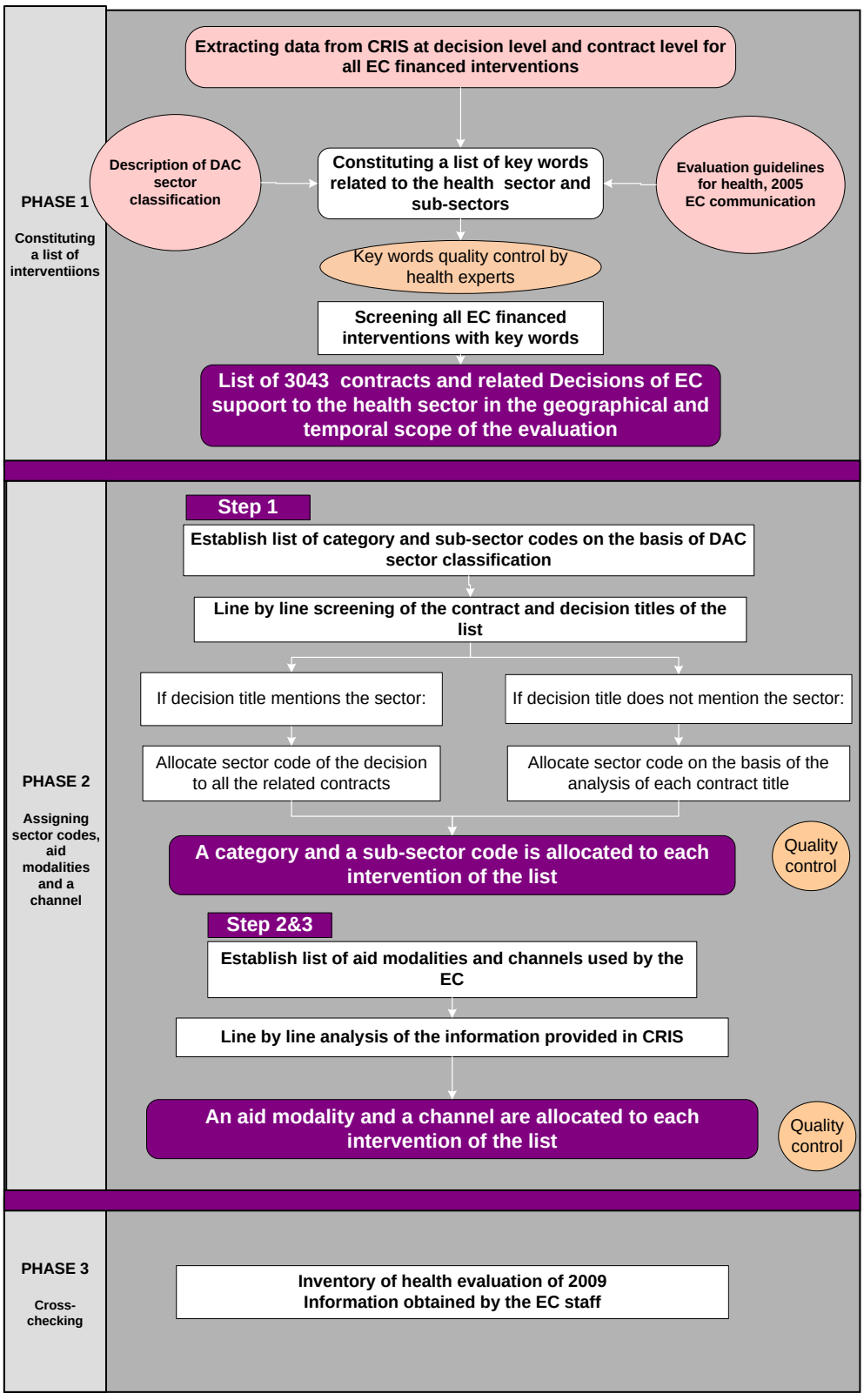
A distinction should be made in this respect between the approach developed to cover the direct support of the EC in the health sector and the indirect support (the GBS). Each of these approaches is further detailed hereafter.

1.4.2 Approach for producing an inventory on the "direct" support to the health sector

The figure below schematises the approach applied to mapping the EC support to the health sector. It included assigning relevant sector codes and showing which modalities and channels have been used.

[22] Only 25% of the interventions have a DAC sector code encoded in CRIS. This percentage has been calculated by the evaluation team on the basis of the data extraction from CRIS for all contracts signed by the EC between 2002 and 2010. Indeed, out of 65,534 contracts, only 16,094 contracts have a DAC sector code attributed.

Figure 27: Schematic approach to mapping EC support to health



As further explained hereafter, two main phases can be distinguished in this approach:

- Phase 1: constituting a list of interventions of EC support to the health sector;
- Phase 2: assigning a sector code to each intervention, identifying the type of modality and channel used.

1.4.2.1 Phase 1: Constituting a list of interventions of EC support to the health sector

As mentioned, the DAC sectors are not always encoded in CRIS. Thus, they could not serve as a basis to identify all interventions financed by the EC to support the health sector.

In order to identify the health related interventions, the evaluation team has undertaken a comprehensive and systematic screening of the information contained in the CRIS-database. The screening has been conducted using a set of key words, as is further explained below. The following individual steps had to be taken in order to constitute a list.

Step 1: Creating a dataset

CRIS does not provide a search option allowing a key word screening. Therefore, as a first step, the evaluation team extracted from CRIS the data at contract and decision level for all interventions financed by the EC between 2002 and 2010. The team then compiled these data in one single list that was suitable for key word screening.

Step 2: Creating a list of screening key words

In order to constitute a set of key words to capture interventions relevant to the health sector, the team systematically derived key words from the health DAC sector codes' descriptions and clarifications defined by the Organisation for Economic Co-operation & Development (OECD)[23] as a basic source. The set of key words obtained in this way is presented in the Appendix. Each key word was translated from English to French, Spanish and Portuguese, so as to be able to capture interventions which would have their title displayed in one of these languages. The list of key words was further checked by the health experts of the evaluation team.

Filters of expression that contains the list of the health related keywords to be systematically applied to the database were applied to select only data entries that included any of the relevant keywords. The set of filter of expression is presented in the Appendix 1.4.2.1.

They were then used to screen the titles of each decision and contract in the database in order to identify the ones falling within the health sector.

Step 3: Screening process

The initial screening process followed a three step approach.

- The 1st screening identified and eliminated interventions which were not in the geographical scope of the present evaluation. Following the Terms of Reference, the evaluation team defined the scope as follows:: *"The scope of the evaluation includes all third countries under the mandate of DG DEVCO, thus excluding the countries that are at the time recognised as being 'candidate countries' or 'potential candidate countries'" to the EU membership*.[24] The list of countries included in the scope, is provided in Appendix.
- The next step was to use the filters of expression (list of keywords) to screen the titles of both "decisions" and "contracts": The 2nd screening selected all contracts related to a decision that contained one of the key terms in its title.
- The 3rd screening selected all contracts related to the remaining decisions. Some decisions were entitled as, for example: "Third Reconstruction Programme for Afghanistan" under which some contracts are relevant to the health sector, such as "Health Care Support Programme - Nangarhar Province, Afghanistan", and some are not. Among these contracts, those that contained one of the key words in their title have been selected.

Step 4: Creating a specific health sector intervention data set

In order to ensure the correct selection of entries, the evaluation team manually checked the preliminary dataset produced through the screening process. A number of financially significant entries stemming from non-health specific sectors were selected through the keyword search. These entries could be classified into two groups:

[23] http://www.oecd.org/document/21/0,3343,en_2649_34447_1914325_1_1_1_1,00.html

[24] These countries are, following the definition of DG Enlargement: (http://ec.europa.eu/enlargement/the-policy/countries-on-the-road-to-membership/index_en.htm)

- "candidate countries": Croatia, Montenegro, Former Yugoslav Republic of Macedonia, Turkey, Iceland
- "potential candidate countries": Albania, Bosnia and Herzegovina, Serbia, Kosovo under UNSC Resolution 1244/99

According to the ToR "The activities in this domain [health] in candidate countries are evaluated within their proper agenda".

- Group1: Irrelevant data entries related to non-health sectors such as contracts to fight against hoof-and-mouth disease related to animal health.
- Group 2: Interventions related to health, but still not pertaining to the health sector strictly speaking, such as food security, water and sanitation, air pollution, drug control, and road safety.[25]

In the first case, irrelevant data have been eliminated manually while, in the second case, the evaluation team extracted them from the main inventory classification but still kept and reported them as contracts indirectly related to the health sector.

The resulting dataset serves as the basis for the analysis. It provides the following information:

- The Decision reference number
- The Decision title
- The contract reference number related to the Decision
- The contract title related to the Decision
- The contract start date (signature by the EC)
- The contract end date (expiry date of the contract)
- The amount contracted (in €)
- The amount paid (in €) – disbursements to the date of the extraction
- The geographical zone (country or region for regional interventions)
- The DAC sector (where encoded)
- The nature and the contract type
- The contracting party

1.4.2.2 Phase 2: Assigning a sub-sector to each intervention and identifying the modality used by the EC to deliver its aid

Step 1: Assigning a sector code

The final dataset obtained displayed the different "direct" interventions of the EC in the health sector. However, this list, due to non-encoding by EC staff, only to a very limited extend contained fields with "sectors" assigned for each contract such as "Basic health" or sub-sectors such as Basic health care and infrastructure" or "Infectious diseases"".

The sub-categories defined build on but also modified the standard DAC scheme to provide information relevant to the evaluation. The significant differences are:

- In the sector "Basic Health" we defined two sub-sectors: "HIV/AIDS" and a "Poverty related diseases" (HIV/AIDS, malaria, and TB) in order to better track the EU's significant contributions to the Global Fund and the contributions to each disease apart from the GFATM.[26]
- In the sector "SRH" we created a category covering sexually transmitted diseases excluding HIV/AIDS to better track the EC support to sexual and reproductive health.[27]

On the other hand, "Health, general" includes the same topics as defined by the DAC classification.

Table 4: Health sub-sector categories used for classification of interventions[28]

Name sector / subsectors	*Corresponding DAC code*	*Definition (adapted from DAC sectors - 2010)*
HEALTH	**120**	
Health, general	**121**	
1.Policy and administrative management	**12110:** Health policy and administrative management **13010:** Population policy and administrative management	Includes health and population policies as well as managerial and administrative training at government level (decentralized): (i) Health sector policy: planning and program; aid to health ministries, public health administration; institution capacity building and advice;

[25] Example: the Decision title: Rural Water Supply and Sanitation Programme Phase II" includes contracts such as "Improved health for remote highlands communities through WASH" or "Health through Improved Access to WASH on Nissan Island (ARB).

[26] Note, however, that research and development related to these diseases was classified under the research and development component of "Health, general."

[27] It should not be interpreted as an additive decomposition; any sum over all the categories must be adjusted to avoid double-counting HIV/AIDS.

[28] www.oecd.org

Name sector / subsectors	*Corresponding DAC code*	*Definition (adapted from DAC sectors - 2010)*
		medical insurance programs; unspecified health activities; (ii) Population/development policies; census work, vital registration; migration data; demographic research/analysis; reproductive health research; unspecified population activities.
2. Human Resources for health	**12181:**Medical Education and training **12281**: Health personnel development **13082**: Personnel development for population and reproductive health	Includes (I) education and training for administration and management at health services level (e.g., hospital directors, provincial nutrition officers, etc.); Training of health staff for basic health care services (e.g. generalist doctors/nurses) and secondary/tertiary care services (e.g. specialized medical doctors/nurses); Education and training of health staff for population (e.g. community health workers) and reproductive health care services (e.g. midwives)
3. Health Research and Development	**12182:** Medical research **13010:** Reproductive health research, Basic Health research, HIV/AIDS, TB, Malaria, etc.	Includes basic and specialized health related research; HIV/AIDS research; RH research; Malaria research; TB research; Internal Classification of Diseases (ICDs) research, vaccines research, pharmaceutical trials, etc.
4. Medical Services	**12191**:Medical services	Includes specialised clinics and hospitals (including equipment and supplies); ambulances; laboratories; dental services; mental health care; medical rehabilitation; control of non-infectious diseases; drug and substance abuse control [excluding narcotics traffic control (16063)].
Basic health	**122**	
6. Basic health care and infrastructure (primary)	**12220:** Basic health care **12230:** Basic health infrastructure **12261:** Health Education	Includes Basic and primary health care programs; paramedical and nursing care programs; health education programs, supply of drugs, medicines and vaccines related to basic health care; District-level hospitals, clinics and dispensaries and related medical equipment; excluding specialized hospitals and clinics (secondary and tertiary care).
7. Basic nutrition	**12240:** Basic nutrition (excluding EC Humanitarian Aid Department (ECHO) interventions)	Includes: feeding programs (maternal feeding, breast-feeding/weaning, school feeding); micro-nutrients interventions; nutrition/ food hygiene education; household food security; exclude: food distribution/emergency nutritional programs (mainly through ECHO)
8. Infectious disease control (IDCs)	**12250:** IDCs	Includes: (ii) IDCS: Immunization; prevention and control of infectious and parasite diseases, except malaria (12262), TB(12263), HIV/AIDS and other STDs (13040). It includes diarrheal diseases, vector-borne diseases (e.g. river blindness and guinea worm), viral diseases, mycosis, helminthiasis, zoonosis, diseases by other bacteria and viruses, pediculosis, etc.; exclude research (refer to sub-sector 3).
9. PRDs (together)	**12262**: Malaria **12263:** Tuberculosis HIV/AIDS	Includes: interventions targeting HIV/AIDS/TB/malaria together (e.g. GFATM)
10. Tuberculosis	**12263:** Tuberculosis	Includes: Immunisation, prevention and control of TB.
11. Malaria	**12262**: Malaria	Includes: Prevention and control of malaria.
12. HIV/AIDS		Includes: All activities related to HIV/AIDS control e.g. information, education and communication; testing; prevention; treatment, care.
Sexual and Reproductive Health	**130**	
13. STDs total (excluding HIV/AIDS)	**13040:** STD control	Includes: all activities related to sexually transmitted diseases control (e.g. information, education and communication; prevention; treatment and care
14. RH	**13020**: RH care	Promotion of RH; prenatal and postnatal care including delivery; safe motherhood activities; prevention and treatment of infertility; prevention and management of consequences of abortion; family planning services including counselling; information, education and

Name sector / subsectors	*Corresponding DAC code*	*Definition (adapted from DAC sectors - 2010)*
		communication (IEC) activities; delivery of contraceptives; (excluded research that refer to sector health general-subsector 3, and capacity building and training that refer to sector health general, subsector 2)

The process of assigning a sub-sector category to each intervention followed the general guidelines of the DAC on "Reporting on the purpose of aid," where it was stated that "*the sector of destination of a contribution should be selected by answering the question "which specific area of the recipient's economic or social structure is the transfer intended to foster."*[29] The evaluation team proceeded as follows:

First, the titles of the decisions were examined one by one. Three scenarios were encountered:

- *Scenario 1:* The decision title indicated clearly a sub-sector category: In this case all contracts related to this decision were classified under this sub-sector category[30];
- *Scenario 2:* The decision title clearly related to the entire health sector but not to a sub-sector in particular: In this case the contracts were examined one by one and classified under the corresponding sub-sector. [31]
- *Scenario 3:* The decision title did not allow assigning a sub-category at all: In this case the related contract titles were examined one by one. They were classified under a sub-category, if this category appeared in the title[32.]

This approach allowed assigning sub-sector categories to all interventions of the list.

A quality check for the allocation of the health sector and sub-sector codes has been undertaken[33]. Moreover, as called for in the Terms of Reference, additional cross-checking with the health sector inventory in the previous health evaluation has been carried out by the team.

Step 2: Identifying the aid modality used

The approach developed by the evaluation team to identify the aid modalities used for each intervention is based on the EC's classification of aid modalities and their definitions**. However, for the purpose of this evaluation and considering the information available in CRIS, the evaluation team has adapted the classification of aid modalities with the purpose of providing more detailed information for the analysis in the next phases of the evaluation**. The following paragraphs explain how this classification has been derived from the EC's definition of aid modalities and how each intervention has been classified under one specific aid modality.

The EC uses three types of approaches to deliver its aid: the project approach, the sector approach and macro/global approach[34]. The table summarizes the EC's definition of these approaches and the related financing modalities.

[29] http://www.oecd.org/document/21/0,3343,en_2649_34447_1914325_1_1_1_1,00.html

[30] Example: the decision title: "SUPPORT FOR STD AND HIV/AIDS ACTIVITIES IN NAMIBIA" was clearly related to the STD control including HIV/AIDS sub-sector, code 13040.

[31] Example: the decision title: "SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR" was clearly related to the entire health sector, but it did not indicate whether this programme was for the sector health, general, for the sector basic health care or for a sub-sector in particular.

[32] Example: the decision title: "Third Reconstruction programme for Afghanistan" did not indicate whether this programme was for the health sector in general. Therefore the contracts' titles under that decision were analysed and health sub-sectors codes were allocated for relevant contracts such as the DAC code 12220 (Basic health care) for the contract with the title: "Delivery of the Basic Package of Health Care Services in 1 cluster of 3 districts in Laghman Province."

[33] The list of interventions with the health sector and sub-sectors code allocated has been sent to the senior members of the evaluation team to check the sector allocation of the first 200 largest interventions. Countries selected for QA were those in which the experts had substantial experience.

[34] See the EuropeAid web site: http://ec.europa.eu/europeaid/how/delivering-aid/index_en.htm

Table 5: Description of aid delivery methods

Type of approach	Related financing modalities
Projects approach (individual projects)	"A **project** is a series of activities aimed at bringing about clearly specified objectives within a defined time period and with a defined budget." It is further explained that "the EC follows the project approach in particular to support initiatives outside the public sector, such as through CS and the private sectors."
Sector approach	"The European EC uses the **sector approach** as a way of working with partner governments, donors and other stakeholders. It ensures partner governments' ownership of development policy, strategy and spending. (…) As a result of following a sector approach, governments in consultation with partner donors and other stakeholders may develop a sector programme." It is further explained that the sector programme may use the following forms of financing : • **"SBS** is the modality of choice, wherever appropriate, and consists of a transfer of funds to the partner government national treasury to be used in pursuit of an agreed set of sector outputs and outcomes. • **Common pooled funds** or common basket funding (resources from a number of donors pooled using one agreed set of procedures) in support of a specific set of activities in the sector programme. Usually one donor will take responsibility for co-ordinating and managing the pooled funds. Funds are released by the donor to government according to agreed criteria. These types of funds can also be channel via a **national trust fund** through an international organisation, such as the World Bank. • **EC procedures** that follow contracting and procurement rules."
Macro/ global approach	"The European EC defines **BS** as the transfer of financial resources of an external financing agency to the national treasury of a partner country. These financial resources form part of the partner country's global resources, and are consequently used in accordance with its public financial management system." It is further explained that there are two main types of BS : • **"GBS**, representing a transfer to the national treasury in support of a national development or reform policy and strategy. • **SBS**, representing a transfer to the national treasury in support of a sector programme."

These categories needed however to be made more workable for this exercise. Indeed, "common pooled funds" and "EC procedures" cannot be differentiated in CRIS. Therefore, the team was using a similar but slightly different set of categories that have the advantage of being workable, while allowing for a comprehensive but mutually exclusive classification. These sets of categories have been adapted to the health sector and are presented in the table below, which cover the "direct" support of the EC to the health sector.

Table 6: Proposed classification, definition and typical characteristics of aid modalities used by the EC to deliver its "direct" (i.e. non-GBS) support to the health sector

Type of aid modality	Definition	Typical characteristics
SBS	As defined by the EC	• Support an entire sector or sub-sector • The partner government is the main actor and is the main direct beneficiary of the funds • Other limited number of actors are involved for audit, evaluation and/or technical assistance
SSP excluding SBS[35]	As defined by the EC under the sector approach but excluding SBS – "includes the modalities EC procurement and grant award procedures" "Common Pool Funds" and "National Trust Funds"	• Support an entire sector or sub-sector • Involve the partner government among other actors
Individual projects	As defined by the EC under project approach	• Does not support an entire sector or sub-sector • Initiative outside the public sector
Financing of Global Trust Funds	Contributions to Development Banks for regional or worldwide interventions, GAVI, GFATM specific to the health sector will be classified under this category	• Financial contributions managed by the Development Banks, GAVI, GFATM, etc.

[35] This term had to be created by the evaluation team in order to describe EC support to a sector or sub-sector that is not SBS, nor a project. The CRIS database does not allow proper identification of all Sector Policy Support Programmes (SPSP) directly. Therefore, this construct had to be chosen. The same has been used in the EC study "Monitoring of EU education and health expenditure in development countries (time scope 2007-2009).

Information on these aid modalities is not available in CRIS. However, CRIS provides some information that is related to typical characteristics of each modality. For instance, funds delivered through SBS are directly transferred to the partner government. This type of information can be found in CRIS, which identifies for each intervention the direct beneficiary of funds. This information alone is however not sufficient to conclude whether the intervention was SBS or GBS; in both cases, the direct beneficiary is the government. Therefore, other information such as the amount contracted, the title of the decision, the level of sector covered and the year of the contract , all of them provided in CRIS, needed to be analysed line by line to conclude whether an intervention was delivered through SBS or another type of modality. In the end, the CRIS sort for aid modality is only a heuristic first cut; there is no substitute for follow-up line-by-line checks to clear up ambiguous or problematic cases.

To be specific, the following four types of information provided in CRIS were taken into account: Title of the Decision, Amounts contracted, Name of the contractor, Title of the Contract. The table below lists the conditions that were applied to identify the aid modality.

Table 7: Information analysis provided in CRIS for each aid modality

Type of aid modality	***Information provided in CRIS***			
	Title of the Decision	***Amounts contracted***	***Name of contractor***	***Title of the contract***
SBS is allocated when:	Indication of SBS or a health sub-sector or the health sector as a whole	One very large amount compared to the other amount contracted under the same Decision	The largest amount contracted is to the partner government	Indication of SBS or limited number of contracts related to the same Decision (of which for audit, evaluation and/or technical assistance)
SSP (excluding SBS) is allocated when:	Indication of a health sub-sector or the health sector as a whole	*no specific condition*	All type of contractor but at least one of the amounts contracted is to the partner government or to an international organisation administrating a national trust fund.	Large number of contracts under the same Decision for constructions, services, supplies, etc.
Individual project is allocated when:	No indication of a health sub-sector or the health sector as a whole	*no specific condition*	All type of contractor except the partner government	Small number of contracts under the same Decision
Financing of Global Trust Funds is allocated when:	Indication of the organization(s) where the funding is directed	no specific condition	Development Banks, GFATM, GAVI	no specific condition

Step 3: Identifying the channel used

The identification of the channels used for each intervention was based on a contract by contract review of the field “contracting party” as defined in CRIS. For the purpose of this evaluation and considering the information available in CRIS, the evaluation team has grouped the numerous contracting parties in five categories based on the nature of the organisation. These categories are based on the CRIS, DAC form manual version 09.03. This manual indicates that two fields must be filled out in relation to channels. The 'Main Channel' which is mandatory in all cases and the 'Detailed Channel' depending on whether or not related values are available to further describe it. The “main channel“ includes five broad categories: Public sector; NGOs and civil society; Public-private partnership, Multilateral organizations and Other. The “detailed channel” includes a series of subcategories that group the different organizations according to their nature. A comprehensive list of these classification is available in the manual and it is presented as the annex 3 in the CRIS, DAC manual, vs. 09.03. The classification of the inventory uses the same type of categories, “main channel” and “detailed channel”. We have classified the organizations according to the list presented in the annex 3. Although this list is rather comprehensive it does not contain any field to classify private companies and development agencies as such. These types of organizations represent a big portion of the channels used by the EC. Therefore, the evaluation team have decided to keep track of them in the inventory by identifying them in the “detailed channel”. For the “main channel” the evaluation team have agreed to classify them taking into account whether they have been financed through budget lines or EDF. Thus, private companies/development agencies as such and universities have been classified under the main channel “public sector” when the instrument used to finance them

was EDF. When they implement the action being financed through budget lines they have been classified as "other channel", following the indications of the CRIS, DAC form manual vs 09.03 (section 3.3 page 17).

In general, the adapted classification of the channels for this inventory is as follows

Table 8: Channel classification of EC support to the health sector, 2002-2010

Main channel	Detailed channel[36]
• Public sector	• Beneficiary countries' national governments; Private companies or development agencies acting as such, contracted by governments under EDF.
• NGOs and civil societies	• International, national and local/regional NGOs,
• Public-private partnerships (PPPs)	• GAVI and the International partnership on microbicides.
• Multilateral organizations	• UN agencies, funds and commissions; other UN bodies refers to WHO, ILO and FAO; World Bank group; regional development banks and other multilateral such as GFATM or African Union.
• Other	• Private companies-development agencies and Research and educational institutions, when it is the institution implementing the action under a thematic budget line.

Source: CRIS database; Particip GmbH analysis

It is worth saying the EC should further encourage the use of the CRIS manual (above mentioned) among its staff. The current database does not show any classification of the channels however there is a clear description on how to fill them out in the manual. More efforts should be done in order to improve the quality and the availability of the data.

1.4.3 Approach for the "indirect" support to the health sector

As defined by the EC, GBS is "***General Budget Support**, representing a transfer to the national treasury in support of a national development or reform policy and strategy."*[37] The main direct beneficiary of funds transferred through GBS is thus the partner government. Other typical characteristics of GBS are:

- Support to the national development or poverty reduction strategy and not to a particular sector or sub-sector;
- Large (and mostly round) amounts contracted compared to interventions delivered through other aid modalities;
- The largest amounts contracted under the same Decision go to the partner government;
- Other limited number of contracting parties are involved, mainly for audit, evaluation and/or technical assistance,

Funds are intended to be used by the country in accordance with its public financial management system. While the funds provided by the EC through GBS are thus not supporting a particular sector directly, they might nevertheless be indirectly linked to a sector. For example, the EC might define performance indicators in a particular sector to guide the release of the so-called "variable tranches."[38] For a considerable number of GBS programmes, indicators refer to the health sector. This inventory thus looks

[36] The Annex 3 of the CRIS-DAC guideline, version 03.09, includes a comprehensive list of all agencies classified under per main channel. The detailed channel classification is based on this list.

[37] European Commission (2007): Guidelines on the Programming, Design & Management of General Budget Support.p.13.

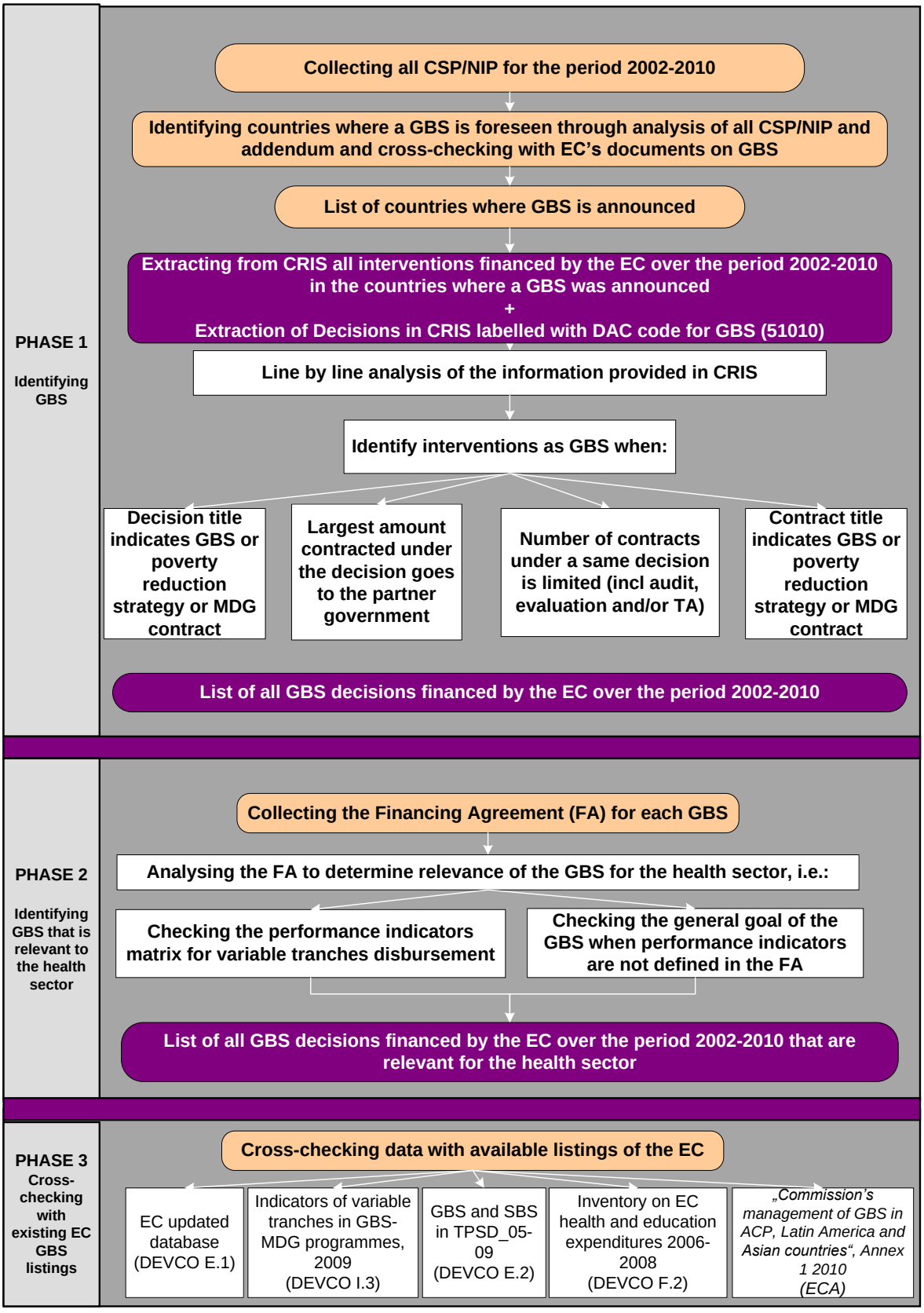
[38] GBS disbursements are made through the use of either fixed or variable tranches. According to the EC guidelines on GBS, fixed tranches have "a fixed value and are disbursed in full (if all conditions set in the Financing Agreement are met) or not at all." Variable tranches" have "a maximum value and are disbursed in full or in part with the amount being disbursed being based on performance achieved in relation to pre-specified targets or designated performance criteria and indicators."

into GBS programmes that are relevant to the health sector, i.e. GBS programmes in which performance indicators or general objectives related to the health sector. Identifying such indirect support required tackling two difficulties:

- First, an overview needed to be established of the EC's GBS provided during the period and in the countries covered by this evaluation. Such an overview on GBS has, to date, only been carried out in the framework of the "Thematic evaluation of EC support to the education sector" for the period 2000-2007. This list was completed for the years 2008-2010.
- Second, within these GBS programmes those that were relevant to the health sector had to be identified.

The approach developed is described in detail below. Its main steps are summarised in the following figure.

Figure 28: Approach used to identify GBS relevant to the health sector



1.4.3.1 Phase 1: Identifying EC's GBS

As explained above, CRIS does not automatically allow identifying all the GBS financed by the EC. Due to the amount of data in CRIS, it is not feasible to proceed with a line by line analysis of a complete extraction at contract and decision level[39]. Therefore, the team made a number of pre-selections with a view to limiting the number of lines to be analysed. In doing so, the team could rely on data collected especially by the "Thematic evaluation of EC support to the education sector".

Step 1: Pre-selecting potential decisions that relate to a GBS programme

For the evaluation period, no official list covering all GBS financed by the EC was available nor a list of countries covered by GBS programmes. In order to get the most complete possible list of GBS countries, several sources had to be combined. As the number of entries in such a list is relatively limited, the team could then proceed with a detailed line-by-line analysis in the CRIS database.

A) List of GBS generated through screening of CSP/NIP

CSP and/or NIPs usually announce if or not a GBS is foreseen during the period covered. Therefore, the first step was to establish a **list of the countries for which GBS was identified in the CSPs/NIPs**[40] over the evaluation period. 181 CSP/NIPs[41] were screened, 48 out of them had a GBS foreseen.

For the 48 countries in which a GBS had been announced, a CRIS extraction of all interventions financed was made. Through a **line-by-line analysis** the decisions related to GBS were identified (see description of the detailed screening process below).

Discussion with EC staff in charge of GBS revealed that this method was effective for ACP countries as GBS programmes are generally foreseen in the CSP/NIP or indicated in their updates following the mid- and end-term reviews. However, for countries outside the ACP region, GBS programmes were not systematically announced in the CSP/NIP.

B) List of GBS through extracting interventions labelled in CRIS with the DAC code for GBS

In order to overcome this problem, a complementary search was launched: A filter was applied to the CRIS database referring to the **DAC code for GBS interventions** (51010). This extraction complemented the GBS list provided via the CSP/NIP screening method.

As, especially for GBS before 2006, not all entries in CRIS are encoded with a DAC sector codes or use the DAC code 51010 exclusively to refer to GBS, this way of generating GBS lists remained rather limited, for the pre-2008 period, but yielding an additional 41 GBS programmes in 25 countries for the period 2008-2010.

C) Cross-checking the list of GBS programmes with various EC inventories

The evaluation team received several lists of GBS programmes[42], stemming from different units within DG DEVCO and from the European Court of Auditors (ECA). They had been established during studies or for internal accounting purposes.

Step 2: Screening GBS decisions

Based on our experience with the education evaluation, our intimate knowledge of CRIS and the broad cooperation programme, we know that number of countries receiving GBS in the evaluation period is situated between fifty and sixty. With the above mentioned distinctive features of GBS programmes it is feasible to identify through a thorough screening in the CRIS database the GBS programmes and their related contracts

In order to ensure the correct selection of GBS decisions, the evaluation team manually checked the dataset. For the screening process, the following criteria were used to decide whether an intervention could be considered as GBS:

- The title of the Decision indicated a GBS or a support to the national development or poverty reduction strategy or MDG;
- The largest amounts contracted under a same Decision went to the partner government;
- The number of contracts under a same Decision was limited and included audit, evaluation and/or technical assistance;

[39] For the evaluation period (2002-2010) the database contains approximately 90 000 entries (contract level).

[40] Which are available on DG EEAS and DG DEVCO web sites

[41] As the temporal scope of this evaluation covers the period 2002-2010, for the ACP regions, the CSPs for the 9th EDF (2002-2007) and the 10th EDF (2008-2013) were screened, while for the ALA, ENP-South and East (former TACIS and MEDA) countries the CSPs/NIPs related to the periods 2002-2006 and 2007-2013.

[42] All in all, the team received five different listings of GBS programmes, done by different Units of DEVCO at different time.

- The title of the contracts indicated a GBS or a support to the national development or poverty reduction strategy;
- The "nature" of the contract is labelled as "Financial Agreement", "not applicable" or "pro forma application (PE, BS)."

Where, after the screening process, doubts remained, the financing agreement of the decision was consulted to confirm of reject the label "GBS" for the intervention.

Subsequently, the team extracted all contracts related to the decision (contracts implemented between 2002 and 2010), thus generating a specific GBS data set. This set provides the following information:

- The decision number, title and year
- The contract number, title and year
- The geographical zone (country receiving GBS)
- The contracting party
- The contract type and nature of the contract
- The contracted and paid (disbursement to date of the extraction) amounts for the contract and the allocated for the decision (in Euro)
- The DAC-sector (when available)
- The Delegation in charge
- The status of the contract (ongoing, closed, chandelled, provisional or decided)

Step 3: Classifying GBS

The GBS programmes found are of heterogeneous nature. In order to be able to proceed to a finer analyse of the data, the evaluation team proceeded with a further classification based on the following two different aspects:

- GBS programmes (in the following text referred to as "GBS decision") and
- contracts related to a specific GBS decision.

This classification allowed producing a more differentiated picture on the objectives of the GBS as well as of the repartition of the funds between "funding towards the treasury" and other kinds of support.

Note: During the desk phase some further analysis of specific GBS programmes will be made.

1) Distinguishing between GBS programmes with short-term and GBS programmes with long term objectives

The GBS guidelines define two main categories of support to the national development or reform policy and strategy of the partner government[43]:

- **Short-term support for stabilisation and rehabilitation**[44]: This category comprises GBS for post-crisis countries, emerging from conflicts or natural disaster or GBS in order to balance fluctuation in export earnings, particularly in the agricultural or mining sectors.

➔ This type of support has been identified through the analysis of the budget lines through which the funds are provided (e.g. Food, Sucre, DCI-Food, DCI-Sucre, DCI-ENVI) or the decision title (e.g., disaster relief, emergency budgetary support).

- **Medium-term support to development or reform policies and strategies**[45]: This category comprises GBS to support the poverty reduction strategy or a MDG contract. For ENPI countries it supports association and economic convergence with the EU. GBS programmes may also have regional integration objectives.

➔ This type of support has been identified through an analysis mainly of the decision title.

In the case of doubts, the Financing Agreements of the GBS decisions were consulted.

2) Introducing categories to distinguish the nature of support through GBS

Three main categories were used to classify contracts related to GBS:

- Financial support (which represents the funds going to the treasury of the partner government via fixed or variable tranches). It must be noted, that a handful of GBS financial support are

[43] European Commission (2007): Guidelines on the Programming, Design & Management of General Budget Support., p.16
[44] Ibid, p.16.
[45] This implies for ACP and DCI countries the support to the PRS or a MDG contract and for ENPI countries the support of association and economic convergence with the EU. All countries may also have regional integration objectives.

channelled via International Organisations, namely the World Bank and the European Investment Bank. These cases have been labelled differently but counted in the financial support category.

- Technical support (technical assistance or capacity building measures related to the GBS).
- Other (including studies, evaluation, audits).

GBS contracts were classified by analysing the title of the contracts.

This second classification allowed a more differentiated view on the nature and provision of the funds, such as the relation between financial support and technical support.

1.4.3.2 Phase 2: Identifying the GBS programmes relevant to the health sector

Once all GBS programmes financed by the EC over the period 2002-2010 were identified, the remaining challenge was to identify those that were relevant to the health sector. As stipulated in the EC guidelines on General Budget Support[46], "*In supporting a national policy and strategy, GBS should be built around the fundamental goals the EC wishes to support."*

In this context, GBS was considered relevant to the health sector if it supported "fundamental goals" relating to the health sector. To determine whether it did so, the evaluation team analysed Financing Agreements (FAs) of the GBS concerned. **Two criteria were used by the team to decide whether the goals of a GBS were health sector relevant**:

- The performance indicators matrix for the release of the variable tranches referred to the health sector. As explained in the EC guidelines for General Budget Support, *"it is important to ensure that any strategic orientations set out in a national policy and strategy find their expression in a matrix of performance indicators."* If this matrix included health indicators, the team considered that this particular GBS was relevant to the health sector;
- When performance indicators were not defined in the FA, but when the general goals of the GBS explicitly referred to the health sector, the GBS was considered as relevant to the health sector.

These steps allowed the team to estimate the proportion of GBS funds that had an explicit link to the health sector.

1.4.4 Limitations and constraints

The following limitations should be taken into account for both inventories when assessing the reliability and accurateness of the inventory:

- The weaknesses of CRIS described above can be addressed, but not entirely eliminated.
- The approach developed and applied to identifying interventions receiving direct support has the following specific limitations:
  - The method of filtering data by keywords is limited by the identification of the keywords themselves; however, the data cross-checking with previous health inventories and internal work of the EC services in charge of health helped the team to obtain the most comprehensive inventory.
  - Some areas of intervention, e.g. water and sanitation, road safety, and air pollution to take only three, contribute to human health in beneficiary countries but are not even remotely covered by the DAC definitions of health interventions. We have proposed the limited set presented here in order to make the evaluation manageable, to the point, and in line with the Terms of Reference.
- The approach developed and applied to identifying interventions receiving indirect support has the following specific limitations:
- The approach starts with the assumption that GBS were foreseen in the CSP/NIP and/or indicated in a related addendum following the mid- and end-term reviews. Although it is considered as the best possible approach to delimit the number of interventions to be screened line by line in order to identify GBS in CRIS, the evaluation team is aware of the possibility that some GBS, especially outside the ACP area, might not have been identified because they were not mentioned in the CSPs/NIPs. However, cross-checking with EC documents on GBS as well as the extraction of interventions labelled with the GBS DAC-code allowed the team to identify a considerable number of the EC's financed GBS programmes that were missed by the survey of CSPs / NIPs.
- It is not possible to estimate reliably how much GBS funding went to support the health sector. However, it was possible, using clear criteria, to determine whether a GBS programme was

[46] European Commission (2007): Guidelines on the Programming, Design & Management of General Budget Support.

relevant to the health sector or not. These were based exclusively on information displayed in the FA. The analysis of the FAs for GBS allowed the team to identify the goals the EC wished to support when providing the funds. However, it is not possible to analyse whether these funds actually did support the health sector and, at this stage of the evaluation, whether the disbursements of these funds was made based on improved health performance indicators set in the FA. **It is important to underline that no judgment can be made of the amount that effectively went to the health sector in GBS with health related indicators. It can only be stated that the amount refers to those GBS for which the EC in one way or another pursued goals for the health sector, among other sectors.**

1.5 Appendix 2: List of key words and country selection

1.5.1 List of Key words

Filter for searching for health-related data:

Filter1	**Filter 2**	**Filter 3**
Like "*health*" OR	Like "*sexual*" OR	Like "*drug*" OR
Like "*illness*" OR	Like "*disease*" OR	Like "*medic*" OR
Like "*hospital*" OR	Like "*prevention*" OR	Like "*doctor*" OR
Like "*sanitary*" OR	Like "*blood*" OR	Like "*family*" OR
Like "*clinic*" OR	Like "*transfusion*"	Like "*morbidity*" OR
Like "*blind*" OR	Like "*virus*" OR	Like "*mortality*" OR
Like "*influenza*" OR	Like "*infection*" OR	Like "*mother*" OR
Like "*flu*" OR	Like "*Microbicides*" OR	Like "*maternal*" OR
Like "*Cancer*" OR	Like "*global fund*" OR	Like "*neonatal*" OR
Like "*nutrition*" OR	Like "*GFATM *" OR	Like "*medical*" OR
Like "*allergy*" OR	Like "*vaccination*" OR	Like "*handicapped*" OR
Like "*HIV*" OR	Like "*vaccines*" OR	Like "*disabled*" OR
Like "*AIDS*" OR	Like "*immunisation*" OR	Like "*care*" OR
Like "*tuberculosis*" OR	Like "*immunization*" OR	Like "*Therapeutic*" OR
Like "*malaria*" OR	Like "*inoculation*"OR	Like "*Mental*" OR
Like "*Chagas*" OR	Like "*global alliance*" OR	Like "*Psychosocial*" OR
Like "*trypanosomiasis*" OR	Like "*GAVI *" OR	Like "*reproductive*" OR
Like "*Tsetse*" OR	Like "*UNAIDS *" OR	Like "*trauma*" OR
Like "*leishmaniasis*" OR	Like "*WHO *" OR	Like "*contraceptive*" OR
Like "*Schistosomiasis*" OR	Like "*epidemic*" OR	Like "*addiction*"OR
Like "*respiratory*" OR	Like "*pandemic*" OR	
Like "*diarrhoeal *" OR	Like "*outbreak*" OR	
Like "*lymphatic *" OR		
Like "*filariasis*" OR		
Filter 4 FR	**Filter 5 FR**	**Filter 6 FR**
Like "*sante*" OR	Like "*sexuel*" OR	Like "*medicament*" OR
Like "*maladie*" OR	Like "*prevention*" OR	Like "*drogue*" OR
Like "*hopitale*" OR	Like "*sang*" OR	Like "*medecine*" OR
Like "*hopitaux*" OR	Like "*transfusion*" OR	Like "*famille*" OR
Like "*sanitaire*" OR	Like "*transfussion *" OR	Like "*mortalite*" OR
Like "*clinique*" OR	Like "*virus*" OR	Like "* morbidité *" OR
Like "*cecite*" OR	Like "*infection*" OR	Like "*mere*" OR
Like "*influenza*" OR	Like "*infectieuse*"	Like "*maternelle*" OR
Like "*epidemie*" OR	Like "*Microbicides*" OR	Like "*néonatale*" OR
Like "*pandemie*" OR	Like "*fonds mondial*" OR	Like "*medicale*" OR
Like "*Cancer*" OR	Like "*GFATM *" OR	Like "*PNLS*" OR

Like "*nutrition*" OR Like "*allergie*"*" OR Like "*HIV*" OR Like "*SIDA*" OR Like "*tuberculose*" OR Like "*paludisme*" OR Like "*Chagas*" OR Like "*trypanosomiase*" OR Like "*tsé-tsé*" OR Like "*leishmaniose*" OR Like "*Schistosomiase*" OR Like "*Respiratoire*" OR Like "*Diarrhéiques*" OR Like "*Lymphatique*" OR Like "*filariose*" OR	Like "*vaccination*" OR Like "*vaccine*" OR Like "*vaccins*" OR Like "*immunisation*" OR Like "*inoculation*" OR Like "*alliance mondiale*" OR Like "*GAVI *" OR Like "*UNAIDS *" OR Like "*OMS *" OR	Like "*handicape*"OR Like "*soin*" OR Like "*Thérapeutique*" OR Like "*mental*" OR Like "*Psychosociaux Like "*reproducti*" OR Like "*trauma*" OR Like "*contraceptif*" OR Like "*toxicoman*" OR Like "*addiction*"*" OR
Filter 7 SP Like "*salud*" OR Like "*sanidad*" OR Like "*enfermedad*" OR Like "*hospital*" OR Like "*sanitario*" OR Like "* clínic*" OR Like "*cieg*" OR Like "*ceguera*" OR Like “*gripe*” OR Like "*epidemia *" Like "*pandemia*" OR Like "*Cancer*" OR Like "*nutricion*" OR Like "*alergia*" OR Like "*VIH*" OR Like "*SIDA*" OR Like "*tuberculosis*" OR Like "*malaria*" OR Like "*Chagas*" OR Like "*trypanosomiasis*" OR Like "*Mosca tse-tsé*" OR Like "*leishmaniasis*" OR Like "*Esquistosomiasis*" OR Like "*respiratorio*" OR Like "*Diarrea*" OR Like "*linfático*" OR Like "*filariasis*" OR	**Filter 8 SP** Like "*sexuel*" OR Like "*prevencion*" OR Like "*sangre*"*" OR Like "*transfusion*" OR Like "*virus*" OR Like "*infeccion *" OR Like "*infeccios *" OR Like "*Microbicidas*" OR Like "*fondo mundial*" OR Like "*GFATM *" OR Like "*vacunacion*" OR Like "*vacuna*" OR Like "*inmunizacion*" OR Like "*inoculacion*" OR Like "*alianza mundial*" OR Like "*GAVI *" OR Like "*UNAIDS *" OR Like "*OMS *" OR	**Filter 9 SP** Like "*medicina*" OR Like "*doctor*" OR Like "*familia*" OR Like "*morbilidad*" OR Like "*mortalidad*" OR Like "*madre*" OR Like "*maternal*" OR Like "*neonatal*" OR Like "*medico*" OR Like "*minusvalid*" OR Like "*discapacitad*" OR Like "*atencion*" OR Like "*cuidado*" OR Like "*assistencia*" OR Like "*terapeutic*" OR Like "*Mental*" OR Like "*Psicosocial Like "*reproduct*" OR Like "*trauma*" OR Like "*anticonceptivo*" OR Like "*toxicoman*" OR Like "*adiccion *" OR
Filter 10 PT Like "* saúde*" OR Like "*doenca*" OR Like "*hospital*" OR Like "*sanitario*" OR Like "*clínic*" OR	**Filter 11 PT** Like "*sexuel*" OR Like "*prevenção*” OR Like "*sangue*" OR Like "*transfusão*" OR Like "*virus*" OR	**Filter 12 PT** Like "*medicina*” OR Like "*medico*” OR Like "*família*" OR Like "*morbidade*" OR Like "*mortalidade*" OR

Like "*cego*" OR	Like "*infecção*” OR	Like "* mãe*" OR
Like "*cegueira*" OR	Like "*infecciosas*" OR	Like "* maternal*" OR
Like "*gripe*" OR	Like "*Microbicidas*" OR	Like "*neonatal*" OR
Like "*epidemia*" OR	Like "* Fundo Global*" OR	Like "*medico*” OR
Like "*pandemia*" OR	Like "*GFATM *" OR	Like "*deficiência*" OR
Like "*Cancer*" OR	Like "*vacinação*" OR	Like "*deficientes*" OR
Like "*Nutrição*" OR	Like "*vacina*" OR	Like "*atenção*" OR
Like "*alergia*" OR	Like "*imunização*" OR	Like "*cuidado*" OR
Like "*HIV*" OR	Like "*inoculação*" OR	Like "*Terapêuticos*" OR
Like "*sida*" OR	Like "*GFATM *" OR	Like "*mental*" OR
Like "*tuberculose*" OR	Like "* Aliança Global* OR	Like "*Psicossocial*" OR
Like "*malaria*" OR	Like "* Fundación GAVI*” OR	Like "*reprodução*” OR
Like "*Chagas*" OR	Like "*UNAIDS *" OR	Like "*"trauma*” OR
Like "*tripanossomíase*" OR	Like "*OMS *" OR	Like "*contracepção*" OR
Like "* tsé-tsé" OR		Like “*toxicoman*" OR
Like "*leishmaniose*" OR		Like "*addiction*" OR
Like "*Esquistossomose*" OR		Like "*clínicos*" OR
Like "*Respiratório*" OR		
Like "*Diarréicas*" OR		
Like "*Linfático*" OR		
Like "*filariose*" OR		

LIST OF POSSIBLY UNSPECIFIC KEYWORDS:

Filter 11

Like "*rehabilitacion*" OR
Like "*rehabilitation*" OR
Like "*rehabilitation*" OR
Like "*child*" OR
Like "*infantile*" OR
Like "*infantil*" OR
Like "*enfant*" OR
Like "*traitement*" OR
Like "*tratamiento*" OR
Like "*treatment*"*" OR
Like "*avian*" OR
Like "*aviar*" OR
Like "*aviaire*" OR
Like "*swine*" OR
Like "*porc*" OR
Like "*cerdo*" OR
Like "*suína*" OR

1.5.2 Filter of expression for searching health-related data

Fields where to apply keywords: **Title-Decision; Title-Contract; Domain; Contracting party.**

Title-Decision; Title-Contract:

Filter 1: Like "*health*" OR Like "*santé*" OR Like "*salud*" OR Like "* saúde*" OR Like "*sanidad*" OR Like "*illness*" OR Like "*disease*" OR Like "*maladie*" OR Like "*enfermedad*" OR Like "*doenca*" OR Like "*hopit*" OR Like "*hospital*" OR Like "*clinique*" OR Like "*clinic*" OR Like "*sanitar*"

Filter 2: Like "*blind*" OR Like "*cecite*" OR Like "*cancer*" OR Like "*nutri*" OR Like "*allerg*" OR Like "*alergi*" OR Like "*respirator*" OR Like "*Diarr*" OR Like "*influenza*" OR Like "*flu*" OR Like "*grip*" OR Like "*epidem*" OR Like "*pandem*" OR Like "*outbreak*"

Filter 3: Like "*HIV*" OR Like "*VIH*" OR Like "*AIDS*" OR Like "*SIDA*" OR Like "* PNLS*" OR Like "*tuberculos*" OR Like "*malaria*" OR Like "*paludism*" OR Like "*Chagas*" OR Like "*trypanosom*" OR Like "*Tsetse*" OR Like "*tsé-tsé*" OR Like "*leishmani*" OR Like "*Schistosom*" OR Like "*Esquistos*" OR Like "*tripanossomíase*" OR Like "*tripanossomíase*" OR Like "*Choler*"

Filter 4: Like "*sex*" OR Like "*reprod*" OR Like "*trauma*" OR Like "*contracep*" OR Like "*anticonceptivo*" Like "*preven*" OR Like "*blood*" OR Like "*transfus*" OR Like "*virus*" OR Like "*infec*" OR Like "*Microbicides*" OR Like "*vaccin*" OR Like "*vacuna*" OR Like "*vacina*" OR Like "*inmuniza*" OR Like "*immunisation*" OR Like "*inocul*"

Filter 5: Like "*drug*" OR Like "*drogue*" OR Like "*medecine*" OR Like "*medic*" OR Like "*doctor*" OR Like "*famil*" OR Like "*morbid*" Like "*morbilidad*" OR Like "*mortal*" OR Like "*mother*" OR Like "*mere*" OR Like "*madre*" OR Like "* mãe*" OR Like "*matern*" OR Like "*neonat*"

Filter 6: Like "*handicap*" OR Like "*disabled*" OR Like "*minusvali*" OR Like "*discapaci*" OR Like "*deficien*" OR Like "*care*" OR Like "*soin*" OR Like "*aten*" OR Like "*cuidado*" OR Like "*asistencia*" OR Like "*therapeutic*" OR Like "*terapeutic*" OR Like "*Mental*" OR Like "*Psychol*" OR Like "*Psicol*" OR Like "*addiction*" OR Like "*adiccion*" OR Like "*toxicoman*"

Contracting partners:

Filter 7: Like "*global fund*" OR Like "* Fundo Global*" OR Like "*fondo mundial*" Like "*fonds mondial*" OR Like "*GFATM *" OR Like "*global alliance*" OR Like "*alianza mundial*" OR Like "*alliance mondiale*" OR Like "*GAVI *" OR Like "*UNAIDS *" OR Like "*WHO *" OR Like "*OMS *"

Filter 8: Domain : Like "*health*" OR Like "*sante*" OR Like "*salud*" OR Like "* saude*" OR Like "*sanidad*"

LIST OF UNSPECIFIC KEYWORDS:

Filter 8:

Like "*rehabilita*" OR Like "*child*" OR Like "*infantil*" OR Like "*enfant*" OR Like "*traitement*" OR Like "*tratamiento*" OR Like "*treatment*"

1.5.3 List of countries in the scope of the present evaluation

Country code	Country	Region
AO	ANGOLA	Africa
BJ	BENIN	Africa
BW	BOTSWANA	Africa
BF	BURKINA FASO	Africa
BI	BURUNDI	Africa
CM	CAMEROON	Africa
CV	CAPE VERDE	Africa
CF	CENTRAL AFRICAN REPUBLIC	Africa
TD	CHAD	Africa
KM	COMOROS	Africa
CG	CONGO	Africa
CD	CONGO, THE DEMOCRATIC REPUBLIC OF THE	Africa
CI	CÔTE D'IVOIRE	Africa
DJ	DJIBOUTI	Africa
GQ	EQUATORIAL GUINEA	Africa
ER	ERITREA	Africa
ET	ETHIOPIA	Africa
GA	GABON	Africa
GM	GAMBIA	Africa
GH	GHANA	Africa
GN	GUINEA	Africa
GW	GUINEA-BISSAU	Africa
KE	KENYA	Africa
LS	LESOTHO	Africa
LR	LIBERIA	Africa
MG	MADAGASCAR	Africa
MW	MALAWI	Africa
ML	MALI	Africa
MR	MAURITANIA	Africa
MU	MAURITIUS	Africa
MZ	MOZAMBIQUE	Africa
NA	NAMIBIA	Africa
NE	NIGER	Africa
NG	NIGERIA	Africa
RW	RWANDA	Africa
SN	SENEGAL	Africa
SC	SEYCHELLES	Africa
SL	SIERRA LEONE	Africa
SO	SOMALIA	Africa
ZA	SOUTH AFRICA	Africa
SD	SUDAN	Africa
SZ	SWAZILAND	Africa
TZ	TANZANIA, UNITED REPUBLIC OF	Africa
TG	TOGO	Africa
UG	UGANDA	Africa
ZM	ZAMBIA	Africa
ZW	ZIMBABWE	Africa
AF	AFGHANISTAN	Asia
BD	BANGLADESH	Asia
BT	BHUTAN	Asia
KH	CAMBODIA	Asia

Country code	Country	Region
CN	CHINA	Asia
IN	INDIA	Asia
ID	INDONESIA	Asia
KZ	KAZAKHSTAN	Asia
KG	KYRGYZSTAN	Asia
LA	LAO PEOPLE'S DEMOCRATIC REPUBLIC	Asia
MY	MALAYSIA	Asia
MV	MALDIVES	Asia
MN	MONGOLIA	Asia
MM	MYANMAR	Asia
NP	NEPAL	Asia
PK	PAKISTAN	Asia
PH	PHILIPPINES	Asia
LK	SRI LANKA	Asia
TJ	TAJIKISTAN	Asia
TH	THAILAND	Asia
TM	TURKMENISTAN	Asia
UZ	UZBEKISTAN	Asia
VN	VIET NAM	Asia
AG	ANTIGUA AND BARBUDA	Caribbean
BS	BAHAMAS	Caribbean
BB	BARBADOS	Caribbean
BZ	BELIZE	Caribbean
DM	DOMINICA	Caribbean
DO	DOMINICAN REPUBLIC	Caribbean
GD	GRENADA	Caribbean
GY	GUYANA	Caribbean
HT	HAITI	Caribbean
JM	JAMAICA	Caribbean
KN	SAINT KITTS AND NEVIS	Caribbean
LC	SAINT LUCIA	Caribbean
VC	SAINT VINCENT AND THE GRENADINES	Caribbean
SR	SURINAME	Caribbean
TT	TRINIDAD AND TOBAGO	Caribbean
DZ	ALGERIA	ENP
AM	ARMENIA	ENP
AZ	AZERBAIJAN	ENP
BY	BELARUS	ENP
EG	EGYPT	ENP
GE	GEORGIA	ENP
IL	ISRAEL	ENP
JO	JORDAN	ENP
LB	LEBANON	ENP
LY	LIBYAN ARAB JAMAHIRIYA	ENP
MD	MOLDOVA, REPUBLIC OF	ENP
MA	MOROCCO	ENP
PS	PALESTINIAN TERRITORY, OCCUPIED	ENP
RU	RUSSIAN FEDERATION	ENP
SY	SYRIAN ARAB REPUBLIC	ENP
TN	TUNISIA	ENP
UA	UKRAINE	ENP
IR	IRAN, ISLAMIC REPUBLIC OF	Gulf
IQ	IRAQ	Gulf

Country code	Country	Region
YE	YEMEN	Gulf
AR	ARGENTINA	Latin America
BO	BOLIVIA, PLURINATIONAL STATE OF	Latin America
BR	BRAZIL	Latin America
CL	CHILE	Latin America
CO	COLOMBIA	Latin America
CR	COSTA RICA	Latin America
EC	ECUADOR	Latin America
SV	EL SALVADOR	Latin America
GT	GUATEMALA	Latin America
HN	HONDURAS	Latin America
MX	MEXICO	Latin America
NI	NICARAGUA	Latin America
PA	PANAMA	Latin America
PY	PARAGUAY	Latin America
PE	PERU	Latin America
UY	URUGUAY	Latin America
VE	VENEZUELA	Latin America
CK	COOK ISLANDS	Pacific
FJ	FIJI	Pacific
KI	KIRIBATI	Pacific
MH	MARSHALL ISLANDS	Pacific
NR	NAURU	Pacific
NU	NIUE	Pacific
PW	PALAU	Pacific
PG	PAPUA NEW GUINEA	Pacific
WS	SAMOA	Pacific
SB	SOLOMON ISLANDS	Pacific
TL	TIMOR-LESTE	Pacific
TO	TONGA	Pacific
TV	TUVALU	Pacific
VU	VANUATU	Pacific

1.5.4 List of interventions financed by the EC to support the health sector between 2002 and 2010

This list of all interventions financed by the EC in the health sector between 2002 and 2010[47] and falling within the geographical scope of the evaluation[48] were extracted from CRIS using the key words screening approach, as detailed in the report. This list provides the following information:

- The Decision reference number
- The Decision title
- The contract title related to the Decision
- The contract reference number related to the Decision
- The contract start date (signature by the EC)
- The contract end date (expiry date of the contract)
- The amount contracted (in €)
- The amount paid (in €) – disbursements to the date of the extraction

[47] The date of signature of the contract by the EC was used to determine the interventions falling within the temporal scope of the evaluation

[48] All regions where EC co-operation is implemented with the exception of regions and countries under the mandate of DG Enlargement

- The status of the contract
- The contracting party
- The nature and the contract type
- The DAC sector
- The geographical zone (country or region for regional interventions)
- The Domain
- The modality used by the EC to deliver its aid
- The channel category used by the EC to get its aid delivered
- The financing instrument
- The disbursement rate

Due to the volume of information the table is not included as annex to this report.

1.5.5 List of general budget support financed by the EC between 2002 and 2010

This annex lists all the GBS programmes which have contracts launched in the evaluation period[49] (2002-2010) and falling within the geographical scope of the evaluation[50]. They were extracted from CRIS using the specific approach explained in the report.

This list provides the following information:

- The country and region where the GBS is implemented
- The decision number of the GBS programme
- The decision year
- The decision title
- The contracted amount for financial support as well as for technical and other support in the evaluation period
- The contracted amount for the "indirect GBS programmes" i.e. channelled through international organisations for the evaluation period
- The GBS programme's objectives and, if relevant, the main short term objective
- Information whether the GBS programme has health related performance indicators or health-objectives

[49] The date of signature of the contract by the EC was used to determine the interventions falling within the temporal scope of the evaluation

[50] All regions where EC co-operation is implemented with the exception of regions and countries under the mandate of DG Enlargement

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
Africa	Benin	FED/1999/014-629	1999	Appui a l'ajustement structurel (PAS 3 1999/2000) - PIN		51.012 €		ST	Structural adjustment & Economic Stabilisation	yes
Caribbean	Jamaica	FED/1999/014-693	1999	Support for economic reform programme (SERP)		895.672 €		LT		yes
Africa	Madagascar	FED/1999/014-400	1999	Appui au programme d'ajustement structurel (PAS II -99/2000)		446.209 €		ST	Structural adjustment & Economic Stabilisation	yes
Africa	Malawi	FED/1999/014-528	1999	Structural adjustment support (SAF IV : 99/01) – PIN	15.490.000 €	34.143 €		LT	Structural adjustment & Economic Stabilisation	yes
Africa	Senegal	FED/1999/014-527	1999	Appui budgétaire direct a l'ajustement structurel (FAS 99/00)	25.300.000 €	266.601 €		ST	Structural adjustment & Economic Stabilisation	yes
Africa	Benin	FED/2000/015-220	2000	Programme appui reformes économiques 2001 (PARE 2001)	8.423.610 €	74.234 €		LT		yes
Africa	Burkina Faso	FED/2000/015-219	2000	Appui budgétaire reduction pauvrete 2001 (ABRP 2001)		38.323 €		LT		yes
Africa	Cameroon	FED/2000/015-224	2000	Programme appui budgetaire lutte contre la pauvretî 2000-2001	18.010.000 €	983.892 €		LT		yes
Africa	Central African Republic	FED/2000/015-206	2000	Programme appui ajustement structurel 2000/2001	4.400.000 €	1.628.327 €		ST	Structural adjustment&Economic Stabilisation	yes
Africa	Chad	FED/2000/015-225	2000	Poverty reduction budgetary support programme (PRBSP	22.452.379 €	920.434 €		LT		yes

[51] All the contacts between 2002 and 2010 have been listed in this inventory. This applies also for contracts that relates to a decision taken before 2002.

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
				01/02)						
Africa	Djibouti	FED/2000/015-263	2000	Programme appui reformes économiques (PARE III 2000/2002)	3.708.355 €	162.963 €		LT		yes
Africa	Gambia	FED/2000/014-793	2000	Structural adjustment support programme (SAF I)		111.390 €		ST	Structural adjustment&Economic Stabilisation	no
Africa	Guinea-Bissau	FED/2000/015-066	2000	Programa de apoio as reformas economicas (PARE I)		1.099.409 €		LT		yes
Pacific	Papua New Guinea	FED/2000/015-106	2000	Structural ajustement support programme (2000/2001)		75.039 €		ST	Structural adjustment&Economic Stabilisation	yes
Africa	Rwanda	FED/2000/015-211	2000	Stuctural adjustment support (SAP 2)	5.100.000 €	918.603 €		ST	Structural adjustment&Economic Stabilisation	yes
Africa	São Tomé & Príncipe	FED/2000/015-222	2000	Programme d'appui l'ajustement structurel (PAS 2001-2002)		186.874 €		ST	Structural adjustment&Economic Stabilisation	yes
Africa	Sierra Leone	FED/2000/015-223	2000	Post conflict budget support (PCBS)	18.180.000 €			LT		no
Africa	Uganda	FED/2000/015-221	2000	Poverty alleviation budgetary support (PABS 4)	24.500.000 €	873.195 €		LT		yes
Africa	Zambia	FED/2000/015-065	2000	SAF V - sysmin	26.490.000 €			ST	Structural adjustment&Economic Stabilisation	yes
Africa	Cape Verde	FED/2001/015-407	2001	Programme d'appui a l'ajustement structurel (PAS 2000)	9.000.000 €	425.943 €		ST	Structural adjustment&Economic Stabilisation	yes
Africa	Ethiopia	FED/2001/015-702	2001	Structural adjustment support (SAS II - BIS)		912.071 €		ST	Structural adjustment&Economic Stabilisation	no
Africa	Ethiopia	FED/2001/015-770	2001	Poverty reduction budgetary support (PRBS	36.412.000 €	1.787.865 €		LT		yes

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
				I)						
Africa	Gabon	FED/2001/015-608	2001	Programme d'appui aux reformes économiques (PARE III2001-02)	3.451.800 €	453.102 €		LT		yes
Africa	Gambia	FED/2001/015-673	2001	Poverty reduction budget support programme 2002		17.570 €		LT		yes
Africa	Ghana	FED/2001/015-662	2001	Support to structural adjustment (SASP VII EX Projet 8 GH) (13+14+15)	20.565.000 €	87.523 €		ST	Structural adjustment&Economic Stabilisation	yes
Africa	Ivory Coast	FED/2001/015-675	2001	Programme d appui a la relance economique (PARE I 2001/2002)	5.000.000 €	300.703 €		ST	Structural adjustment&Economic Stabilisation	no
Caribbean	Jamaica	FED/2001/015-469	2001	Support to the economic reform programme (2001-2003 SERP II)	6.400.000 €	262.601 €		LT		yes
Africa	Lesotho	FED/2001/015-408	2001	Poverty reduction budgetary support program (PRBSP 2001/2002)		184.105 €		LT		yes
Africa	Mauritania	FED/2001/015-414	2001	Appui budgetaire au cadre stratÎgique lutte contre pauvrete (FAS 2000)	10.198.496 €	166.647 €		LT		yes
Africa	Niger	FED/2001/015-535	2001	Contribution supplementaire au programme communautaire d'appui a l'ajustement structurel (PAPAS IV) (EX 8 NIR 39)	3.160.000 €			LT		no
Africa	Tanzania	FED/2001/015-457	2001	Poverty reduction budget support (FAS 2000)		266.594 €		LT		yes
Africa	Burkina Faso	FED/2002/015-886	2002	Appui budgetaire pour la reduction de la pauvrete (ABRP 2002-2004)		2.299.865 €		LT		yes
Africa	Burundi	FED/2002/016-048	2002	PROGRAMME d'allâgement De La Dette Et Appui Aux RÎformes Îco Nomiques (ADARE 2003)	26.520.000 €	248.772 €		ST	Debt reduction	no
Caribbean	Jamaica	FED/2002/016-	2002	Support to economic	24.744.335 €	2.101.377 €		LT		yes

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
		017		reform programme III (SERP III)						
ENP	Jordan	MED/2002/003-312	2002	Structural Adjustment Facility III – (SAF III)	59.700.000 €	114.000 €		ST	Structural adjustment&Economic Stabilisation	no
Africa	Madagascar	FED/2002/016-091	2002	Programme d appui budgetaire d urgence (PABU)	69.327.000 €	538.740 €		ST	Emergency	no
Africa	Mali	FED/2002/016-063	2002	Appui budgetaire au cadre strategique de lutte contre la pauvrete (CSLP) 2001	22.395.000 €	521.116 €		LT		yes
Africa	Mozambique	FED/2002/015-996	2002	Poverty reduction budget support II (PRBS II) 2002-2005	171.067.294 €	487.963 €		LT		yes
Africa	Niger	FED/2002/015-890	2002	Programme d appui a la restauration des equilibres macro economiques	19.250.000 €	327.278 €		ST	Structural adjustment&Economic Stabilisation	no
ENP	Occupied Palestinian Territory	MED/2002/004-348	2002	Direct Budgetary Assistance (DBA)-III (50 Mio) + Avenant 1 (DBA IV) 30 Mio + Avenant 2 (DBA V) 20 Mio	98.000.000 €			LT		no
ENP	Tunisia	MED/2002/003-350	2002	Programme d'ajustement structurel (FAS-III)	66.906.000 €	198.470 €		ST	Structural adjustment&Economic Stabilisation	no
Africa	Benin	FED/2003/016-395	2003	Appui budgetaire conjoint pour la reduction de la pauvrete (2003-2005)	90.374.250 €	1.390.715 €		LT		yes
Africa	Chad	FED/2003/016-363	2003	Programme d'appui budgetaire pour la reduction de la pauvrete et la croissance (2003-2006)	20.000.000 €	2.526.151 €		LT		yes
Africa	Congo (Dem Rep)	FED/2003/016-375	2003	Programme d'appui a l'allegement de la dette exterieure			105.702.058 €	LT		no
Africa	Ethiopia	FED/2003/016-288	2003	Poverty reduction budgetary support (PRBS-II)	57.214.286 €	859.417 €		LT		probably yes
ENP	Jordan	MED/2003/005-	2003	Emergency Budgetary	34.900.000 €			ST		no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
		635		Support in Jordan						
Africa	Madagascar	FED/2003/016-531	2003	Programme d'appui budgetaire a la reduction de la pauvrete (PARP)	30.675.000 €	2.280.982 €		LT		yes
Africa	Mali	FED/2003/016-414	2003	Programme pluriannuel d'appui budgîtaire au cadre stratîgique de lutte contre la pauvrete	158.730.000 €	5.165.201 €		LT		yes
Africa	Niger	FED/2003/016-251	2003	Programme pluriannuel d'appui a la reduction de la pauvrete 2003-2005 - (PPARP 2003-2005)	74.250.000 €	326.133 €		LT		yes
ENP	Occupied Palestinian Territory	MED/2003/004-837	2003	Reform Support Instrument (RSI)-B: Finance Facility	80.000.000 €			LT		no
Africa	Rwanda	FED/2003/016-320	2003	Programme pluriannuel d'appui a la reduction de la pauvrete 2003-2005 (PPARP 2003-2005)	45.764.000 €	1.356.549 €		LT		yes
Africa	Tanzania	FED/2003/016-313	2003	Poverty reduction budget support programme 2003-2006	96.450.000 €	2.152.357 €		LT		yes
Africa	Zambia	FED/2003/016-366	2003	Poverty Reduction Budget Support programme 2003-2006 (PRBS01)	103.700.000 €	486.160 €		LT		yes
Africa	Burundi	FED/2004/016-893	2004	Appui à la réduction de la pauvreté 2004-2006 (PPARP 2004-2006) et d'allégement des arriérés multilatéraux - programme général d'importations	43.303.333 €	615.668 €		LT		yes
Africa	Cape Verde	FED/2004/017-422	2004	Preogramme d'appui budgetaire d'urgence (2004-2005)	5.500.000 €			LT		no
Africa	Ghana	FED/2004/016-608	2004	Poverty reduction budget support 2 (2004-2006)	55.200.000 €	5.108 €		LT		yes
Caribbean	Guyana	FED/2004/016-892	2004	Poverty Reduction Budget Support	38.959.650 €	1.142.891 €		LT		yes
Caribbean	Jamaica	FED/2004/016-	2004	Emergency Assistance -	25.000.000 €			ST	Emergency	yes

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
		973		Budgetary Support						
Africa	Kenya	FED/2004/017-389	2004	Poverty reduction support progamme	120.000.000 €	4.750.000 €		LT		yes
Latin America	Nicaragua	ALA/2004/016-837	2004	Programa de apoyo al Plan Nacional de Desarrollo con enfoque rural	68.000.000 €			LT		yes
Africa	Senegal	FED/2004/017-388	2004	Appui budgetaire a la strategie de reduction de la pauvrete	51.145.300 €	1.333.749 €		LT		yes
Africa	Sierra Leone	FED/2004/017-043	2004	Poverty reduction budget support	65.420.000 €	1.643.384 €		LT		yes
Asia	Vietnam	ASIE/2004/016-769	2004	Support to Vietnam's Poverty Reduction and Growth Strategy under PRSC-3		2.560.087 €	16.500.000 €	LT		yes
Africa	Burkina Faso	FED/2005/017-744	2005	Appui budgetaire pour la reduction de la pauvrete 2005-2008	187.848.383 €	3.914.439 €		LT		yes
Latin America	El Salvador	ALA/2005/017-587	2005	Programa de alivio a la pobreza en El Salvador (PAPES)	35.000.000 €	1.682.750 €		LT		no
Africa	Madagascar	FED/2005/017-741	2005	Programme d'appui budgetaire pour reduction de la pauvrete II	92.500.000 €	1.800.000 €		LT		yes
Africa	Malawi	FED/2005/017-849	2005	Poverty reduction budgetary support programme	35.100.000 €	859.935 €		LT		yes
Africa	Niger	FED/2005/017-874	2005	Programme pluriannuel d'appui a la reduction de la pauvrete	88.047.000 €	2.740.078 €		LT		yes
Africa	Rwanda	FED/2005/017-852	2005	Budget support for poverty reduction	61.755.063 €	1.684.937 €		LT		yes
ENP	Tunisia	MED/2005/017-322	2005	Facilité d'Ajustement Structurel IV	77.750.000 €	121.107 €		LT		no
Africa	Uganda	FED/2005/017-078	2005	5th poverty alleviation budget support (PABS V)	76.124.545 €	4.896.256 €		LT		yes
Africa	Cape Verde	FED/2006/017-927	2006	Programme d'appui budgetaire a la strategie	11.870.722 €	403.541 €		LT		no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
				national de reduction						
Africa	Central African Republic	FED/2006/018-424	2006	Programme de réduction des arriérés multilatéraux et internes de la République Centrafricaine (RAMICA)	8.066.698 €	6.243.669 €		ST	Structural adjustment&Economic Stabilisation	no
Africa	Guinea-Bissau	FED/2006/017-936	2006	Appui budgetaire a la stabilisation (ABS1)	5.500.000 €	500.000 €		LT		no
Africa	Guinea-Bissau	FED/2006/020-749	2006	Appui budgetaire de stabilisation (ABS II)	5.700.000 €	395.769 €		ST	Structural adjustment&Economic Stabilisation	no
Caribbean	Haiti	FED/2006/020-710	2006	Convention de financement appui budgetaire d'urgence	10.000.000 €			LT		probably no
Africa	Mozambique	FED/2006/017-943	2006	Poverty reduction budget support programme (PRBS III)	133.793.000 €	39.929 €		LT		yes
Latin America	Paraguay	ALA/2006/018-053	2006	Programa de apoyo presupuestario a la lucha contra la pobreza focalizada	23.000.000 €	872.767 €		LT		yes
Africa	Tanzania	FED/2006/017-917	2006	PRBS03 poverty reduction budget support programme 2006-2008 see also numbers 9 ACP TA 20 and 9 ACP TA 21	80.802.574 €	146.224 €		LT		yes
ENP	Tunisia	MED/2006/018-438	2006	Tunisie - Programme d'appui à la compétivité (PAC I)	38.000.000 €	1.191.258 €		LT		no
Caribbean	Turks and Caicos Islands	FED/2006/020-686	2006	Budget support programme		1.583.587 €		LT		yes
Pacific	Vanuatu	FED/2006/018-697	2006	Support to the Economic Reform Programme (SERP) 2007-2010	2.400.000 €	586.149 €		LT		yes
Africa	Zambia	FED/2006/018-569	2006	PRBS 02 (2007-2008)	60.000.000 €	1.767.437 €		LT		yes
Africa	Burundi	FED/2007/018-917	2007	Programme d'Appui budgétaire à la	35.565.878 €	790.037 €		ST	Structural adjustment&Econo	no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
				stabilisation macro-économique					mic Stabilisation	
Asia	Cambodia	DCI-ASIE/2007/019-017	2007	EC General Budget Support for Cambodia	22.200.000 €	371.105 €		LT		no
Africa	Central African Republic	FED/2007/019-287	2007	Appui à la stabilisation économique de la République centrafricaine (ASERCA)	3.950.000 €	36.823 €		ST	Structural adjustment&Economic Stabilisation	no
Caribbean	Dominica	FED/2007/020-828	2007	Private sector and growth development programme	12.044.000 €	587.850 €		LT		yes
Caribbean	Dominica	FED/2007/020-829	2007	private sector and growth development programme	4.380.000 €			LT		no
Caribbean	Dominican Republic	FED/2007/018-825	2007	budget support for poverty reduction	33.300.000 €	74.945 €		ST	Sugar	yes
Africa	Ghana	FED/2007/020-799	2007	poverty reduction budget support 3 (PRBS 3)	6.020.000 €	1.900.000 €		LT		yes
Caribbean	Grenada	FED/2007/020-805	2007	poverty reduction through private sector development employment and growth	18.090.000 €	578.244 €		LT		probably no
Africa	Guinea-Bissau	FED/2007/020-858	2007	appui budgetaire a la stabilisation (ABS III)	9.270.000 €	285.682 €		LT		probably no
Caribbean	Haiti	FED/2007/020-775	2007	programme d'aide budgetaire	27.580.000 €	508.946 €		ST	Structural adjustment&Economic Stabilisation	no
Caribbean	Jamaica	FED/2007/019-603	2007	Budget Support Programme for Hurricane Dean Rehabilitation	2.500.000 €			ST	Emergency	probably no
Caribbean	Jamaica	DCI-SUCRE/2007/018-943	2007	Accompanying measures 2007 for sugar protocol countries - Jamaica	24.940.000 €			ST	Sugar	no
Asia	Laos	DCI-ASIE/2007/019-166	2007	Support to the Third Poverty Reduction Support Operation	3.000.000 €	198.902 €		LT		yes
Africa	Malawi	FED/2007/019-638	2007	Poverty Reduction Budget Support Programme 2	41.710.000 €	3.189.396 €		LT		yes
Africa	Mauritius	FED/2007/019-007	2007	Improved Competitiveness for Equitable Development	19.642.531 €			LT		no
Africa	Mauritius	DCI-	2007	Improved Competitiveness	36.000.000 €			ST	Sugar	no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
		SUCRE/2007/019-104		for Equitable development - Sugar Budget Part						
Africa	Mauritius	FED/2007/019-443	2007	Improved Competitiveness for Equitable Development Part II	25.980.000 €			ST	Structural adjustment&Economic Stabilisation	yes
Caribbean	Saint Kitts & Nevis	DCI-SUCRE/2007/019-334	2007	Accompanying Measures 2007 for Sugar Protocol Countries;	9.777.000 €	512.305 €		ST	Sugar	yes
Asia	Vietnam	DCI-ASIE/2007/018-849	2007	Poverty Reduction Support Credit 6			19.800.000 €	LT		yes
Africa	Benin	FED/2008/020-955	2008	Appui budgetaire general a la SCRP	87.723.500 €	472.952 €		LT		yes
Africa	Burkina Faso	FED/2008/020-972	2008	Appui budgetaire pour la croissnce et la reduction de la pauvrete (Contrat OMD ABCRP 2009-2014)	320.142.936 €			LT		yes
Africa	Burundi	FED/2008/020-921	2008	Programme d'appui budgetaire la relance economique	72.917.855 €	392.960 €		ST	Structural adjustment&Economic Stabilisation	probably no
Africa	Cape Verde	FED/2008/021-001	2008	Appui budgetaire a la strategie de croissance et de reduction de la pauvrete	24.000.000 €	201.416 €		LT		yes
Africa	Central African Republic	FED/2008/020-987	2008	Appui a la stabilisation economique de la RCA (ASERCA II)	34.235.000 €	281.485 €		ST	Structural adjustment&Economic Stabilisation	yes
Latin America	Ecuador	DCI-ALA/2008/019-031	2008	Programa de apoyo al sistema economico solidario y sostenible. – (PASES)	16.000.000 €	2.702.971 €		LT		no
Africa	Ghana	FED/2008/020-951	2008	MDG contract (MDG-C)	209.000.000 €	10.500 €		LT		yes
Africa	Guinea-Bissau	FED/2008/020-979	2008	Appui budgetaire a la stabilisation 2009/11-(ABS IV)	28.180.000 €	246.908 €		ST	Structural adjustment&Economic Stabilisation	no
Caribbean	Haiti	FED/2008/021-047	2008	Appui budgetaire generale a la strategie nationale pour la croissance et la	59.000.000 €	1.413.017 €		LT		no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
				reduction de la pauvrete (ABG-SNCRP)						
Latin America	Honduras	DCI-ALA/2008/019-893	2008	Apoyo Presupuestario a la Estrategia de Reducción de Pobreza (APERP)	59.100.000 €			LT		yes
Caribbean	Jamaica	FED/2008/021-024	2008	Debt Reduction and Growth Enhancement Programme (DRGEP)	56.500.000 €	106.647 €		ST	Debt reduction	no
Caribbean	Jamaica	DCI-SUCRE/2008/019-863	2008	Debt Reduction and Growth Enhancement Programme (DRGEP)	9.000.000 €			ST	Sugar	no
Asia	Laos	DCI-ASIE/2008/019-518	2008	Second General Budget Support to Lao PDR	12.000.000 €	886.058 €		LT		yes
Africa	Lesotho	FED/2008/021-005	2008	10th edf poverty reduction budget support	47.000.000 €			LT		yes
Africa	Malawi	FED/2008/020-959	2008	Poverty reduction budget support III	122.250.000 €	1.000.000 €		LT		yes
Africa	Mali	FED/2008/020-938	2008	Contrat OMD pour le Mali – (PPAB 2)	140.266.668 €	2.197.400 €		LT		yes
Africa	Mauritius	DCI-SUCRE/2008/019-957	2008	Improved Competitveness for Equitable Development II	32.323.000 €			ST	Sugar	probably no
ENP	Morocco	ENPI/2008/019-686	2008	Programme d'appui aux Investissements et aux Exportations	55.500.000 €	128.433 €		LT		probably no
Africa	Mozambique	FED/2008/020-970	2008	MDG contract 1 Mozambique	326.670.000 €			LT		yes
Africa	Niger	FED/2008/020-992	2008	Programme pluriannuel d'appui la rduction de la pauvrete (PPARP) 2009-2011		537.930 €		LT		probably yes
Africa	Rwanda	FED/2008/021-004	2008	MDG contract	67.000.000 €			LT		yes
Caribbean	Saint Kitts & Nevis	SUCRE/2008/019-969	2008	Accompanying Measures 2008 for Sugar Protocol Countries for St.Kitts & Nevis	8.773.000 €			ST	Sugar	yes
Africa	Senegal	FED/2008/020-	2008	Appui budgetaire a la	69.000.000 €	4.490.971 €		LT		yes

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
		993		strategie de reduction de la pauvrete						
Africa	Sierra Leone	FED/2008/020-947	2008	General budget support (MDBS)	61.000.000 €	6.073.513 €		LT		yes
Africa	Togo	FED/2008/020-926	2008	Programme d'assainissement macroeconomique du togo			3.126.239 €	ST	Structural adjustment&Economic Stabilisation	no
ENP	Tunisia	ENPI/2008/020-221	2008	Programme d'appui à l'intégration économique	49.000.000 €	449.453 €		LT		no
Africa	Uganda	FED/2008/020-357	2008	Millennium Development Goals Contract (MDG-C) for Uganda	175.000.000 €			LT		yes
Asia	Vietnam	DCI-ASIE/2008/019-692	2008	Poverty Reduction Support Credit 7-9	43.000.000 €			LT		no
Africa	Zambia	FED/2008/020-949	2008	PRBS 3 - MDGcontract 1 - Cris ref. 2008/199-76	255.000.000 €			LT		yes
Africa	Cape Verde	FED/2009/021-707	2009	Aide budgétaire au développement du Partenariat Spécial	10.500.000 €			LT		no
Africa	Comoros	FED/2009/021-602	2009	Programme d'appui budgétaire à la stabilisation socio-économique des Comores	7.270.000 €			LT		yes
Africa	(Congo (Dem Rep)	FED/2009/021-645	2009	Programme d'Appui Budgétaire à la Stabilisation Economique de la RDC	22.620.000 €			LT		no
Africa	Congo (Dem Rep)	DCI-FOOD/2009/021-684	2009	Programme d'Appui Budgetaire pour la Stabilisation Economique de la RDC (facilité alimentaire)	26.000.000 €			ST	Food	no
Africa	Ghana	DCI-FOOD/2009/021-815	2009	Ghana - general budget support in response to high international food prices	15.000.000 €			ST	Food	yes
Caribbean	Haiti	DCI-FOOD/2009/021-	2009	Set of measures implementing the Facility	5.800.000 €			ST	Food	no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
		911		for rapid response to soaring food prices in developing countries						
Caribbean	Jamaica	FED/2009/021-184	2009	Tropical Storm Gustav Rehabilitation	1.900.000 €			ST	Emergency	no
Caribbean	Jamaica	DCI-SUCRE/2009/021-295	2009	Debt Reduction enhancement programme 2009	8.350.000 €			ST	Sugar	no
Africa	Liberia	FED/2009/021-455	2009	Budget Support for Macroeconomic Stabilisation (BSMS)	32.600.000 €			LT		no
Africa	Malawi	DCI-FOOD/2009/021-735	2009	Food Facility to address the budgetary and social impact of soaring international food prices in Malawi	15.900.000 €			ST	Food	no
Africa	Mauritius	FED/2009/021-620	2009	Promoting Sustainable and Equitable Development: EDF part	68.180.000 €			LT		no
Africa	Mauritius	DCI-ENV/2009/021-552	2009	General Budget Support - Global Climate Change for Mauritius	2.800.000 €	171.080 €		ST	Sugar	no
Africa	Mauritius	DCI-SUCRE/2009/021-298	2009	'Promoting Sustainable and Equitable Development'	66.652.000 €			ST	Sugar	no
Africa	Mozambique	FED/2009/021-031	2009	Addendum to PRBS III	12.110.000 €			LT		yes
Africa	Seychelles	FED/2009/021-770	2009	Seychelles Economic Reform Programme	15.500.000 €			LT		no
Africa	Seychelles	DCI-ENV/2009/021-555	2009	Seychelles Climate Change Support Programme (SCCSP)	2.000.000 €			ST	ENVI	no
Africa	Tanzania	FED/2009/021-300	2009	MDG Contract (2009/2015) for Tanzania	300.000.000 €	556.971 €		LT		yes
Africa	Togo	FED/2009/021-630	2009	TOGO - Appui budgétaire à la Réduction de la Pauvreté	27.000.000 €			LT		yes
Caribbean	Antigua & Barbuda	FED/2010/022-407	2010	General Budget Support - Vulnerability Flex 2010 in	9.000.000 €			ST	VFLEX	no

Region	Country	Decision No.	Decision year[51]	Decisions Title	Contracted amount for financial support	Contracted amount for technical & other support	Indirect GBS (through IOs)	GBS objective (Short term/long term)	Main short term objectif	Health-related GBS
				Antigua and Barbuda						
Africa	Congo (Democratic Republic of)	FED/2010/022-389	2010	VFLEX - Appui budgétaire pour atténuer les effets de la crise économique et financière en RDC	35.508.014 €			ST	VFLEX	no
Caribbean	Dominican Republic	FED/2010/022-276	2010	General Budget support to fight against poverty	58.500.000 €			LT		yes
Latin America	El Salvador	DCI-ALA/2010/021-847	2010	Programa de Recuperación Economica para El Salvador – (PARE-ES)	22.000.000 €			LT		yes
ENP	Occupied Palestinian Territory	ENPI/2010/021-955	2010	PEGASE 2010 : Support to Recurrent Expenditures of the PA	158.500.000 €	11.000.000 €		LT		no
ENP	Occupied Palestinian Territory	ENPI/2010/022-594	2010	PEGASE 2010 : Additional Support to Recurrent Expenditures of the PA (Part III)	41.400.000 €			LT		no
Pacific	Solomon Islands	FED/2010/022-271	2010	Solomon Islands Economic Recovery Assistance (SIERA) Programme	15.000.000 €	5.000 €		ST	Structural adjustment&Economic Stabilisation	no
Africa	Tanzania	DCI-FOOD/2010/021-769	2010	Food Facility: General Budget Support component for Tanzania	20.000.000 €			ST	Food	no
Africa	Togo	DCI-FOOD/2010/022-043	2010	Programme d'appui budgétaire au Gouvernement du Togo dans le cadre de la Food Facility	8.100.000 €			ST	Food	no

1.5.6 List of recipient countries of EC funds in the health sector

This annex provides the list of all recipient countries of EC funds to support the health sector falling within the scope of the evaluation. They are sorted by total amount contracted starting with the highest. It also provides the share of the amount contracted by country on the total amount contracted, the total amount disbursed by country and the disbursement rate on the amount contracted by country.

Table 9: List of recipient countries of EC funds in the health sector

COUNTRY/REGION	Amount contracted (m)	% on total amount contracted	Amount disbursed	Disbursement rate
ACP	728,593,888	18%	658,389,454	90%
ALL COUNTRIES	681,815,133	16%	561,631,595	82%
EGYPT	245,644,981	6%	130,924,376	53%
MOROCCO	154,528,705	4%	122,916,070	80%
AFGHANISTAN	149,373,043	4%	114,489,765	77%
SOUTH AFRICA	130,784,218	3%	116,289,602	89%
BANGLADESH	111,231,762	3%	80,046,929	72%
INDIA	110,962,276	3%	7,293,318	7%
MOZAMBIQUE	99,256,536	2%	78,350,785	79%
NIGERIA	94,747,375	2%	75,244,356	79%
DR CONGO,	92,482,220	2%	65,181,672	70%
ASIAN COUNTRIES	91,377,284	2%	54,507,292	60%
ZIMBABWE	81,286,205	2%	74,722,707	92%
BOTSWANA	70,529,222	2%	24,529,222	35%
MOLDOVA, REPUBLIC OF	61,559,739	1%	38,708,457	63%
PHILIPPINES	52,599,090	1%	31,794,084	60%
ZAMBIA	49,546,972	1%	24,461,034	49%
ANGOLA	47,287,992	1%	36,483,020	77%
INDONESIA	43,172,562	1%	32,342,589	75%
MYANMAR	42,866,111	1%	29,000,727	68%
TUNISIA	40,758,837	1%	40,758,837	100%
SIERRA LEONE	38,389,689	1%	28,097,390	73%
OCCUPIED PALESTINIAN TERRITORY	36,835,603	1%	30,402,890	83%
RUSSIAN FEDERATION	35,743,070	1%	32,872,162	92%
TIMOR-LESTE	33,189,978	1%	33,166,942	100%
VIET NAM	32,919,283	1%	21,684,774	66%
SOMALIA	30,865,856	1%	25,949,956	84%
YEMEN	29,911,038	1%	13,701,699	46%
CHAD	29,563,853	1%	24,485,494	83%
ECUADOR	28,832,418	1%	23,960,150	83%

COUNTRY/REGION	Amount contracted (m)	% on total amount contracted	Amount disbursed	Disbursement rate
SYRIAN ARAB REPUBLIC	28,018,645	1%	24,958,555	89%
UGANDA	25,089,450	1%	21,526,087	86%
KENYA	24,451,261	1%	16,536,659	68%
UKRAINE	23,480,849	1%	21,523,146	92%
SAINT LUCIA	21,600,718	1%	1,050,766	5%
ETHIOPIA	21,392,551	1%	16,386,204	77%
MALAWI	20,163,404	0%	18,127,919	90%
BURUNDI	19,364,333	0%	10,853,306	56%
GUINEA	19,336,497	0%	16,285,896	84%
GEORGIA	19,072,318	0%	15,500,871	81%
EAST AFRICAN COUNTRIES	17,878,300	0%	8,246,063	46%
CENTRAL AFRICAN REPUBLIC	17,036,901	0%	9,958,451	58%
ARGENTINA	15,952,204	0%	14,247,197	89%
TACIS COUNTRIES	15,933,844	0%	15,284,019	96%
CONGO	15,497,089	0%	13,190,620	85%
NIGER	15,255,005	0%	6,320,982	41%
LESOTHO	14,824,939	0%	4,368,443	29%
CÔTE D'IVOIRE	14,203,061	0%	9,658,026	68%
MALI	14,107,294	0%	13,254,154	94%
CAMBODIA	13,361,844	0%	7,795,061	58%
THAILAND	13,340,051	0%	7,344,865	55%
IRAQ	13,000,000	0%	3,933,459	30%
MEDA	11,389,159	0%	10,628,080	93%
BARBADOS	10,429,281	0%	6,684,669	64%
CAMEROON	10,044,561	0%	9,223,770	92%
KIRIBATI	8,580,000	0%	8,143,249	95%
LIBYAN ARAB JAMAHIRIYA	8,291,079	0%	4,135,241	50%
SWAZILAND	8,188,110	0%	6,240,933	76%
Ghana	7,725,501	0%	7,159,796	93%
BENIN	7,436,076	0%	6,742,553	91%
DOMINICAN REPUBLIC	7,220,989	0%	7,220,989	100%
MADAGASCAR	7,213,552	0%	6,214,124	86%
NAMIBIA	6,823,180	0%	5,734,368	84%
LATIN AMERICAN COUNTRIES	6,755,859	0%	6,755,859	100%
NEPAL	6,562,547	0%	3,190,590	49%
PAKISTAN	6,532,021	0%	4,199,984	64%

COUNTRY/REGION	Amount contracted (m)	% on total amount contracted	Amount disbursed	Disbursement rate
TANZANIA, UNITED REPUBLIC OF	6,482,776	0%	3,777,686	58%
LEBANON	6,410,533	0%	2,492,316	39%
SENEGAL	6,336,562	0%	6,261,802	99%
TRINIDAD AND TOBAGO	6,120,354	0%	3,747,904	61%
LIBERIA	6,104,460	0%	4,183,202	69%
UZBEKISTAN	5,948,277	0%	5,399,252	91%
GUATEMALA	5,934,588	0%	5,325,951	90%
RWANDA	5,698,658	0%	5,175,510	91%
GUYANA	5,618,448	0%	862,200	15%
PAPUA NEW GUINEA	5,537,358	0%	4,199,624	76%
VENEZUELA	5,347,598	0%	4,730,274	88%
TACIS	5,026,794	0%	4,294,357	85%
NICARAGUA	4,690,286	0%	2,926,275	62%
SOUTH AFRICAN COUNTIRES	4,577,368	0%	1,864,322	41%
COLOMBIA	4,521,617	0%	3,287,257	73%
LAO PEOPLE'S DEMOCRATIC REPUBLIC	4,307,588	0%	2,400,137	56%
SOUTH ASIA REGION	4,104,324	0%	2,002,528	49%
KAZAKHSTAN	4,085,317	0%	2,261,438	55%
CHINA	3,412,096	0%	1,949,678	57%
PERU	3,387,656	0%	2,089,860	62%
CAPE VERDE	3,084,801	0%	2,938,128	95%
TAJIKISTAN	2,982,343	0%	2,138,708	72%
SRI LANKA	2,743,759	0%	1,662,713	61%
SUDAN	2,741,501	0%	2,228,485	81%
MONGOLIA	2,572,918	0%	1,390,186	54%
BOLIVIA, PLURINATIONAL STATE OF	2,280,448	0%	1,766,773	77%
MEXICO	2,155,752	0%	1,183,384	55%
HAITI	2,071,790	0%	2,051,842	99%
TOGO	2,057,902	0%	2,013,168	98%
HONDURAS	2,026,626	0%	2,026,626	100%
EL SALVADOR	2,026,427	0%	1,055,805	52%
MAURITANIA	2,008,380	0%	1,071,746	53%
KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	1,449,054	0%	978,111	67%
ARMENIA	1,394,541	0%	1,198,381	86%

COUNTRY/REGION	Amount contracted (m)	% on total amount contracted	Amount disbursed	Disbursement rate
CARIBBEAN COUNTRIES	1,138,503	0%	1,138,503	100%
BELARUS	1,132,802	0%	963,087	85%
URUGUAY	1,041,506	0%	685,434	66%
JAMAICA	1,001,482	0%	926,482	93%
ERITREA	949,868	0%	573,899	60%
SURINAME	869,234	0%	744,730	86%
GUINEA-BISSAU	735,462	0%	344,977	47%
ASIA	648,702	0%	648,702	100%
NIUE	599,680	0%	599,680	100%
ALGERIA	498,163	0%	463,913	93%
PANAMA	434,926	0%	434,926	100%
ISRAEL	380,664	0%	99,846	26%
ANTIGUA AND BARBUDA	321,714	0%	203,148	63%
IRAN, ISLAMIC REPUBLIC OF	300,000	0%	52,127	17%
PARAGUAY	281,096	0%	252,025	90%
GRENADA	278,150	0%	199,888	72%
DOMINICA	275,170	0%	272,163	99%
SAINT VINCENT AND THE GRENADINES	241,895	0%	192,715	80%
MEDITERRANEAN COUNTRIES	230,478	0%	205,767	89%
CHILE	201,660	0%	201,660	100%
KYRGYZSTAN	188,693	0%	176,932	94%
BELIZE	117,035	0%	117,035	100%
BRASIL	77,950	0%	77,950	100%
SAMOA	67,487	0%	53,990	80%
BURKINA FASO	51,429	0%	51,429	100%
GABON	21,383	0%	21,383	100%
MALAYSIA	4,750	0%	-	0%
Grand Total	**4,139,546,198**	100%	**3,103,650,323**	75%

2 Annex 3: EUD Survey

List of abbreviations

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
AIDOS	Syrian Health Counselling Centres
AIDS	Acquired Immuno-Deficiency Syndrome
ARVs	Antiretroviral drugs
AWP	Annual Work Programme
BPHS	Basic Package of Health Services
BS	Budget Support
CAG	Support Unit and Management in DRC
CAMEG	Supervision committee of medical provision
CCM	Country Coordination Mechanism (of the GFATM)
CDC	US Centers for Disease Control
CDMT	Cadre des Dépenses à Moyen Terme
CM	Coordination Mechanisms
CMB	Couverture médicale de base (Morocco)
CNPS	Comité National de Pilotage de la Santé
CSO	Civil Society Organisation
CSP	Country Strategy Paper
DCI	Development Cooperation Instrument
DHMT	District Health Management Team (Zambia)
DHS	Demographic and Health Survey
DoH	Department of Health
DoH	Department of Health
DP	Development Partners
DPG	Development Partners Group
DPGH	Development Partner group on Health
DRC	Democratic Republic of Congo
EBAS	Health project on Human Resources in Ecuador
EC / CE	European Commission
EC-TA	European Commission - Technical Assistance
EDCCTP	European and Developing Countries Clinical trials Partnership
EDF / FED	European Development Fund
EDF/DCI	European Development Fund / Instrument for Development Cooperation
EIDHR	Human Rights Budget Line
ENPI	European Neighbourhood Policy Instrument
EPDPHC	European and Developing Countries Clinical Trials Partnership
EPHS	Essential Package of Hospital Services
EU	European Union
EUD	European Union Delegation
EU MS	European Union Member States
FDA	Food and Drug Association
FHF	Family Health Fund
FM	Financial Mechanisms
FMS	Financial Management System
FP7	Research Framework Programme number 7
FY	Financial Year
GAVI	Global Alliance for Vaccines and Immunization

GBS	General Budget Support
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFATM-CCM	Global Fund to Fight AIDS, Tuberculosis and Malaria - CCM
GH	Ghana
GHS	Ghanaian Health Service
HDC	Health Development councils
HEF	Health Equity Fund (Laos)
HEMA	Health project in Vietnam
HFIN	Health Finances
HIPC	Heavily Indebted Poor Country
HIV/ VIH	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HNP	Health, Nutrition & Population (Bangladesh)
HNPSP	Health, Nutrition & Population Support Programme
HQ	Headquarter
HR	Human Resources
HSF	Health Service Fund
HSP	Health Sector Policy
HSPSP	Health Sector Policy Support Programme
HSRP	Health Sector Reform Programme (Egypt)
IAU	Internal Audit Unit
ICC	Inter-agency coordinating committee
IFMIS	Integrated Financial Management Information System
IHP	International Health Partnership initiative
IHP+	International Health Partnership initiative
INCOP	Public electronic purchase corporation in Nigeria
iNGO	International Non-Governmental Organisation
JANS	Joint assessment of national strategies
JBIC	Japan Bank for International Cooperation
LA	Latin America
LGA	Local Government Authorities
LGUs	Local Government Units
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MDBS	Multi-Donor-Budget-Support
MDGs	Millennium Development Goals
MEDA-ENPI-TACIS	EC Budget lines for Neighbourhood countries
MNCH	Maternal neonate and child health
MoF	Ministry of Finance
MoH	Ministry of Health
MoPH	Ministry of Public Health
MoPHP	Ministry of Public Health and Population
MoU	Memorandum of Understanding
MS	Member States
MTBF	Medium Term Budgetary Framework
MTEF	Medium-Term Expenditure Framework
MZN	Mozambican Metical
NAC	National Association for children (South Africa)
NAO	National Authorising Officer

NGO	Non-Governmental Organisation
NHP	National health programme
NHS	National health service
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
OCHA	UN Office for the Coordination of Humanitarian Affairs
ODA	Official Development Aid
OOP	Out Of Pocket Payments
PADS	Common health basket fund in Burkina Faso/Health Project in DRC
PAF	Performance Assessment Framework
PAPNDS	Health programme in DRC
PASS	Programme d'appui sectoriel à la réforme du système de santé
PASSE	Health Sector Programme in Ecuador
PDPHC	Health Programme in South Africa
PFM	Public Financial Management
PHC	Primary Health Care
PHIC	Philippine Health Insurance Corporation
PIN (NIP)	Programme Indicative National
PLWH	Health Programme in Ecuador
PNDS	Plan National de Développement Sanitaire
PPP	Public-private partnerships
ProS II	Health programme in Mozambique
RA	Republic Acts
RAMED	Regime d'Assistance Médicale
RCH	Reproductive and Child Health
RDF	Revolving Drugs Funds
RMC	Coordination Mechanisms in South Africa
SA	South Africa
SANTE	EC Budget Line for Health issues
SBS	Sector Budget Support
SDAH	Sector Development Approach to Health
SFPA	Syrian Family Planning Association (SFPA)
SPSP	Sector Policy Support Programme
SUCOP	Health /HIV/AIDS programme in South Africa
SWAp	Sector-Wide Approach
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TF	Trust Fund
TSA	Treasury Single Account
TWG	Technical Working Group
UHI	Universal Health Insurance
UK	United Kingdom
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund

UNHCR	United Nations High Commissioner for Refugees
USA	United States of America
USAID	United States Agency for International Development
USD	US Dollar
WB	Worldbank
WG	Working Group
WHO	World Health Organization

2.1 Introduction

The survey to EU Delegations (EUDs) constitutes a major building block of research to strengthen the evidence-base of the evaluation. It aimed at obtaining relevant EUDs perceptions on a number of topics such as quality and affordability of the health care, health governance, co-ordination and complementarity of the different health actors in the country and the usefulness of various aid modalities and channels.

The web-survey was launched on 1st July 2011, with a deadline for 25 EUDs selected (= desk study sample countries) to respond until 4th October, 2011. The response rate has been 96% which corresponds to 24 Delegations (out of 25) for the first four building blocks of the survey (chapter on Quality, Affordability, Governance and Coordination and of 92% for the last chapter on 'Channels and Aid Modalities')[52]. Tanzania EUD indicated that it could not respond as the EUD is not any more in charge of the health sector (Delegated partnership).

The survey form including all quantitative and qualitative questions is attached. The results are presented below.

2.2 Quality of health care services

2.2.1 Specific characteristics in the health system

Question 1: How would you rate the availability of the following characteristics of the health system in the early period of evaluation (i.e. 2002/2004) and 2010 and between rural and urban areas? In your opinion, how and to what extent has EC support contributed to the changes during the period, if any?

In order to assess quality of the health care services the questionnaire asked the EUDs to provide answer to two questions. In question 1 a set of nine sub-questions was created to evaluate the EUD's perceptions toward the quality of the health care system in their assigned countries. This set aimed to capture how satisfactory the following characteristics of quality of the health systems were:

- availability and coverage of primary and secondary health facilities,
- infrastructure and budget allocated to primary and secondary health facilities,
- availability of drugs and presence of sufficient qualified health human resources in the countries where the EUDs are located.

The respondents rated the quality characteristics mentioned above on a 1 to 5 response scale (from "excellent" to "fully unsatisfactory"). Furthermore, in order to capture how the quality of health care services evolved over the evaluation period (according to the EUDs) respondents were asked to retrospectively answer the questions for two points in time: 2002-04, i.e. for an early period of the evaluation, and for the year 2010. In addition, a comparison was made between rural and urban sites in order to obtain a geographical comparison.

2.2.1.1 Availability of primary health care facilities

The graph below shows the breakdown of the proportion of answers to the first quality characteristic **"Availability of primary health care facilities"**: In the rural areas availability seems to have improved over the evaluation period.

For instance, in 2002-04, most EUDs, 17 out 24 (77%) reported availability as "fully unsatisfactory" (seven EUDs) or "unsatisfactory" (10 EUDs). Exceptions were EUD *Barbados* that rated it as excellent and EUD *Syria* and EUD *Moldova* that considered it satisfactory.

- For 2010 the picture improves. More than half of the EUDs, 13 out 24 EUDs (55%) shifted their answer to satisfactory (eight EUDs), good (five EUDs) and/or excellent (*Barbados*). Eight EUDs account for the shift to better rates: *Lao, India, Nigeria, Vietnam, Bangladesh, Afghanistan, Morocco, Congo and Zambia*.

Although the overall situation seems to have improved since earlier periods of the evaluation, still 33% of the EUDs (eight out of 24) reported "unsatisfactory" levels of availability of primary health care facilities in the rural areas and even one, EUD *El Salvador* rated the availability as fully unsatisfactory, at the same time indicating that the EC had no projects in the health sector.

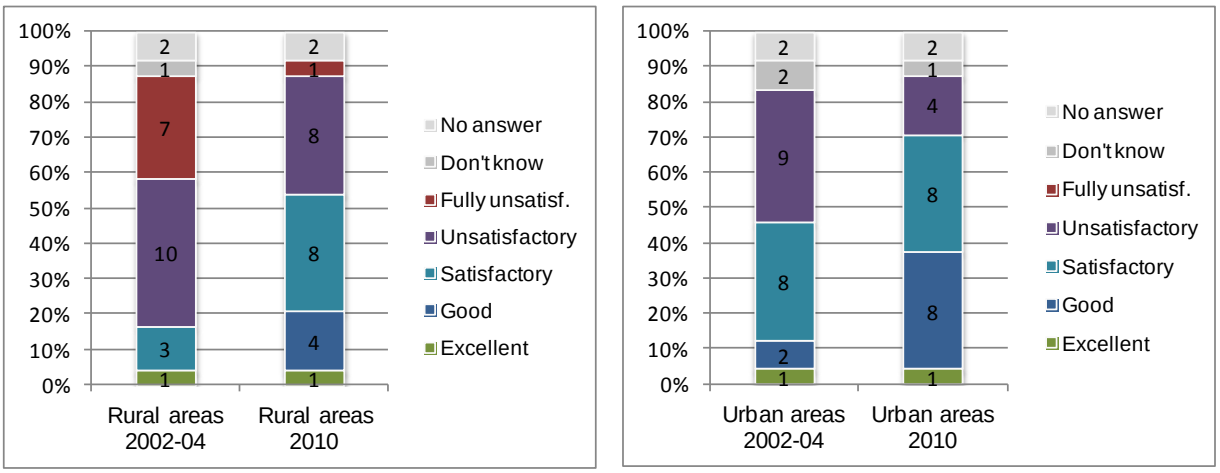
[52] This is due to the fact that EUD *Zambia* did not finalise the survey. The questions 23 to 27 have not been filled out.

The availability of **primary health care facilities** is scored better in the **urban areas**.

The ratings obtained for the period 2002-04 were 38% for "unsatisfactory" and 34% for "satisfactory" respectively. Only three EUDs reported "good" and "excellent" availability (EUD, *South Africa*, EUD *Moldova*, EUD *Barbados*). This was also reflected in the EUD comments where EUD *Moldova* confirmed that "Overall, primary health care facilities are available in 2002-04".

For 2010 the situation improved and the EUDs reporting "good availability" increased from 8% in 2002-04 to 34% (from two to eight EUDs). The most remarkable improvement was reported by EUD *Timor-Leste* that shifted two levels of the scale from "unsatisfactory" in 2002-04 to "good" in 2010. The EUD also commented that this improvement was made thanks to the EC contribution to "reconstructing at least 6 health centres and supporting the mobile services".

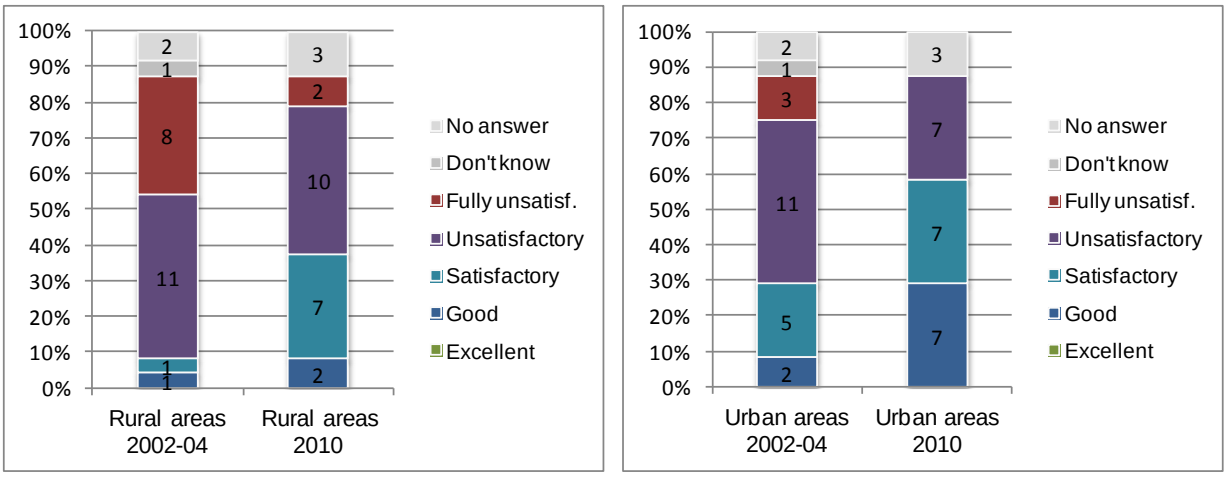
Figure 29: Q1a: Availability of primary health care facilities



Source: EUD Survey, 2011, Particip GmbH

2.2.1.2 Availability of secondary health care facilities

Figure 30: Q1b: Availability of secondary health care facilities



Source: EUD Survey, 2011, Particip GmbH

As regards the **availability of secondary health care facilities in rural areas**, the figures above show the perception of an overall improvement although unsatisfactory rates were still quite high in 2010:

In **2002-04** 46% of the EUDs rated availability of secondary health care facilities as "unsatisfactory" in rural sites, 34% of the EUDs said it was "fully unsatisfactory". Only two EUDs were more optimistic. EUD *Syria* that rated as "satisfactory" and EUD *Barbados* that said it was "good".

In **2010** the negative rates were 30% less than for the earlier period and the positive rates considerably increased accounting for 37% of the total answers (from 8% in 2002-04). Those who made the move from unsatisfactory rates to better ones were EUD *Morocco*, EUD *Afghanistan*, EUD *India*, EUD *Timor-Leste* and EUD *Zambia*, the first two being the one doing the most remarkable shift.

Regarding EUD *Timor-Leste* the same could has been observed as it was the case before with primary health care facilities' availability. In this case, the EUD *Timor-Leste* also highlighted the EC contribution to "reconstructing three district hospitals and the National referral hospital". Whereas EUD *Zambia* mentions the support of "*implementation of the National Health Strategic Plan which includes improving access to health facilities by constructing new health facilities ensuring the health services are provided as close to the people as possible."*

As regards the **urban areas**, the answers of the EUDs reveal the following

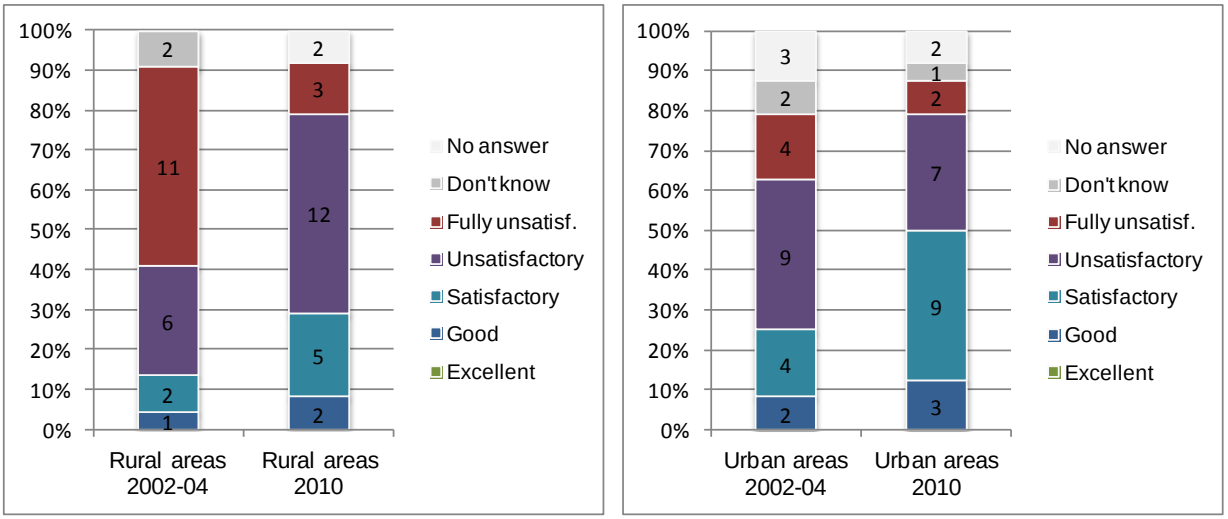
46% of the EUDs reported "unsatisfactory" rates of availability in 2002-04 and 13% (three out of 24) said it was fully unsatisfactory. Those three EUDs were *El Salvador*, *Mozambique* and surprisingly *Timor-Leste*.

In 2010 that percentage decreased to 29% and correspondingly, more satisfactory rates for availability increased up to 58% in 2010. Among those mentioned before, only EUD *Timor-Leste* reported an important improvement, shifting its rate from "fully unsatisfactory" in 2002-04 to "good" in 2010. The other reported that availability remained "unsatisfactory in 2010. The other of EUDs that reported an improvement were: EUD *Laos*, EUD *Vietnam*, EUD *Bangladesh*, EUD *Afghanistan*, EUD *Syria*, EUD *Burkina Faso*, EUD *Morocco*, EUD *Zambia* and EUD *Ecuador*.

Although, overall, the **availability of secondary health facilities** has improved, it **remains quite unsatisfactory compared to the availability of primary health care facilities**. The EUDs' comments go mainly in the direction that the EC keeps its primary focus on primary health care. Only one EUD (EUD *Philippines*) has recognized that secondary health care is covered by the EC support; however, the EUD added, that this support is made in a secondary level.

2.2.1.3 Coverage with primary health care facilities with appropriate equipment and budget for maintenance and expenditure

Figure 31: *Q1c: Coverage with primary health care facilities with appropriate equipment and budget for maintenance and expenditure*



Source: EUD Survey, 2011, Particip GmbH

In 2002-04, 11 EUDs out of 24, (50%), reported that the coverage with **primary health care facilities in rural areas with appropriate equipment and budget for maintenance and expenditure** was "fully unsatisfactory". In addition, 27% reported it as "unsatisfactory". In the perception of the EUDs, this dramatic situation in 2002-04 slightly improved until 2010 although still 50% of the EUDs reported "unsatisfactory" coverage and three, EUDs *El Salvador*, EUD *Myanmar* and EUD *Zambia* remained with it scoring as "fully unsatisfactory".

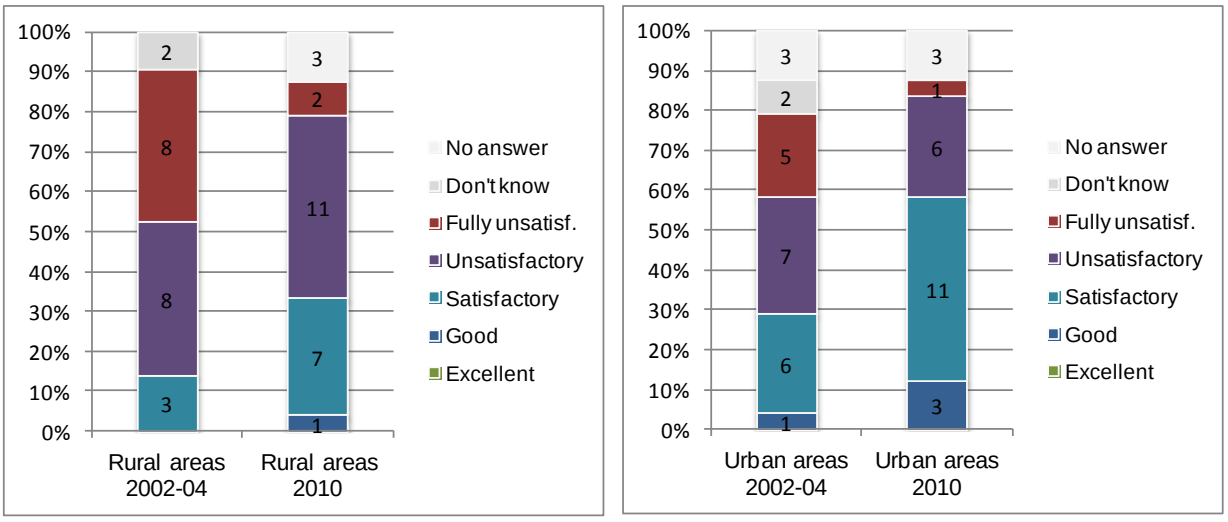
In the **urban areas** coverage seems to be better compared to rural sites; however, still 54% of the EUDs reported "unsatisfactory rates". Four EUDs (17%) reported coverage primary health care facilities with appropriate equipment and budget for maintenance and expenditure as "satisfactory" and 8% (two out of 24, EUD *Barbados* and EUD *Syria*) reported it as good. For 2010, the situation definitely improved and 51% of the EUDs reported satisfactory rates of coverage. The best rates "good" were provided by the same EUDs as for 2002-04, EUD *Barbados* and EUD *Syria* with the EUD *Afghanistan* adding up to the list.

Although the availability of primary health care facilities has substantially improved, as seen in the question before, **the coverage with appropriate equipment and budget for maintenance and expenditure remains quite problematic** in the eyes of the EUDs. Some explanatory reasons given by EUDs are related to issues of corruption. 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 recognized that the EU has contributed immensely to the improvement of coverage with primary health care facilities with appropriate equipment and budget for maintenance and expenditure health system; however they both argued that sustainability after the projects ended remain a challenge, hence more emphasis should be put on health governance in further EU support. 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 that "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. Health system is now in recovery phase".

On the other hand, other EUDs offered explanatory reasons for the improvements observed from 2002-04 until 2010. These comments were mainly in the direction that the presence 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.

2.2.1.4 Coverage with secondary health care facilities with appropriate equipment and budget for maintenance and expenditure

Figure 32: *Q1d: Coverage with secondary health care facilities with appropriate equipment and budget for maintenance and expenditure*



Source: EUD Survey, 2011, Particip GmbH

In relation to the degree of **coverage with secondary health care facilities in rural areas with appropriate equipment and budget for maintenance and expenditure importance**, the pictures look as follows:

- In 2002-04, eight out 24 EUDs (38%) rated the coverage with secondary health care facilities with appropriate equipment and budget for maintenance and expenditure in rural areas as "fully unsatisfactory". An equal percentage of 38% considered it "unsatisfactory" for the same years. Only three EUDs (EUD *Syria*, EUD *Zimbabwe* and EUD *Barbados*), said that coverage was satisfactory.
- In 2010, the situation was better and the number of EUDs finding the coverage "satisfactory" increased up to 29%. Only one EUD (EUD *Afghanistan*) rated as good.

For **urban areas** the picture looks a bit better, in general.

In 2002-04, five EUDs out of 24 (21% - EUD *Bangladesh*, EUD *Myanmar*, EUD *Burkina* and EUD *Congo*) declared the coverage as "fully unsatisfactory".

- In 2010 their rates were the same except for EUD *Burkina Faso* scoring higher with "satisfactory". Summarizing, satisfactory and good rates increased from 29% in 2002-04 to 58% in 2010.

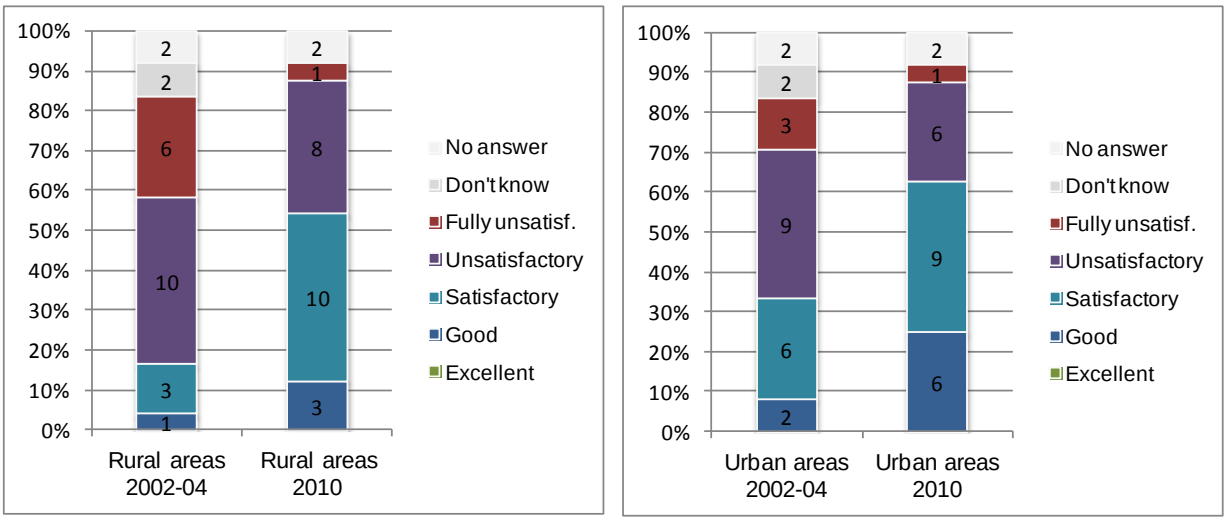
Although, according to the EUDs, overall improvements have been achieved, still **problems remain with coverage with secondary health care facilities with appropriate equipment and budget for maintenance and expenditure importance.** Among the reasons given by the EUDs are the following: problems of sustainability, as in the case of coverage with primary health care facilities and not enough attention paid to secondary health by the EC. This was illustrated by EUD *Vietnam* that commented *"Bilateral support of the EC focuses on primary health care, promotion and preventive care only. It is expected, however, EC's capacity building support will indirectly benefit service delivery at different levels"*.

Problems of budget were repeatedly mentioned, with e.g. the EUD *Nigeria* commenting that *"Secondary Health facilities have not generally been a direct recipient of EU support from the EDF except of course via Budget line call for proposals."* EUD *Burkina Faso* and EUD *Myanmar* also highlighted *"problems with maintenance of budget"* and *"very limited procurement of medical equipment"* respectively. Only one EUD, *India*, commented specific support from EC to support secondary health care.

2.2.1.5 Availability of essential drugs

The percentage 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*). "Satisfactory" rates also improved considerably from 13% (three out of 24) in 2002-04 to 42% in 2010. In urban areas, according to the EUD's perception, the situation has globally improved and the countries with either satisfactory or good availability of essential drugs, increased from 33% in 2002-04 to 63% in 2010. On the other hand, still six out of 24 EUDs (*India, Philippines, Timor-Leste, Zambia, South Africa and El Salvador*) attributed "fully unsatisfactory "rates to the issue of **availability of essential drugs in rural areas during the period 2002-04**. This number was reduced to one (EUD *El Salvador*) in 2010. EUD's scoring with "Unsatisfactory also reduced from 42% in 2002-04 to 33% in 2010.

Figure 33: *Q1e: Availability of essential drugs*



Source: EUD Survey, 2011, Particip GmbH

Overall, EUDs seem to perceive a trend towards increasing availability of drugs. Generally, they attribute the reasons for that improvement to EC policy support and technical assistances, EC contributions to logistic and procurement reforms and the opportunity that SBS brings to governments to allocate funds and set up priorities about the diseases to be tackled, and essential drugs. Examples include:

- *" While the general EC program provided some funds for medicines, the **EC also provided support at the policy level with TA** facilitating the passage of 2 important laws, i.e. Universally Accessible Cheaper and Quality Medicines Act of 2008(RA 9502) and the Food and Drug Administration (FDA) Act of 2009(RA 9711). These two Republic Acts increase the*

power of the government in oversight and regulation and the results of their implementation would produce important public benefits; another important TA complement is the Good Pharmaceutics Procurement Practices at the local government level". (EUD *Philippines*).

- *"EU support has largely been in the area of Immunization and excluding the purchase of vaccines or medicines. However, EU contribution to logistics and infrastructure at the LGA and State levels has enhanced the storage and distribution of various medical supplies including vaccines and essential drugs".* (EUD *Nigeria*).
- "*Les programmes d'appui budgétaire focalisent aussi leur action sur la disponibilité des médicaments essentiaux dans les centres de santé".* (EUD *Morocco*).
- "*Sector budget support and corresponding SWAp policy dialogue gave opportunity to government to allocate funds and set up priority disease control programmes including essential drugs".* (EUD *Mozambique*).

2.2.1.6 Coverage with medical doctors

Figure 34: *Q1f: Coverage with medical doctors*

Source: EUD Survey, 2011, Particip GmbH

For 2002-04, most EUDs perceived that the **coverage with medical doctors in the rural areas** of their assigned countries as quite unsatisfactory. 38% of EUDs (nine out of 24) rated the coverage as fully unsatisfactory and 29% as unsatisfactory. On the other hand, only three EUDs (*Moldova*, *Syria*, *Zimbabwe*) rated it as satisfactory and EUD *Barbados* found it "excellent".

In 2010, those EUDs that rated the coverage with medical doctors in rural sites as "fully unsatisfactory" decrease to 13% (three out 20, EUDs *El Salvador*, *South Africa* and *Yemen*). Despite this improvement the situation is still perceived as problematic, since 63% (15 out of 24) of EUDs continued finding the coverage with medical doctors in rural areas "unsatisfactory" in 2010.

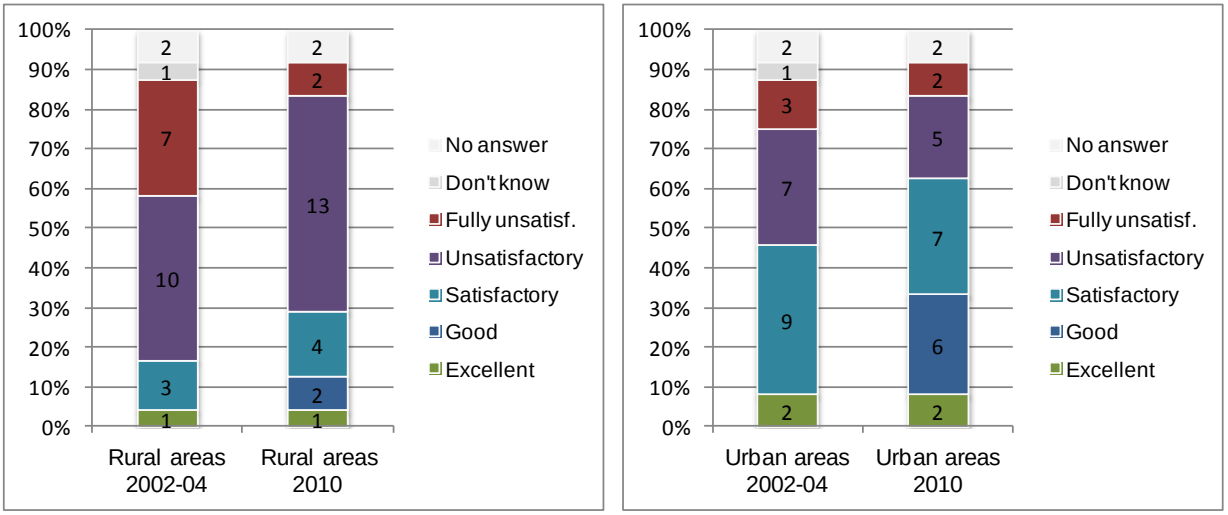
For the **urban areas the picture looks totally different**. The number of EUDs reporting an improvement in the coverage with medical doctors increased to 67% in 2010 from 37% in 2002-04. The EC supports to policy and to capacity building have been put forward as factors that contribute to the improvement of the availability of doctors (e.g. EUD *India, Vietnam, Afghanistan, Burkina Faso, Zimbabwe, Mozambique, Egypt, Moldova, Yemen and Ecuador*), .

Nevertheless the EUDs' comments suggested that, in order to step forward on this issue, the **emphasis should be put on combating absenteeism more than increasing the number of doctors**. This is 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* was another EUD denouncing poor retention capacity of health workers by the health system*: "University Training collapsed during 2007-2009.*

Poor Retention capacity of the public health system". 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".*

2.2.1.7 Coverage with nurses/midwifes

Figure 35: *Q1g: Coverage with nurses/midwifes*



Source: EUD Survey, 2011, Particip GmbH

For the first period of the evaluation (2002-04), 29% of the EUDs, seven out of 24, indicated that the **level of coverage with nurses/midwives in the rural areas** was "fully unsatisfactory". This perception changed until in 2010 where only 8%, two EUDs out of 24, concretely the EUDs *El Salvador* and *Yemen*, were that pessimistic. Although this decline is important still 54% of the EUDs agreed that the situation remain unsatisfactory in 2010. So in total more than 60% of the respondents indicate that the situation is far from being acceptable.

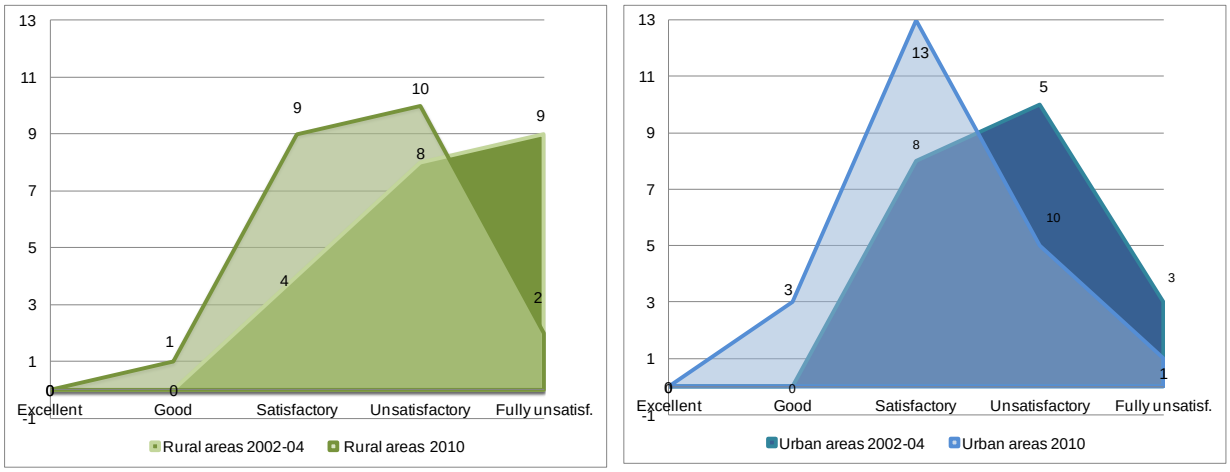
Only EUD *Barbados* considered the availability with nurses/midwives as "excellent", while only two EUDs (*Congo and Timor-Leste*) said it was "good" and only four EUDs out 20 stated it was "satisfactory".

According to the EUDs, the **situation regarding nurses/midwives is better in urban areas**. 29% of the EUDs indicated "unsatisfactory" rates in 2002-04 and 13%, three out of 20 EUDs (*El Salvador*, *Timor-Leste* and *Mozambique*) found it "fully unsatisfactory". In 2010 the picture improved and a total of 54% of EUDs rated "good" (25%) and "satisfactory" (29%) while EUD *Barbados* and EUD *South Africa* found it "excellent".

From the few qualitative comments made by the EUDs only one, EUD *Nigeria* mentioned a specific programme to increase the number of midwifes in rural areas. The EC supports the National Primary Health Care Development Agency which has recently introduced a midwifery service scheme that has increased the average number of midwives in the rural areas. Also EC support in *Timor Leste* includes this aspect, providing scholarships for more than 500 students for nurse/midwifery diplomas, and helping to re-establish quality curriculum and providing teaching equipment to the National Medical Teaching Centre.

2.2.1.8 Overall quality of health care provision

Figure 36: Q1h: Overall quality of health care provision



Source: EUD Survey, 2011, Particip GmbH

For 2002-04, 71% of the surveyed EUDs (17 out of 20) indicated a **'low overall quality' of health care provision in rural areas**: nine EUDs said that the overall quality was 'fully unsatisfactory' (*Philippines, Vietnam, Timor-Leste, India, El Salvador, Yemen, Burkina Faso, South Africa and Congo*), eight EUDs indicated "unsatisfactory" rates. On the other hand, 17% of the EUDs (four EUDs out of 24 - B*arbados, Moldova, Syria and Zimbabwe*) scored the overall quality of health care provision as "satisfactory" in their respective countries.

For 2010 the picture appears to have changed. Those EUDs rating overall quality in the lower rates decreased to 50% while those indicating better overall quality increased up to 42%. Perhaps surprisingly, the EUD *Afghanistan* scored the overall quality of health care provision for rural areas as "good" in 2010 while in 2002-04 the same was scored as "unsatisfactory".

For **urban areas** the improvement put forward by the EUDs between 2002-04 and 2010 was quite substantial: the number of EUDs finding the overall quality "satisfactory" or "good" improved from 33% in 2002-04 to 67% in 2010. Among those who moved from negative scores ("unsatisfactory" or "fully unsatisfactory") in 2002-04 to "satisfactory" or "good" scores in 2010 are the EUDs *Bangladesh*, *Timor-Leste*, *Afghanistan*, *Morocco*, *Nigeria*, *South* Africa and *Ecuador*.

In general the **EUDs' perceptions of the quality of the health provision tend to indicate signs of remarkable improvement over the evaluation period**.

However, most of the EUDs commented that although the quality is satisfactory, there are still many imbalances between urban and rural areas in terms of coverage with medical professionals, provision with medical equipment and general service delivery for health programmes. Although EUDs agreed that the EC has contributed to improve the overall quality of the health provision in the rural sites, this improvement has been achieved only to a certain extent and the situation remains challenging.

For instance, the EUD *Philippines* highlighted important geographical variation across provinces in the achievement of better health outcomes and EUD *Moldova* and EUD *Ecuador* commented that the differences on the quality of the health provision between rural and urban area still an issue to be resolved.

Examples include:

- *"Overall, the quality of health care is satisfactory, but there are many rural areas facing severe problems in terms of coverage with medical professionals and provision with medical equipment"*. (EUD *Moldova*)
- *"There is a gap between the health services provided in the rural and urban areas. EC has contributed to its improvement in four provinces of the country: Esmeraldas (North of the country - border), Bolivar, Cotopaxi and Chimborazo (Central part of the country) but not nationwide)."* (EUD *Ecuador*)
- *"Overall, the progress in achieving better health outcomes showed variation across provinces with pockets of successful implementation of service delivery for health programs. Most LGUs directed EU, DoH and other supplemental funds to investments in infrastructure and equipment along the main thrusts of the reform agenda with high priority to mother and child care and the rehabilitation and upgrading of rural health units and hospitals to basic emergency obstetric*

care and comprehensive emergency obstetric care. However, the progress has not yet been fully translated into public benefit results and achievement in health-related MDGs". (EUD *Philippines*).

- "*The EUD has supported the Ministry of Health in developing and revising the Health Management information System to enable the Ministry to effectively monitor the progress in implementing the key health targets including the MDGs. The EUD has also worked with Health Professions Council of Zambia, which is a regulatory body accrediting health facilities and health professionals, in developing Healthcare Standards for accreditation and inspection of Public and Private Health Care facilities ensuring quality is maintained."* (EUD *Zambia*)

2.2.2 Constraining factors on health care provision

Question 2: What, in your view, are the major constraining factors of quality health care provision in your country?

The survey suggested four major constraining factors related to the overall quality of the health care between 2002-04 and 2010. Not all EUDs who had answered this question provided these six factors and it was difficult to group factors into regional patterns. This is an attempt to group together the trends which emerged from the 16 EUDs (out of 21) that replied to this qualitative question.

According to the EUDs, the first issues that seemed to have hampered further improvements of sector performance and outcomes in primary and secondary health care between 2000 and 2010 are clearly **limited number of qualified health human resources** (mentioned by 12 countries) and **governance issues** (cited by ten countries of the sample) followed by **poor infrastructure and equipment issues** (mentioned by five countries) and **limited financial resources** (given by five countries). The rest of the issues cited were concerning other country specific issues.

Table 10: Q2: Top four constraining factors most mentioned by EUDs

Constraining factor	Commented by:
• Lack of enough qualified human resources	EUDs in Lao, Philippines, Bangladesh, Moldova, Syria, Nigeria, Yemen, Egypt, Burkina Faso, Congo, Zimbabwe, El Salvador, *Zambia*
• Governance and sector management issues	EUDs in Barbados, Philippines, India, Moldova, Syria, 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

2.2.2.1 Lack of qualified human resources

In the **ACP region**, the EUDs *Nigeria*, *Burkina Faso, Congo, Zambia and Zimbabwe* commented numerous issues related to availability of health human resources, curriculum and competency of the health workers. The EUDs provided detailed comments on several issues affecting success; such as low motivation of health workers, perhaps due to inappropriate salary scale (EUD *Burkina Faso*), limited qualification of the health staff (EUD *Congo*) as well as "brain drain" of health professionals with good technical skills and knowledge. It is worth noting the comment by EUD *Zimbabwe* which suggested a negative impact of "bilateral projects" on the issue of "brain drain". Its comments are as follows: "*The best elements with knowledge of clinic and management of priority programmes were drained towards bilateral projects including huge actors mainly USAID/CDC (+1000 of local staff) and iNGOs. Also EU member states bilateral programmes take some individuals".*

In the **Asia region**, the EUD *Philippines and EUD Bangladesh* noted that an important barrier to the provision of quality health care is the lack of quality health workforce, particularly in the rural areas, more so in remote and poor areas. In *Lao* according to the EUD there is a very low human resource capacity and health schools and universities. In the **MEDA-ENPI-TACIS countries**, the EUD to the *Syria*, highlighted the shortage of nurses, especially in under-privileged areas such as the North East, while EUD *Yemen and Egypt* criticized the non-existence of human resources policy and the inappropriate salary scale for health workers. There was only one **Latin American** respondent, EUD *El Salvador,* which, in the same way as the others, commented on issues of low qualified health workers (doctors, nurses and administrative staff).

2.2.2.2 Governance issues and sector management issues

For three of the EUDs in **ACP countries** that replied, governance issues are considered to have hampered further improvements in primary and secondary health care. While *"lack of clear prioritization of health interventions in the Ministry"* was noted in *Nigeria*, problems of "supervision and control" were highlighted for *Burkina Faso* and the lack of a quality assurance system was mentioned by EUD *Barbados*.

In the Asian region, EUDs pointed towards governance issues, including inadequate capacity of public health planning and management in *India* and lack of political will in *Philippines* where issues of poor management capacities especially at decentralized levels were also mentioned.

In **MEDA-ENPI-TACIS region,** EUD *Yemen* mentioned the lack of clear policies in the health sector and poor donor coordination process along with the donor support options. The EUD claimed that "*harmonization suffers from a lack of leadership of the MoPHP on one hand and of the still young and slow-moving harmonization process among donors on the other hand".* EUD *Moldova* and EUD *Syria* highlighted the poor management of health districts and health care facilities respectively.

There was only one **Latin American** respondent, EUD *Ecuador*, that highlighted poor national coordination and leadership*: "The Ecuadorian health sector has lacked of continued long term state policies. The sector is much segmented. The Ministry of Health is weak rector".*

2.2.2.3 Lack of infrastructures and equipment

In **Asia region**, the *India* EUD drew attention to problems on procurement, logistics and maintenance, exemplified with the problems of availability of drugs and lack of equipment in the health centres especially in rural areas. It argued that *"infrastructure did not keep up with population growth*". In the **ACP region** the EUD *Zimbabwe* pointed out the deterioration of health infrastructures, drugs shortages and a drastic decline in the quality of health services available for the population most likely accelerated by the hype-hyperinflation during 2007-2009. The same statement was made by the EUD *Zambia*.

Lack of modern medical equipment and poor management of the scarce resources (i.e. distribution of health facilities that follows more the political patterns rather than needs and mainstreaming) were also noted by the two EUDs in the **MEDA-ENPI-TACIS** region, *Moldova and Yemen respectively.* In **Latin America** region, the EUD *El Salvador* mentioned the insufficient infrastructure in terms of buildings, equipment, furniture and ambulance.

2.2.2.4 Limited financial resources

For two of the EUDs in **ACP countries** that replied, limitations in financial resources was cited as an issue that seemed to have hampered further improvements of sector performance and outcomes. While *Nigeria* highlighted issue of more than 70% out of pocket expenditure for health and a lack of clear understanding of the political economy of health *Burkina Faso* noted inadequate budget for maintenance of the improvements of sector performance and outcomes.

In the **MEDA-ENPI-TACIS** region *Yemen* indicated low government prioritisation that lead to ineffective allocation of resources.

In **Asia region**, EUDs in *Lao and Philippines* highlighted insufficient government recurrent budget to health sector and out-of-pocket expenditures as the major problems. The EUD *Vietnam* also added as a key problem the "*lack of understanding about what does it really mean by quality health care and good performance in service provision"*.

2.3 Affordability of health care

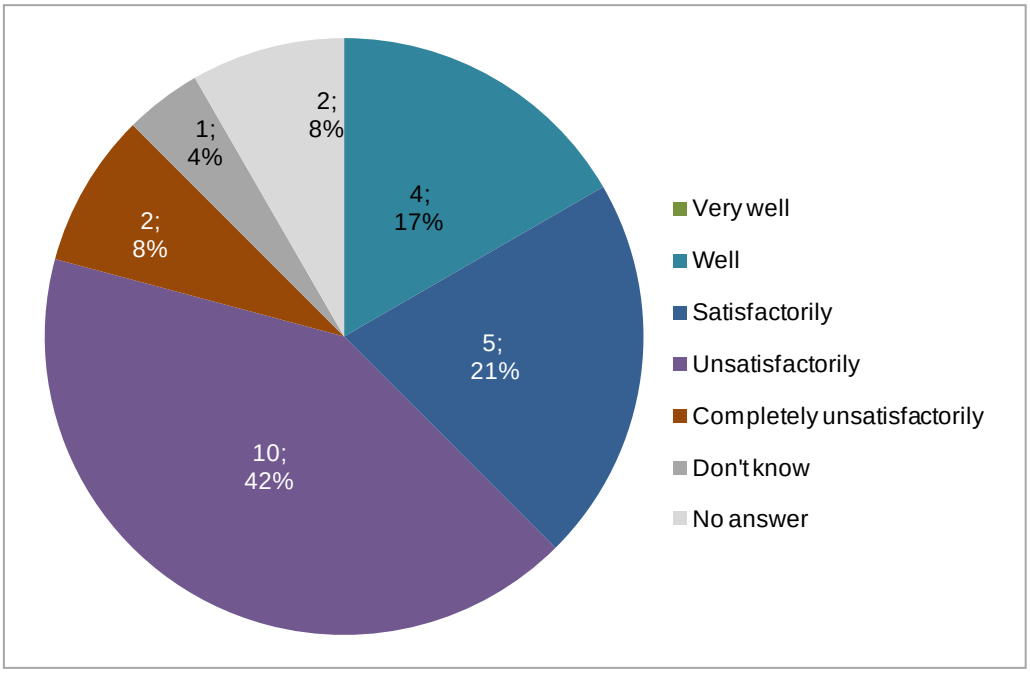
2.3.1 Needs of the poor addressed in health finance policy

Question 3: How well does the country's health finance policy explicitly address needs of the poor and of persons with special health care needs?

As shown in the graph below, the responses on how well the country's health finance policy is **addressing the needs of the poor and of persons with special health care needs** were mainly scored as **"unsatisfactorily"** (10 out of 22 responses) and completely unsatisfactory (two out of 22 responses).

Together, only one third of the respondents answered this question either with "satisfactory" or "well". The countries answering "satisfactory" (five out of 22 respondents) where *Lao, Afghanistan, Nigeria, DRC, Morocco,* whereas *Egypt, Syria, South Africa* and *Zimbabwe* rated the question with "well".

Figure 37: Q3: Needs of the poor addressed in health finance policy



Source: EUD Survey, 2011, Particip GmbH

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

Burkina Faso and *Vietnam* also claimed to have in place such a policy however both replied "unsatisfactorily" to the question before. EUD *Burkina Faso* argued that with 43% of the population living below the poverty line ensuring financial access to services is a huge challenge as such while EUD *Vietnam* reported that the policy implementation is hindered by other policies, by the limited capacity of staff and by the unavailability of essential services.

In *South Africa*, the EUD reports that the SA National health Act (2003) grants free access to primary health care for those who cannot afford it and specifically for pregnant women and children under five. Also RVs and TB-treatment are provided for free. At the same time, the SA Government does not control the prices in the private health care sector, which makes those services of often higher quality inaccessible for the poor.

Among those EUDs who declared that the country's health finance policy was "**unsatisfactorily"** addressing the needs of the poor and of persons with special health care need, only two EUDs reported to have no policy in place (*Moldova, Yemen*). All other EUDs stated that the needs of the poor and of persons with special health care needs are insufficiently addressed with the existing policies.

The main **reasons that explain why the needs of the poor and of persons with special health care needs were insufficiently address** are:

In **Asian region**:

- EUD *India* specified that while the government instituted a health insurance for people below the poverty line (460 million people) – the "RSBY" – the **financial treatment thresholds were too low** to be competitive with better paying clients and could not cover special needs. The "very poor" population which is still above the poverty line was not covered at all (it accounts for 400-500 million people) and many hospitals refused treatment under RSBY. **Regulatory mechanisms** to prevent rejection of poor people **were missing.** According to the EUD, *"Special care needs are poorly addressed one out of 35 states has recently introduced palliative care. Given the huge number of people who are not covered for special care, if care at all, health financing is not satisfactory"*.
- 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 despite the implementation of universal health insurance (UHI). In 2006, the share of health spending in per capita expenditures was at its highest level 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.

- In *Myanmar* the EUD commented that "*although social security **policy and laws** have been drafted since the 1950s, they are often **poorly designed** and thus the implementation of social protection in health is extremely limited to date*".

In **ACP region**:

- EUD *Mozambique* commented that *"**fungibility** is a problem: the USD 100 million SBS (not counting bilateral and project support) is wiped out by a decreasing proportion of Government funding (although in absolute local currency terms it kept on increasing); the share of Government funds to health decreased from 14% in 2006 to 7% in 2010. Private sector contribution is marginal in a very poor population but is an important earner for the very few health professionals. Insurance base is still unrealistic as the population is still too poor and has no salaries to afford it"*.

In the **Latin American region**, EUD *Ecuador* reported that while the health services are free of charge and there has been an increase in attention and access, quality remains an issue. It added that although there was an increase in the budget, the needs are still high.

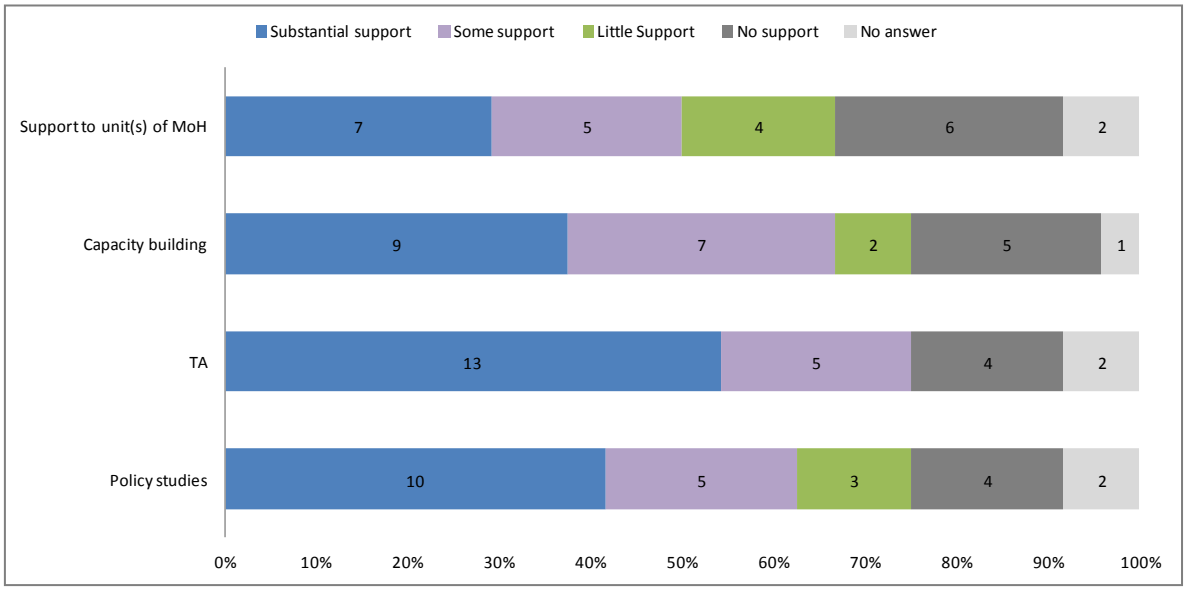
2.3.2 Means of EC support to pro-poor health finance policies

Question 4: Through which of the following means did the EC support pro-poor health finance policies?

The following figures provide an overview of EUDs' responses which means have been used by EC to support pro-poor finance policies.

The **general trend** showed that, according to EUDs, the main means used by EC to provide support to pro-poor health finance policies has been **technical assistance (13 EUDs rate give substantial support through TA)** followed by policy studies (10 EUDs), capacity building (nine EUDs) and in the last place through supporting the units in the MoH dealing with health finance (seven EUDs).

Figure 38: Q4: Means used by EC to support pro-poor health finance policies (several answers possible)



Source: EUD Survey, 2011, Particip GmbH

The **regional trend**, extracted from the qualitative analysis of the answers from EUDs, showed the following:

In the **ACP region** the four means were used to a certain extent in order to support pro-poor finance policies in *DRC*.

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 quoted by three EUDs of this group (*Barbados*, *Mozambique* and *DRC*) and only one (*Mozambique*) reported to also provide support to the units in the MoH dealing with health finance.

A deeper look at the countries show for instance that in *Barbados*, the EC provided technical assistance together with policy studies on chronic non-communicable disease and also capacity building to the government.

EUDs in *DRC* and *Mozambique* confirmed the same trend than in *Barbados*, however their experiences of technical assistance were different. While in *DRC*, technical assistance was successfully used, according to the EUDs, at long and short terms and also at both, 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 according to the EUD has lead to "waste opportunities to improve provincial and central projects".

In the region of **Asia,** the trend observed by seven EUDs, confirmed that technical assistance was the most used mean followed by capacity building and support the units of the MoH dealing with health finance. Policy studies were less reported than in ACP region. A more detailed look at country level shows that those EUDs who reported the use of policy studies were in *Afghanistan*, *Myanmar*, *India* and *Timor-Leste*.

Technical assistances were provided in all of the seven Asian countries and were mainly done to support the development of Health Care Financing Strategies. As regards capacity building, the main objectives were to upgrade the financial skills of the staff from the ministry at central and decentralized level and to train them on technical aspects of setting up social protection schemes. The units in the MoH supported by the EC were the department of Finance and Planning support to central and state level, the Health Department of Planning and Finance and the department of Health Insurance.

In **ENPI-MEDA-TACIS region** the trend was different. Four EUDs from this region (out of five from the sample of 25) *Moldova, Yemen, Syria and Morocco* (exception being *Egypt*) reported the use of capacity building to support pro-poor health finance policies. EUD *Egypt* reported using only policy studies like the 'Primary Health Care Provider Network Review of the National Strategy'. EUD *Yemen* declared using specific capacity building measures only in the area of reproductive health. 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, to a certain extent.

For the **Latin American region**, EUD *Ecuador* reported using the four means to an equal degree. For instance, the EC collaborated with consultancies to support the design of policies in areas such as drugs, model of health care, management information of the health sector, a proposal of the reform of the model of management of the health sector, social network in health sector, certification and recertification, actuarial and financial studies of health services.

Technical assistance was also provided through the PASSE programme to support the undergoing reform of the health sector.

Capacity building was financed by the EC at central level and for local authorities, medical staff, indigenous traditional health care providers and social health promoters. The EC also provided some support to units of the MoH on the above mentioned "actuarial and financial studies of the health services".

Question 5: Through which other means did the EC support pro-poor health finance policies?

The further comments from the EUDs indicated the following other means used by the EC to support pro-poor health finance, such as:

- Projects under thematic instruments - NSA and LA;
- General Budget Support;
- SBS within the framework of a strategic health sector plan ;

Projects under thematic instruments - NSA and LA

The most mentioned "other" mean was the financing of projects under thematic instruments such as **"**Non-state actors and local authorities in development" (NSA and LA) that aims at encouraging non-state actors and local authorities to get more involved in development issues. It is based on Article 14 of the EU Regulation establishing the Development Co-operation Instrument (DCI) and it replaces the ancient NGO co-financing and decentralised co-operation programmes.

This mean was mentioned by EUDs from all the regions, for instance in **Asia** the EUD *Timor-Leste* and *Myanmar* indicated that the EC 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 ethnic areas which included pro-poor and exemption mechanisms and the same for vertical services (e.g. TB, HIV, malaria). It initiated mechanisms of service delivery, hoping that MoH would pick up the initiative and financing the services.
In **ENPI-MEDA-TACIS** region EUDs *Moldova* and *Syria* have also indicated the use of this mean 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.
In the **ACP region** the EUD *Nigeria* indicated the use of grants to CSOs o NGOs but added that compared with the size of the country, most of these were small grants.
In the **Latin American** region the EUD *Ecuador* also indicated the use of projects under thematic instrument NSA-LA and reported that since 2009 the EUD had contracted several projects on this nature.

General budget support

General budget support was mentioned in EUDs from **Asia and ACP regions**. In particular EUD *Lao* and EUD *Burkina Faso* indicated the use of a **variable tranche based on health outcomes**, 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 the MDG performance tranche in *Burkina Faso*.

Sector budget support

Sector budget support was mentioned in the **ACP region** by EUD *Mozambique* where according to the EUD the strategic health sector plan focused on creating basic health care on the basis of universal access free at the point of use. Very small user fees were maintained (1 Mozambican Metical (MZN) per consult = 0.02 Euro).

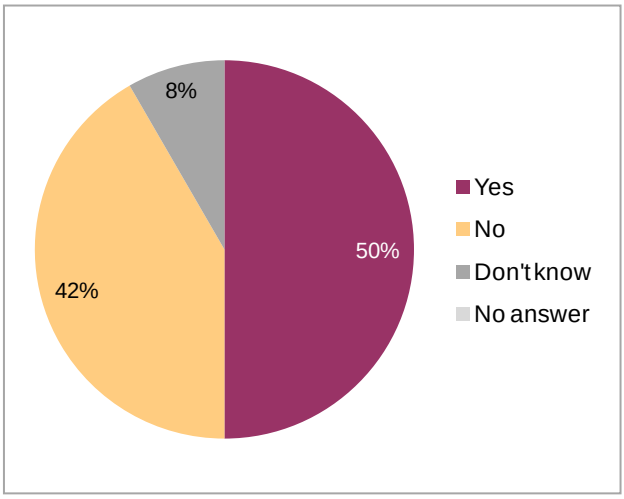
2.3.3 Financing schemes

2.3.3.1 Existence of financing schemes

Question 6.1.: Is there a public health care financing scheme available to the general public?

Out of 24 EUDs giving their answer to this question, **12 EUDs** (**50%** *Vietnam, Lao, Philippines, Timor-Leste, Myanmar, Morocco, Moldova, Nigeria, Egypt, DRC, Ghana,* and *Ecuador)* reported that there was a **public health care financing scheme available to the general public** in their countries. Ten EUDs out of the 22 (42% *India, Bangladesh, Yemen, Syria, South Africa, Zambia, Zimbabwe, Burkina Faso*, *Barbados, and El Salvador*) responded negatively whilst two out of 24 (8%) indicated they didn't know (EUD *Afghanistan* and *Mozambique)*.

Figure 39: Q6.1: Existence of a health care financing scheme available to the general public



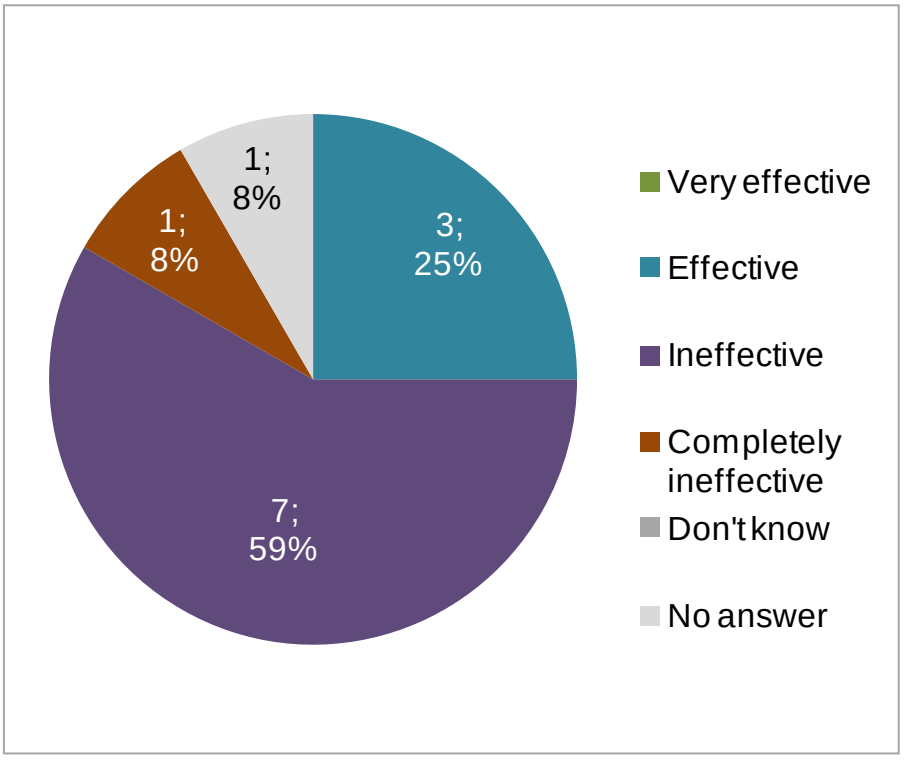
Source: EUD Survey, 2011, Particip GmbH

From the results it appears that the availability of public health care financing scheme is at good level since it is available to the general public in half of the countries surveyed. However when asking for the level of effectiveness of those public health care financing schemes the picture looks quite different (see figure below).

2.3.3.2 Effectiveness of financing schemes

Question 6.2.: In your opinion, how effective is it in financing needed care?

Figure 40: Q6.2: Effectiveness of financing needed care



Source: EUD Survey, 2011, Particip GmbH

The figure above shows the proportions of the ratings from the EUDs as regards the level of effectiveness of the public health financing schemes to finance the needed care. From the 12 EUD which answered the previous question by saying that public health care financing scheme was available to the general public, only three EUDs (25% *Egypt*, *Moldova* and *Morocco*) considered that these schemes were effective in financing the needed care. The vast majority, seven EUDs (*Lao, Philippines, Vietnam, Timor-Leste, Nigeria, DRC* and *Ecuador*) considered the schemes ineffective and one of them (EUD *Myanmar*) reported it was completely ineffective.

Overall, it seems that while availability of public health care financing scheme is at good level, the **effectiveness of the schemes was quite low**.

The general trend indicates **regional variation**.

Overall the **highest level of effectiveness of the public health financing schemes was reported in ENPI-MEDA-TACIS region**. The type of schemes reported in these countries was:

- EUD *Egypt*, said there was illustrative actuarial scenario designed by the GoE that explored several financial aspects of the new health insurance by means of simulations and projections.
- 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.
- 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.

The **worst levels of ineffectiveness were reported in the Asian region**.

- EUD *Lao* 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.

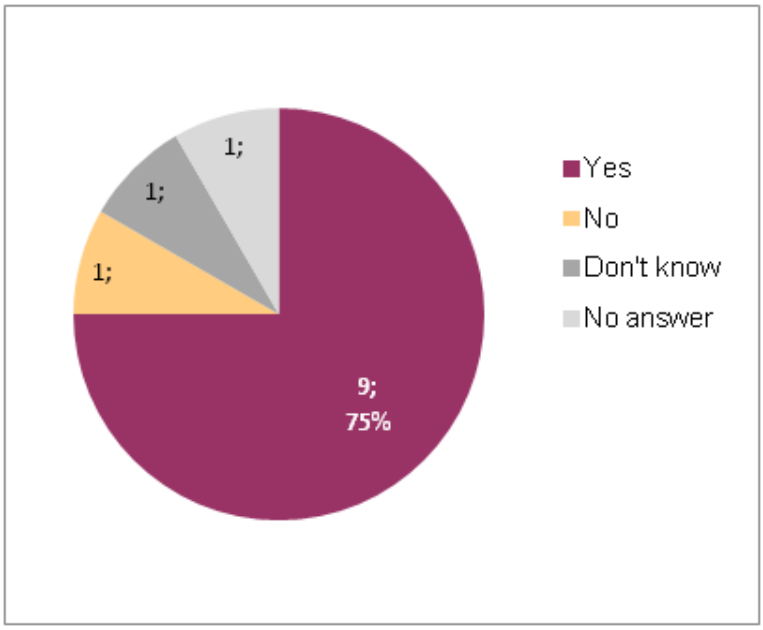
- EUD *Philippines* declared that despite the implementation of universal health insurance under the Philippine Health Insurance Corporation (PHIC of 1995), coverage in the country remained low particularly for the poor and that health insurance coverage was no guarantee of financial protection and enhanced 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; 2) decentralisation and hospital autonomy distort the health financing.

2.3.3.3 Outcomes of financing schemes

Question 6.3.: In your opinion, has the public health care financing scheme resulted in additional health care consumption by households?

11 of the 12 EUDs with an existing public health care financing scheme considered that public health care financing scheme had resulted in additional health care consumption by households. Only EUD *Philippines* answered negatively. The following tables show the answers by country on this question:

Figure 41: Q6.3: Public health care financing scheme has resulted in additional health care consumption by households



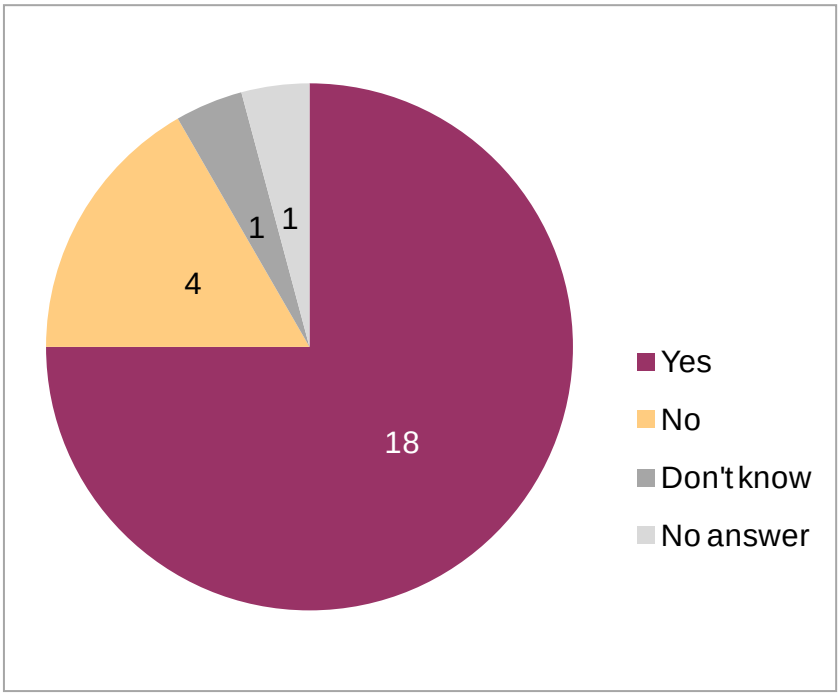
Source: EUD Survey, 2011, Particip GmbH

2.3.4 Cost recovery schemes

Question 7.1.: Have cost recovery schemes been (put) in place between 2002 and 2010?

The answers from the EUDs were almost **equally positive and negative**. Out of 24 EUDs that answered to this question, nine EUDs (*Lao, Philippines, Myanmar, India, Barbados, DRC, Zambia, Morocco and Egypt*) stated that cost recovery schemes were put in place between 2002 and 2010; eight EUDs more (*Vietnam, Bangladesh, Timor-Leste, Afghanistan, Mozambique, Zimbabwe, Yemen and El Salvador*) said that cost recovery schemes were not put in place and six EUDs (*Moldova, Syria, Burkina Faso, Ghana, Nigeria, South Africa and Ecuador*) reported to not be aware of it. EUD *Barbados, Philippines* and *India* reported that those schemes were put in place approximately since 2008. In *Egypt* the EUD indicated the schemes were in place since 2006, in *Lao, Zambia and DRC* the schemes were available since 1980, 1993-2005 and 1996 respectively and finally the EUD *Myanmar* reported that cost recovery schemes have “always” been in place.

Figure 42: Q7.2: Have cost recovery schemes been (put) in place between 2002 and 2010?



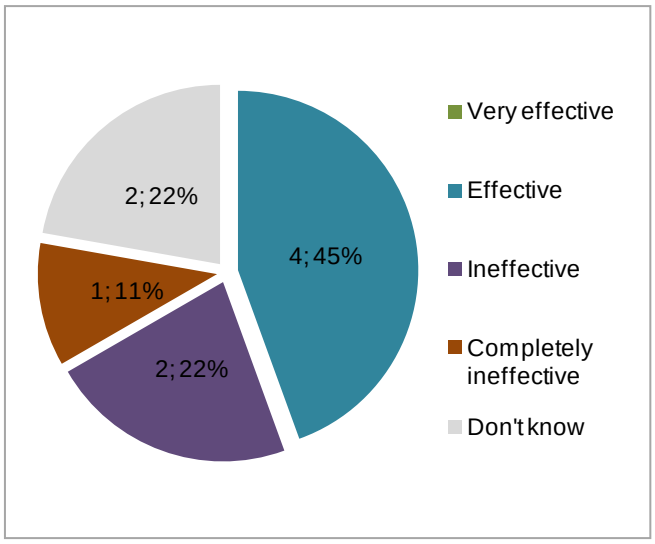
Source: EUD Survey, 2011, Particip GmbH

2.3.4.1 Effectiveness of cost recovery schemes

Question 7.2.: To what extent were they effective in generating anticipated revenue for the health sector?

As regards the **level of effectiveness for generating anticipated revenue for the health sector**, the figure below shows the overall rating reported by the EUDs. Of the nine EUDs that positively replied the question before, **only four** (45% EUD *Egypt, Zambia, Lao and Philippines)* **found them effective**.

Figure 43: Q7.3: Effectiveness of cost recovery schemes in generating anticipated revenue for the health sector



Source: EUD Survey, 2011, Particip GmbH

Reasons for the effectiveness of the cost recovery schemes in generating anticipated revenue.

EUD *Egypt* commented that the financial management of the "Family Health Fund" (FHF) had strengthened over time and that the gap between revenues and expenditures decreased year after year while the cost recovery index started to increase, as an average of the five FHF, from 37% in FY

2006/2007 to 136% in FY 2008/2009. It also added that currently, none of the five FHF presented a net deficit.

In *Lao*, the EUD said that the "Revolving Drugs Funds" (RDF) was very successful in making standard drug list available (and cheaper than doctor-pharmacy before). However, the EUD noted that RDF is sometimes abused as source of recurrent budget for facilities (over-prescription).

The EUD *Philippines* commented that some of the factors that contributed to the effectiveness of the cost recovery schemes were for instance: (i) at the local level, a mechanism established at some local government units income retention for LGU hospitals in terms of facility-accreditation with the Philippine Health Insurance and (ii) at the national level, the DoH-retained hospitals that had pursued income retention as well.

For the EUD in *Zambia* "The health financing reforms initiated in 1993 introduced out-pocket charges for users of health services at all public facilities. Previously, health services were free at the point of use. These charges, referred to as user fees, were advocated as an additional source of revenue for a health sector that was undergoing severe economic difficulties. During the time when user fees were charged, community representatives used to be informed about the revenues collected from / by their respective health centres. Part of these user fee revenues was used to provide community representatives with a small financial inducement for their work in mobilising the community and disseminating health information, as well as for costs incurred in attending monthly meetings with the district health management team. In these regular meetings, the DHMT shared planning and budgeting information with community representatives."

Reasons for ineffectiveness of cost recovery schemes

EUD *India* and EUD *Morocco* reported that the cost recovery schemes were ineffective in their countries.

- In *India* the EUD explained that user fees, introduced in about 1996, were not well managed. According to the EUD, funds had not always been used for re-financing expenses and were therefore missing for the facilities. The EUD perceived that it was due to weak public health management and lack of knowledge on what to do with the income.
- In *Morocco* the EUD criticized that the existing system was ineffective, with the exception of the 30% of the population covered by the cost recovery schemes and for which the expenses are covered. Logic to pay for each health care service is not existent."

Finally, the **EUD *Myanmar* believed that the cost recovery schemes were completely ineffective** in order to generate anticipated revenue for the health sector. According to the respondent of the EUD *Myanmar*, since the independence in 1948, a public health system with some government funding exists. Since 1954, Social Security Act has shown good intentions to create social protection, but have never really developed and implemented them. The EUD also commented that cost recovery relies on more than 80% on out of pocket (OOP) payments at time of use and that the OOP is usually not considered as a 'scheme'.

2.3.4.2 Impact of these schemes

Question 7.3.: What has been the impact of these schemes on the poor seeking needed health care?

In relation to the **impact that cost recovery scheme had on the poor** seeking needed health care the answers were **equally positive and negative**.

Out of the nine EUDs with cost recovery schemes, two EUDs *Lao and Philippines* indicated that the cost recovery schemes implemented in their countries encouraged the poor population to seek health care.

- In *Lao* the EUD explained that the exemption system of RDF never worked well and therefore non profit health insurance and HEF were created to mitigate the impact on the poor. According to the respondent, private unregulated pharmacies are not a solution for the poor.
- In *Philippines*, the EUD commented that those facilities were income retention is applied (see answer above) were able to provide health care services as needed by the communities.

EUDs *Barbados*, *Zambia* and *India* answered that cost recovery schemes rather discouraged to seek health care.

- EUD *India* commented that in 2002, the public health facilities and services were still very unsatisfactory and unattractive (lack of drugs, equipment, hygiene, good food, absent doctors

and nurses). According to the EUD, people above the poverty line increasingly chose the private services over public services.

- In *Barbados,* the EUD didn't give further explanations but commented that many news reports highlight the fact that cost recovery scheme discourages poor population of seeking needed health care.
- EUD *Zambia* stated: *"Between 1993 and 2005, evidence shows that little success was achieved with regard to improving access to health services by all."* Many studies show reluctance among providers (the District Health Management Teams) to sacrifice revenue generation for exemptions, while indicators of access were showing significant problems with access to health care. For example, evidence from the *Zambia* Demographic and Health Survey (DHS 2001/2002), gathered through a nationally representative household survey, indicating that 22% of urban and 30% of rural patients were turned away from health facilities as they could not pay for services upfront. Other studies based on household surveys (Diop et al, 1998; Hjortsberg, 2003) offer further evidence that a significant proportion of the poor population cannot seek care at public health facilities when they fall sick, partly on account of their inability to pay user fees.

The rest of the EUDs declared to not know. For instance EUD *Morocco* explained that they could not rate as "Regime d'Assistance Médicale" (RAMED) was still in experimentation phase; the EUD *Egypt* assumed that some decrease exist, but due to lack of monitoring of the access especially of the poor to health care, no rating can be made. Furthermore the EUD states that this lack is tackled in the HSPSP II signed in October 2010.

2.3.4.3 Role of the EC in setting up cost recovery schemes

Out of the nine EUDs responding positively on the existing of a cost recovery schemes, five EUDs (*India*, *Philippines*, *Myanmar, Morocco* and *Egypt*) *recognized* **the role of EC in setting up or help managing cost recovery schemes**.

In the **region of Asia**,

- EUD in *India* described that the EC had played several roles on: (i) developing policy studies on user fees, (ii) encouragement of public private partnerships to rationalize expenses, (iii) financing capacity building at district level and (iv) introducing the system of health insurances.
- In *Philippines* the EUD reported that the EC program provided TA to LGUs interested in income retention or becoming an economic enterprise.
- In *Myanmar* the EUD explained that the set-up of cost recovery schemes was just started (12/2009), however according to the EUD the EC was playing an active role participating in dialogue on health financing mechanisms.

In the **MEDA-ENPI-TACIS region**,

- EUD *Egypt* described that the EC, in collaboration with other partners (WB, USAID, ADB), supported the reform of the PHC by developing the Family Health Model.
- In *Morocco* the EUD described the role of the EC as encouraging technical support and council meetings in order to ensure and improve the management.

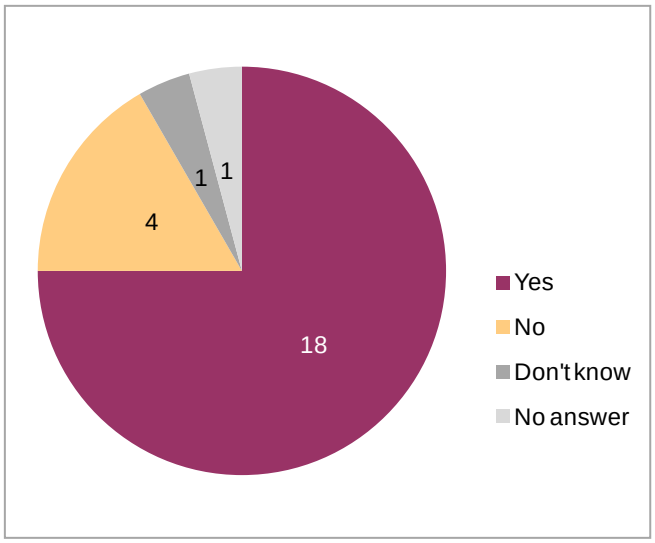
On the other hand, four EUDs *Lao*, *Barbados*, *DRC* and *Zambia* clearly stated that the EC played no role in setting up (or help managing) the cost recovery scheme. EUD *Lao* and *DRC* explained that the cost recovery schemes were set up prior to the EC support in the country. In *Lao*, the EUD commented that the EC has been supporting alternative mechanisms to cost-recovery at time of use such as pre-payment and risk pooling. EUD *Zambia* stated that the EUD was not directly involved in the setting up, but was on involved in the monitoring of the use of user fees in the district.

2.3.5 Cost waiver schemes

Question 8: Are there cost waiver schemes in place for vulnerable groups such as children, the elderly, persons living with HIV/AIDS, and the disabled?

In the majority of countries of the sample. In 18 of the 23 EUDs that answered this question, 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*, *Afghanistan*, *Egypt*, *Moldova*, *Yemen*, *Syrian Arab Republic*, *Morocco*, *Barbados, Burkina Faso*, *Mozambique*, *Zambia, Zimbabwe*, *DRC, South Africa* and *Ecuador*.

Figure 44: Q8: Existence of cost waiver schemes in place for vulnerable groups such as children, the elderly, persons living with HIV/AIDS, and the disabled



Source: EUD Survey, 2011, Particip GmbH

Only four EUDs (*India*, *Bangladesh*, *Timor-Leste* and *El Salvador*) reported that cost waiver schemes for vulnerable groups such as children, the elderly, persons living with HIV/AIDS, and the disabled were not in place.

In the view of these EUDs the **main reasons for not (yet) having adopted such schemes** were: (i) lack of welfare attitude and (ii) lack of budget and administrative inefficiency.

Cost waiver schemes – modus operandi and EC contribution

In the view of EUD **the way that these waiver schemes for vulnerable groups are operating** *is:*

In the **Asian region**,

- EUD *Philippines* described that the schemes operated though a sponsored program covering the poorest of the poor in the country, where the insurance premium is being paid by the National Government and the Local Government Unit. One of the issues raised by the program was however problems on the identification of the real poor and the sustainability of the subsidy.
- The same problem was reported in *Lao* where the EUD indicated although exemption schemes exist officially they have never worked because issues with identifying the poor and no funding mechanism to pay for 'free care'.
- In *Vietnam* the schemes were operated through the *Vietnam* Health Insurance Law that introduced a road map towards universal coverage of compulsory insurance. It also introduced waiver schemes for different beneficiary groups, including children, the poor, the elderly, the disabled, etc.
- In *Myanmar* the EUD reported that theoretically the poor should be covered by 'Hospital Trust Fund' but the programme is unsuccessful in covering large proportions of population. According to the EUD one of the main problems is on the design of the program, for example while certain capital has to be deposited in a certain bank, according to the number of beds per hospital, only the extremely low interest can be used for paying health care of the poor.
- EUD *Afghanistan* explained all health services in public health facilities are provided for free to the general population.

The **EC contribu**tion in the Asian region has been:

EUD	EC contribution according to EUD
Philippines	EC TA to the Department of Health to improve the financing reform.
Vietnam	EUD support on the formulation of the Law and the drafting of Decrees.
Lao	GBS and PRSO, keep attention/priority to the social protection schemes.
Timor-Leste	EC TA to the MoH-TL for developing medium term strategic plan and MTEF.
Myanmar	EC funds.
Afghanistan	EC support to MoH on provision of primary health (Basic Package of Health Services BPHS) in 10 provinces and secondary health services (Essential Package of Hospital Services EPHS) in 5 provinces.

In the **MEDA-ENPI-TACIS region:**

- EUD *Egypt* reported that most of the preventatives health services are free of charge however the EUD declared to have no information concerning the elderly, persons living with HIV/AIDS, and the disabled population.
- According to the EUD *Morocco* transversal programs for people living with HIV/AIDS are in place and also specific programs for some pathologies related to children.
- In *Moldova* the EUD said that the most vulnerable layers of population are insured by the state, which pays the contribution directly to the National Health Insurance Company.
- EUD *Yemen* reported that the health system still works by parallel vertical programs that have their own exemption schemes. According to the EUD there is a lack of policies and willingness to step towards the harmonization of the practices.
- In *Syria*, the EUD explained that following the establishment of the 'National Social Aid Fund' (NSAF) in January 2011 (targeting the most vulnerable), the Ministry of Health asked all state-owned entities (hospitals, medical centres, clinics) to provide medical treatment and necessary medicines/drugs free of charge to all beneficiaries of the fund.

The **EC contribution** in the region has been:

EUD	The EC contribution according to EUD
Egypt	Support the development of the Family Health Model (integration of the Primary Health Care programs)
Morocco	Programmes régionaux gérés par siège (HIV/AIDS) Budget support with indicators of performance (Child health)
Yemen	EU support to the HDC (Health Development councils)
Syrian Arab Republic	EC funding for decentralization of the National Social Aid Fund (support to UNDP under the Social Protection Program signed with the Ministry of Social Affairs and Labour).
Moldova	EU-funded project "Support to the Ministry of Health of Moldova" (2001-2003) assisted the Ministry of Health in developing the legal framework necessary for implementing the mandatory health insurance system.

In the Latin American region:

- The EUD *Ecuador* described that waiver schemes for vulnerable groups are operating since 2000 through laws that guarantee free health services (e.g. Ley de Maternidad y Atención Gratuita). It seems they were not fully implemented at the begging but since 2007 the EUD has observed more interest in the Government to assist vulnerable groups such as children, elderly persons living with HIV/Aids and disabled persons and since then the law has been regularly implemented.

The **EC contribution** in the region has been:

EUD	EC contribution according to EUD
Ecuador	EUD promotes the “Ley de Maternidad y Atenciónn Gratuita” in the public health units and in the communities.

For the ACP region:

- EUD *Barbados* described that children and elderly were provided specific limited services covered by government tax collection while persons living with HIV/AIDS were provided services funded from external sources.
- According to the EUD *Burkina Faso*, there is free care for the general population (fully financed by the national budget) for treatments related to: the obstetric and neonatal services

(80%), vaccination services, treatment of severe malaria cases fewer. ARVs are also provided free of charge.

- In *DRC* and *Zimbabwe*, the EUDs declared that vulnerable groups are exempted from paying user fees at health facilities but no further clarifications were provided.

The **EC contribution** in the region has been:

EUD	EC contribution according to EUD
Nigeria	Policy dialogue but not specific to health (still considered a non-focal sector).
Burkina Faso	General budget support.
DRC	Principalement à travers le Fond Monétaire et les achats de MEG dans les projets CE
Zimbabwe	EC support to the Health Service Fund (HSF) aiming at decentralizing financial resource at the most peripheral level health facilities in order to pay for running cost and improve quality of the services. Due to application of art. 96 of the Cotonou Agreement to Zimbabwe, the EC support stopped in 2006.

2.4 Health governance

2.4.1 Changes in the quality of MoH and MoF financial management

Question 9: What kind of changes have you observed in the quality of MoH and MoF financial management (audit function, financial management systems, control of transactions, etc.) between the early period under evaluation (i.e. 2002 - 2004) and 2010?

21 EUDs (of 23 answers) answered that changes in the quality of MoH and MoF financial management have been observed between 2002 and 2010. There is clear evidence of **overall improved financial management by MoH over the period of the evaluation** although there is still a large margin of improvement to be done. Among the most observed changes in the quality of MoH and MoF financial management are:

- Improved coordination between MoH and MoF
- Decentralization of administrative and financial function in the health systems
- Improved coordination across local health system
- Improved audit function

Eight out of the 23 EUDs that answered were located in **Asian countries**. Except *Myanmar* and *Yemen*, all of them (EUD *Afghanistan*, *Lao*, *Philippines*, *India*, *Vietnam* and *Bangladesh*) perceived an **improvement of the quality of MoH and MoF financial management** between the early period under evaluation (2002 - 2004) and 2010.

- For instance EUD Lao reported that relation between MoH and MoF has improved (with PRSO support) however it criticized that the yearly budget cycle remains outside the control of donors or the MoH. It added that the information on prior expenditure have improved but remained slow and unreliable. According to the EUD the budget plan is not credible enough.
- In *Philippines* the EUD reported an improvement in the local health systems due to enhanced coordination 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 system.
- According to EUD *India* the Indian states have decentralized lots of administrative and financial function in their health systems between 2002 and 2010. It added that all states introduced, in 2008-2010, the e-banking system which is functional to a varying degree of maturity.
- In *Vietnam* the EUD commented that the State Audit has been working on guidelines for introducing internal audit function at all service delivery units.
- In *Bangladesh* the EUD stated that there was clear evidence of improved financial management by MoH over the period of the evaluation and that internal audit were undertaken along with issuing of a financial management handbook. The EUD also observed improvements in reconciliation of accounting system.
- The EUD in *Afghanistan* reported the development of Health Care Financing policy and the establishment of national health account.
- The EUD in *Myanmar* and *Yemen* did report that no or very little changes have been observed.

When talking about the **EC's role** in encouraging such changes:

- EUD *Lao* said that prior to 2005 it was unknown to it but since 2007 the EC supported the improvement mentioned before by: (i) supporting the nationwide quality implementation of HMIS and data flow (incl. financial data which is the most difficult), (ii) supporting data quality (timeliness and completeness, (iii) drafting of statistic health reports, (iv) curriculum development and piloting of a course on using HMIS for evidence based (pro-poor) decision making.
- EUD *Philippines* indicated that the EC program on health provided TA to support both the local government units and the DoH in systems strengthening including capacity building activities in the areas of planning, procurement, logistics and warehousing capacity at the DoH, internal control, performance-based monitoring. In addition improving budget credibility and budget execution at the DoH was also supported by the EC-TA.
- EUD *India* reported that EC SIP and SPSP have been addressing governance, including e-governance (banking, monitoring).
- In *Vietnam* the EUD reported it was financing a multi-donor trust fund, administered by the World Bank, in support of the above mentioned reform agenda. The Delegation also participated in regular dialogue on PFM with other partners and relevant government agencies. In the health sector, the EC capacity building project also assisted in the implementation of PFM reforms which contribute to good sector governance.
- In *Bangladesh* the EUD said that as a part of the Pool Funders, the EC has been always very active in the dialogues on FM with the Government. Moreover, among the few donors, EC was one of the members of the financial management Task Group (working group of Government and donors).

In **ACP countries**, the EUDs comments (*Barbados*, *DRC*, *Burkina Faso*, *Nigeria*, *South Africa* and *Zambia* and *DRC*) pointed towards an overall **improvement in the quality of the financial management** as experienced in Asian regions. Only EUD *South Africa* reports management problems especially at decentralised level.

- For instance EUD *Nigeria* said that given that general or sector budget support has not been operated there is little interaction with the MoF, however, under the project approach the EUD observed capacity building of country partner institutions such as the National Primary Health Care Development agency (NPHCDA) and State Ministries of Health in the areas of audit function and procurement.
- In *Burkina Faso* the EUD reported that common basket fund (PADS) put in place a biannual audit of the health financing system and that a superior control agency was also created by the state authority.
- EUD *DRC* also reported the Establishment of a new funding system based on a trustee at central and provincial levels.
- EUD *Barbados* reported that the audit function has improved and noted that the link of the budget with activities was a direct result of the EC support.
- EUD *South Africa* states that the national DoH had a clean audit for the first time in 7 years for the year 2009/10, but provincial DoHs still have huge problems with financial management. This is why the national DoH together with the National Treasury attempts to support the provincial DoHs through assessments.
- EUD *Zambia* reports that the quality of financial management following the scandal in the health sector in 2009 has been strengthened significantly to restore confidence in the Ministry of Health systems. A Joint Governance Action plan was developed between the co-operating partners and ministry of health/government to improve the systems. It is at the time of the survey, in its final year of implementation.
- Finally, EUD *Zimbabwe* reported that most of health and financial management policies were currently quite sound but that the lack of financial resources negatively affected their implementation.

When looking for the **EC's role** in encouraging such changes:

- EUD *Nigeria* only commented that the EC involvement was progressive but no further explanations were provided.

- In *Burkina Faso* the EUD reported that the EC provided support to public finance system and control of auditors while EUD *DRC* indicated that the EC was one of the key partners supporting the MoH to implement the new funding system above described.
- A positive EC contribution was stated by the EUD *Barbados* which reported that EC sector budget support (2005-2009) was directly responsible for the improvements.
- The EUD *Zambia* also acknowledges the positive role of the EC: "Together with other Co-operating partners in the Health Sector (the EUD) has worked with government to develop the Joint Governance Action Plan. At a wider government level, the EUD has also been instrumental in Public Finance Management reform by supporting the introduction of The Integrated Financial Management Information System (IFMIS) Project which aims at improving the acquisition, allocation, utilisation and conservation of public financial resources using automated, integrated, effective, efficient and economic information systems. It will also aid strategic management of public financial resources for enhanced accountability, transparency, cost effective public service delivery, and economic growth and poverty reduction efforts. IFMIS was introduced in the Ministry of Health in July 2011.
- In *South Africa,* the EC contributed *"only through policy dialogue and by making good financial management a pre-condition for Financing for a new PHC sector policy Support Program as well as one of the indicators for the variable tranche".*

In **MEDA-ENPI-TACIS** region, according to the four EUDs surveyed in this region the quality of MoH and MoF on financial management have **partially improved**, however there is a lot of variation on the degree of this improvement by country.

- For instance, the EUD *Egypt* reported the strongest improvement in the region and the changes observed were: (i) the implementation of a basic Treasury Single Account and in addition, (ii) in 2009, the establishment at the MoF of the Central Accounting Unit for the TSA, tasked with servicing the TSA on debit and credit and receiving payment bills from all accounting units linked to the state budget.
- In *Moldova*, the EUD confirmed the establishment of an Internal Audit Unit (IAU), which conducted five audit missions in 2010.
- EUD *Syrian Arab Republic* commented that while for the early period (2002-2004), no particular change was noticed (the HSMP was signed in 2002 but its 'real' implementation started in 2004/2005), for the period 2004-onwards, the financial management of the MoH slightly improved. According to the EUD, despite technical assistance allocated to the financial department of the Syrian MoH, its competency level remained very limited technically and linguistically. In addition the EUD said that the financial management capacity remained under-resources and as a consequence, the cost control and financial supervision under HSMP were almost entirely managed by the Technical Assistance Team (transforming it from an advisory role to a much resented control function).

When talking about the **EC's role** in encouraging such changes:

- EUD *Egypt* said that the EC included in all its Budget Supports complementary reform benchmarks that supported the reform of PFM.
- EUD *Syrian Arab Republic* indicated that the EC's role had mainly been the following: (i) capacity-building through trainings and TA; (ii) increase awareness of the MoH on the issue of financial management.
- EUD *Moldova* reported that the establishment of the Internal Audit Unit was one of the conditionality foreseen by the Policy Matrix of the EC Health Budget Support Programme.

In **Latin American**, the EUD *El Salvador* said there was a general improvement since in 2011, the government (2009-2013) increased the budget allocated to MoH in USD (the budget is 22% of the total budget). The EUD *Ecuador* mentioned that the EC encouraging changes in the following areas: (i) developing the health model, (ii) training health staff at local level and (iii) helping the health local authorities to elaborate annual and monthly financial plans. Furthermore, an evaluation report gives evidences that the EC improved quality of services and also access at local level. In general, the EUD action concentrates more on local level.

2.4.2 Quality of public health sector procurement system

Question 10: How would you rate the quality of the public health sector procurement system in the early period under evaluation, i.e. 2002/04 and 2010 related to the issues of transparency and accountability?

2.4.2.1 Transparency of the public health procurement systems

Overall there has been an **improvement in the quality of the public health sector procurement system** since the early period under evaluation, 2002/04 until 2010 related to the issues of transparency and accountability.

In **2002-02,** 38% or nine EUDs (*Philippines, India, Vietnam, Timor-Leste, Afghanistan, Syrian Arab Republic, Nigeria, Ecuador and El Salvador*) out of 20 that answered this question, replied that the public health procurement system was "**not transparent**" Five EUDs (*Bangladesh, Zimbabwe, Zambia, South Africa and Morocco*) reported that it was sufficiently transparent and only one, In 2010 this percentage shrank to 21%.

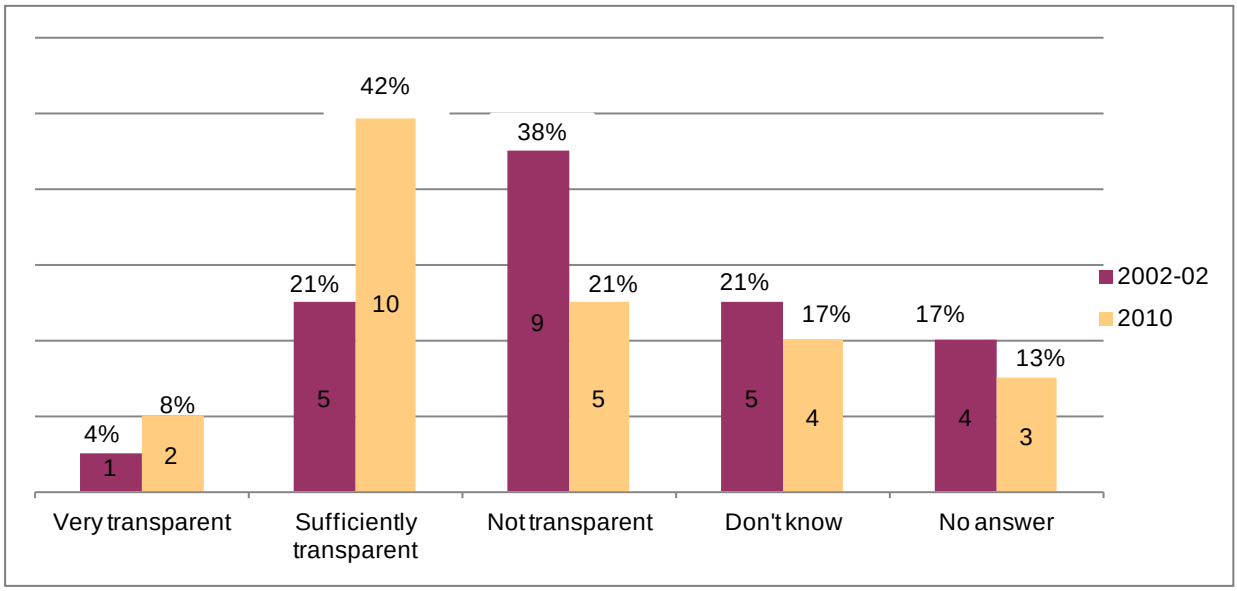
In 2002/04 only the EUD *Barbados i*ndicated the procurement system was very transparent.

In 2010 the levels of transparency have improved and most EUDs, ten out of 20 (42%), declared the public health sector procurement system **was sufficiently transparent,** in comparison with only 21% in 2002-04).

Among those EUDs that in 2002-04 perceived the procurement system was not transparent, five EUDs (*Philippines, Vietnam, Timor-Leste, Nigeria and Ecuador*) changed their view to "sufficiently transparent" in 2010.

EUD *Zambia* changed the rating from "sufficiently transparent" to "very transparent" in 2010. EUD *Barbados* continued reporting it was very transparent.

Figure 45: Q10.1: Transparency of the public health procurement systems



Source: EUD Survey, 2011, Particip GmbH

Elements contributing to transparency

According to the EUD the element that contributes to this transparency is that **rules and regulations are in place and are followed and overseen by several committees**. These elements, that seem to ensure quality in *Barbados*, tend to be present (to a lower extent) in all those countries where the EUDs have perceived satisfactory levels of quality in the public health sector procurement management. For instance:

In *Philippines* the EUD indicated the existence of a Government Procurement Act that was signed into law in January 2003 (as RA 9184) and that it is the standard for all government procurement.

EUD *Timor-Leste* reported that the use by the MoH of an international bidding for medical equipment and materials, following the internationally accepted system/procedures.

In *Nigeria*, the EUD also reported an enactment of a Public Procurement Act and in *Ecuador* the EUD explained that since 2007 the procurement systems are decentralized and local governments may

procure their needs and purchase their goods through a public electronic purchase corporation INCOP.

Elements limiting transparency

Although the overall perception of the transparency in the public health procurement system have improved over the evaluation period, still five EUDs kept reporting that the system was **not transparent** in 2010.

These EUDs were EUD *India, Moldova, Syrian Arab Republic, El Salvador* and *Mozambique.* The comments provided by these EUDs pointed at **issues of corruption and limited efforts by the government to initiate reforms** as the main reasons for "non-transparency".

For instance in *India* the EUD indicated that the procurement system was transparent due to system reforms only in two of 35 Indian states but not so in the rest of the states. According to the EUD, the topic was (deliberately) neglected due to high levels of corruption and weak governance.

In *Moldova,* the EUD commented that the Government was supposed to introduce the electronic procurement for drugs and medical equipment, which, according to the respondent, would have improved the transparency of the public procurement system, however it was never introduced.

2.4.2.2 Accountability of the public health procurement systems

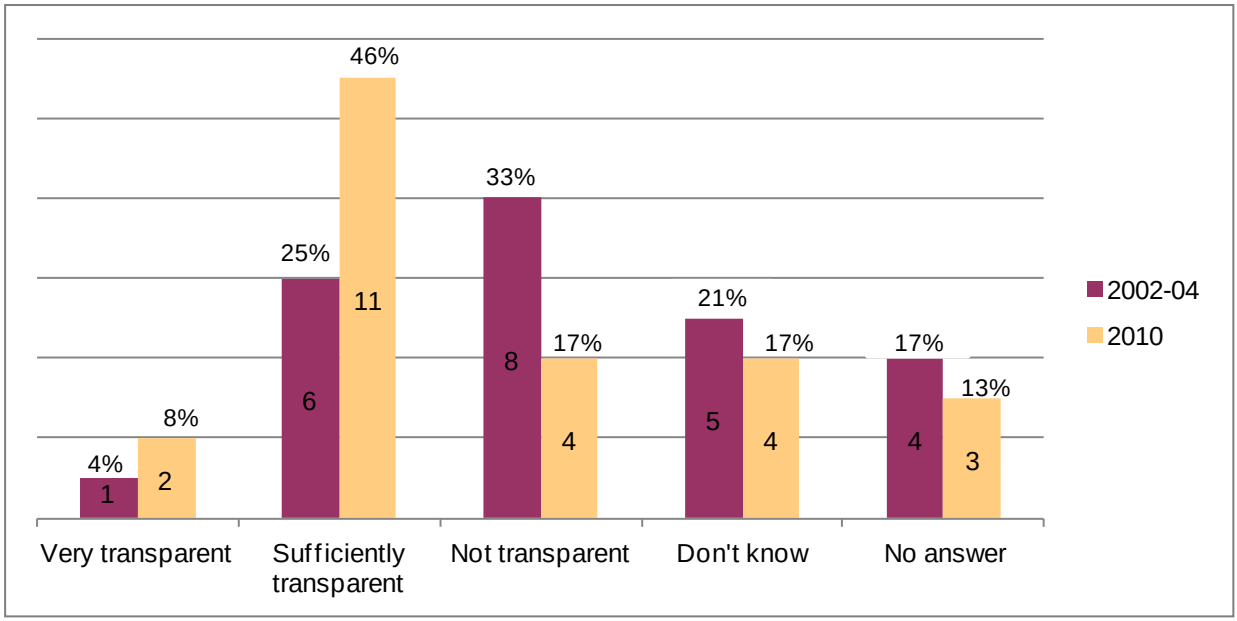
In 2002-04, eight EUDs (*Philippines, India, Vietnam, Timor-Leste, Afghanistan, Nigeria, El Salvador and Syrian Arab Republic)* out of the 20 EUDs, a total of 33% rated the accountability of the public heath procurement system in their countries as "not transparent". This falls down in 2010 to 17%, with a substantial increase of rates for "sufficiently transparent".

Six out of these 20 EUDs (*Bangladesh, Zimbabwe, Zambia, South Africa, Morocco and Ecuador*) considered it "sufficiently transparent" and only one EUD *Barbados* said it was "very transparent" (as for the transparency in the procurement system).

In 2010 the number of EUDs considering the accountability "sufficiently transparent" increased up to 11. Those that improved their rates since 2002-04 were EUD *Philippines, India, Vietnam, Timor-Leste and Nigeria*. These are the same EUDs that also improved their rates for the transparency of the procurement system (see previous Figure 45) with the exception of EUD *Ecuador* which was more optimistic as regards the accountability of the procurement system and rated it as "sufficiently transparent" since 2002-04.

As for the transparency issue, EUD *Zambia* changed its rate from "Sufficiently transparent" to "Very transparent" from 2002-04 to 2010.

Figure 46: Q10.2: Accountability of the public health procurement systems



Source: EUD Survey, 2011, Particip GmbH

As for the previous case, four EUDs kept reporting "not-transparent" accountability of the health system in 2010, they were: EUDs *El Salvador, Moldova, Syrian Arab Republic and Mozambique*. The issues considered by the EUDs to have hampered further improvements in accountability of the public

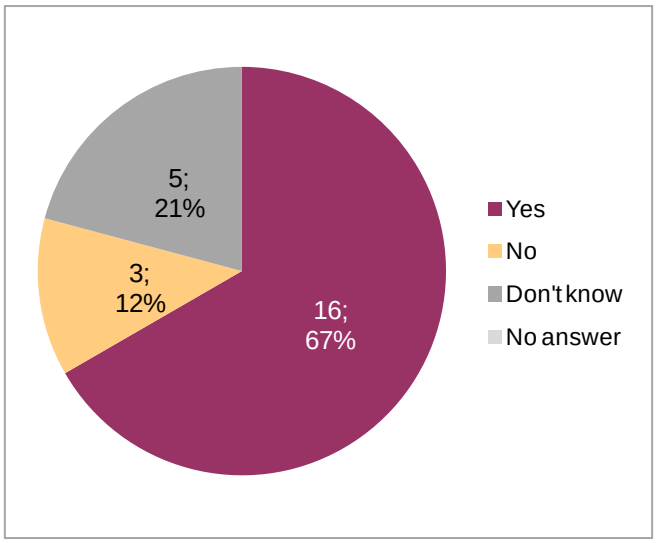
health procurement system are the same expressed before and no further elements were introduced to explain issues of accountability.

2.4.3 Procurement system

Question 12: During the period 2002 to 2010, has the public health sector procurement system been reformed?

Most EUDs (16 out 24) (*Lao, India, Vietnam, Bangladesh, Timor-Leste, Afghanistan, Egypt, Morocco, Barbados, Nigeria, Ghana, DRC, Mozambique, Zambia, Ecuador and El Salvador*) reported that during the period 2002 to 2010 the public health sector procurement **system was reformed** in their country.

Figure 47: Q12.1: Reform of the public health sector procurement system during 2002 to 2010



Source: EUD Survey, 2011, Particip GmbH

The year of the reform' implementation was indicated as follows:

Year 2003	Year 2005	Year 2006	Year 2007	Year 2007	Year 2008	Year 2011	NA
Ghana	Barbados	Bangladesh	Nigeria	Nigeria	Ecuador	India	Mozambique, Zambia
DRC		Morocco	Vietnam	Vietnam	Timor-Leste		Lao

Only **three EUDs (*Philippines, Yemen and Syrian Arab Republic*)** reported to have **no reform**. Five EUDs (*Moldova, Burkina Faso, Zimbabwe, South Africa and Myanmar*) reported to not know it.

2.4.3.1 Reasons for the non-reforming

The **reasons for non-reforming** the procurement systems provided by these three EUDs are:

- The procurement system is separated from MoPH

For example, EUD *Philippines* described that the country's procurement system was established according to the World Bank and it is aligned with the international standards. According to the EUD the World Bank, ADB and JBIC are using the country's procurement system.
In *Yemen*, the EUD also reported that procurement system is separated from MoPH. The EUD also explained that *Yemen* does not have any data collection tool (i.e. HMIS) thus the entire planning of procurement (goods as well as human resources) does not rely on any sound basis. According to the EUD "there is for sure a strong political will in leaving things as they are now".

- Limited expertise and high staff turnover

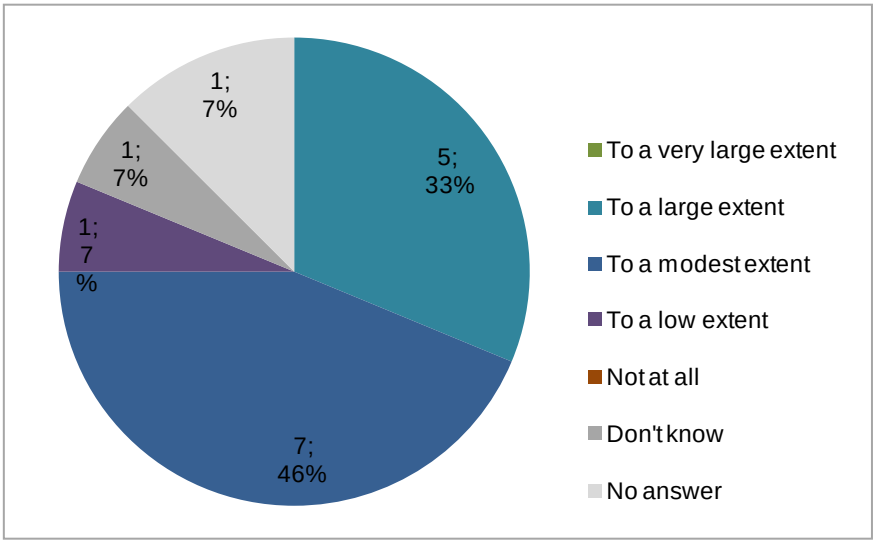
In *Syrian Arab Republic* the EUD reported that the limited expertise and high staff turnover were the major reasons for non-reforming the procurement system. The EUD suggested that (Project) financial integrity is a structural problem that can only be resolved by legislative reform involving the Ministry of Finance.

2.4.3.2 Reform helped to enhance accountability and transparency

The figure below shows the proportion of answers for the question: to what extent the EUDs considered that the reform helped to enhance accountability and transparency in the health sector of their respective countries?

Out of the 46% (*Lao, Vietnam, Afghanistan, Barbados, Nigeria, Ghana and Morocco*) of the 16 countries in which the procurement system has been reformed reported that the reform helped to enhance accountability and transparency in the health sector only to a **"modest extent",** while five EUDs (33% *India, Bangladesh, Timor-Leste, DRC and Ecuador*) answered that the reform helped to large extent to enhance accountability and transparency in their countries.

Figure 48: Q12.2: Reform has enhanced accountability and transparency in the health sector



Source: EUD Survey, 2011, Particip GmbH

2.4.3.3 How did EC support contribute to procurement reform?

Statements from EUDs having had a procurement reform during the evaluation period, highlighted that **the EC contribution to these reforms varies a lot between countries**, even within the same region. Only 12 EUDs provided insights on the EC contribution to the procurement reform which makes it difficult to group factors into regional patterns. However, despite this variability some common points were observed.

According to the comments provided by the EUDs, the EC support has contributed to procurement reforms mainly through: (I) public financial assessments of the current system and (ii) technical assistance to the government.

- EC- **PFM assessments** and recommendations to the government (cited by EUD *India*, EUD *Vietnam*, EUD *Barbados* and EUD *DRC*)
- EC- **Technical assistance** and capacity building in the area of procurement albeit using EDF procedures (cited by EUD *Timor-Leste and* EUD *Nigeria*)

Other means mentioned by the EUDs through which the EC has also contributed to the procurement reform are:

- EC participation in policy dialog (EUD *Bangladesh*)
- EC support to government on poverty reduction support operation (PRSO) (EUD *Lao*)
- EC support to Mop on the establishment of the Grant and Contract Management System (EUD *Afghanistan*)
- EC support to the National Planning Commission through its NAO support (EUD *Nigeria*)

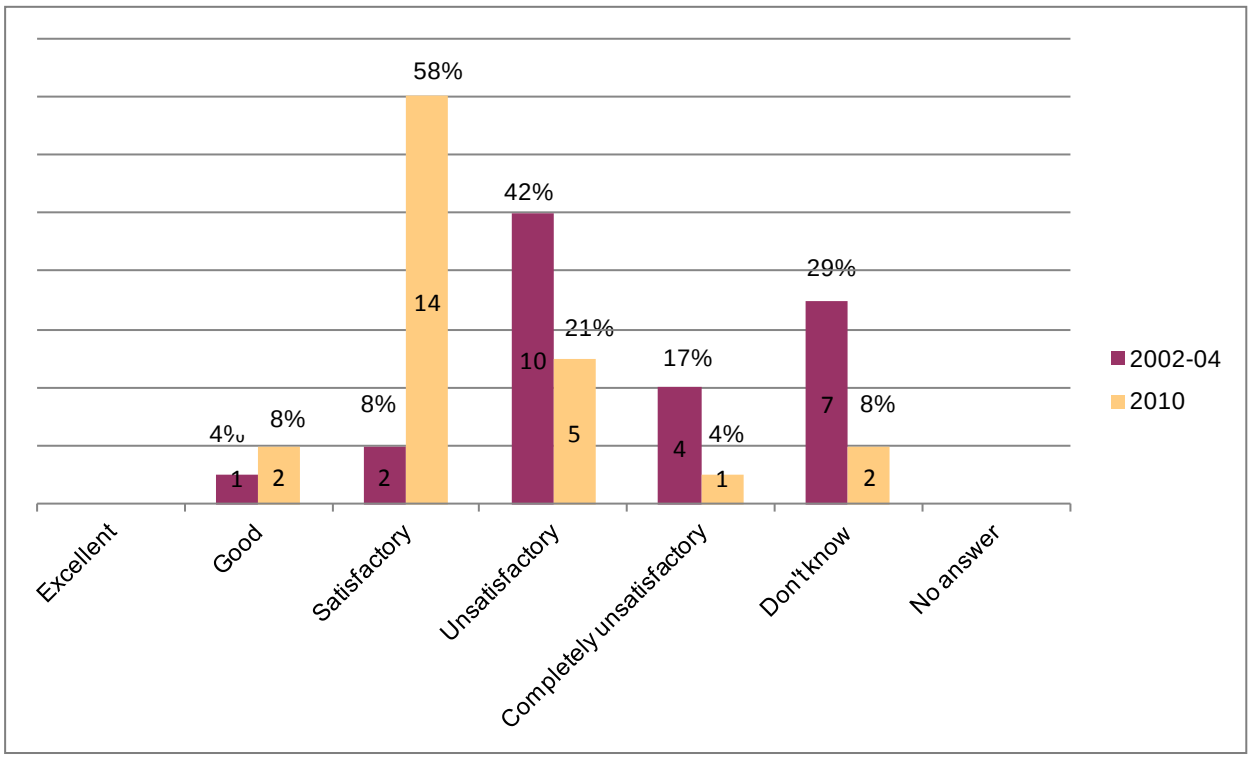
2.4.4 Capacity of MoH to establish and monitor AWP and Budgets linked to HSP and MTEF

Question 13: How would you rate the capacity of the Ministry of Health to establish and monitor Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing) for the early period under evaluation, i.e. 2002/04 and 2010?

In **2002-04**, the majority of EUDs replied that the capacity of the Ministry of Health to establish and monitor Annual Work Plans and Budgets linked to health sector plans and MTEF was either "unsatisfactory" (42%, 10 EUDs out of 21) (EUD *Philippines*, *Vietnam*, *India*, *Bangladesh*, *Morocco*, *Moldova*, *Nigeria*, *Burkina Faso*, *Mozambique* and *Ecuador*) and/or completely unsatisfactory, (17%, four EUDs out of 21) (EUD *Yemen*, *DRC*, *Barbados* and *Timor-Leste*). Only two EUDs (*Ghana* and *Zimbabwe*) rated it "satisfactory" and one EUD rated it "good" (EUD *South Africa*).

In 2010 the perception of the EUDs as regards the capacity of the MoH to establish and monitor annual work plans linked to the health sector **substantially improved.** More than half of EUDs (52%, 14 out of 24) rated the capacities of the MoH as "satisfactory" or "good" (8%, EUD *South Africa* and EUD *Barbados*)

Figure 49: Q13: Capacity of the Ministry of Health to establish and monitor Annual Work Plans and Budgets linked to health sector plans and MTEF



Source: EUD Survey, 2011, Particip GmbH

Nine EUDs changed from "unsatisfactory" scores in 2002-04 to "satisfactory" in 2010; they were EUDs *Philippines, India, Vietnam, Bangladesh*, *Moldova, Morocco, Nigeria, Mozambique and Ecuador*.

Some of the progress observed and reported by the EUDs scoring "unsatisfactory" in 2002-04 was:

- In *India* the EUD highlighted that in certain programs (RCH, HIV/AIDS) much progress in plan oriented implementation has been seen.
- Also a HMIS has been set up. In *Bangladesh* since 2004, the Medium term budgetary framework (MTBF) was introduced and the MoH was included in it since 2006. In *Morocco* the Ministry of Health has produced the first MTEF for 2008-2010. The impressions of the EUD were that "the MoH budget is improving every year and takes into account the transverse *and vertical programs".*
- In *Nigeria* since 2010 a result based National Strategic Health Development Plan and IHP+ compact with cost state operational plans and a joint assessment of national strategies (JANS) schedule are in place. All these, according to the EUD, will facilitate the work of the

Federal Ministry of Health whose institutional capacity has been built over the years to monitor annual work plans in conjunction with other health related agencies, the state ministries of health and partners like the EU.

- In *Mozambique* the EUD reported that it is due to the SBS (which was on conditionality) that the monitoring of the annual work plans and budget is done by the annual joint review within the common funds. It is worth noting that the most impressive move was made by EUD *Barbados* that changed from "completely unsatisfactory" in 2002-04 to "good" in 2010. Unfortunately no further comments were made by the EUD to explain such a big change.

Accordingly, EUDs reporting "unsatisfactory" capacities of the MoH in 2002-04 were reduced by half in 2010. Only five EUDs (*Lao, Timor-Leste, DRC and Syrian Arab Republic*), out of 24, continued reporting, **in 2010, "unsatisfactory" capacities** of the MoH to establish and monitor annual work plans linked to the health sector. Reasons for that lay mainly on **difficulties to adapt MTEF into annual plans and to stick to them**. Examples of these are:

- In *Timor-Leste* the EUD commented that the MoH personnel failed to adapt MTEF into annual plans because they tend to follow what have been done in the previous year.
- In *Syrian Arab Republic* the EUD perceived great difficulties to finalize Annual Work Plans and to stick to them. According to the EUD, *"planning does not seem to be a well-understood concept. In the case of the HSMP, the log frame was rapidly abandoned by the Ministry of Health as an instrument of planning and control*".

Only one EUD *Yemen* rated the capacity of the MoH to establish and monitor annual work plans "completely unsatisfactory" in 2010. This EUD similarly reported that the main problem was that "*even when plans exist they are not linked to i.e. epidemiological situation or resource management".*

2.4.4.1 EC contribution to the change in the MoH capacities

Question 13.1.: In your opinion, how and to what extent did EC support contribute to changes observed?

ACP region

Inn **ACP countries** the EC support has largely contributed to the changes observed.

- For instance, in *Nigeria*, according to the EUD, the EC have largely contributed through **country level dialogue** at various for such as the development partner group on health and the inter-agency coordinating committee on immunisation.
- In *DRC* the EUD reported that the EC is a key actor together with the MoH for the **provincial programming.**
- In *Mozambique***,** the EUD explained that they played a leadership role in the MoU for the SWAp "ProSaude II". According to the EUD it was determinant to lay **emphasis on the PFM elements**.
- Similarly, EUD *Ghana* explained that the EC dropped out of the Health sector and therefore the direct influence to the sector is limited, however according to the EUD the EC keeps very active in the PFM area and therefore influence the entire system including the MoH and GHS.
- The EUD *Barbados* stated that the EC support has been critical in enabling changes in this area.
- EUD *Burkina Faso, South Africa* and *Zambia* reported very limited contribution, if any but no further explanations were given.

Asian region

Asian respondents also pointed towards a satisfactory contribution of the EC to the changes observed thanks mainly to the **technical support and capacity building** provided by the EC.

- In *Lao*, for example, the EUD explained that the EC support to TWG helped drafting AWPs for the MoH (financing, but also on MCH, HR) linked to the Health Master Plan and the Health Financing Strategy and that a large progress have been observed.
- EUD *India,* 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, much, but no more than satisfactory, progress has been made in this area.

- In *Philippines*, the EUD noted that the EC programme on health has contributed to the capacity building of the Department particularly in establishing performance-based assessment.
- In *Afghanistan*, the EUD also confirmed that the EC provided technical assistance and supported the grant and contract management unit which is the head of health economics. In *Bangladesh*, the EUD highlighted that the EC was part of the sector policy dialogue.

MEDA-ENPI

In **MEDA-ENPI** region, EUD *Egypt* reported that **thanks to the EC budget support**, several important **financing tools were developed**. Some of these tools are: (i) the performance based budgeting method was introduced concerning the "population based vertical health programs" implemented by the MoHP; (ii) new Illustrative Actuarial Scenario was also developed and it explores the financial aspects of the new Social Health Insurance scheme, including contribution tables and sources of revenue for the new model; (iii) new Health Insurance Law legislation was prepared which, once approved by the Parliament, will become the legal basis of the new Health Financing Model and (iv) new "Government Actuarial Department" created within the Ministry of Finance which will be a key factor towards the long term sustainability of the model.

In *Moldova* the EUD commented that the EC largely contributed in the establishment of the **MTEF** for the health sector since it was one of the conditionalities of the Policy Matrix for the Health Sector Budget Support Programme.

Latin America

In **Latin America**, EUD *Ecuador* commented that the EC **technical support to the local health units** have helped them to elaborate, follow up and monitor the annual plans and the budget spending.

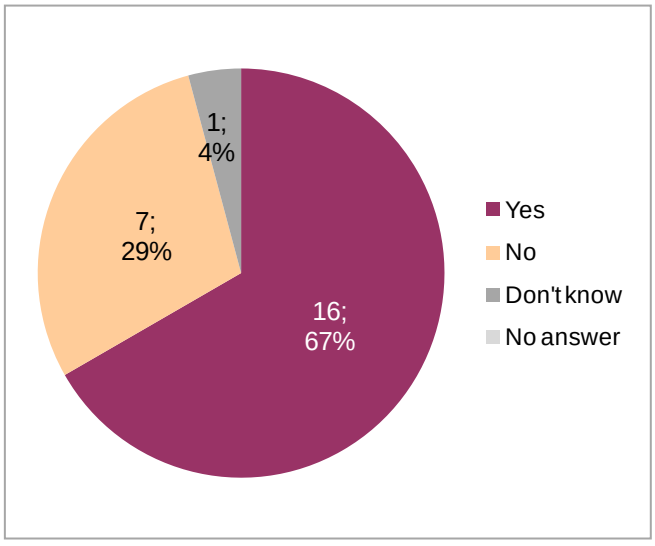
2.5 Coordination and Complementarity

2.5.1 Coordination and Complementarity during the programming process

2.5.1.1 Existence of a joint and harmonized donor health assistance strategy

Question 14: During the period under evaluation is there /has there been a joint and harmonised donor health assistance strategy?

Figure 50: Q14: Existence of a joint and harmonised donor health assistance strategy



Source: EUD Survey, 2011, Particip GmbH

The positive answers of 67% EUDs, 16 out of 23 (*Lao, Philippines, Lao, Bangladesh, Timor-Leste, Myanmar, Mozambique, DRC, Ghana, Burkina Faso, Nigeria, Zambia, South Africa, Morocco, Egypt, and Ecuador*), confirm the existence of a joint and harmonized donor health assistance strategy during the evaluation period.

However some issues have been reported by several EUDs describing that **joint and harmonized health assistance strategy is 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.
- EUD *Timor-Leste*, also confirmed there were semi-annual joint donor missions to discuss strategy and programming but it criticized that the sector performance framework and policy matrixes were not fully adapted by both MoH and partners.

Another issue extensively commented (10 out of 16 EUDs) was related to the **existence of 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".*

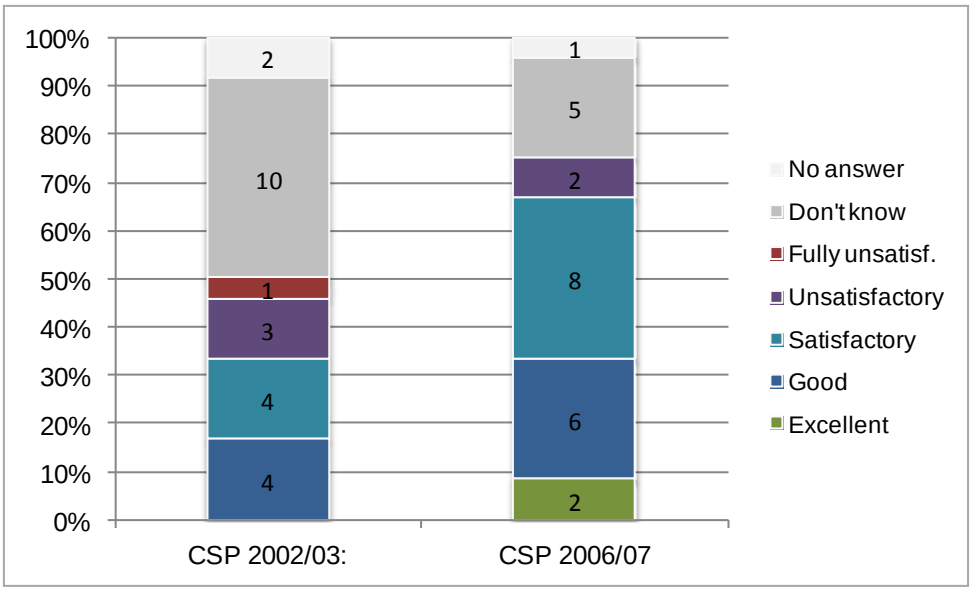
Although the overall rate is pretty good, still 29% EUDs (seven out of 23) (*Vietnam, Afghanistan, Barbados, Zimbabwe, Yemen, Syrian Arab Republic and El Salvador*) answered negatively to this question. Among them only EUD *Afghanistan* provided some further comments and explained that "*although there is no written harmonised donor health assistance strategy donors coordinate their activities with the MoPH through various technical forums (working groups, task forces, etc.)".* EUD *El Salvador* stated that the EUD has now programmed in this sector.

2.5.2 Coordination of EU programming process with other donor activities

Question 15: How would you rate the extent to which the EU programming process related to health sector support has been coordinated with other donor activities during the two programming periods covered by this evaluation, i.e. covering the processes taken place for the preparation of the CSPs 2002/03 and 2006/7?

2.5.2.1 Coordination with the donor community in the country

Figure 51: Q15a: Coordination with donor community in the country



Source: EUD Survey, 2011, Particip GmbH

During the **first round of CSPs (2002/03)**, 42% of the EUDs (10 out of 23) replied not to know whether the EU programming process related to health sector support was coordinated with other donor activities. Of the 12 remaining, four EUDs (*Timor-Leste, Myanmar, South Africa and Ghana*,) said there was a "good" coordination and four EUDs (*Philippines, India, Vietnam, and Burkina Faso*) considered it "satisfactory". On the other hand, three EUDs (*Nigeria, Zimbabwe and Morocco)* considered "unsatisfactory" the EC coordination with the donor community and only one, EUD *Ecuador*, rated it as "fully unsatisfactory".

For the **second programming period (2006/07),** two EUDs (*Timor-Leste and Myanmar*) considered "excellent" the EC coordination with other donor activities. It is worth noting that these two EUDs were the same recognizing the coordination as "good" during the previous programming exercise.

Six EUDs (*Vietnam, Philippines, Egypt, Zambia, South Africa and Ghana*) considered "good" the coordination with the donor community while eight EUDs, double than for the previous programming exercise, considered the level of coordination "satisfactory" (*Lao, India, Afghanistan, Nigeria, Burkina Faso, DRC, Barbados and Morocco*).

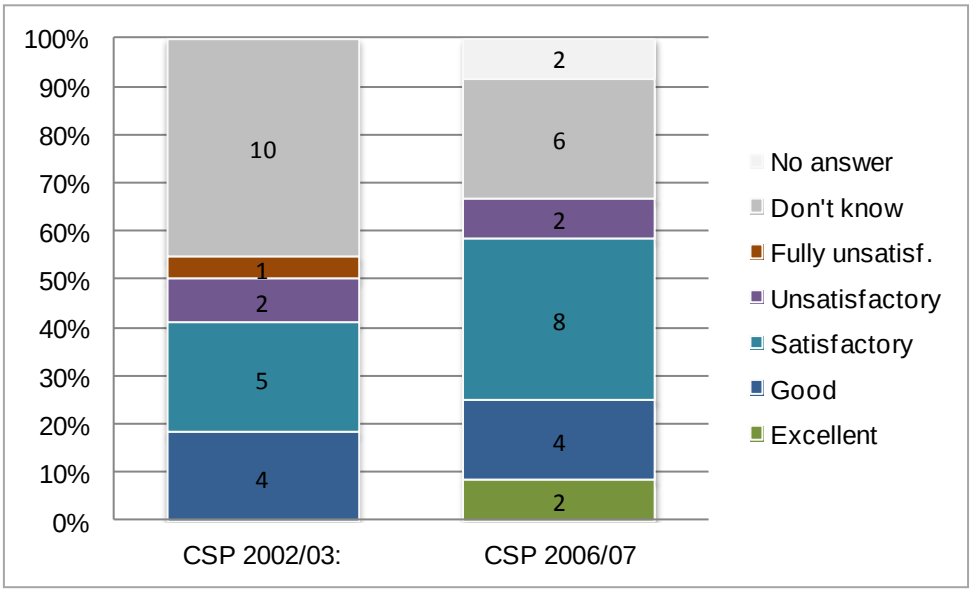
EUD *Nigeria and Morocco* were the two that did the move from "unsatisfactory" in 2002/03 to "satisfactory" in 2006/07.

For this programming period, only two EUDs (*Zimbabwe and Ecuador*) considered the EC coordination with the donor community "unsatisfactory".

2.5.2.2 Coordination with EU Member States in the country

With regard to the coordination specifically between EU MS, the picture is mostly the same but slightly less well rated than for the donor coordination in general.

Figure 52: Q15b: Coordination with EU Member State donors in the country



Source: EUD Survey, 2011, Particip GmbH

As regards the coordination of the EC with the EU member states (MS) donors in the country for the **first round** of CSPs, ten EUDs out 24 (45%) said they did not know how the level of coordination between MS was. From those who provided a score (12 out of 24) four EUDs (*Ghana, South Africa Timor-Leste and Myanmar*) reported the coordination was "good" and five EUDs (*Philippines, India, Vietnam, Burkina Faso and Nigeria*) considered the coordination "satisfactory". Contrarily, two EUDs (*Zimbabwe and Morocco*) considered that the coordination with member states was "unsatisfactory" and only EUD *Ecuador* said it was "very unsatisfactory".

For the **second round** of CSPs, the EUDs perceived that the coordination between the EC and MS present in the country substantially improved. Two EUDs (*Timor-Leste and Myanmar*) found the coordination "excellent", four EUDs (*Philippines, Vietnam, Ghana and Egypt)* said it was "good" and eight EUDs (*India, Afghanistan, Nigeria, DRC, Burkina Faso, Zambia, Morocco and Ecuador*) considered it "satisfactory".

The EUD (*Zimbabwe*) continued perceiving that the coordination between EC and MS was "unsatisfactory" and commented that "*Up to middle 2007 each EU MS was adopting different health strategy and target population".*

Interestingly the EUD *South Africa* changed from a rating "good" in the first CSP period to "unsatisfactory" for the second period, without providing explanations.

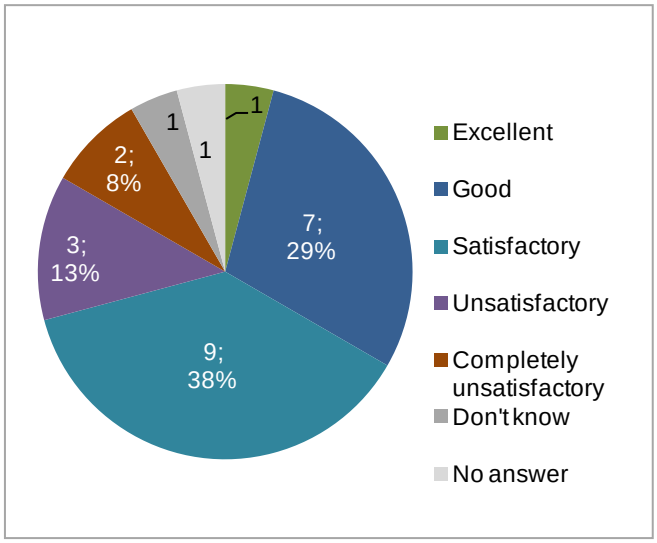
2.5.3 Coherence between different EC instruments

Question 16: How would you judge the coherence between the different EC (financial) instruments (e.g. EDF/DCI and thematic budget lines such as SANTE, EIDHR) used for supporting the health sector in your country?

Out of the 23 EUDs that replied to this question, 17 confirmed that the use of the different EC (financial instruments) has been coherent. One EUD (*Syrian Arab Republic*) reported that coherence between the different EC (financial) instruments was "excellent", seven EUDs (*India, Myanmar, Afghanistan, Bangladesh, Barbados, Ecuador and El Salvador*) found it "good" while nine EUDs (*Lao, Philippines, Timor-Leste, Nigeria, Ghana, Mozambique, Zimbabwe, South Africa and Morocco*) rated it as "satisfactory".

On the other hand, three EUDs (*Burkina Faso, Zambia and Vietnam*) found "unsatisfactory" level of coherence between the different (financial) instruments used by the EC and other two (*Yemen and DRC*) rated it as "completely unsatisfactory"

Figure 53: Q16: Coherence between the different EC (financial) instruments



Source: EUD Survey, 2011, Particip GmbH

Some of the issues highlighted to explain the rate "unsatisfactory" by the EUD *Burkina Faso* were that the priorities of the **PIN were not necessarily taken into account by thematic budget lines** as the latter are often subject to general multi-country guidelines. The EUD added an example to this: "*recently the delegation evaluated very positively a project in human resources in health, which would have had good complementarities with a MDG contract objective in health, but it was rejected by HQ".*

Similarly, EUD *Vietnam* commented that there was little sharing of information from thematic budget lines with bilateral one.

In *Yemen,* the issues reported by the EUD were similar. According to the EUD, the "*thinking brains for country based activities (i.e. DCI) and for other budget lines (EIDHR, SANTE, Investing in people) do not seem to communicate too much with one another. If local resources (i.e. DCI) must follow a peer review process with HQ (notably the quality support group) the same does not go for the thematic budget lines (peer review with countries that most likely will have to follow up the implementation)".*

The answer of the EUD of *DRC* tackles the same problem and highlights the fact that the EDF programming is done by the country, but the budget line programming in Brussels.

All in all, the EUDs perceived there is rather good coherence in the use of the different EC (financial) strategies to support the health sector in their respective countries. In those countries where EUDs have scored coherence as rather unsatisfactory the comments pointed towards the same pattern of

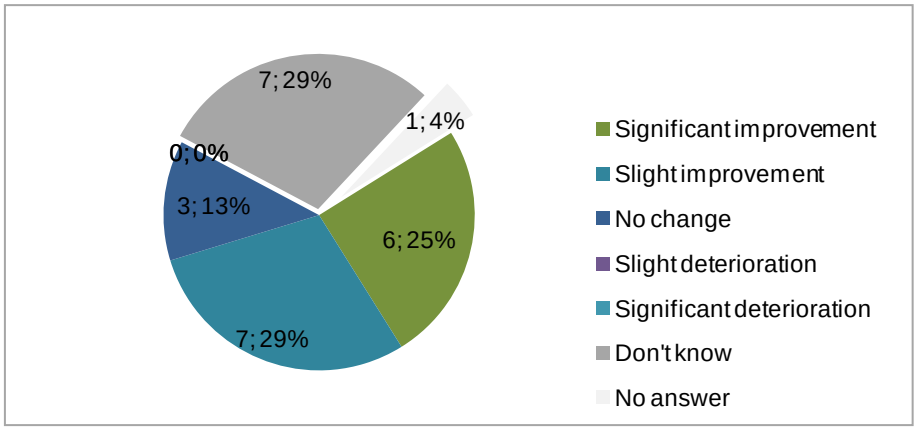
"harmonisation vs. vertical programs" that the EUDs keep on criticising since the first question on harmonised donor health assistance strategy.

2.5.3.1 Changes between the first and second programming period related to the use of EC instruments

Q 16a: How would you judge changes in coherence between the first programming period in 2002/03 and the second programming period 2006/07?

Only few EUDs provided a rating to this question (eight EUDs answered "don't know" or did not answer). The remaining 16 EUDs recognised either a positive change (54% rated either with "significant improvement" or "slight improvement") or did not see any change (13%, corresponding to three EUDs).

Figure 54: Q16a: Changes in coherence between the first programming and second programming period



Source: EUD Survey, 2011, Particip GmbH

2.5.3.2 Reasons for change between 2002 and 2010

ACP region

In the **ACP region** EUD *Nigeria* said that the budget and EDF practical guides were slightly more coherent. In addition, it added that at country level, programming for the Health Sector under the 10th EDF was viewed from a more holistic point of view. Another element that according to the EUD has "greatly contributed to internal coherence" was the increased dialog with potential beneficiaries of grants under the thematic budget lines such as CSOs and NGOs.

In *Ghana*, where the EC moved from Pool fund and SBS to GBS the EUD confirmed they still financed some very specific health projects through thematic budget line. This was perceived by the EUD as not coherent with the EDF programming with very high transaction cost.

EUD *Mozambique* also estimated an improvement in the coherence since, according to the EUD, there is more involvement of the EU delegations in the selection of the budget line projects and greater possibility of NGOs in the health SWAp. However, the EUD noted that multi-country proposals are problematic since they often have an iNGO impetus and objective and not so much an overall country focus.

In *Timor-Leste*, the EUD explained that coherence and complementarily became criteria in the decision process of other thematic support to the sector.

Asia region

In **Asia region,** EUD *Lao* observed that in recent years there were very few thematic budget grants in health selected.

EUD *Philippines* reported to have observed more synergy and complementation in the programming period 2006/07.

Latin America

In **Latin America,** EUD *Ecuador* reported that the EC keeps on using thematic budget lines in santé and EIDHR (health is not receiving support in the 2007-2013 CSP) and that they do help support actions in the health sector. According to the respondent they are coherent with the national policies: such as HIV/Aids, Sexual Reproduction projects.

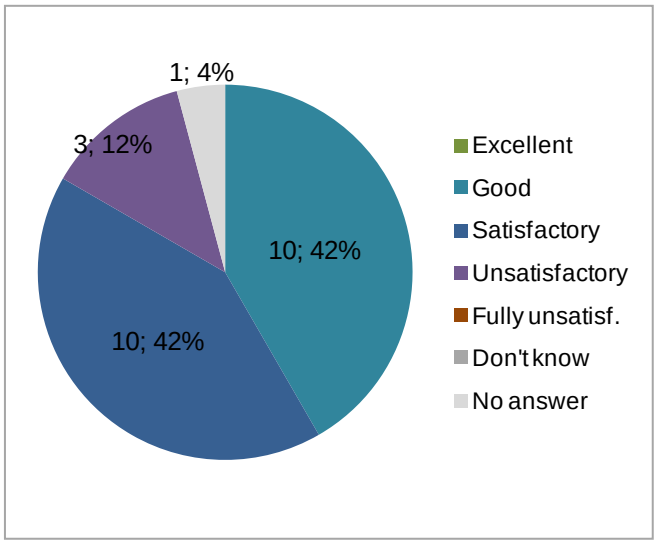
2.5.4 Coordination and Complementarity during implementation of health support at the level of the sector

2.5.4.1 Donor coordination

Question 17: Regarding coordination during implementation of EC support to health, how would you score donor coordination, including with EU MS, in the health sector in your country in 2010?

As for coordination and complementarily related to EC support to health sector between donors, including the EU MS, survey results shows a rather positive picture.

Figure 55: Q17: Coordination during implementation of EC support to health in the country in 2010



Source: EUD Survey, 2011, Particip GmbH

42% corresponding to ten EUDs (*Philippines, India, Bangladesh, Myanmar, Afghanistan, Morocco, Syrian Arab Republic, Moldova, South Africa and Ghana*) said that the coordination was "good" and ten EUDs more (*Lao, Vietnam, Egypt, Barbados, Nigeria, Burkina Faso, DRC, Zambia. Zimbabwe and Ecuador*) rated it "satisfactory".

A majority of EUDs describe operational health working groups or coordination meetings or donor for, which involve the main donors (EUD *Egypt, India, Nigeria, Moldova, Syria, DRC, Afghanistan, Ecuador, Ghana*).

The EUD *Vietnam* makes a clear distinction between EU Member States and other donors: *"Donor coordination between the Delegation and EU MS is quite good. Normally, the Delegation and EU MS speaks a common voice in sector dialogue, However, the coordination between the Delegation and other partners is not very good due to the unwillingness of non-EU donors to share information and to speak in a single voice*."

The EUD in *Nigeria* and *Bangladesh* report a considerable improvement of coordination mechanism and coordination in the last years:

- EUD *Nigeria*: *"There is a regular (monthly) meeting of all key Development Partners supporting the Health Sector with a senior member of the Federal Ministry of Health usually also in attendance. This platform has greatly contributed to improved coordination amongst the EU and member states as well as other Development Partners."*
- EUD *Bangladesh*: *"The coordination 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 assessment of the new health strategy along with joint policy dialogues is some of the outcome of this better coordination during 2010."

While giving a positive rating, the EUD *Laos* and *Burkina Faso* state, that there is still space for improvement.

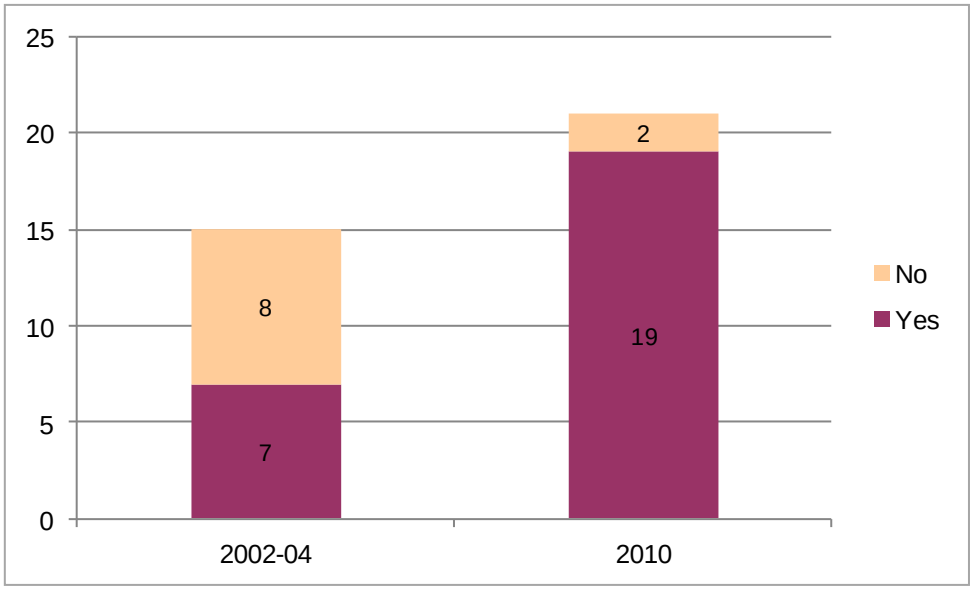
Only three EUDs (*Yemen, Timor-Leste and Mozambique*) found the coordination was "unsatisfactory".

- EUD *Yemen* commented that donor coordination exist however the outputs of the coordination were unclear and there was a lack of follow up;
- In *Timor-Leste*, the EUD reported that sector policy reform and sector performance framework was not agreed in the coordination meeting and
- on *Mozambique*, the EUD found that one of the problems was the presence of too many other donors and that the EU MS continue to develop bilateral projects to, according to the EUD, serves their own constituencies.

2.5.4.2 Existence of joint field missions and shared analytical work

Question 18: Did joint (government and other development partners) field missions and shared analytical work take place related to health support in the early period under evaluation, i.e. 2002/04 and 2010?

Figure 56: Q18: 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

As with the previous case, **progress has also been made on increasing the number of joint field missions and shared analytical work**.

For the **first reference period, 2002-04** seven EUDs (*Lao, India, Bangladesh, Afghanistan, Nigeria, Zambia and Zimbabwe*) indicated that jointed field missions and analytical work took place in their countries during the period 2002-04. Eight EUDs (*Philippines, Vietnam, Timor-Leste, Morocco, Barbados, DRC, South Africa and Ecuador*) reported there were no joint missions related to health in their countries during that period.

In 2010 the picture changed considerably. Not only did the answer category "don't know" fall from seven to one, but also the EUDs indicating that no joint action took place decreased to two (EUD *Zimbabwe* and *South Africa*). In 2010, 79 % (in 2002-04: 29%) of the respondents confirmed that joint action related to the health sector took place in their countries.

Examples of joint missions and shared analytical work conducted in the countries presented below:

In the **Asian region:**

- EUD *Lao* reported that donors assist the national government in almost all matters. Japan was the first to support a profound planning cycle in health in early 2000's. Now in the different sector coordination forums many donors/UN have their input on topics such as financing, MCH, human resources and vertical programs.
- EUD *Philippines* commented that there has been a notable improvement in terms of joint field missions in 2010 under the DoH-led Sector Development Approach to Health (SDAH), a swap-like mechanism that promotes alignment and harmonization among the activities of development partners.
- EUD *India* reported that the number of joint missions have been reduced from three to two missions annually. All DPs, government officials, CSO representatives and consultants to donors participate in these missions. Teams were composed according to technical skills and donor interest in particular states and topics. The EUD also explained that there was a problem on communicating the centrally released recommendations to the States and having them implemented.
- EUD *Vietnam* explained that the delegation and the World Bank regularly have joint supervision missions under HEMA bilateral project for the poor. It added that all technical assistance missions, financed by the EC, are requested to meet relevant donors in Vietnam.
- EUD *Bangladesh* reported that since the duration of the last health sector programme HNPSP was from 2005-2011, most of the joint missions revolved around the annual review of the sector programme. The participants were both GoB and development partners.
- EUD *Timor-Leste* explained that since 2006, there have been regular joint missions every six months to discuss sector planning and programming and to evaluate the sector performance.

In the **ACP region:**

- EUD *DRC* reported that two or three joint missions per year between the Ministry of Health, the EC and the WHO in the provinces beneficiaries of the support.
- EUD *Ghana* said there was one annual health review and that the review was well coordinated.
- EUD *Burkina Faso* reported the existence of several joint missions such as: (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. According to the EUD the factors ensuring success were: adequate notification and realistic duration.
- EUD *Nigeria* explained that there were more or less ad hoc joint monitoring missions for instance on the Immunization Plus Days and joint assessment of National Strategies.
- EUD *Zambia* reported that regular Annual Joint Health Sector Reviews are held. Participants are wide and include, MoH, Health Cooperating Partners, Civil Society Groups, and Regulatory bodies (Health Professionals Council, Nursing Council, Pharmaceutical Regulatory Body).

In the **MEDA-ENPI-TACIS region**:

- EUD *Syrian Arab Republic* described the Global Fund - CCM was quite active and that joint field missions took place every year (four or five missions every year). The EUD added that the EC is the CCM's donors' representative, so that outcomes of the missions are discussed with the EC.
- EUD *Morocco* reported that two joint missions took place every year; in addition several internal meetings of preparation are hold between the partners.

In Latin America

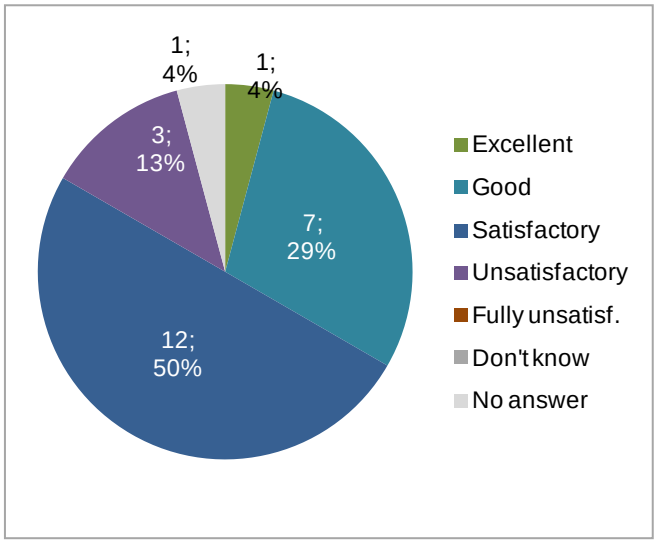
- EUD *Ecuador* explained that after 2007, the government started to show an empowerment over the health projects implemented by donors. It participated more and had better and closer followed up in the project implementation. It participated in the various missions, commented on the various studies or seminars organized within the several projects implemented. According to the EUD, the elimination of the co-direction in the projects had as result a better and more active participation of the government.

2.5.4.3 Judgment of overall donor coordination

Question 19: How would you judge the overall donor coordination in the health sector in your country in 2010?

The overall donor coordination in the health sector in 2010 was judged by the EUDs as rather positive, with 83 % of all respondents rating the overall donor coordination either 'Excellent', 'Good' or 'Satisfactory'.

Figure 57: Q19: Overall donor coordination in the health sector in your country in 2010



Source: EUD Survey, 2011, Particip GmbH

One EUD, *Philippines* found that the donor coordination in the health sector was excellent.

Out of the 23 EUDs that answered, seven EUDs (*Myanmar, Bangladesh, Afghanistan, Moldova, Syrian Arab Republic, Ghana and South Africa*) rated the coordination as "good" and 12 EUDs (50% *Lao, Vietnam, Timor-Leste, Morocco, Egypt, Mozambique, Zimbabwe, Burkina Faso, Nigeria, Zambia and Barbados*) said it was "satisfactory".

Only three EUDs (*India, Yemen and Ecuador*) reported "unsatisfactory" levels of donor coordination in the health sector.

- EUD *India* commented that overall donor coordination in the health sector does not exist but only for specific health sector programs.
- Similarly EUD *Ecuador* reported that there was no really donor coordination in the health sector. According to the EUD, *"although the EC has for long time promoted that the Ministry of Health coordinates all donors that are involved in the health sector, this has not been done until the present date"*.

2.5.4.4 Elements enhancing/hindering coordination

All in all the qualitative comments from the EUDs confirm that the coordination between donors in the health sector has considerably improved however more could be done in this area.

Qualitative comments from EUDs suggested that one of the factors that enhance coordination is the **presence of a National Strategic Health Development plan** which provides the **framework for joint partnership** and collaboration in the health sector while one of the factors to be improved is the **empowerment of the MoH** to become more pro-active in this area.

Examples of some relevant comments are provided below:

- EUD *Philippines: "Development partners have been progressively aligning, formally or informally, with the health sector reform strategy. The further development of the Sector Development Approach for Health (SDAH) was the main mechanisms by which this happened".*
- EUD *Nigeria*: *"Coordination was weak but improving compared with what obtained in the past. The National Strategic Health Development plan and IHP+ compact has provided result based framework for joint partnership and collaboration in the health sector".*
- EUD *Syrian Arab Republic*: "*Coordination has considerably improved, but lot of room to improve. The MoH (and the GoS in general) should be much more active in this area. UNDP has been supporting the State Planning Commission in this area - but results are still limited (no donors' matrix in the 11th Five-Year Plan)."*
- EUD *Bangladesh*: *"During 2010, the preparatory activities of the next sector programme really took off where strong coordinated approach was followed by all the donors of the health sector. Starting from the assessment of the concept note of the next health sector programme, the overall consultations with the GoB as well as expert missions/support to the GoB for the next programme, all were discussed and agreed among the donors beforehand".*
- EUD *Lao* (on coordination): *"still opportunity to improve. Very many donors and agencies, and then support e.g. from China and Vietnam is not really coordinated".*
- EUD *Zambia*: *"Post 2009 financial scandal in the health sector, dialogue focused primarily on governance issues at the expense of health service provision. The dialogue between government and cooperating partners suffered due to lack of trust."*

2.5.4.5 Major changes during the evaluation period in relation to sector coordination

Question 19a: Major changes with regard to health sector coordination during the evaluation period?

Regarding the major changes on the health sector coordination that occurred during the period under evaluation (2002 to 2010), the information provided by 21 EUDs pointed out four major changes:

- enhanced communication among donors
- set up of health sector review
- improved coordination within the Development Partners
- increased leadership of the MoH in the coordination and partnership mechanism
- development/revision of health sector policies

Examples of changes in the health sector coordination among donors, between 2002 and 2010 reported by the EUDs, are presented below:

- EUD *Vietnam* that listed several changes: 1) the Joint Annual Health Review 2) the Statement of Intent between MoH and Development Partners on aid effectiveness and harmonization 3) the 5-year national health plan 4) the 10-year sector strategy 5) the Master Plan on HMIS 6) the Joint Assessment of National Strategies (as part of IHP+ initiative) 7) the Health System Financing Platform.
- EUD *Bangladesh* said that *"one of the major changes during this period was the improved coordination within the Development Partners. The HNP Consortium Chair was on lead for the dialogues with the Gob and coordinates the events like Joint Assessment of the Concept as well as the Strategic document and appraisal of the overall programmed document*".
- EUD *Nigeria* also listed some changes: 1) Revision of the National Health Policy in 2004 2) Demand by host government for mutual accountability from partners 3) Introduction of donor coordination platforms notably the Development partner group on Health 4) Establishment of a National Strategic Health Development Plan and IHP+ 5) Preparation of a National Health Account in view.
- EUD *Burkina Faso* listed: 1) Set up of health basket fund in 2005 2) Set up of annual health sector review as of 2010 Signature of IHP compact in 2010 3) Drafting of new national strategy and revision of participation for NHP coordination groups (work in progress).
- EUD *Syrian Arab Republic* observed that *"more donors seem to be involved in the health sector. The EC has been for example very active in this area since 2002 (it is now the biggest donor) and has tried to improve coordination - notably with the EU MS and partners (such as the European Investment Bank, which signed its second health loan in December 2010). More attention is now given to the Paris Declaration and its principles".*

- EUD *Zambia* reports that the health sector coordination during the period was affected by different events in the Health sector such as 1) Restructuring of MoH with the abolishment of Central board of Health; 2) abolition of User Fees; 3) IHP and discussions; 3) Increased support from the vertical programmes.

2.5.5 Coordination mechanisms used in the health sector

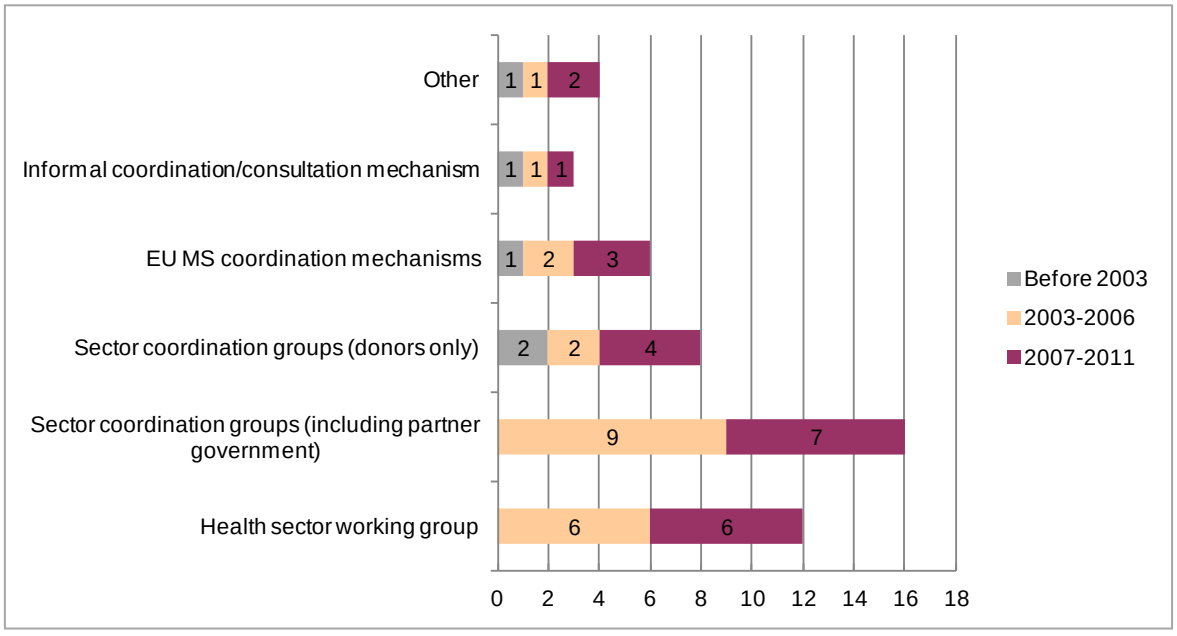
2.5.5.1 Existence of specific sector coordination mechanisms for the health sector

Question 20: In 2010, what kind of sector coordination mechanisms exists for the health sector?

This question aimed at capturing the different types of co-ordination mechanisms related to support the health sector during the evaluation period. We asked the respondent to tell us which kind of sector coordination existed in their countries for the health sector: Five coordination mechanism were listed

- Health sector working group
- Sector coordination groups (including partner government)
- Sector coordination groups (only donors)
- Coordination mechanisms between EU Member States
- Informal coordination mechanisms

Figure 58: Q20: Range of sector coordination mechanisms used in the health sector (per period), several answers possible



Source: EUD Survey, 2011, Particip GmbH

According to the 22 EUDs that have answered this question, the most used coordination mechanism during both periods 2003/06 and 2007/2011 were **Sector coordination groups which includes partner government.**

Health sector working groups were the second most used (18 out of 22 EUDs) and in the third place was **Sector coordination groups in which only donors participate** were also quoted by 18 out of the 22 EUDs.

Before 2003 only informal coordination mechanisms and EU MS coordination were reported; though since 2003 the **general trend was to have more formal coordination**, specific to the health sector, involving all donors working in the health sector and engaging the governments in the coordination tasks for the health sector.

In addition these coordination mechanisms are very country specific, and naturally related to the type of support the EC is giving towards the health sector. The list of the each type of coordination mechanisms reported by the EUDs per country is given below:

Q20b: Sector coordination groups (including partner government)

Most of the EUDs responded being involved in one or several formal sector working group, including partner-government. Most of them meet on a regular base; frequencies vary from monthly to bi-annual.

- In *Lao*: Sector Working Group receives proposals from TWGs.
- In *India*: A donor partner forum meets monthly to discuss development/s and update on events in RCH service delivery and health sector reform.
- *Philippines:* Sector coordination group is part of the health working group.
- In *Vietnam*: Health Partnership Group.
- In *Bangladesh:* HNP Forum, HNPSP Coordination Committee.
- In *Afghanistan*: Technical Advisory Group (TAG), Consultative Group for Health and Nutrition.
- In *Timor-Leste*: Regular meetings and missions to review sector performance and programming.
- In *Egypt*: Development Partners Group (Health subgroup) meetings are convened by the MoHP.
- In *Morocco:* Sector dialogue meetings.
- In *Nigeria*: Development Partner group on Health (DPGH) with co-chairs from any of the key development partners working in the area of health. Senior members of MoH usually in attendance.
- In *Burkina Faso:* NHS Sectoral commissions (six in total) - but only one is actually active. There exist subgroups for specialised topics such as vaccinations, Global fund, epidemic monitoring, nutrition, etc.
- In *Ghana:* The health working group include all active DP as well as core NGO and key government institution such as Ministry of Health and *Ghana* Health Service.
- In *DRC*: National Steering Committee.
- In *Zimbabwe*: health planning forum health transition Fund.
- In *Mozambique*: Six joint groups presently.
- In *South Africa:* ODA planning Forum - twice a year, chaired by DG of DoH - ODA Coordinating Forum, once a year, chaired by the Minister of Health.

A specific donor forum to be highlighted is the **Country Coordination Mechanism of the Global Fund.** EUD *Myanmar* and *Burkina Faso* and the *Syrian Arab Republic* mention it*:* In *Syria* this mechanism includes broad range of stakeholders (GoS, donors, civil society, etc.).

Only the EUD *Moldova* refers to an informal meeting of donors-government, in place since 2006 that converted to a regular formal meeting in 2008.

Q20a: Health sector working group

Most of the EUDs reports of several working group in the countries, working either with different technical topics or donors and government or even NGOs (e.g. *Ghana*)

- In *Lao:* Several technical working groups with support from specific donor: HR by WHO, MCH by Japan, Health Finances by EU, each having several Task Forces under them
- In *India:* Thematic working groups: of individuals from donors and government meet to discuss priority areas for development in the health sector
- In *Afghanistan:* National Technical Coordination Committee, Community Based Health Care and many more
- In *Timor-Leste:* Regular meetings and missions to review sector performance and programming
- In *Vietnam:* Health Partnership Group
- In *Syrian Arab Republic:* Health Coordination Meeting co-chaired by the UNHCR and WHO (focus on Iraqi refugees' health needs in *Syria*)
- In *Morocco:* health group with a sub-group maternal health. In *Ghana:* Health working group include all active DP as well as core NGO and key government institution such as Ministry of Health and *Ghana* Health Service
- In *DRC:* National Steering Committee

- In *Zimbabwe:* Health Cluster under OCHA but only for Humanitarian and emergency response
- In *Mozambique:* Health Partners Group - Joins all health partners
- In *Ecuador:* Health sector working groups only EC with the government
- In *South Africa*: three working groups exist, but not all are yet formalised. Currently only developments partners attending the following groups: - Health Systems WG - Maternal and Child Health WG - HIV and TB WG

Q20c: Sector coordination groups (donors only)

The sector coordination groups with donors only have various shapes. They can be on very specific topics e.g.

- In *Egypt*: Main Donors coordination meetings are convened on demand
- In *Vietnam*: There are some sub-groups on specific topics, such as reproductive health; HIV/AIDS
- In *Bangladesh*: Health, Nutrition and Population Consortium
- In *Nigeria*: Development partner group on HIV/AIDS (DPG HIV/AIDS)
- In *Lao:* CCM/UN

Or general donor fora in the health sector:

- In *Myanmar:* Donor forum
- In *Afghanistan:* Health Donors Coordination Forum.
- In *Burkina Faso:* Bimonthly meetings of donors
- In *DRC:* Groupe Inter Bailleurs Santé
- In *Zimbabwe:* Health Development Partners Coordination Group
- In *Timor-Leste:* Donor coordination meeting to share sector programming
- In *Morocco:* Réunions semestrielles
- In *Mozambique:* ProS II de Donors
- In *Ecuador:* We have started this year a meeting with some donors
- In *South Africa*:, Aids and Health Development Partners Forum (AHDPF), name before 2011: EU+ working group on HIV and Health): chaired by Sweden, now co-chaired by Germany and WHO, meets every 2 months, with bilateral donors and UN agencies. DoH and NAC as observers.

Q20d: EU MS coordination mechanisms

The shape and use of EU MS coordination is quite divers: In some countries (*Lao, Myanmar and Bangladesh*, EU MS meetings exist, but are not health specific.

In *Vietnam, Zimbabwe, Ecuador, Yemen, Timor-Leste and South Africa* the technical staff working on health issues of the different MS gather together. This can be ad hoc (*DRC*) or on a regular bases (e.g. *South Africa* a EU MS health counsellors meeting was set up in 2010 and meets four times a year to a minimum, to prepare joint EU positions if needed, chaired by EU Delegation), around a health round table of EU MS (in *Ecuador*, but not working anymore) or to prepare in an informal manner sector meetings (*Yemen*: Meetings are usually held prior to the monthly sector meetings in order to consolidate positions prior to the meeting itself). *Zimbabwe* reports of a GFATM-CCM coordination.

Furthermore, coordination between MS takes place on a higher level. EUD *Philippines, India, Afghanistan, Mozambique, Morocco and Egypt* report EU Delegation Development Counsellors Meeting or ENPI Management Committees (*Egypt*).

Q20e: Informal coordination/consultation mechanism

All informal coordination mechanisms take place ad hoc and on specific issues. It is decided by the stakeholders. In *Burkina Faso* the donors gather in an informal maternal health and nutrition group and in *South Africa* on specific health or HIV issues. In *Mozambique* the technical support group meets upon request.

A lot of EUDs state these mechanisms to emphasis the day to day exchange (email/phone) with other donors.

In *Afghanistan and Ecuador* ad hoc meeting are used to exchange with the Ministry of health or key experts and consultants or the head of MoPH units.

Q20f: Other

The most quoted other coordination mechanisms in the health sector, more specifically on HIV/AIDS and Malaria related issues refers to the CCM, coordination instance for the GFATM. It is mentioned by the EUD *Laos, India, and DRC*.

Other coordination mechanisms are:

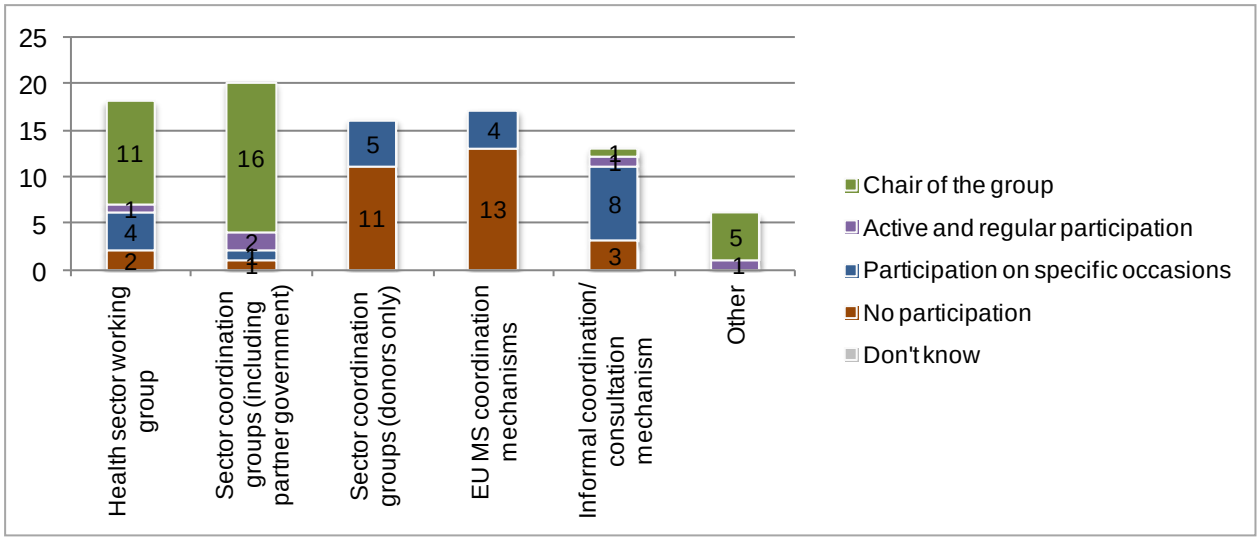
- In *Nigeria:* Inter-agency coordinating committee (ICC) on Immunization chaired by the Hon. Minister of Health and with the National Primary Health Care Development Agency as the secretariat.
- In *Burkina Faso:* Supervision committee of medical provision (CAMEG).
- In *Yemen:* DEVELOPMENT PARTNERS COORDINATION. Gathers all donors, Ministry, UN family and ideally also NGOs.
- In *Myanmar:* Pandemic Preparedness Mechanism (MoH, MoLivestock, UN, NGOs, donors).
- In *South Africa*: CM, called RMC in SA, chaired by the Minister of Health, development partners are presented since April 2010. EU was represented by Italy and just replaced in October 2011 by Germany.

2.5.6 Role of the government in coordination mechanisms

Question 20a: How would you characterise the role of government in each of these groups, if applicable?

According to the vast majority of EUDs (21 out 24 that answered this question) the played a considerable role in the coordination existent mechanisms. Government played a key role in countries where **sector coordination groups (including partner government)** and **health sector working groups** were established (see figure below).

Figure 59: Q20a: Role of government in each of these groups



Source: EUD Survey, 2011, Particip GmbH

Within sector coordination groups the EUDs reported that the government had **the chair of the sector coordination groups** in *Bangladesh Philippines, Myanmar. Afghanistan, Timor-Leste, Moldova, Yemen, Syrian Arab Republic, Egypt, Barbados Burkina Faso, Ghana, DRC, Zimbabwe and Mozambique.*

The government chaired the **health sector working groups** in *Lao, Barbados, Vietnam, Bangladesh, Afghanistan, Timor-Leste, Philippines, Nigeria, Burkina Faso and Ghana*,

In *Morocco* and *Nigeria* the government had an active participation in the sector coordination groups, but it did not hold the chair of the group.

- In *Nigeria* for instance, the group was co-chaired by the key development partners working in the area of health. According to the EUD, senior members of MoH were usually attending it.

- In *India* where the donor partner forum met monthly to discuss development/s and update on events in RCH service delivery and health sector reform, the government participated only on specific occasions.
- And in *Ecuador* the government had no participation at all in the sector coordination groups because no sector coordination groups exist.

Government's involvement in sector working groups

In other countries sector working groups exists, but concentrate on specific, non-permanent, health issues and occasions.

- For instance in *Zimbab*we, health sector working groups existed but only for Humanitarian and emergency response (Health Cluster under OCHA); the government didn't have the chair of the health sector working group. Thus, according to the EUD, it had an active and regular participation in the coordination meetings.
- In the *Syrian Arab Republic* where health sector working groups are co-chaired by the UNHCR and WHO and the focus is on Iraqi refugees' health needs, the involvement of the government was only in specific occasions.

Similar situation was encountered in *India, Morocco and Ecuador* where the involvement of the government was also in specific occasions. In *Mozambique*, according to the EUD, the government didn't participate at all.

Government's involvement in sector working groups

The government also has pretty good involvement in "other" coordination mechanisms which mainly include: **country coordination mechanism of the Global Fund for AIDS, Tuberculosis and Malaria** for instance in *Lao, India and /or DRC*

In *Nigeria* the **Inter-agency coordinating committee (ICC) on Immunization** includes the government, while in *Yemen* it participate in the **development partner coordination** or in *Burkina Faso* in **the supervision committee of medical provision (CAMEG** and the **Pandemic Preparedness Mechanism** in *Myanmar.* In all of them the government has the chair of the coordination group except in *India* where the MoH maintained a very active and regular participation in the CCMs.

Government's involvement in EU MS coordination mechanisms and donor-only coordination groups on the other hand, the government didn't play any role in other coordination mechanisms between EU MS and the sector coordination groups celebrated among donors only. No more than occasionally participations in the coordination meetings between EU MS were reported by EUDs in *Philippines, Afghanistan, Nigeria and Ecuador* and the same was reported for overall donor coordination meetings in *Nigeria, DRC, Zimbabwe and Ecuador.*

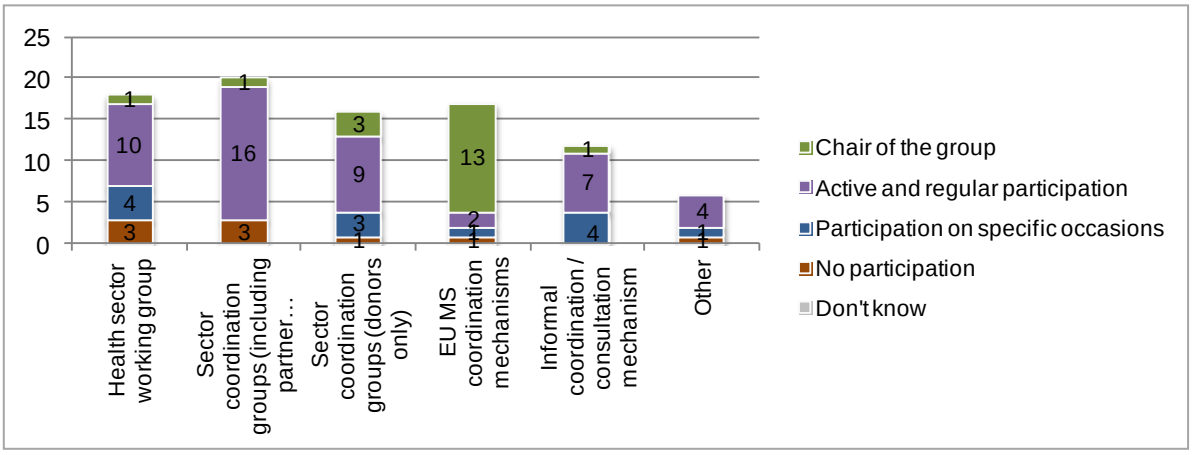
Some occasional participation of the government was also reported during informal coordination meetings in *Barbados* where according to the EUD the coordination tasks worked in ad hoc manner as decided by the actors. EUD *Syria* also reported ad hoc meetings with the government to exchange information; in *Ecuador* the comments of the EUDs noted informal meetings between the EC and the Ministry of health. In *Afghanistan,* the EUD explained that meetings with key experts and consultants were hold with the head of the specific unit of the MoPH and in *Timor-Leste and* in *Myanmar;* informal communication between major donors and government was constantly ongoing.

2.5.7 Role of EC in coordination mechanisms

Question 20b: How would you characterise the role of EC in each of these groups, if applicable?

As regard to EC participation in the coordination groups, it appears that the EC participates actively and on regular bases in the sector coordination and health sector working groups.

Figure 60: Q20b: Role of EC in each of these groups



Source: EUD Survey, 2011, Particip GmbH

The EC has also been quite active in all the other coordination mechanisms, being sector coordination groups involving the partner government or with donors only and through health sector working groups and informal coordination consultations. Only few EUDs reported no participation at all of the EC in the coordination groups. For instance, three EUDs (*Ghana, Myanmar and Ecuador*) reported that the EC did not participate at all in the sector coordination groups involving the partner government. No further comments were provided except EUD *Myanmar* that said that in the country the UK represented donor constituency. Two EUDs *Burkina Faso and Ghana* reported the no participation of the EC in the health working groups. In *Burkina Faso*, the EUD explained that limited places were available for donors, however it commented that the EUD was in the process of joining the NHS monitoring committee and that it had requested observer status in common basket. EUD *Ghana* did not provide any further comments on it.

Although the EC is actively participating in the coordination mechanism, the survey revealed that (at the moment of the survey) the **EC chaired** only one health working group and sector coordination group including partner government (both EUD *Morocco*)

In sector coordination group including only donors, the EUDs of *Bangladesh, DRC and Zimbabwe chaired the group at the time of the survey*. In *Afghanistan*, the EC had the chair of the group in informal coordination meetings between key experts and consultants and the head of the specific unit of the MoPH.

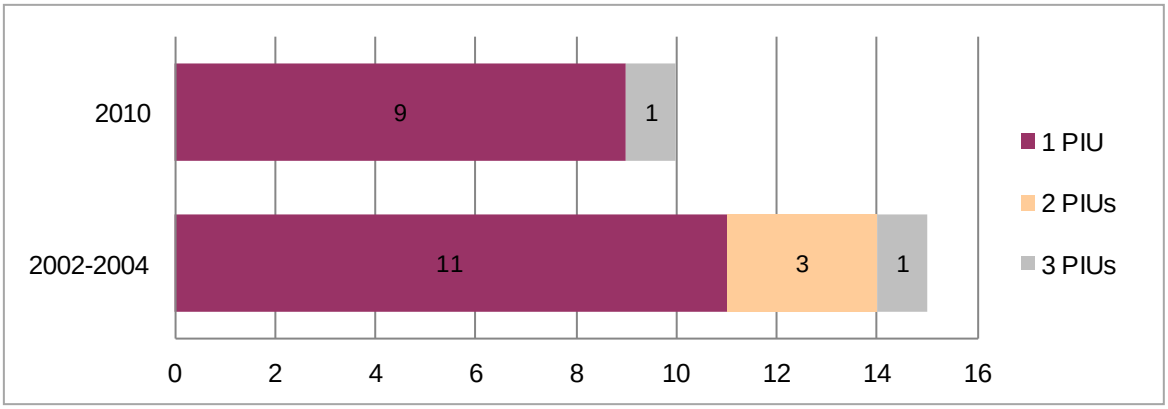
The EC has played a key role in EU MS coordination mechanisms and has chaired these coordination groups in 12 (*Egypt, Syrian Arab republic, Morocco, Philippines, Afghanistan, Bangladesh, Vietnam, Timor-Leste, Mozambique, Zimbabwe, DRC and Nigeria*) out of 17 countries which had this mechanism established over the evaluation period. EUD *Barbados* reported no participation of the EC in the EU MS coordination meetings however this statement has to be balance as no member state is present in the country.

2.5.7.1 Number of EC supported project implementation unit

Question 21: In the Paris Declaration donors committed themselves to reducing parallel project implementation units (PIUs) by two thirds until 2010. How many EC supported project implementation units have been/are running in parallel to government institutions in the health sector?

The following figure shows the number of project implementation units running parallel to government institutions within the health sector in the early period of evaluation and at the time of the evaluation.

Figure 61: Q21: 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 first reference year 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*) exited in their country in the health sector.

45%, corresponding to 11 EUDs, indicated that one PIU was running in their country at the beginning of the evaluation period.

These figures change considerably in the **second reference** year, in **2010**. Although still one country (EUD *Bangladesh*, no information where provided by this EUD 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. No EUD stated having two PIU and the number of countries having 1 PIU, decreased from 11 to nine.

It can be noted that *Moldova* and *Mozambique* reduced their PUI from two to one, and in *Timor-Leste* two PIU merged to a separate TA in 2008.

Furthermore, the qualitative comments make clear, that in most countries, the PIUs were not running anymore in 2011, with the only exception of EUD *Vietnam* that reported a new PIU established for sector capacity building project.

In quantitative terms, the average number of parallel units for the first period of the evaluation was 0.7 and for the second period 0.4. This clearly shows that **the trend was to phase out parallel PIUs during the course of the evaluation period and demonstrates that there has been a progress of the EUDs in achieving Paris Declaration indicators.**

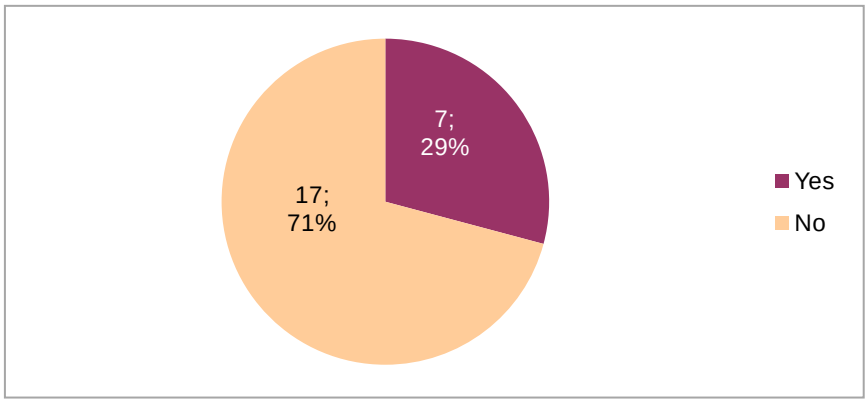
2.5.7.2 Establishment of national health specific trust fund agreements

Question 22: Has the EC established national health-specific trust fund agreements with UN organisations, Development Banks and bilateral organisations in your country?

Most respondents, 17 EUDs (*Egypt, Morocco, Moldova, Syrian Arab Republic Yemen, Lao, India, Afghanistan, Mozambique, DRC, Burkina Faso, Nigeria, Barbados, South Africa, Zambia, El Salvador and Ecuador*) out of 24 that answered the question said that they had not established any health specific trust fund agreements with UN organisations, Development Banks and bilateral organizations during the evaluation period.

Out of the seven EUDs that replied to have established health specific trust fund agreement, five were Asian countries (*Philippines, Vietnam, Bangladesh Myanmar, Timor-Leste,)* and the other two ACP countries *(Ghana and Zimbabwe)*.

Figure 62: Q22.1: Use of national health-specific trust fund agreements with UN organisations, Development Banks and bilateral organisations in your country



Source: EUD Survey, 2011, Particip GmbH

According to the EUDs the **major strengths** of the implementation of trust agreements were: (i) enhanced coordination between donors themselves and with the partner government, (ii) better harmonized interventions between donors and (iii) greater ownership and leadership by the partner government. Among the **major weakness** cited were: (i) complicated administrative procedures that lead into delays in the project implementation; (ii) reduced donor visibility. The table below shows a complete summary of the strength and weaknesses that occurred during and after the implementation of the agreements.

Table 11: Q22.2: Strengths and weaknesses that occurred during and after the implementation of the trust agreements

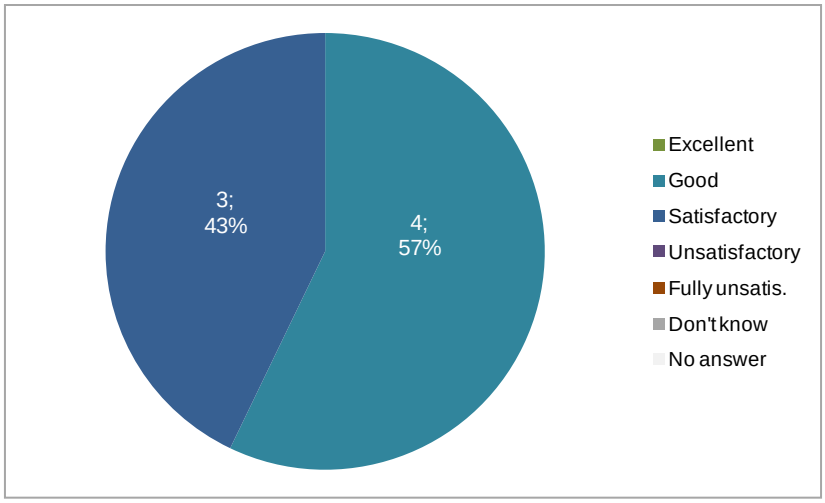
EUD	Strengths	Weaknesses
Philippines	• Good working relationship and closer coordination between EC and the World Bank	• Delay releases of funds particularly in the initial stage due to the Bank's requirements
Vietnam	• Better harmonization of support by the WB and the EC	• Complicated procedures that pro-long project implementation
Bangladesh	• Harmonized donor interventions aligned with Government strategies/policies	• Wasted resources/time on meetings and monitoring • EU visibility remains a concern
Myanmar	• Good quality of partnership, efficiency, effectiveness, impacts, coordination	• Limitation linked to vertical approach
Timor-Leste	• WB-TA improved capacity of MoH-PMU in various subjects (PSM, FMS, reconstruction, management of drug store etc.) • EC-TA helped the MoH in developing important sector documentation (medium sector strategic plan, MTEF etc.)	• EC became the single donor to the TF
Zimbabwe	• Health Transition Fund (HTF) (multi-donor pooled fund) assist ensure coherence between donor's interventions • Better coordination of resources. • MoH played an important role in determining priorities	• Cost effectiveness is hampered because of the utilization of a fund manager and implementing partner • Reduced donor agenda and visibility due to increased direct dialogue between fund manager and MoH

2.5.7.3 Complementarity of trust funds to other EC funded health support

Question 22a: How would you rate the extent to which the activities implemented through EC supported trust funds have been complementary to other EC funded health support?

As can be seen in the figure below, the complementarity of EC funded trust funds with other EC support is overall rated positively.

Figure 63: Q22a: Complementary of trust funds to other EU funded health support (response rate: 7 EUDs with trust funds)



Source: EUD Survey, 2011, Particip GmbH

Out of the seven EUDs indicating that trust funds were used in their country, four of them (*Philippines, Bangladesh, Myanmar and Zimbabwe*) indicated that the **EC activities supported through trust funds had a "good" complementarity with other EC funded health support**.

- In *Bangladesh*, for instance, the EUD commented that through Trust Funds, EC has contributed in the health sector programme through a programme based approach using the national system, whereas the other health projects following a classical project approach tried to complement the areas where the national programme needed more focus.
- In *Myanmar*, the EUD reported that EC activities supported through trust funds were totally complementary to other EU health projects (financed under EU thematic instruments).
- EUD *Zimbabwe* also explained that all EC health funded intervention were under one umbrella strategy aiming at: (i) ensuring availability of HR in quantity and quality, (ii) ensuring availability of essential medicines and medical supplies; (iii) supporting the delivery of basic health services to the population with special emphasis to mother and their children. According to the EUD, the Delegation played an oversight role on the trust fund and technically participated to the definition of priorities and related interventions.

The other three EUDs (*Vietnam*, *Timor-Leste* and *Ghana*) rated complementarity as "satisfactory".

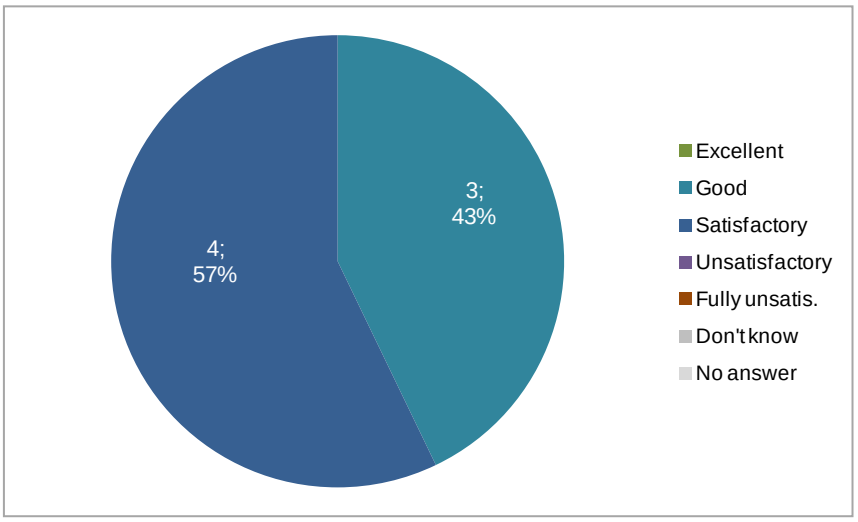
- In *Vietnam* the EUD indicated that need assessment was done jointly with project interventions and that a single set of objectives and indicators were jointly defined;
- Similarly, in *Timor-Leste* the EUD described there was a single programming matrix for both TFs, however other thematic projects were managed separately by contractors.

2.5.7.4 Coordination of trust funds with other EU funded health interventions)

Question 22b: How would you rate the extent to which the activities implemented through EC supported trust funds have been coordinated to other EC funded health support?

As regards coordination between the EC activities supported through trust funds and other EU funded health interventions, the coordination is still assessed as overall positive. Nevertheless, the majority of respondents chose the category "satisfactory", instead of the "good", contrarily to the answers given in the question on complementarity of trust funds.

Figure 64: Q22b: Coordination of the trust funds with other EU funded health interventions in the country



Source: EUD Survey, 2011, Particip GmbH

Out of the seven EUDs that reported to have established trust funds agreements, three said there was a "good" coordination (*Philippine, Myanmar and Zimbabwe*) between the EC activities supported through trust funds and four EUDs found that coordination was "satisfactory" (*Vietnam*, *Bangladesh*, *Timor-Leste* and *Ghana*).

- EUD *Vietnam* reported there was a regular and transparent dialogue between EC trust funds activities and EU health interventions.
- In *Bangladesh* the EUD further explained that the parallel activities outside the trust fund emphasised only those areas where special attention was needed.
- EUD *Timor-Leste* confirmed that the two EC supported trust funds used a single programming matrix and has always been coordinated with MoH-PRs who managed GAVI & GFATM grants to avoid duplication.

Overall, according to five EUDs that reported EC trust funds in the country, the main issues of concerns with such trust funds were related to the management of the procedures and the external communication and visibility of the different funders of the TF. **Complicated procedures of the World Bank (WB),** which are applicable to loan projects that lead to **delay releases of fund** to the recipient agencies (cited by EUD *Philippines and Vietnam).*

- **Conflict of interest between the World Bank and other funders.** For instance in *Bangladesh*, according to the EUD, the fact that the Development Bank was the fund manager and the main communicator between the Government and the Pool Funders group led to the government's perception that the Bank would be the lead partner for the policy dialogue.
- **Communication with the MoH rather difficult**. For instance in *Timor-Leste*, the EUD similarly reported that the remote management of WB task managers made communication difficult and that consistency of MoH to agree with programming was difficult to be observed.

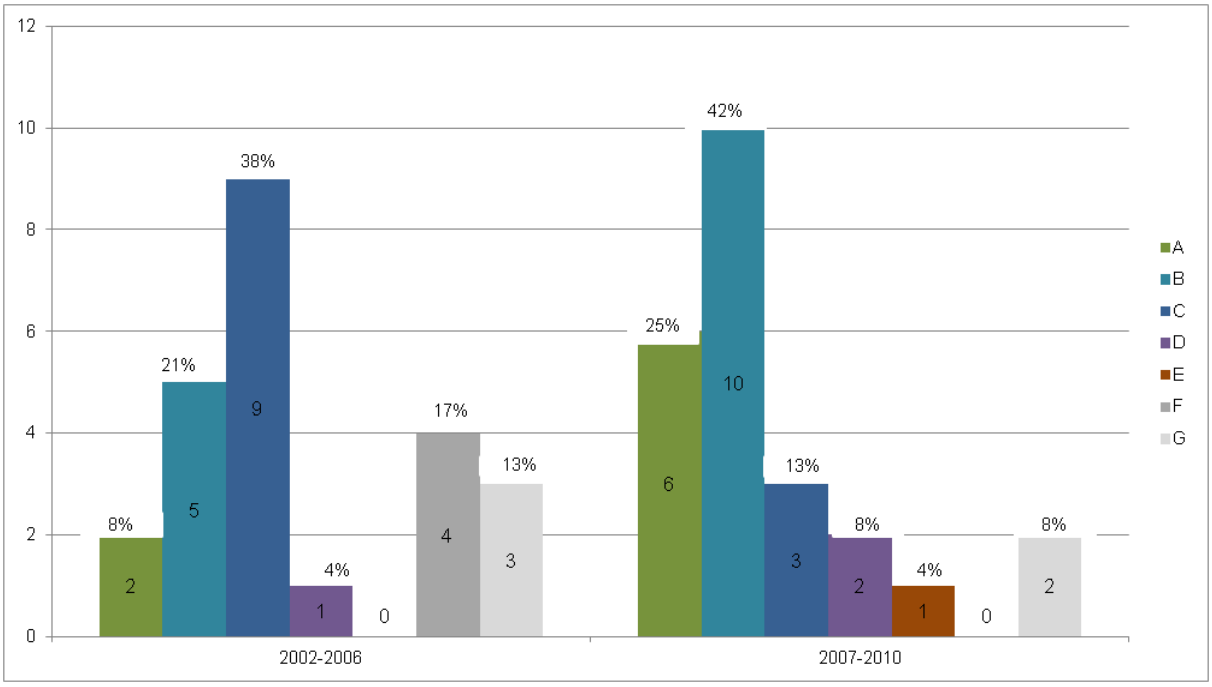
2.6 Financing channels

2.6.1 Extent to which the selection of aid modalities and channels has been based on partner country needs and capacities

Question 23: Overall, for the two programming periods under evaluation, how would you rate the extent to which the selection of aid modalities and channels has been based on partner country needs and capacities?

Overall, choice was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities.

Figure 65: Q23: Selection of aid modalities and channels has been based on partner country needs and capacities? In 2002-2006 and 2007-2010



Source: EUD Survey, 2011, Particip GmbH

Legend:

A	Excellent, the choice is grounded on an extensive analysis and excellent knowledge of the sector situation
B	Good, the choice is grounded on a sound analysis and sound knowledge of the sector situation
C	Satisfactory, an analysis has been made showing a good knowledge of the sector situation
D	Unsatisfactory, only limited analysis of the sector has been made; aid modalities and channels were partly taken from previous CSP periods without further reviewing the context situation.
E	Completely unsatisfactory, neither has an analysis of the sector been made; nor an analysis of aid modalities and channels.
F	Don't know.
G	No answer

For the first programming period most EUDs, nine (*Egypt, Moldova, Philippines, Vietnam, Timor-Leste, Myanmar, Nigeria, DRC and Ecuador*) **indicated it was "satisfactory"** meaning that an analysis was made showing a good knowledge of the sector situation.

Two EUDs found that the selection of aid modalities and channels was "excellent" meaning that it was grounded on an extensive analysis and excellent knowledge of the sector situation (EUD *South Africa* and *Bangladesh*. Other five EUDs (*Ghana, Zimbabwe, Mozambique, Afghanistan and Morocco*) said it was "good" meaning that the choice was grounded on a sound analysis and sound knowledge of the sector situation.

Only one, EUD *Yemen* found the selection of aid modalities and channels "unsatisfactory" meaning that only limited analysis of the sector was made and that aid modalities and channels were partly taken from previous CSP periods without further reviewing the context situation.

For the second programming period the countries reporting a "good" selection of aid modalities and channels based on partner country need considerably increased. 10 out of 20 EUDs (*Lao, Philippines, Timor-Leste, Bangladesh, Vietnam, Moldova, Syrian Arab Republic, Ghana, DRC and Zimbabwe*) said that the EC selection of aid modalities was "good" and grounded on a sound analysis and sound knowledge of the health sector situation.

Six EUDs (*India, Afghanistan, Myanmar, Morocco and Mozambique, South Africa*) found that selection "excellent" since the choice was grounded on an extensive analysis and excellent knowledge of the health sector situation of their countries and three EUDs (*Egypt, Nigeria and Ecuador*) reported it as "satisfactory".

Only two EUDs (*Yemen* and *Burkina Faso*) reported "unsatisfactory" scores. In the case of *Burkina Faso*, the EUD commented that MDG contract with a health MDG performance tranche was the choice of modality for 2009-2014. According to the EUD this mechanism did not take adequately into account elements such as (i) dominance of common basket fund for health policy dialogue, (ii) lack of coordination between the Ministry of Health and Ministry of Finance.

2.6.1.1 Changes occurred in the analyses of partners needs and capacities between 2002-06 and 2007-2010

Question 23: In your view, what changes have occurred regarding the level of analysis between the first and the second programming period under evaluation (i.e. CSPs 2002/03 and CSPs 2006/07?

As regards the changes that have occurred regarding the level of analysis between the first and the second programming period under evaluation, the overall situation has improved from the first round of CSPs 2002/03 to the second round of CSPs in 2006/07. This is mainly explained by the following changes reported by 12 EUDs:

Increased availability of relevant data

In *Lao: "Good Poverty Reduction Support Operation documentation."*

In *Barbados: "Better accounting, programming and evaluation with targets and performance indicators."*

In *Afghanistan: "Afghan House Hold Survey and NRVA (National Risk and Vulnerability Assessment) and more surveys are conducted and government and donors considered their report in making decisions."*

Improved consultation process and increase exchange between DPs

In *Philippines: "The second evaluation has more in-depth analysis due to more information and wider consultation from the different levels of society."*

In *Timor-Leste: "There is better reporting and coordination mechanism after 2008."*

In *Morocco: "We have now better coordination and division of labour mechanisms."*

Increased experience by the EC because of continuous support

In *Bangladesh (in relation to the first sub-period): "It was the 1st health sector programme, where neither the Government nor the Development partners had any experience managing the funds."*

In *Syria: "Much better knowledge of the health sector - which was a new area of interest for the EC in 2001/2002 in Syria."*

Adequate staffing in EUD

In *Ecuador: "In the first period, the Delegation of Ecuador was not opened. In the second programme, 2004 there was staff that accompanied the mission, had meetings with the government and other organisations to define the needs and priorities of the sector."*

Use of BS modality which requires an important preparation phase

In *Egypt: "The design of the budget support HSPSP-II has been achieved through a participative methodology. All the reform benchmarks were reviewed at several occasions by the authorities of the MoHP. The institutional capacities of the MoHP were taken into consideration during the whole process of formulation."*

In *Burkina Faso: "We are currently preparing a submission for sector budget support in health and we are consulting with all relevant partners to gain from their experience / expertise (UNICEF, WHO, UNFPA)."*

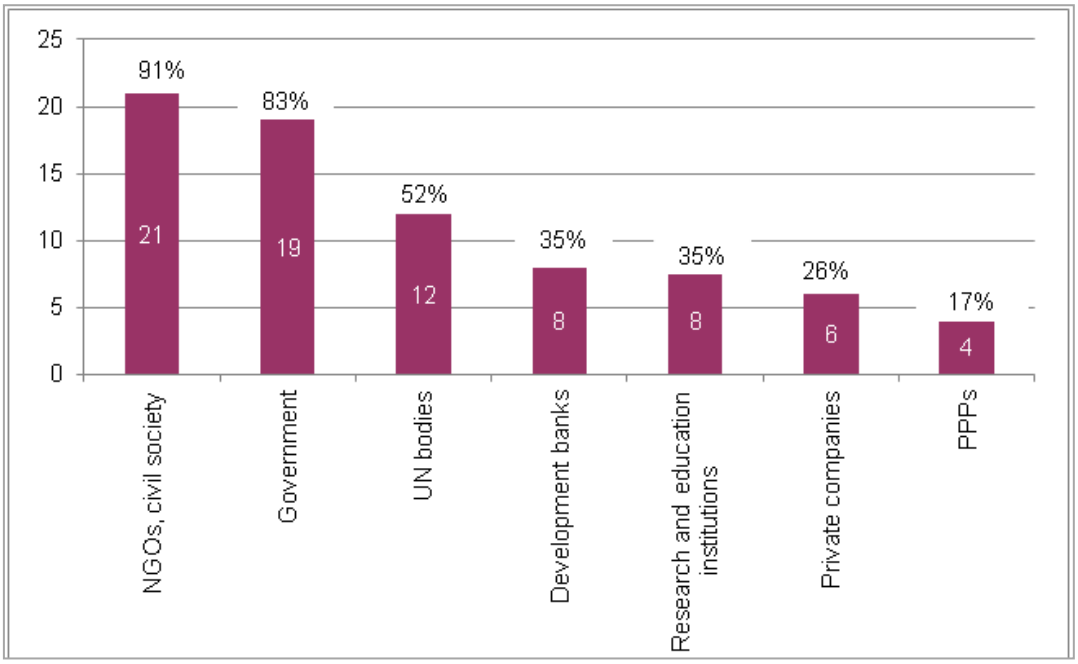
2.6.2 Suitability of channels to support country's effort to improve health outcomes

Question 24: Between 2002 and 2010, the EC may have used a number of channels to support your country's effort to improve health outcomes. According to your experience, how suitable have these channels been to contribute to improving the health system performance and health outcomes of your country?

2.6.2.1 Channel used

The questionnaire survey revealed an overview of the general suitability of various aid channels, as perceived by responsible EUD staff. The channels under consideration were: the partner government, NGOs, Public-private partnerships (PPPs), Development Banks, UN Bodies, private companies, and research and education institutions. The following paragraphs summarise the responses related to each channel, providing quantitative as well as qualitative data.

Figure 66: Q24a: Channels used by the EC in order to support countries' effort to improve health outcomes, between 2002 and 2010 (several answers possible)



Source: EUD Survey, 2011, Particip GmbH

According to the results of the survey, the channels most used by the EC in order to support countries' effort to improve health outcomes, between 2002 and 2010, were in the first place: 'NGOs and civil societies'. 91%, corresponding to 21 EUDs out of a total of 23 EUDs that answered this question used this channel. Next to it were the channel Governments cited by 19 EUDs (83%). In the third place UN bodies were reported by 12 out 22 EUDs. The use of channels such as Development banks (cited by 8 EUDs), research and education intuitions (eight EUDs) and privates companies (six EUDs) was quite low since they were mentioned by less than 10 EUDs. The channel used the least was public private partnerships that were reported only by four EUDs. The table below shows the general overview of the main channels used in each country.

Table 12: Q24a: Overview of channels used in surveyed countries during the two sub-periods covered by the evaluation

EUD	NGO	Government	UN bodies	Development Banks	Research and education institutions	Private companies	PPPs
Lao	X	X	X	X			
Philippines	X	X		X			
India	X	X	X	X	X	X	X
Afghanistan	X				X	X	
Timor-Leste	X	X		X			
Vietnam	X	X		X			
Bangladesh	X		X	X			
Myanmar	X		X				
Egypt		X					
Moldova	X	X	X			X	
Morocco	X	X		X			X
Yemen	X	X				X	
Syrian Arab Republic	X	X	X				
Burkina Faso	X	X	X				
Ghana	X	X	X	X	X	X	X
Barbados	X	X	X		X		
Nigeria	X	X	X		X	X	
DRC (Kinshasa)	X	X	X				X
Mozambique		X					
Zimbabwe	X	X	X		X		
South Africa	X	X			X		
Ecuador	X	X			X		
El Salvador	X						
Total	**21**	**19**	**12**	**8**	**8**	**6**	**4**

Source: EUD Survey, 2011, Particip GmbH

2.6.2.2 Impact on quality of health services

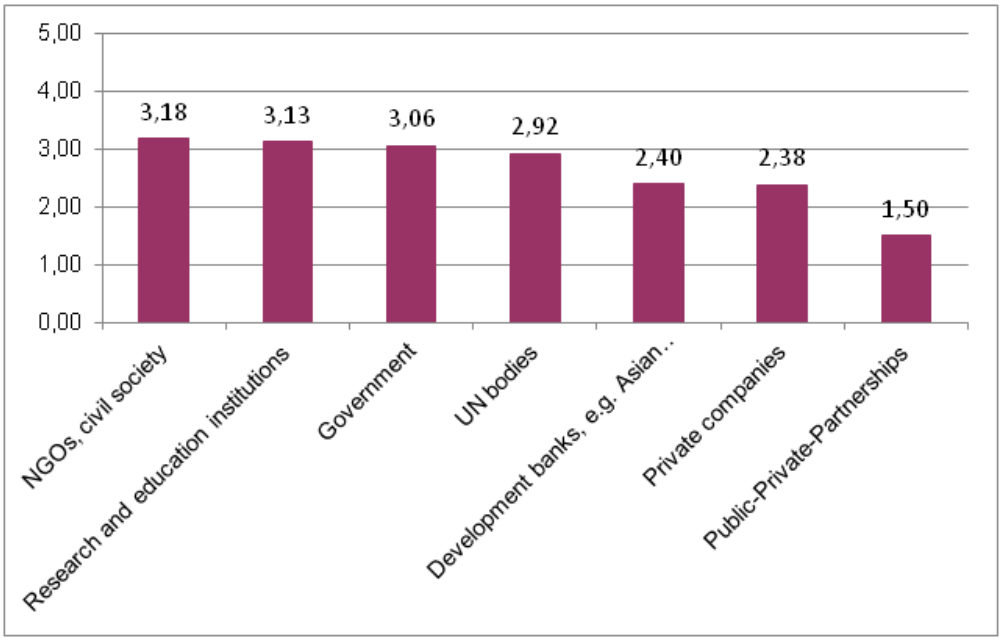
NGOs and civil society as having the highest suitability to improve quality of the health services, with a 'satisfactory' score being the highest (13 EUDs out of 24 rated it satisfactory, compared to six 'good' and only one 'excellent'). Closely behind rank Research and Education institutions.

Governments were also perceived with quite high suitability to improve quality of the health services, with a 'good' score given by eight EUDs. Closely behind, UN bodies were perceived to have both an average suitability of around three.

Development Banks and Private companies/development agencies acting as such scored between two and three (but less than 2.5) and thus have suitability below medium, but above low.

Public-Private partnerships were perceived the channel with the lowest suitability for improving quality of the health services.

Figure 67: Q24b: Impact on quality of health services



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

Source: EUD Survey, 2011, Particip GmbH

The table below indicates the exact scoring per category.

Table 1: Q24b: Detailed answers per category: Impact on the quality of health services

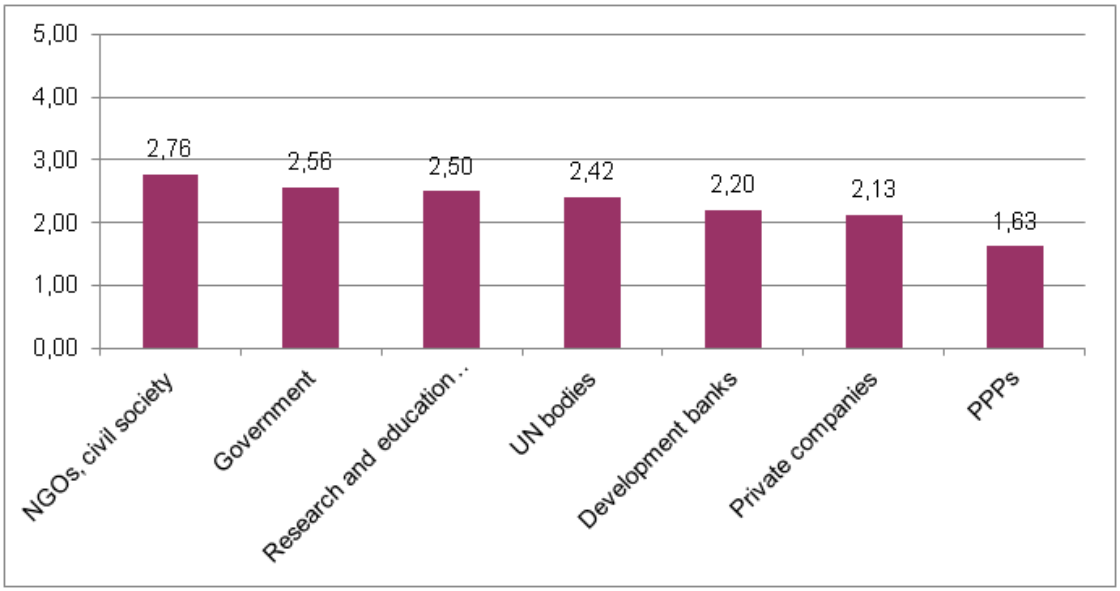
Channel	Excellent	Good	Satisfactory	Unsatisfactory	Fully unsatisfactory	Weighted Average
NGO and CSO	0	8	5	4	0	**3,18**
Government	1	6	13	1	0	**3,13**
UN Bodies	0	1	1	2	1	**3,06**
Research and education institutions	0	3	3	1	1	**2,92**
Development Banks	0	1	9	2	0	**2,40**
Private companies / dev. agencies acting as such	0	2	2	2	1	
Public-Private Partnerships	1	2	4	0	0	**1,50**

Source: EUD Survey, 2011, Particip GmbH

2.6.2.3 Impact on affordability of health

The vast majority of all respondents who answered this question indicated that they perceive **governments and NGOs** to have quite high suitability as a channel to improve affordability outcomes with an average score of around 3 in both cases.

Figure 68: Q24c: Impact on affordability of health



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

Source: EUD Survey, 2011, Particip GmbH

The table below indicates the exact scoring per category.

Table 2: Q24c: Detailed answers per category: Impact on affordability of health

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

In the qualitative comments EUDs recognized the **essential role that governments** play in providing health services for instance in *Egypt* where according to the EUD "*the reform of the Primary Health care and the development of the Accreditation Programme impacted positively on the access to quality health care*". EUD *India* also commented that "*government ownership has increased technical skills in PFM and programme management and overall results were much better*".

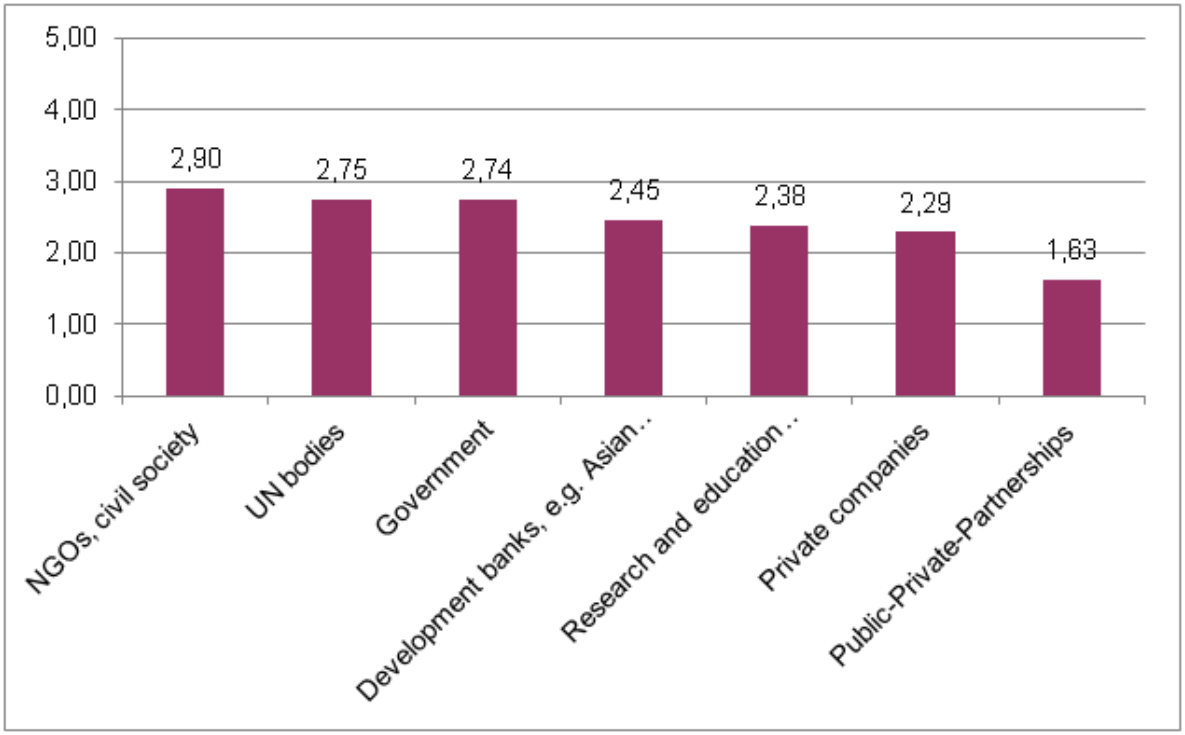
As for the **NGOs**, EUDs agreed that the results **depend on the activities of the NGOs**, CSOs and the funds they have. In *Syrian Arab Republic*, the EUD reported excellent outcomes of the project on reproductive health and sexual rights (with the SFPA and the AIDOS). In *Ecuador*, the EUD also commented on two NGO projects on HIV/Aids sector and EUD and confirmed the results were satisfactory and recognized.

The rest of the channels scored medium since the averages were between 2 and 3 but lower than 2.5. Again, **Private-public partnership scored the lowest** with an average below 2 which means that EUDs perceived this channel as the least suitable to improve affordability of health. EUD *India* suggested that "*PPP needed to be many more to fill the gaps of public service weaknesses and to lead to improvement of quality. Some gaps that could be filled were for example referral transport ambulances".*

2.6.2.4 Impact on health facilities availability

In terms of the average score for each channel's suitability with regard to the improvement of health facilities availability the **channel NGO and CSO** was the highest again followed by the **UN bodies** and government. With an average score of just below 2.5 were Development banks, private companies/development agencies as such and research and education institutions. Private-public partnerships (PPPs) scored again the lowest.

Figure 69: Q24d: Impact on health facilities availability



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

Source: EUD Survey, 2011, Particip GmbH

The table below indicates the exact scoring per category.

Table 3: Q24d: Detailed answers per category: Impact on health facilities availability

Channel	Excellent	Good	Satisfactory	Unsatisfactory	Fully unsatisfactory	Weighted Average
NGOs, civil society	1	5	11	1	1	**2,90**
UN bodies	0	2	7	2	0	**2,75**
Government	0	4	10	3	0	**2,74**
Development banks,	0	4	2	2	1	**2,45**
Research and education institutions	0	3	2	0	1	**2,38**
Private companies	0	1	3	1	1	**2,29**
Public-Private-Partnerships	0	1	2	1	1	**1,63**

Source: EUD Survey, 2011, Particip GmbH

The few qualitative answers elicited, mostly refer to previous statements made for other outcomes researched. EUD *India* added some new information by commenting that "*although private health facilities dominate the Indian health sector; however, their cooperation with the public sector is limited*" The respondent explained that private companies were mostly in urban areas and does not help improving availability.

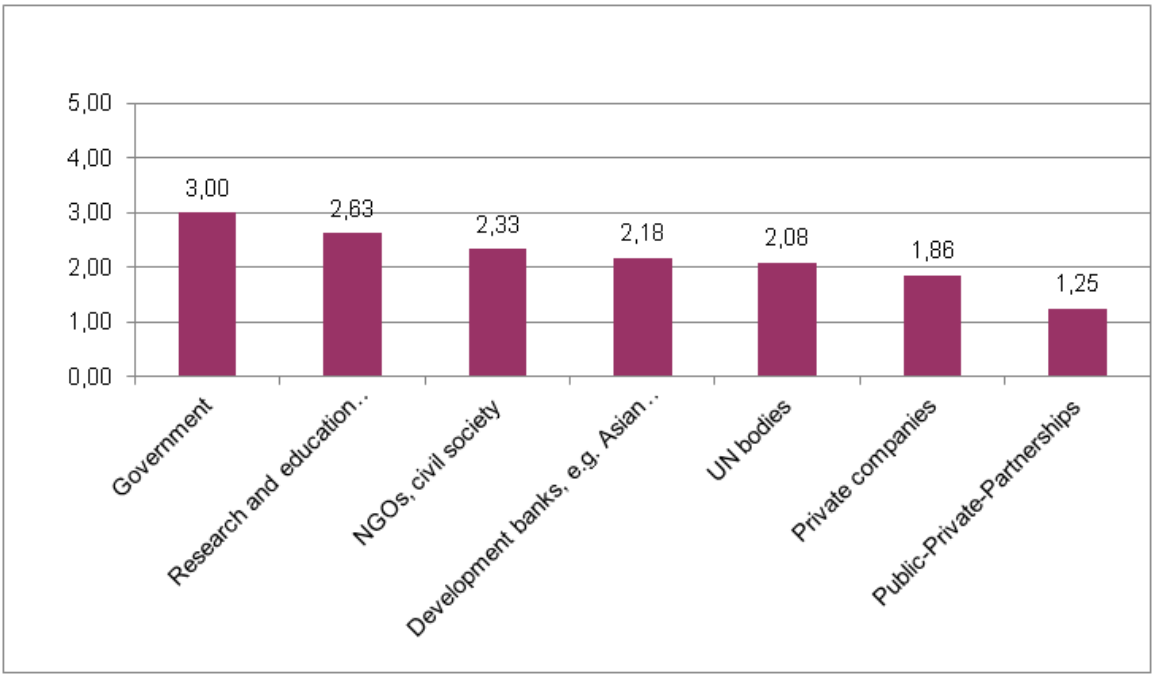
2.6.2.5 Impact on governance and management of the sector

In terms of the average score for each channel's suitability with regard to improving the governance and management of health service delivery, the **channel government** received the highest score, followed by Research and Education institutions.

NGOs, Development Banks and UN bodies scored below medium (below 2.5) and the lowest scores were for private companies and development agencies acting as such and Public-Private partnerships that were even lower.

The few qualitative answers elicited, mostly refer to previous statements made for other outcomes researched.

Figure 70: Q24e: Impact on governance and management of the sector



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

Source: EUD Survey, 2011, Particip GmbH

The table below indicates the exact scoring per category.

Table 4: Q24e: Detailed answers per category: Impact on governance and management of the sector

Channel	Excellent	Good	Satisfactory	Unsatisfactory	Fully unsatisfactory	Weighted Average
Government	0	4	12	2	1	**3,00**
Research and education institutions	0	3	10	3	1	**2,63**
NGOs, civil society	0	0	1	3	1	**2,33**
Development banks	0	1	5	2	1	**2,18**
UN bodies	0	0	6	3	1	**2,08**
Private companies	0	1	2	1	1	**1,86**
Public-Private-Partnerships	0	2	3	2	0	**1,25**

Source: EUD Survey, 2011, Particip GmbH

2.6.2.6 Conclusion on the suitability of channels to improve health outcomes

In conclusion, it appears that the channels are in most cases **not fully appropriate in order to improve health outcome**. Only for the category "health quality" and "governance and management", the average scoring was above three, meaning a satisfactory rating.

The biggest difference between the rankings of channels appears in the governance and management issues. Here the government is by far the preferred channel.

NGO and civil society scored best for all, except the management and governance category, when it comes to improve health performance. Public-private-partnership are not (yet) seen as performing channel.

The qualitative statements give an interesting insight in the use of specific channels (without differentiating the different health outcomes:

- EUD *Burkina Faso* says on the channels "government" and "NGO": "General budget support by definition does not allow assessment of additionally, so question on performance is not really pertinent though of course financing a national budget does indirectly provide increased means for the sector". And concerning channelling through NGOs: "EU support to NGOs has been at very small scale via local projects, some of which have had positive results but in general do not lead to systemic changes in the health sector."
- Also EUD *Myanmar* states difficulties to assess outcomes on macro-level when channelling through NGO projects: "Although many projects the impact of NGOs remains limited." Same reasoning from the EUD *India*: "Given their limited means their overall impact is limited, though their intentions are noble."
- EUD *Philippines* explains the rather negative rating the following way: "Impact on quality and affordability has yet to be realised. While the EC programme provided funds on infrastructure and capacity on the systems, the longer term objective on quality and affordability has yet to take place".

2.6.3 EC support changes regarding modalities and channels

Question 25: Taking account of these parameters (i.e. implementation experience and changing needs), please describe briefly how EC support to the health sector has changed between 2002 and 2010 regarding modalities and channels. Please also describe what were the main reasons for the changes.

22 EUDs provided a brief description of how the EC support to the health sector has changed between 2002 and 2010 regarding modalities and channels. These descriptions as well as the main reasons for these changes, as reported by the EUDs, are presented below organised by regions.

All in all the most commented change for all the regions was the **move from project approach to budget support approach**.

2.6.3.1 According to EUDs in the Asian region

- In *the Philippines:* The EC assistance on health in the mid-1990s were in project mode and after realising the **weak partnership and poor sustainability** of project activities further identification work was undertaken to provide adequate information on the modality of the intervention. This further study confirmed that the channel of intervention should be the Department of Health and the aid modality should be a mix (based on PFM analysis) of Trust Funds and Budget Support.
- In *India:* The EC adopted a budget support approach. **Direct contracting between government and programme management became impossible for TA**. Government found it hard to accept it and blocked TA envisaged in Budget support programme for 2.5 years. In 2010 direct TA contracting was still not possible for the same reason. According to the EUD, the Indian government does not have the concept of budget support clear.
- In *Vietnam:* The focus of the EC support moved from direct support to health facilities (the supply side) to the poor (demand side) and to improve institutional capacity.
- In *Yemen:* The EUD was only opened in Sana'a in 2007. A health expert was attached to the delegation but only until the end of 2010. Cohesion and joint thinking amongst donors started to grow in early 2010

2.6.3.2 According to EUDs in the MEDA-ENPI-TACIS region

- In *Egypt:* In 2002, the HSRP was a project supporting the development of the Family Health Model (project approach). Signed in October 2010, the budget support HSPSP-II, did not only entail quantitative and qualitative improvement of public health care services through the national roll-out of the Family Health Model, but also addressed the utilisation and universal access of these services by beneficiaries.
- In *Moldova:* In 2002, all of the EC funds were provided via project approach. In 2010, the major part of the EC funds was provided in the framework of the Health Budget Support Programme. The reason for this change was to get **better alignment to the country needs**.

- In *Syrian Arab Republic:* Modalities and channels have not changed since 2002. The EC support is still implemented through a traditional project approach. The 'investment in people' instrument and local call for proposals have complemented EC's traditional (GoS) support.
- In *Morocco:* The EC support has moved from project approach to budget support.

2.6.3.3 According to EUDs in the ACP region

- In *Nigeria:* For support to polio eradication, there has been a change in modality and channel **from basket funds managed by the Government to contribution agreement with the WHO.** The reason for this was to have a **more efficient disbursement** of funds and fiduciary management.
- In *Burkina Faso:* There has not been a significant change in the modality of support to *Burkina Faso*'s health sector in the period concerned - i.e. still via GBS with health performance tranche (though now via MDG contract). The EUD's experience with **WHO partnerships in Burkina has been very mixed,** depending on the architecture of the project and eventual issues concerning the UN agency.
- In *Ghana:* The EC support moved from Project/Pool Fund approach to a GBS approach.
- In *DRC:* The EC support moved from a total implementation by NGOs to the full integration at the Ministry of Health and its structures.
- In *Mozambique:* The EC support moved from project approach to sector budget support - country and sector met the criteria for budget sector support and recognised importance to strengthen national public sector and capacity for services delivery.
- In *Barbados:* According to the EUD, Sector budget support during the period 2005-2009 was a major disaster. The EC support with Project approach was more effective.
- The EUD *South Africa* highlights the shift from project approach to sector budget support. "The PDPHC was designed in a project approach, but changed in its second phase into a sector budget support programme. In 2010 a large EUR 126 million public health care SBS programme was approved by the Commission. But EC continues to fund health CSOs through its thematic budget lines and research projects through the FP7 and the EDCCTP.
- In *Timor-Leste:* The focus of the EC support moved from reconstructing health facilities in 2002 to sector policy and programming in 2008.

2.6.3.4 According to EUDs in the Latin American region

- In *Ecuador:* There was a more responsible and better implementation of health projects when the co-direction in the EC was eliminated. More dynamic and active participation of the health authorities was observed as they had to take more responsibility of the project implementation. The EUD motivated the health authorities to fully take ownership of the PASSE programme.

2.6.4 Analysis of capacities of relevant organisations and institutions

Question 26: Based on your in-country experience, at the time of preparing EC support to the health sector, how have the capacities of relevant organisations / institutions to implement a specific modality been analysed (i.e. in what ways and how well)?

22 EUDs provided an answer to this question. According to them, the capacity assessment of relevant organisations / institutions to implement a specific modality were analysed mostly through technical assistant (TA) teams, consultation with partner government and other stakeholders and previous EC experiences in the field.

A summary of the information provided by the EUDs organised per region is presented below:

2.6.4.1 According to EUDs in the Asia region

- In *Philippines:* Part of the preparation was the analysis on stakeholder's (institutional) capacity to determine the readiness, capacity, structures in implementing the health programmes.
- In *India:* Capacities were well assessed through consultations with the selected institutions; according to the EUD this selection included too few of relevant institutions since some stakeholders did not feel well addressed.
- In *Vietnam:* Capacity assessment was done jointly by TA team(s), partner government and development partners.

- In *Myanmar:* Selection of UN agency for fund management in Trust Fund was based on capacity assessment, and for NGOs: systematic analysis of capacity at time of selection.
- In *Afghanistan:* The EC provided TAs and they supported the MoPH in development of policy, strategies and guidelines.

2.6.4.2 According to EUDs in the MEDA-ENPI-TACIS region

- In *Moldova*: Before approving the Health Budget Support, a team of international experts assessed the following elements: public finance management; macro-economic stability; sector strategy; sector allocations within MTEF; sector coordination mechanism; institutional capacities.
- In *Egypt:* The design of the budget support HSPSP-II has been achieved through a participative methodology. All the reform benchmarks were reviewed at several occasions by the authorities of the MoH. The institutional capacities of the MoHP were taken into consideration during the whole process of formulation.
- In *Morocco:* The analyses were centred on the eligibility criteria of the budget support.

2.6.4.3 According to EUDs in the ACP region

- In *DRC:* The capacity assessment was conducted based on previous extensive EU field experience.
- In *Zimbabwe:* The capacity assessment was conducted through TA, ad hoc Studies and field experience.
- In *Mozambique:* Various comprehensive studies were made and shared by different agencies, the EC carried out a very thorough identification phase and there was a solid and continuous monitoring system in place.
- In *Burkina Faso:* To prepare the submission for sector budget support in health, the EUD consulted with all relevant partners to gain from their experience / expertise (UNICEF, WHO, UNFPA).
- In *Nigeria:* The capacity of the National Primary Health care agency to implement the Routine Immunization component of new EU support to the health sector was based on a detailed satisfactory institutional assessment by Deloitte.
- In *South Africa*: Different assessments take place according to the financing modality used: In preparation of budget support programmes, the SA government undergoes an assessment of their institutional capacity to manage the funds. For the SuCoP project there was still a PMU - For CSOs there skills will be assessed during the calls for proposals process.

2.6.4.4 According to EUDs in the Latin American region

In *Ecuador:* In the PSIE project 2002-2007, the modality implemented was co-direction. After that and based on the experienced the co-direction was eliminated and we followed the other modality of co-responsibility.

2.7 Aid modalities used in the health sector

2.7.1 Support to Sector Programmes (SPSP) Budget support and policy dialogue

2.7.1.1 Types of support to the health sector

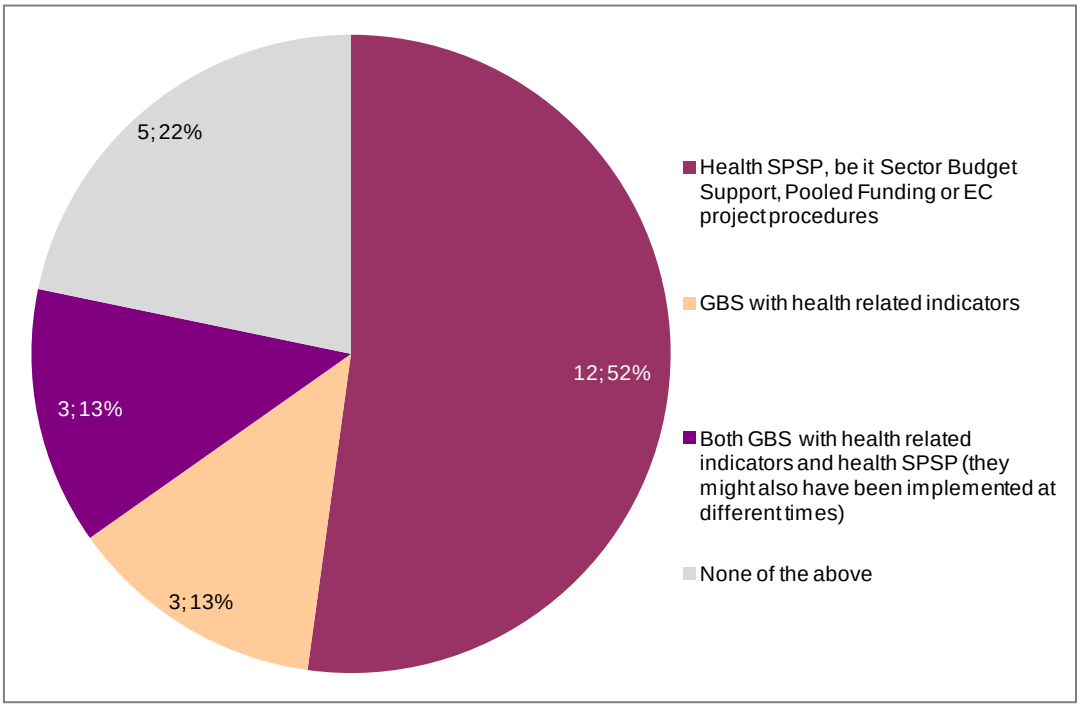
Question 27: What types of support to the health sector, directly or indirectly, but with a broader scope than individual project support, have you been using in your country?

The questionnaire survey revealed that Health SPSP is the most used type of support to the health sector. More than 50 % of EUDs surveyed (12 out of 23 which answered this question) (*Philippines, India, Bangladesh, Afghanistan*[53]*, Timor-Leste, Barbados Egypt, Moldova, DRC, Zimbabwe*[54]*, South Africa and Ecuador*) used as a form of sector programme support (SBS, pool funding, SWAp) to finance the health sector. Three more other EUDs reported to support the health sector through both SPSP and GBS, although SPSP and GBS had not necessarily to be used at the same time (EUD

[53] Chose the option "SPSP, but no names of programmes were mentioned.
[54] Chose the option "SPSP, but no names of programmes were mentioned.

Ghana, Mozambique and Morocco[55]). Three other EUDs (*Laos*, *Vietnam* and *Burkina Faso*) the health sector was financed through General Budget Support (*Burkina Faso* is currently submitting a proposal for a health SBS). Only five EUDs (*Yemen, Syrian Arab Republic, Myanmar, Nigeria and El Salvador*) reported not to use any of these aid modalities.

Figure 71: Q27: What types of support to the health sector, directly or indirectly, but with a broader scope than individual project support, have you been using in your country?



Source: EUD Survey, 2011, Particip GmbH

All in all, over **two-thirds of the EU Delegations** answering the survey use either a sector approach or a macro approach with health related indicators.

The table below presents the name and period of the SPSP or GBS mentioned by each EUD. There is a clear trend towards the use of Budget Support. Although the second period of the evaluation (2007-2010) is shorter than the first one (2002-2007) an increase in Budget support can be seen: 13 SPSPs have been reported by the EUDs, starting from 2008 on, in comparison to 10 SPSP that run between 2002-2007. The same trend is visible for the GBS programmes. From 2008 only four GBS are quoted by the EUDs, in comparison to five GBS in the period between 2002-2007, but it should be noted that two of the GBS programmes of this period only started in 2006 and 2007.

[55] Chose the option “SPSP and GBS, but no names of GBS operation were mentioned. No further information on GBS was filled in.

Table 13: Q 27: Overview of SPSP and GBS during the evaluation period

EUD	SPSP		GBS	
	Period 2002 - 2007	Period 2008 -2010	Period 2002 - 2007	Period 2008 -2010
Vietnam	-	-	-	Poverty Reduction Support Credit: 2008-2009
Bangladesh	HPSP: 1998-2003 HNPSP: 2005-2011		-	-
Laos	-	-	PRSO: Poverty Reduction Support Operation: 2007	
Philippines	-	Health Sector Policy Support Programme I: 2007-2010	-	-
India	SIP Support to Health and Family Welfare: 1998 - 2003	SPSP/NRHM/RCH II: 2008-2011	-	-
Moldova	-	SPSP Health: 2009-2012	-	-
Egypt	-	HSPSP: 2006-2011 HSPSP II: 2010-2013	-	-
DRC	PADS 1 et 2: 2001-2006	Projet santé 9ème FED: 2006-2010 PAPNDS: 2010-2013	-	-
Morocco	Programme d'appui à la réforme de la couverture médicale de base CMB : 2000-2008	Programme d'appui à la consolidation de la couverture médicale de base CMB II : 2008-2012 Programme d'appui sectoriel à la réforme du système de santé au Maroc (PASS) : 2009-2013	-	-
Burkina Faso	-	-	ABRP (Appui budgétaire pour la Réduction de Pauvreté : 2002-2004 ABRP 2005-2008	MDG contract 2009-2014
Ghana	8 ACP GH 03	-	PRBS 1. 2004-2006 PRBS 2 : 2006-2009	PRBS 3: 2010-2014
Mozambique	-	Health 10th EDF SPSP: 2009-2010	-	MDG contract : 2009
South Africa	-	EPDPHC: 2007-2011 PrimCare SPSP: 2011-2014	-	-
Barbados	Barbados Health Programme: 2005-2009	-	-	-
Timor-Leste	HSRDP2: 2002-2006 SIHSIP: 2004-2009	-	-	-
Ecuador	PSIE: 2002-2007 Programa de apoyo al sector salud en Ecuador- PASSE: 2004-2010	UNIDOS PARA COMBATIR EL VIH/SIDA : 2007-2010	-	-

2.7.1.2 Budget Support and health performance outcome

Question 27.1: According to your experience, how suitable has/have GBS/SPSP(s) been to contribute to improving the health performance and outcomes of your country?

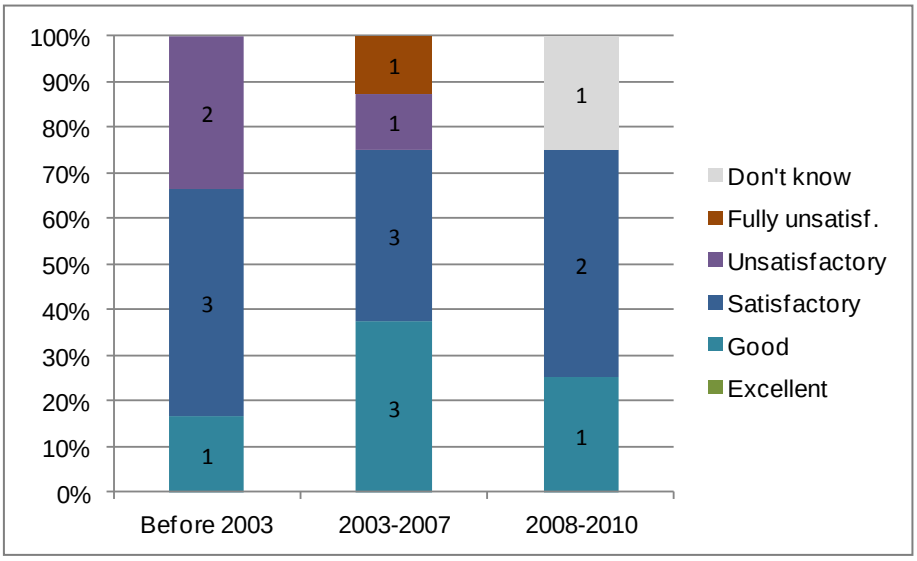
2.7.1.2.1 Effects on quality of health services

The EUDs were asked to rate the contribution of each SPSP and GBS programme on the improvement of health performance and outcomes.

SPSP programmes

The following graphics show the ranking of 18 SPSP programmes mentioned by the EUDs with regards to the effect on quality of health services.

Figure 72: Q27.1a: Effect on quality of health services: 18 SPSP



NB: Graphic shows only the 18 SPSP programmes for which the EUDs gave a ranking

Source: EUD Survey, 2011, Particip GmbH

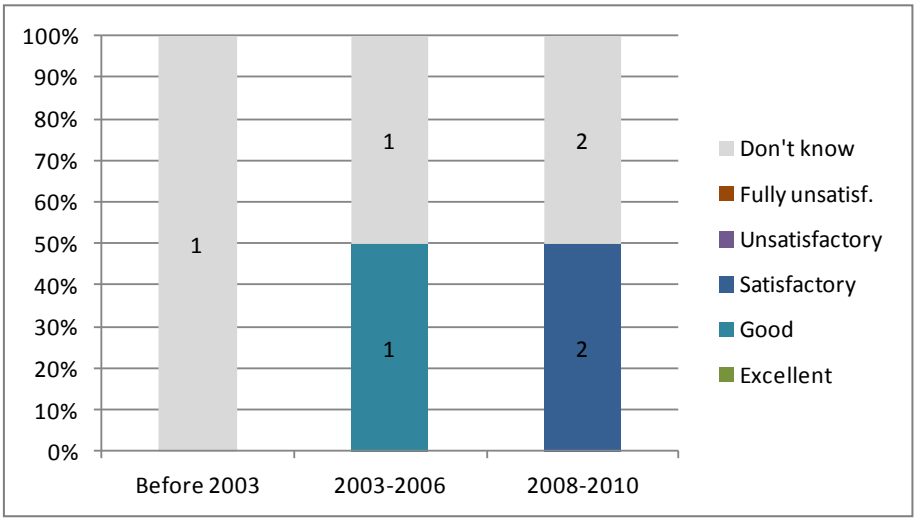
It is interesting to notice, that the suitability of SPSP to improve quality of health care is constantly rated "at least satisfactory" (65% of answers over all period lists satisfactory or good) over the three periods shown in the graph. There is a clear trend towards a "good" rating, which is for the period 2003-2007 just under 40% and in 2008-2010 just under 30%.

Overall the trend shows that the perception of the EUDs on the suitability of the SPSP to improve quality of the health services have improved over the evaluation period.

GBS programmes

Although only seven GBS programmes participated at the ranking, the trend is the same than for the SPSP programmes. While the effects on quality are ranked "good" for the GBS programme in 2003-2007, the two GBS programmes ranked in 2007-2010 show a less positive assessment.

Figure 73: Q27.1b: Effect on quality of health services: 7 GBS

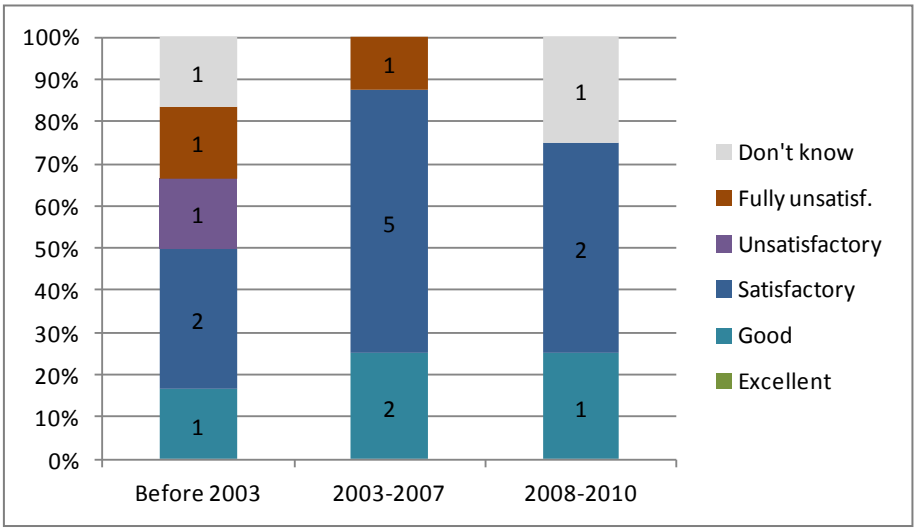


Source: EUD Survey, 2011, Particip GmbH

2.7.1.2.2 Effects on quality of affordability of health

In terms of the SPSP modality's suitability with regard to affordability of the health services, the distribution of the answers show a slight less favourable ranking for the SPSP before 2003 than for the quality of health care services. It is interesting to notice the SPSP in the period 2003-2007 are ranked "good" or "satisfactory" to almost 90%. For the period 2008-2010 none of the SPSP was ranked less than "satisfactory", which let conclude that SPSP are seen by the EUDs as suitable to improve affordability of health.

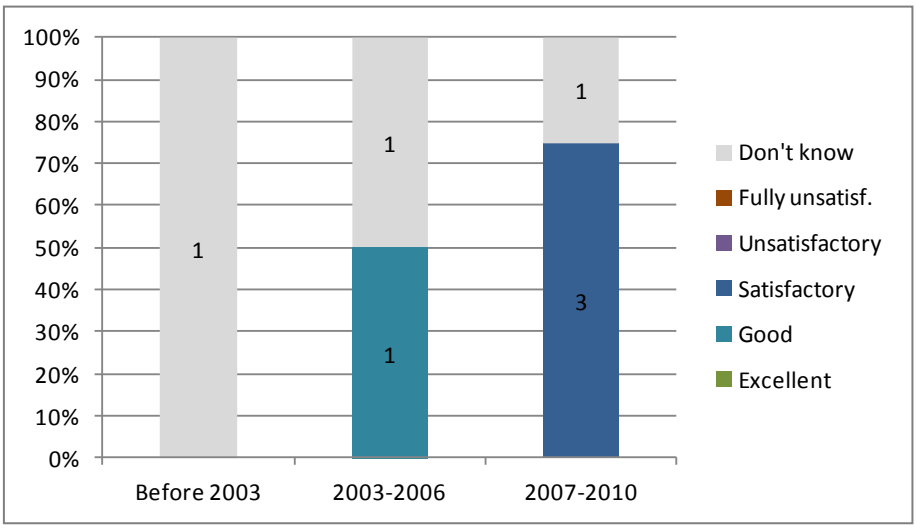
Figure 74: Q27_2a: Effect on affordability of health: 18 SPSP



Source: EUD Survey, 2011, Particip GmbH

The same trend can be seen for the GBS programmes.

Figure 75: Q27_2b: Effect on affordability of health: 7 GBS programs

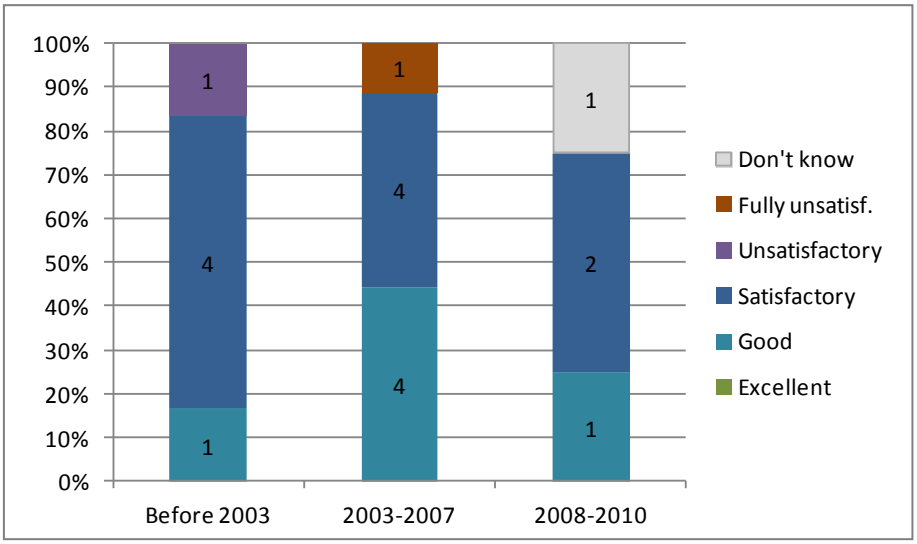


Source: EUD Survey, 2011, Particip GmbH

2.7.1.2.3 Q27_3: Effect on health facilities availability

The distribution of the answers shows that already for the very early SPSP the effects on health facilities availability was ranked satisfactory (over 80% ranked the SPSP implemented before 2003 as either good or satisfactory). This figure even increases for the period 2003-2007 with a satisfaction rate of almost 90%. Compared to the effect on quality and affordability of health, this category is ranked highest in comparison to all health outcomes.

Figure 76: Q27_3a: Effect on health facilities availability: 19 SPSP

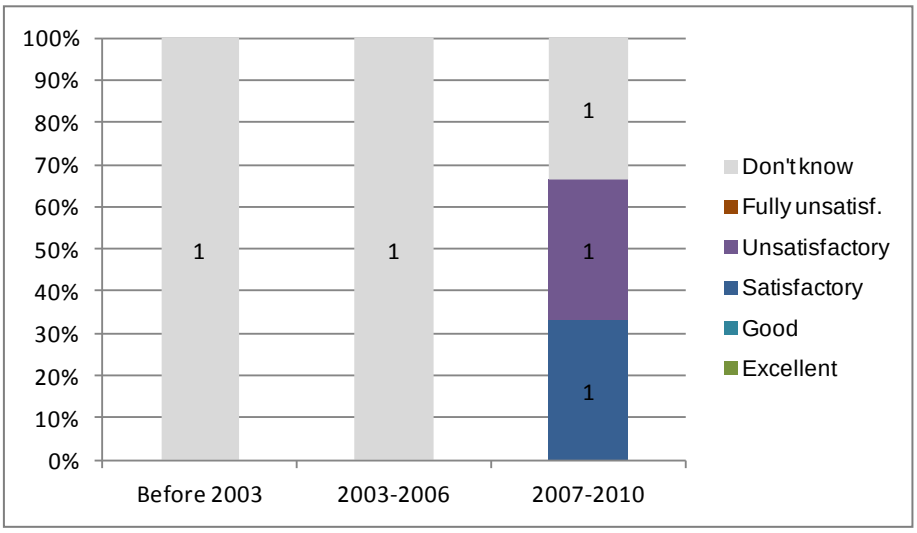


Source: EUD Survey, 2011, Particip GmbH

For the GBS programmes, the "don't know" category prevails which can either be explained by the difficulties to attribute the effects to the health sector or by the non-availability of information by the person, as often, GBS programmes and sector programmes are under the responsibilities of different persons.

Only five GBS programmes got rated for this category. It is interesting to highlight that one GBS programme has been rated unsatisfactory in order to show results on the availability for health facilities (EUD *Lao*).

Figure 77: Q27_3b: Effect on health facilities availability: 7 GBS

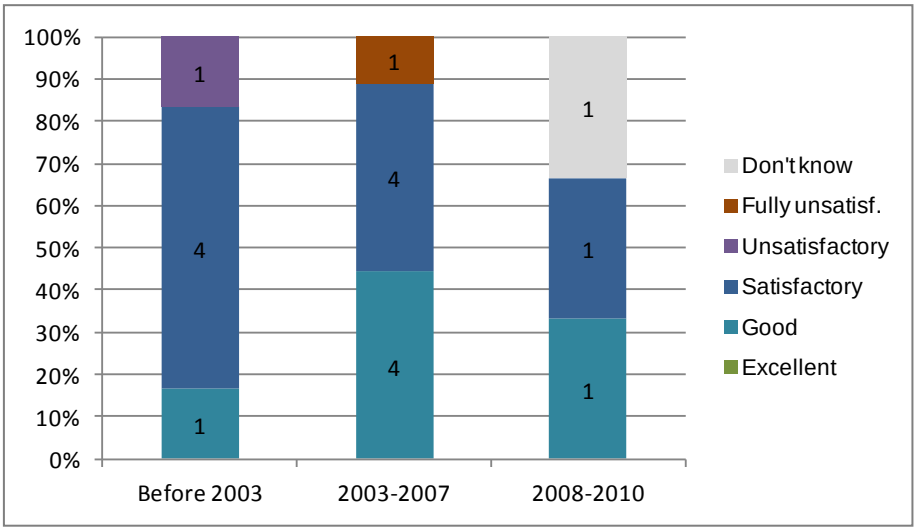


Source: EUD Survey, 2011, Particip GmbH

2.7.1.2.4 *Q27_4: Effect on health service utilisation related to MCH*

The same picture as for the effects on health facilities availability can be seen for the utilisation of health services related to MCH.

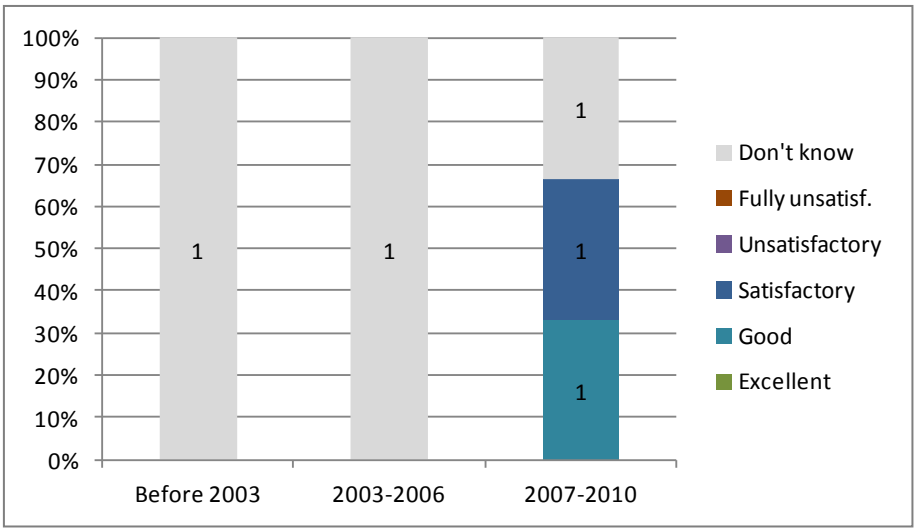
Figure 78: Q27_4a: Effect on health service utilization related to MCH: 19 SPSP



Source: EUD Survey, 2011, Particip GmbH

Only five GBS programmes have been ranked. Again, for three GBS programmes no answer could be provided by the EUD.

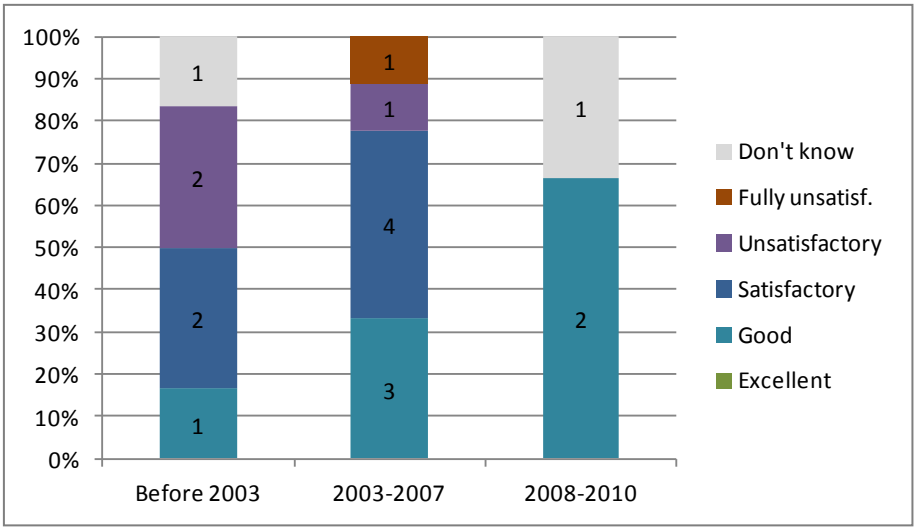
Figure 79: Q27_4b: Effect on health service utilisation related to MCH: 7 GBS



Source: EUD Survey, 2011, Particip GmbH

2.7.1.2.5 *Q27_5: Effect on Governance and Management of the sector*

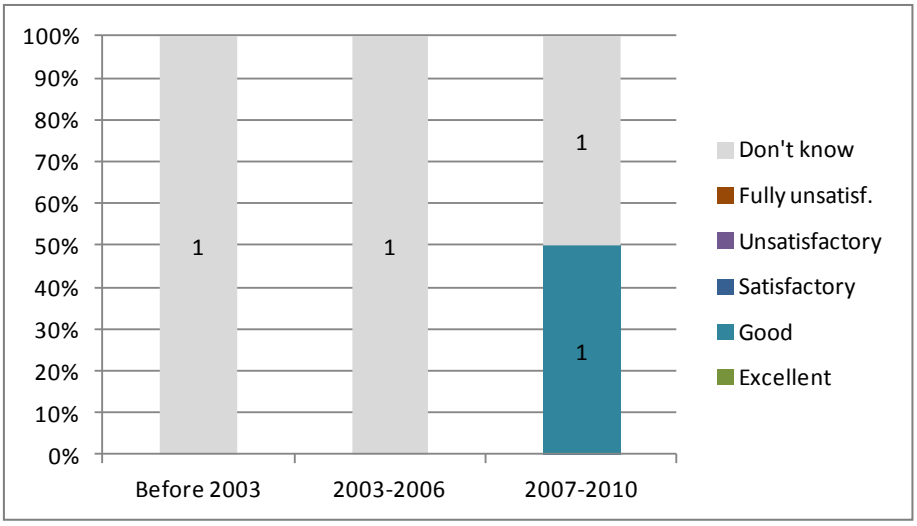
Figure 80: Q27_5a: Effect on Governance and Management of the sector: 19 SPSP



Source: EUD Survey, 2011, Particip GmbH

The distribution of the scored for the SPSP modality's suitability with regard to governance and management of the health sector presented a trend towards improvement over the evaluation period. But the trend is less obvious than for the health facilities availability of the use of MNCH related health services.

Figure 81: Q27_5b: Effect on Governance and Management of the sector -GBS



Source: EUD Survey, 2011, Particip GmbH

2.7.1.2.6 *Explanations' provided by the EUDs for their ranking (for all categories for each SPSP/GBS).*

The high number of "don't know" or no answer, especially in the period 2008-2010 are justified by the EUDs by the fact that it was still to early to draw conclusion as most effects are still unknown (EUD *Egypt* (HSPSP 2006-2011), EUD *Laos* (PRSO 2007), EUD *Bangladesh* (HNPSP), EUD *DRC* (Projet Santé 9ème 2006-2010), EUD *South Africa* (EPDPHC 2007-2011).

Specifically for GBS programmes it is difficult to relate effects in the health sector to GBS funding, as the Delegation in *Burkina Faso* highlights "*For all 3 GBS (the Delegation has been implementing) it is not really possible to attribute causality and additionality of GBS in health is not really possible, though the general budget has clearly contributed. But where external financing is so significant one should be cautious about such claims.*"

The ranking "fully unsatisfactory" in the SPSP programmes has only been made by the EUD *Barbados* which explained this ranking by the fact that whole programme has been a disaster.

Positive effects are nonetheless seen:

The EUD in *Bangladesh* and *Timor-Leste* moved their subsequent SPSP programmes from "unsatisfactory" to satisfactory" and "satisfactory to good, acknowledging a learning effect from the first to the second SPSP.

In *Ecuador* the EUD reported: For the 1st SPSP "*The EC contributed to the improvement of health performance in quality and quantity in the Province of Esmeraldas. The project helped strengthened local health authorities to implement the national health system. It formed and trained health staff in quality and efficiency, in planning and management. Although an effort was made, there are other facts that prevent the progress and continuation of some activities: such as the high level of rotation (17 health directors in 4 years), the lack of financial resources, lack of health personnel, low paid staff, so doctors work only 4 hours in the public sector and the turn overs that are still very high. In general and the final evaluation notes improvement in the zones of intervention of the project"*

For the 2nd SPSP it is stated: *"The final evaluation indicated that this project helped to the improvement of various areas of the health sector at local level (3 Andean provinces of Ecuador) and the Central Office of the Ministry of health. At the national level and central MSP, the project help in the design of the new integral health care model based focusing in interculturality and community. It also formed in a 4th level more than 340 professional from the whole health sector. At local level improvements were seen and people see recognised it. Provision and improvement of health facilities, medical equipment, transportation, training and strengthening health networks, approaching the traditional medicine to occidental one... strengthening community participation in health care"*

And the 3rd SPSP: *"This thematic project helped the public entities to a better and more qualitative care of VIH/Aids patients. Additionally, it had an effect in policy incidence and supported laws that prevent discrimination among PLWH. A very interesting network was put into place with partners and other NGOs and private companies that supported and participated in the diffusion of HIV/Aids."*

The EUD *Philippines* notes that an effect on quality and affordability, has be realised, while the EUD I*ndia* stated: "*For the first SPSP the overall satisfactory development was that health services reform was initiated, health financing was not addressed sufficiently". F*or the 2nd SPSP the statement 'unsatisfactory', relate only *"to RCH (Reproductive and Child Health) Services. Relevant quality assurance is being introduced since 2009 but health financing is not yet addressed except for institutional delivery services which have brought about increases in inst. deliveries and pregnancy check-ups. Quality assurance is introduced, maintenance improved, affordability."*

2.7.2 GBS/SBS indicators

2.7.2.1 Elaboration of Indicators

Question 27_5: Kindly indicate how the indicators have been elaborated respectively on what type of sources / consultation processes they are based. You may specify for each SPSP if different modalities have been used.

The majority of these comments indicated that the elaboration of indicators are made mainly by the EUD and/or with external expertise but in the majority of cases discussed and agreed with national authorities and other donors through an active consultation process with various stakeholders. However in some cases the indicators were also directly influenced by or related to the achievement of MDGs (*Mozambique*, *Burkina Faso*) The primary data are in most cases taken statistics related to country specific programmes or strategies, e.g. the HIS in *DRC*, the annual MDBS review (*Ghana*).

No major difference can be seen between the elaboration of a SPSP or a GBS. Especially the new MDG-contract tries to establish a complementarity between health SPSP and this type of GBS programme (EUD *Mozambique*).

A summary of the comments provided by the EUDs is presented below:

- In *Egypt:* The HSPSP has been designed by an external expertise and the Egyptian authorities. The design of the budget support HSPSP-II has been achieved through a participative methodology, between the EUD programme manager and the Egyptian authorities. All the indicators were elaborated taking into account the monitoring system existing at the MoHP.
- In *Philippines:* The general indicators have been discussed with the Government but specific indicators at the local level were further identified using as basis the Local Government Scorecard on health in outcomes.
- In *India:* Assessment took place with government and donors. The indicators were agreed and used uniformly. For the reform agenda, different indicators were evolved and adopted bilaterally by government and donors.

- In *Bangladesh* the indicators were developed on consultation basis among the different Governmental agencies and Development Partners.
- In *DRC:* The indicators were developed on the basis of the health system information.
- In *Ecuador:* In general the indicators were elaborated based on primary data: interviews, meetings, surveys and other indicators were taken from secondary sources of information such as health statistics and living conditions surveys.
- In *Mozambique* the indicators for the Health SPSP of the 10th EDF were chosen from the Health PAF and relates to areas of priority focus to respond to needs and level of representation and how representative they are for. For the MDG-GBS, indicators are more directly related to the achievement of the MDGs, complementary to the Health SPSP (one presently overlaps between programmes).
- In *Ghana* the GBS indicators have been elaborated in the context of MDBS annual review and health annual review.
- In *Burkina Faso* the MDG indicators have largely influenced the choice in *Burkina Faso* i.e. emphasis on maternal and child health as well as access / utilisation of services.
- In *Vietnam* the policy actions were jointly defined by development partners and government and a dialogue was jointly done on health policy actions.

2.7.2.2 GBS/SBS indicators: ambitious, achievable and of quality

Question 27_6: In your opinion, have GBS/SPSP indicators been ambitious enough and at the same time achievable for government?

The figures below show that most EUDs that answered this question found that SPSP indicators were ambitious enough and also time achievable for the government (*Philippines, India, Moldova, DRC, Ecuador, Timor-Leste, South Africa, Lao, Morocco, Mozambique and Vietnam*). For two EUDs (*Ecuador and Morocco*) this has been the case over the whole evaluation period, pointing to a clear positive trend to be seen from 2008 on.

Figure 82: Q27_6a: SPSP indicators have been ambitious enough and at the same time achievable for government

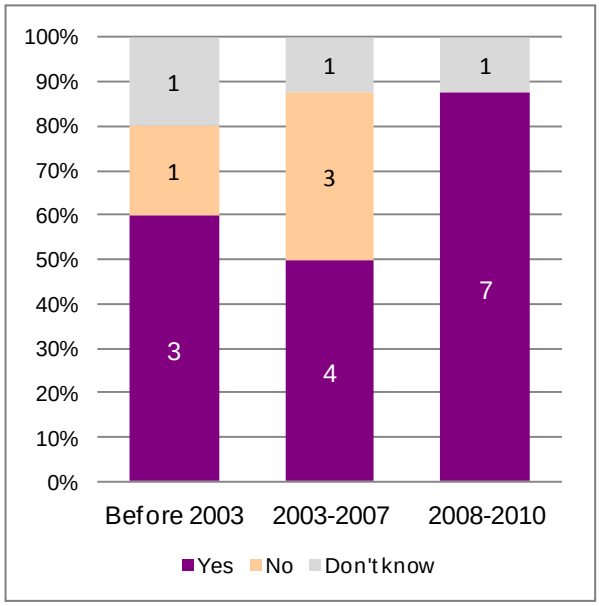
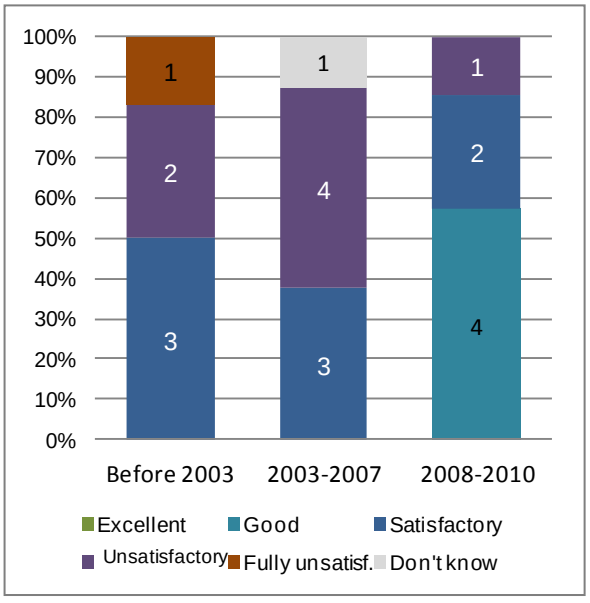


Figure 83: Q27_7a: SPSP Quality of the evidence base of SPSP indicators (reliability, validity, timeliness)



Source: EUD Survey, 2011, Particip GmbH

In terms of quality of the evidence base of the **SPSP** indicators the answers were also rather concentrated towards "good" (*Egypt, Moldova, Morocco and Mozambique*) and "satisfactory" (*Egypt, India, Bangladesh, Ecuador, Timor-Leste and Morocco*) scores, with a 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.**

The picture for the **GBS** indicators shows as in the chapter 2.7.1.2, a higher percentage of 'don't know' answers. But, when looking at the GBS rating, it shows even clearer positive trend than for the SPSP. More than 60% of GBSs programmes between 2003-2007 state that indicators are ambitious enough and achievable (*Ghana, Mozambique, Lao and Vietnam*) and find the quality of the evidence base "good" (*Ghana, Mozambique*) or "satisfactory" (*Lao, Vietnam and Burkina Faso*).

Figure 84: Q27_6b: GBS indicators have been ambitious enough and at the same time achievable for government

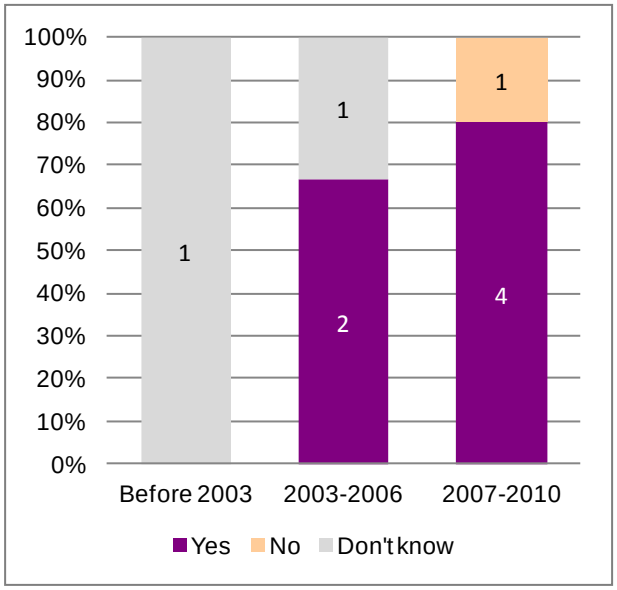
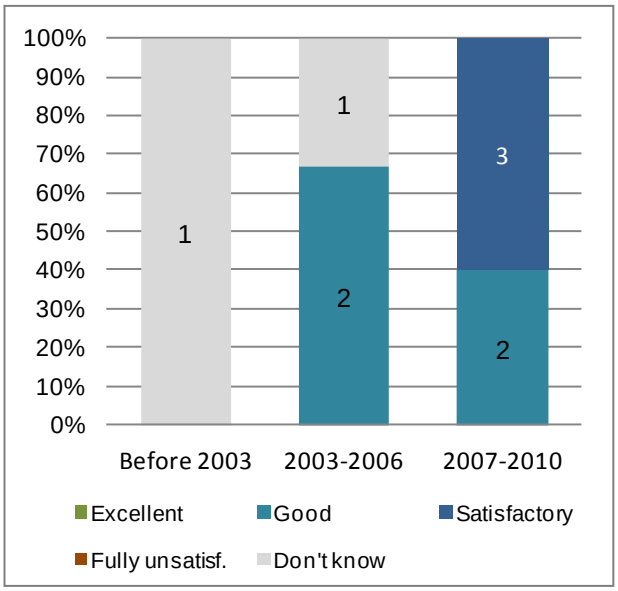


Figure 85: Q27_7b: Quality of the evidence base of GBS indicators (reliability, validity, timeliness)



Source: EUD Survey, 2011, Particip GmbH

Overall the EUDs perceived that the GBS/SBS indicators have been ambitious enough time achievable for governments.

As for the qualitative information, the answers confirm what the graphics have already shown. Most of the comments pointed out that the indicators were ambitious enough. Although some EUDs have recognised that they were only partially achieved, the majority of EUDs agreed that an overall progress has been made over the evaluation period.

Hindering factors with regard to ambition and achievement of indicators are seen in weak institutional capacity (*Bangladesh, DRC*) and inadequate consultations (*Philippines*), whereas regarding the evidence base, lacking and inadequate systems (*Egypt, Philippines, South Africa, Barbados, DRC and Bangladesh*) put a strain on quality.

The following comments were provided with regard to **ambition and achievement** of the indicators.

Countries of the **ENPI/MEDA/TACIS** region highlight the role of the government:

- The EUD *Egypt* stated for the first HSPSP that some of the reform benchmarks of the HSPSP were formulated too optimistically (e.g. in term of timeframe) but acknowledged for the second HSPSP confirmed that all the reform benchmarks were elaborated by the authorities of the MoH.
- The EUD *Morocco* stated that the reform of the health insurance (CMB) was a major structuring reform and thus politically very sensitive.

Asian countries

- In *India* indicators were developed on background of health sector and reform activities to have realistic indicators. They were ambitious to continue the reform drive. They have proven to be achievable; the development was evidence based and experience based concerning possible achievements.
- In *Bangladesh* indicators were ambitious but not always achievable with the existing weak institutional capacity.

- EUD *Laos* points out that for the GBS the indicators were often too ambitious, e.g. the indicator states 'Decree will be signed' instead of submitted.
- For the GBS in *Vietnam* the EUD explains that the policy actions were linked to the laws and decrees of the government.
- The EUD *Philippines* highlights the fact that inadequate consultation was undertaken in terms of the specific indicators.

ACP countries

- The *DRC* highlights the limited capacities of the administration due to the political situation which also impacts the design of the indicators and states that for the 9ème FED santé programme the weak capacities have taken into account.
- The EUD *Burkina Faso* notes that there is always a pay-off between ambitious indicators and those that are achievable. As example is quoted the disbursement for the health tranche of only 65% for the ABRP 2002-2004. The disbursement figures for the next GBS programmes show a learning effect through a higher disbursement ratio (75% of the health tranche for the GBS ABRP 2005-2008. With regard to the MDG- contract, the EUD states that the indicators seem all achievable, but not all are ambitious. It should be noted, that the health tranche of the MDG contract will be done only on the performance of one year.
- In *Timor-Leste*, the indicators have been agreed during a consultation phase.

Latin America

In *Ecuador*, the EUD mentions the shift of the health strategy from a decentralized process to a sector based approach based on a new health care model. This shift has an impact on the PASSE SPSP although it was able to adopt it to this change. The EUD mentions nevertheless that the former project procedure was more suitable to archive the foreseen goals due to a greater flexibility of EC procedures. From a governance aspect, the shift to budget support is seen positively by the EUD, as a more centralized approach discharges local authorities from certain tasks for which they have not the capacities to implement, according to the EUD.

With regards to the **quality of the evidence base** of the indicators, following comments were provided:

In the ENPI/MEDA/TACIS region:

- In *Egypt,* baselines are almost non-existent and information systems are antiques, thus unable to provide the required data and information.
- In *Moldova*, the evidence was collected and checked by annual independent review missions. Later on (at the end of the year) the Government was preparing the Compliance statement accompanied by all the relevant evidence. Then, the EU Delegation was rechecking the evidence item by item.

Asian countries

- In the *Philippines*, "*The indicators are based on the Facility-based information system which has an issue with regard to its robustness."*
- In *India* data pertaining to the indicator assessment were made on safe academic ground. The EUD notes however that *"not all indicators are covered by the available routine studies. There is still too much information that is not exactly reliable by means of monitoring methods, therefore validity is not always given and timeliness also needs to be improved. SIP database was even less thin."* The EUD estimates the data reliability to 60%. Several states have not validated their data timeliness but due to increased pressure on monitoring activity, timeliness of submission is improved.
- In *Bangladesh*, the EUD states: *"As the Health Management Information System is very weak, quality surveys are done in order to measure the indicators. Several surveys have been done with different time intervals since the 1st SPSP to have more reliable and quality data."*
- *In Timor-Leste***:** Health statistic and measurement (availability of documents) are available.

ACP countries

- The EUD *Burkina Faso* states: *"While the quality of certain health indicators remains questionable due to questions regarding the denomination of a target population (e.g. for vaccination*

campaigns) progress has been achieved in overall quality - EU support to statistics has been helpful in that regard".

- In *Mozambique* joint data verification missions carried out in which the EC participated. This has generated data with an acceptable level of error.
- As in *DRC* the data reliability is very weak, most evaluation relies on qualitative assessments.
- In *Barbados*, baselines are almost non-existent and information systems are antiques unable to provide the required data and information.
- In *South Africa* regarding the PrimCare SPSP "*it is understood that the DoH's M&E system is quite weak and needs improvement, but it is the only system/data available*."

Latin America

- The EUD *Ecuador* reports: *"In the PASSE program, there were difficulties in launching the data base line study at the beginning of the program. So in some indicators, there was not real substantial date on the actual state before intervention of the program."*

2.7.3 Policy dialogue and Budget Support

Question 27_8: How would you judge the extent to which policy dialogue on GBS/SPSP has incorporated a) Public Financial Management (PFM), b) accountability and c) capacity building measures in the health sector?

Please name the changes related to these three issues in the health sector between 2002/04 and 2010 and try to elaborate what have been the main factors enhancing their inclusion into the agenda of policy dialogue. We'd also appreciate if you could indicate EC contributions to changes observed.

As regards the extent to which policy dialogue on GBS/SPSP has incorporated a) Public Financial Management (PFM), b) accountability and c) capacity building measures in the health sector the distribution of the responses by the EUDs show a rather positive picture.

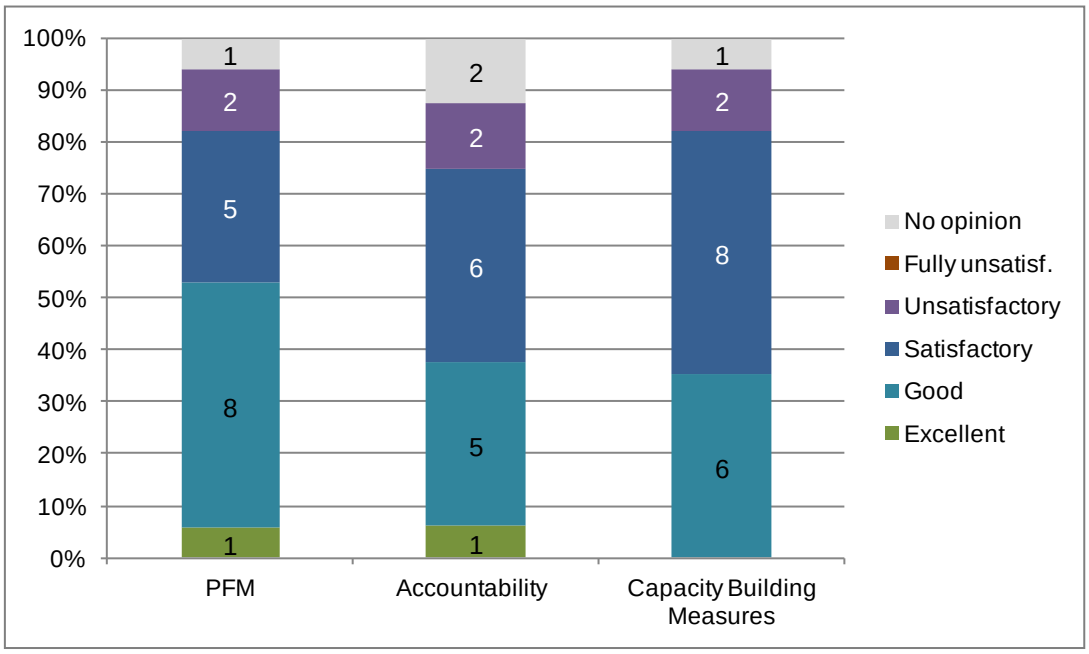
Eight EUDs (*Egypt, Barbados, Lao PDR, India, Afghanistan, Morocco, Mozambique and South Africa*) out of 17 that answered the question found that the incorporation of **PFM** in policy dialogue was "good" and five EUDs (*Philippines, Moldova, Burkina Faso, Vietnam, Ecuador*) (out of 15) said it was "satisfactory". One EUD (*Ghana*) said it was "excellent" and only two (*Bangladesh and DRC*) rated it as "unsatisfactory".

In terms of **accountability**, five EUDs (*Barbados, Vietnam, Afghanistan, Morocco, Mozambique*) (out of 15) said it was "good" and six EUDs (*Philippines, India, Moldova, DRC, Ecuador, Timor-Leste*) found it "satisfactory. One EUD (*Ghana*) found it "excellent" and again only two (*Lao PDR and Burkina Faso*) said it was "unsatisfactory".

As for the extent to which **capacity building measures** policy dialogue was incorporated in policy dialogue, six EUDs (*India, Bangladesh, Afghanistan, Morocco, Mozambique and South Africa*) found said it was "good" and eight EUDs (*Egypt, Lao PDR, Barbados, Philippines, Moldova, Burkina Faso, Ecuador and Timor-Leste*) "satisfactory". Only two EUDs (*Ghana and DRC*) rated it as "unsatisfactory".

The figure below summarises the trend.

*Figure 86: Q27_8abc: Policy dialogue has incorporated Public Financial Management (PFM), accountability and capacity building measures in the health sector**?***



Source: EUD Survey, 2011, Particip GmbH

For most of the 17 EUDs which have answered the questions, the **differences** between PFM, accountability and capacity building measures regarding the extent to which policy dialogue on GBS/SPSP has incorporated it, **have been rather small**. For twelve EUDs (*Egypt, Barbados, Philippines, India, Moldova, Vietnam, Ecuador, Afghanistan, Timor-Leste, Morocco, Mozambique and South Africa*) the answers ranked between good and satisfactory for all three aspects (this includes the EUDs which responded *"no opinion"* for one of the three aspects – EUDs *South Africa, Vietnam, Egypt*).

The greatest variance has been identified for EUD *Ghana,* which ranked PFM and accountability as "*excellent"* and capacity building measures as "*unsatisfactory".* Unfortunately EUD *Ghana* did not provide reasons for its assessment.

Furthermore, for the EUDs *Lao* and *Bangladesh* a great extent of variation of their answers has been identified. For EUD *Lao,* there is a "*good"* incorporation of PFM, but only an *"unsatisfactory"* incorporation of accountability into the policy dialogue. The explanation given for this rating was that no HMIS were yet successful which could have improved accountability.

EUD *Bangladesh* rated incorporation of PFM as "*unsatisfactory",* whereas capacity building measures are ranked as "*good".* As reason for the good ranking of capacity building measures the EUD stated the learning effect from previous health sector programme, which incorporated capacity building measures and experiences from previous sector programmes to improve the approach towards the health sector.

Overall these figures provide evidence of the contribution of policy dialogue on SPSP to improve capacity building support and enhance PFM and accountability.

Complementing the quantitative data, the EUDs were asked to provide qualitative answers to several aspects, such as **changes, factors enhancing the putting on the policy agenda of topics and EC contribution to the changes**, related to the incorporation of PFM, accountability and capacity building measures.

2.7.3.1.1 PFM

The following chapters summarise the comments of EUDs related to the c**hanges that happened, the factors enhancing the putting on the policy dialogue agenda of topics and EC contribution to the changes**. All relates to the aspect of PFM.

Six (*Egypt, Barbados, India, Afghanistan, South Africa and Lao*) of the nine EUDs which considered incorporation of PFM in the health sector as **good** or **excellent** (*Ghana*) provided qualitative information on the kind of changes.

- In *Egypt* a PEFA exercise has been conducted. The reform on PFM is being monitored given that reform benchmarks were included in all the budget support operations*. These benchmarks, which are included in all BS operations, are seen as a mean of enhancing policy dialogue. The EC has contributed to the development of the benchmarks, according to the EUD.*
- The *EUD India* stated that due to PFM elements "*Financial Management Report improved and became more timeliness."* For the EUD the key issues to enhance the policy dialogue was the close relationship with government. Furthermore EUD staff as well as government officials have been trained in PFM, on questions on accountability and transparency. The **EC contributed** to the positive development by developing an indicator framework that focuses on PFM functions, monitoring of PFM and providing technical assistance.
- In *Afghanistan,* PFM measures include "quarterly follow up, regular reporting system and an annual budget planning exercise". The EUD *Afghanistan* saw the **EC contribution** through "TA support".
- In *South Africa,* due to the SPSP (2011-2014) there is now more dialogue compared to 2002-2004, because of greater willingness of SA government for discussion with development partners. The **EC contributed** to that by including PFM as one of the three conditions for the fixed tranche, and including one PFM related indicator in the variable tranche.
- Even though *Barbados* considered incorporation of PFM as good, the EUD commented that the improvements of PFM issues *"were very modest",* which was probably due to an unwillingness of government. A problem raised by the **EUD is the "dogmatic demands" in PFM related matters.**
- In *Lao,* PFM is obligatory in the case of GBS, with an active involvement of the EC together with the WB, Japan and Australia.

For the five EUDs (*Philippines, Moldova, Burkina Faso, Vietnam, Ecuador*) which voted **satisfactory** in relation to the extent to which policy dialogue on SPSP/GBS has incorporated PFM three EUDs (*Moldova, Burkina Faso, Vietnam*) provided qualitative comments.

- In *Moldova* "establishment of the Internal Audit Unit in MoH is seen as a major change. This unit has realized e.g. audits of real value of important medical equipment purchased from public funds in 2008 and 2009 or an external independent audit of the National Health Insurance Company. The EC contribution is seen in terms of incorporating these activities into the policy matrix of the health BS (i.e. SPSP Health).
- In *Burkina Faso* changes involve a greater inclusion of the issue in policy dialogue at time of sector review", due to number of donors who also see the issue as a priority. A problem highlights the weight of national funding versus external funding which may not pass through the PF system".
- In *Vietnam* there is now an annual publication of financial report of the health insurance fund, due to the pressure for more transparency in expending public finances channelling via the Health Insurance Fund. The EC contribution is seen here in "joint dialogue".

Only two EUDs (*Bangladesh and DRC*) rated the extent to which PFM is incorporate into the policy dialogue on SPSP/GBS as **unsatisfactory**. Both EUDs provided qualitative information regarding their assessment.

- In *Banglades*h there is now a "much more focused discussion on strengthening the national PFM system" due to "aid effectiveness agenda and its principle of alignment". EC contributed to this as the "EC was the 2nd biggest donor in HNSPSP and a member of the Financial Management Task Group".
- In *DRC* there has been an elaboration of a medium-term budget plan, but it is still considered as weak. The changes were due to reform processes in public finances. The EC contribution is seen in terms of being one of the principal contributors of CDMT in the health sector.

Overall, an **important aspect** which determines the possibility of incorporating PFM into policy dialogue on GBS/SPSP seems to be the degree of willingness of governments, but also recognising PFM as a priority issue by other donors to increase pressure. Further aspects are: focusing on PFM in the indicators framework and making it obligatory may lead to an increase of incorporating PFM into the policy dialogue.

2.7.3.1.2 Accountability

With regard to the incorporation of accountability in the policy dialogue of GBS/SPSP three (*Barbados, Afghanistan and Vietnam*) out of five EUDs which voted "good" and one EUD (*Ghana*) which voted excellent provided qualitative answers to changes, factors enhancing the putting on the policy dialogue agenda of topics and EC contribution to changes.

- In *Barbados,* the improvements to accountability were considered as moderate as well. Again unwillingness of government seems to be the hindering factor, together with dogmatic demands made by the EC.
- EUD *Afghanistan* commented that changes included *"establishment of procurement committees and internal and external audits".* The **EC contributed** to that by participating and through technical assistance.
- In *Vietnam,* the changes in relation to accountability contain the establishment of a "*law on examination and treatment with disciplinary mechanisms for health staff".* Factors which enhanced the putting on the policy agenda are calling for greater accountability at public health services in the context of decentralisation and autonomy.

For the six EUDs (*Philippines, India, Moldova, DRC, Ecuador, Timor-Leste*) who voted **satisfactory** in relation to the extent to which policy dialogue on SPSP/GBS has incorporated accountability only three EUDs (*India, DRC and Timor-Leste*) provided qualitative comments.

- In *India,* "capacity and methods in accounting, better accountability, simplified expenditure positions and reporting timeliness" are seen as major changes. Frequent interaction with financial managers and seminars with beneficiary government officials is stated by the EUD as a success factor for change to which the EUD contributed by supporting. Capacity building and participating in reviews.
- In *DRC* there exists now a coordination systems (Comité National de Pilotage de la Santé; CNPS), which has been developed through a long process and accelerated with the Kinshasa agenda (L'agenda Kinshasa) recommending a forum about aid efficiency. In this context the EC ensured coordination of international donors in the health sector and was responsible for the creation of CNPS.
- In *Timor-Leste,* the change seen is the introduction of an internationally accepted procurement system. The factors which enhanced a putting of accountability into the policy agenda included the agreement of "partners and MoH to reduce the level of drug stock out in every level." With regard to this, the EC funded SIHSIP and provided technical assistance to autonomous national medical store and MoH.

For accountability only two EUDs (*Lao* PDR and *Burkina Faso*) rated the extent to which PFM is incorporate into the policy dialogue on SPSP/GBS as **unsatisfactory,** as well. Both EUDs provided qualitative information regarding their assessment.

- For EUD *Lao "accountability is a difficult issue, after decentralisation and semi-autonomy with big cost recoveries".* Furthermore, financial reporting through HMIS (in PRSO) is considered as a factor which enhances the putting of capacity building measures into the policy dialogue, however it has not been very successful. The EC provided support regarding capacity development in HMIS, yet the EUD commented that there is a *"need for more financial accountability"*.
- In *Burkina Faso,* accountability has only to a small extent been included in policy dialogue. Factors which enhance the putting on the policy dialogue agenda of topics involve 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"*

In summary the answers show a high degree of variance between the different aspects provided for good incorporation of accountability into the policy dialogue. Generally it seems that willingness of government is a crucial factor which enhances the possibility of incorporation of accountability. Other aspects involve the establishment of certain mechanisms, such as the creation of committees and audits and establishing specific laws and regulations which monitor and ensure accountability.

2.7.3.1.3 Capacity building measures

Regarding capacity building measures four (*India, Bangladesh, Afghanistan, South Africa*) out of six EUDs who answered the extent to which policy dialogue on GBS/SPSP includes capacity building measures is ***good*** provided a qualitative response to the question.

- 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 this regard it is seen as an **important factor** that government monitors variances quarterly and seeks feedback on findings and financial management reviews.
- In *Bangladesh* coordination among donors to avoid duplication is seen as a **change** which has been induced by the incorporation of capacity building measures. There, experiences of working in SWAp context and learning from the previous sector programmes contributed towards putting this issue on the policy agenda.

- In *Afghanistan* an increased number of trainings is a major change due to incorporation of capacity building measures. The EC contributed to that by supporting trainings by means of financial support.
- In *South Africa* capacity building is part of all EU programmes in the SA health sector. This has not changed but there is now better coordination between development partners on the different TA provided. The EUD *South Africa* commented that the fact that HMIS and HFin are very health system related and not vertical supports the putting on the policy dialogue.

For the eight EUDs which voted **satisfactory** in relation to the extent to which policy dialogue on SPSP/GBS has incorporated capacity building measures, five EUDs (*Barbados, Moldova, Ecuador, Timor-Leste and Burkina Faso*) provided qualitative comments.

- In *Barbados,* there were only *"moderate improvements",* due to an *"unwillingness of government"* and *"very dogmatic demands".*
- In *Moldova* changes *include "capacity building in MoH on management and budgeting issues",* due to *"lack of capacities"* in this area. The EC contributed to these changes through *"incorporating these activities into the Policy Matrix of the Health Budget Support".*
- For EUD *Ecuador* the provinces in which the EUD intervene, the *"EC always had a component in helping increase local capacities through improvement of facilities and equipment, but also through the continuous training of local government authorities and health care providers".* The EUD believed it is important to *"have help in the projects to improve sustainability of actions after projects are closed."*
- In *Timor-Leste,* the changes include availability of specific plans, such as *"health human resource plan, training and capacity building plan."* An **essential factor** which has contributed to this is seen in a *"perceived need of MoH-TL to lead the partnership processes".* The EC in this context "provided through technical assistance support to develop and implement the plan till 2008".
- EUD *Burkina Faso* commented that the issue of capacity building measures is *"now an issue of on the agenda and efforts to coordinate are more explicit with the existence of the Paris Declaration". In this context, the EU provided "support to statistics and support to PF".*

For accountability only two EUDs (*Ghana* and *DRC*) rated the extent to which PFM is incorporate into the policy dialogue on SPSP/GBS as **unsatisfactory,** as well. One EUD (*DRC*) provided qualitative information regarding their assessment.

- In *DRC,* the capabilities of the ministry are still weak, but progress has been made in comparison to recent years. The creation of the Support Unit and Management (CAG) has catalyzed efforts to enforce the MoHs capacity to manage external support. The EC is the first TFP that has supported the creation of the CAG and to manage its programs by the CAG.

Overall, it seems that it is important that the need for capacity building measures is recognised. In these cases the EC supported capacity building measures to a great extent by providing technical assistance and financial support to carry out trainings.

2.7.4 Policy dialogue in relation to government's priority setting in the health sector

Question 27_9: In your opinion, has EC's policy dialogue related to GBS/SPSPs encouraged sound government's priority setting in the health sector?

In terms of SPSP a total of 14 EUDs answered the question (out of the 18 surveyed). Most of them, 11 out of 13 EUDs (*Philippines, Bangladesh, Afghanistan, Timor-Leste, Barbados, Ghana, Mozambique, Ecuador, Egypt, Moldova and Morocco*) perceived that policy dialogue related to SPSP encouraged government's priority setting in the health sector whilst only three EUDs (*India, DRC and South Africa*) said it didn't encourage it. EUD *India* commented that "EC policy dialogue at higher level was too weak" and EUD *DRC* reported that "*Despite the debt relief in 2010 (HIPC) budgets for the social sectors have not increased".*

The figure below shows the detailed answers for this question.

Figure 87: Q27_9: EC's policy dialogue related to GBS/SPSP encouraged sound government priority setting in the health sector

Source: EUD Survey, 2011, Particip GmbH

18 EUDs out of a total of 22 EUDs surveyed provided an answer for this question in relation to GBS/SPSP.

Out of these 18, five EUDs (*Lao, Ghana, Vietnam, Morocco and Mozambique*) found that the EC policy dialogue related to **GBS** has encouraged sound government's priority setting in the health sector while only one EUD (*Burkina Faso* answered negatively).

11 EUDs that used **SPSP** (*Egypt, Barbados, Philippines, Moldova, Ghana, Vietnam, Morocco and Mozambique*) voted **positively** regarding whether EC policy dialogue encouraged sound government priority setting in the health sector, whereas three EUDs (*India, DRC and South Africa*) voted "no".

Positive answers include for example EUD *Morocco* which states that *"health indicators of GBS are always present"* again emphasising the importance of the EC policy framework, as seen in Q_27_8.

For EUD *Bangladesh,* the EC played a very important role in encouraging the priority setting of government as well, as *"EC was once the Chair of the donor group and vice chair for the last one year. Moreover, in different high level meetings and forums, EC has always played as one of the most visible donors in the health sector".*

EUD *Ecuador* stressed the importance of the EC even more by its statement that the EC not only encouraged policy dialogue but *"has helped the MoH-TL in developing required policy documentation".*

On the other hand, EUD *Moldova* highlights the importance of government willingness by stating that *"All the problems and bottlenecks were discussed in the Steering Committee, and the Government was taking active measures to solve them."*

According to the EUD *Burkina Faso* the reason for that **negative** answer is that "*The success of a health tranche cannot be taken in isolation of other factors such as: (i) communication/dialogue between the Ministry of health and the Ministry of finance; (ii) existence/domination of external funding which does not necessarily pass through the budget and (iii) the number of donors who share the GBS vision*".

For EUD *India,* "*EC policy dialogue at higher level was too weak. Some support was given concerning PFM which might have impacted on government commitment to enhance PFM and accountability. Other areas were only addressed on technical level."*

For EUD *South Africa,* the EC did not play an important role as the government "*is capable enough to set its own priorities."*

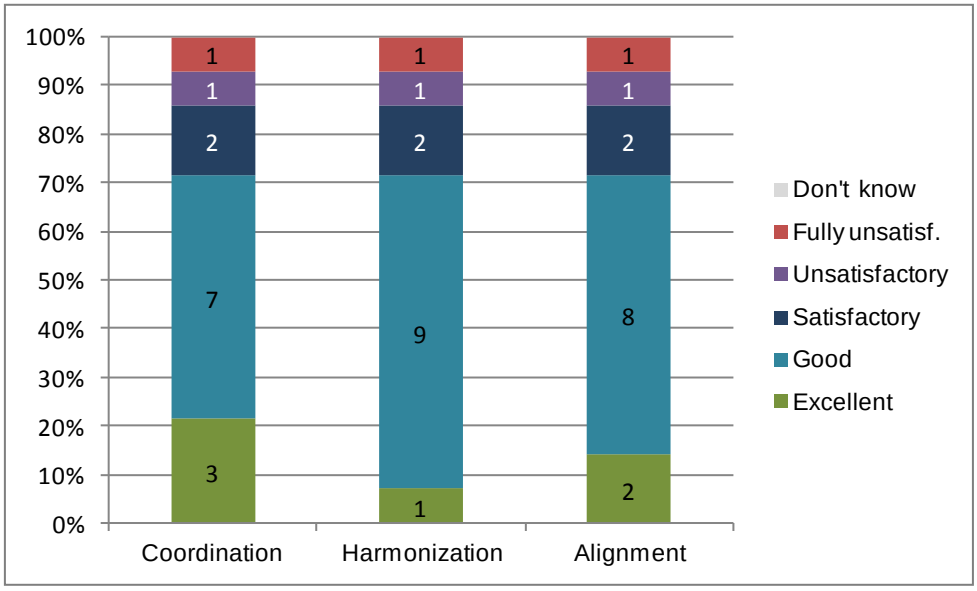
2.7.5 Achievements of Budget Support related to coordination, harmonisation and alignment

Question 27_10: At a general level, how would you rate the performance of the EC **GBS/SPSP** regarding strengthening coordination, harmonisation and alignment related to the health sector?

SPSP

The figure below shows that the **performance of SPSP** l regarding the strengthening of coordination, harmonisation and alignment is assessed excellent or good by the majorities (over 70%) of the EUDs. A total of 14 EUDs provided an answer to this question.

Figure 88: Q27_10a: Performance of the EC GBS regarding strengthening coordination, harmonization and alignment related to the health sector – SPSP



Source: EUD Survey, 2011, Particip GmbH

Coordination: Three EUDs (*Ghana, Morocco, Mozambique*) found that SPSP was "excellent" for strengthening coordination tasks, seven EUDSs (*Philippines, India, Moldova, Bangladesh, Afghanistan, Timor-Leste, South Africa)* said it was "good" and two (*Egypt, DRC*) found it "satisfactory". Only one EUD rated it as "unsatisfactory" (*Ecuador*) and "fully unsatisfactory" (*Barbados*) respectively.

Harmonisation: As regards harmonization, one EUD (*Ghana*) said SPSP was "excellent" for strengthening harmonization, eight EUDs (*Egypt, Philippines, Moldova, Bangladesh, Afghanistan, Timor-Leste, Morocco, Mozambique, South Africa*) rated it as "good" and two EUDs (*Ecuador, India*) as "satisfactory". Only one EUD found it was "unsatisfactory" (*DRC*) "fully unsatisfactory" (*Barbados*) respectively.

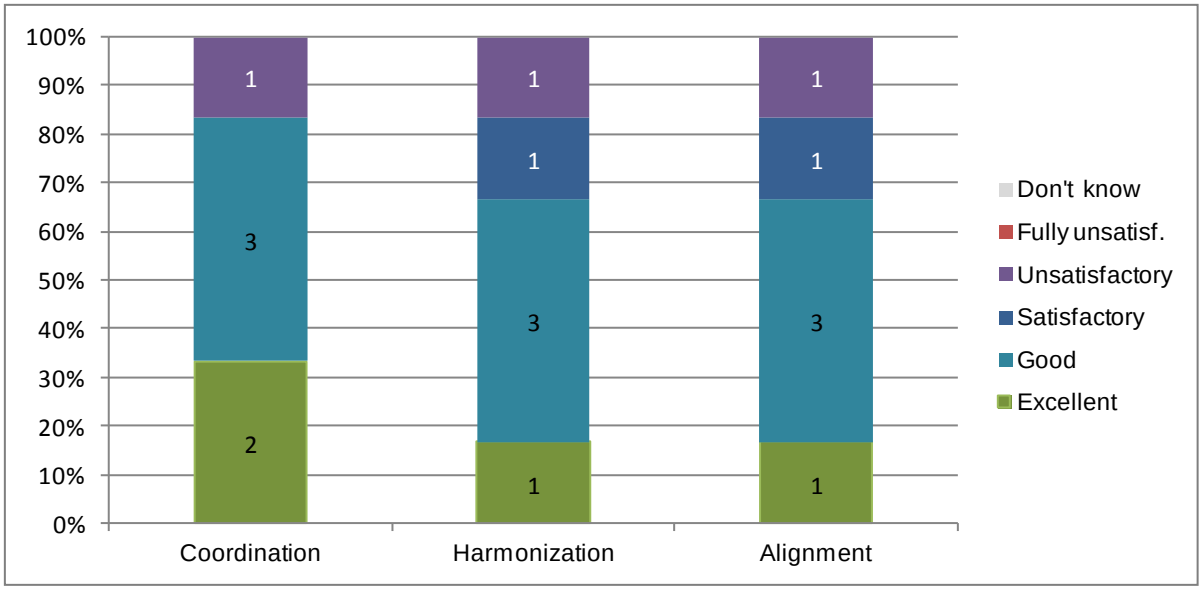
The unsatisfactory-ranking of *DRC* can be explained by the fact that development partners are still in alogic of humanitarian aid. But the EUD noted that steadily the development partners align to the strategy of the reform of the health sector.

Alignment: As for the case before, the distributions of answers for alignment were exactly the same than for harmonization.

GBS

The rates for GBS are similarly positive, almost reaching 70% of excellent or good ratings for all three categories. The figure below shows that a total of six EUDs (*Lao PDR, Burkina Faso, Ghana, Vietnam, Morocco, Mozambique*) (out of the 6 countries using GBS) provided an answer for this question in relation to GBS.

Figure 89: Q27_10a: Performance of the EC GBS regarding strengthening coordination, harmonization and alignment related to the health sector - GBS



Source: EUD Survey, 2011, Particip GmbH

Coordination: Two EUDs (*Ghana, Morocco*) rated that the GBS had an "excellent" performance to strengthen coordination and three EUDs (*Lao PDR, Vietnam, Mozambique*) rated it as "good". Only one EUD (*Burkina Faso*) found that GBS was "unsatisfactory" to improve coordination. The reason provided by the EUD was the following: "*The EC approach was good in terms of coordination, harmonisation and alignment to national procedures and systems but it cannot be judged in isolation of other factors - other dominant modalities, approaches of other donors."*

Harmonisation: As regards harmonization, one EUD (*Ghana*) said it was excellent, three EUDs (*Vietnam, Morocco, Mozambique*) rated it as "good" and one EUD (*Lao PDR*) said it was "satisfactory". As in the case before, only one EUD (*Burkina Faso*) found that GBS contributed "unsatisfactorily" to strengthen harmonization.

Alignment: The distribution of answers was the same for the case of alignment. One (*Ghana*) said that GBS was "excellent" to strengthen alignment, three EUDs (*Vietnam, Morocco, Mozambique*) said it was "good", one (*Lao PDR*) more found it "satisfactory" and only one (*Burkina Faso*) said it was "unsatisfactory".

Overall, EUDs presented a rather positive perception of the GBS performance for strengthening coordination, harmonization and alignment related to the health sector.

The **qualitative feedback** of the EUDs provided some impressions on the issues of coordination, harmonisations and alignment in each country. Overall, these comments confirmed the positive picture revealed by the quantitative answers.

The positive contribution of Budget Support to **coordination issues** is due to several factors according to the EUD answers. The factor which was brought forward by a great number of EUDs is the more and more regular participation in donor for or other donor coordination mechanisms. (EUD *India, Afghanistan, Philippines, DRC, Egypt*). The EUD *Timor-Leste* also stated that the EC was active in joint donor missions. A lack of regular meeting is seen as hindering for good coordination, as highlighted by the EUD *Egypt*.

Most problems where highlighted in relation to **harmonisation issues**. One recurrent problem is related to the procedures of different donors of allocating and implementing funds. The EUD *India* states that the harmonisation of EC Budget Support with the existing pool funds was impossible. The EUD in *Laos* highlights that big donors have all their independent instructions and working rules.

Different ways of providing aid or differing conception on aid delivery in the health sector is another problematic factor. The EUD in *Burkina Faso* states that the EC is the only donor following the health sector development by providing fund via GBS, which poses problems of harmonisation. In *DRC*, the EUD reports that development partners are still in a logic of humanitarian aid. But the EUD noted that steadily the development partners align to the strategy of the reform of the health sector.

A positive factor, inducing a better harmonisation as a result of budget support, is the joint design of the Budget Support, as it was the case for the HSPSP in *Egypt*. Furthermore, the Egyptian authorities

were in charge of the execution of the programme and its activity and therefore making full use of country procedure.

Most of comments related to alignment, quote as positive factor the alignment of EC support to national plans (EUD *Timor-Leste, Afghanistan, Philippines, DRC, Ecuador, Egypt, Moldova*).

Problems arise when government's priorities change suddenly, as it was the case in *India*. Another problem highlighted by the EUD *Lao* is the lack of ownership of the MoH.

2.7.6 Technical assistance and capacity building component

Q27_10 Q27_11: SPSP and GBS often have technical assistance and capacity building components. How has co-ordination between donors been ensured in that regard?

As regards, **how the co-ordination between donors was ensured**, 15 EUDs *(Philippines, Bangladesh, Vietnam, Lao, India, Timor Leste, Afghanistan, Barbados, Burkina Faso, DRC, South Africa, Ecuador, Moldova and Morocco)* provided information. They showed that the ways to ensure coordination between donors were specific to each country and region.

However it seems that MoHs and the WB play an important role as for seven EUDs *(Bangladesh, Vietnam, India, Timor Leste, Afghanistan, Ecuador, Moldova*) either MoHs *(Bangladesh, India, Timor Leste, Ecuador, Moldova*) or the WB (*Vietnam, Timor Leste, Afghanistan*) provide mechanisms to ensure co-ordination. Only EUD *Morocco* explicitly mentioned the EC in this context by stating that "*coordination meetings convened and chaired by the EU were held with all the PTF.*

The individual answers are provided below:

Asian countries

- In *Philippines* coordination was ensured under the SDAH (sector development approach for health) mechanisms and also during informal development partner meetings.
- In *Bangladesh* the TA from the Pool Fund were coordinated by an institutional mechanism established within the ministry and the TA by parallel funders. It was shared within the DP group in HNP Consortium.
- In *Vietnam* the EUDs reported that *"GBS/PRSC in Vietnam is administered by the WB while TA and CB are provided by different development partners. Dialogue associated with the scheme enforced greater coordination between partners in that regards".*
- The *Lao* EUD stated that there is "*good coordination in planning, joint drafting ToR, sharing consultants, fielding consultants in good coordination. And of course also strong arguments when vision differs*".
- In *India "coordination was good to fine-tune the TA, prioritize certain TA and avoid duplication. However, donors competed for work areas and had advantage to start up if having had the better lobby with government, regularly through donor partner forum and through pre-programme consultations".*
- In *Timor-Leste "Capacity building activities were coordinated by MoH with the help of both WB and EC TA. This was discussed and shared during the regular joint mission.*
- In *Afghanistan* coordination is ensured through various means. For example through coordination forums, sharing plan and report (support of BPHS and EPHS in 10 by EC, 11 by WB and 13 by USAID is a good example).

ACP countries

- In *Barbados,* "there are not enough donors active for co-ordination to be a priority".
- The EUD *Burkina Faso* did not think coordination was ensured "though efforts are now being made in discussions on division of labour / Dec. of Paris".
- In *DRC,* donor coordination was done through the Inter Donors Group Health
- The EUD in *Mozambique* stated that "mapping of general TA was tried but not as successful as expected".
- In *South Africa,* "there is now better coordination between development partners on the different TA provided."

Latin American countries

- In *Ecuador,* "the projects had had a very good relation with the MoH. But real coordination with other donors that has been more relegated. The three projects were designed prior 2005.

ENPI/MEDA/TACIS region:

- In *Moldova,* the "ToR for this technical assistance was coordinated with MoH, which chairs the health sector council. The preliminary results of this project are discussed with other donors too."
- In *Morocco,* coordination meetings convened and chaired by the EU were held with all the PTF.

3 Annex 4: CSP analysis

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3.1 Introduction

The analysis of CSPs and NIPs is a tool helping to highlight some trends related to EC support to the health sector in partner countries. Per se, it cannot cover all judgement criteria and indicators identified, as CSPs do only provide partial information related to these issues.

This analysis is based on review of CSPs covering the countries that have been selected for the desk study:

- 24 CSPs (including NIPs where available) covering the period 2001/2-2006/7,
- 23 CSPs (including NIPs where available) covering the period 2007/8-2013.

To ease the reading "CSP I" refers to the period 001/2-2006/7, "CSP II" to the period 2007/8-2013.

The following table summarizes the documents analysed for each country:

Table 14: Overview of scrutinised documents for the CSP analysis

Country	Region	Document analysed 1	Document analysed 2
Afghanistan	Asia	CSP II003-2006	CSP II007-2013
Bangladesh	Asia	CSP II002-2006	CSP II007-2013
Barbados	Caribbean	CSP II002-2007	CSP II008-2013
Burkina Faso	Africa	CSP II001-2007	CSP II008-2013
Democratic Republic Congo	Africa	CSP II003-2007	CSP II008-2013
Ecuador	Latin America	CSP II002-2006	CSP II007-2013
Egypt	ENP	CSP II002-2006	CSP II007-2013
El Salvador	Latin America	CSP II002-2006	CSP II007-2013
Ghana	Africa	CSP II002-2007	CSP II008-2013
India	Asia	CSP II002-2006	CSP II007-2013
Laos	Asia	CSP II002-2006	CSP II007-2013
Moldova	ENP	CSP II002-2006	CSP II007-2013
Morocco	ENP	CSP II002-2006	CSP II007-2013
Mozambique	Africa	CSP II002-2007	CSP II008-2013
Myanmar	Asia	Not existing	CSP II007-2013
Nigeria	Africa	CSP II001-2007	CSP II008-2013
Philippines	Asia	CSP II002-2006	CSP II007-2013
South Africa	Africa	CSP II002-2006	CSP II007-2013
Syria	ENP	CSP II002-2006	CSP II007-2013
Tanzania	Africa	CSP II001-2007	CSP II008-2013
Timor-Leste	Pacific	CSP II002-2007	CSP II008-2013
Vietnam	Asia	CSP II002-2006	CSP II007-2013
Yemen	Gulf	CSP II002-2006	CSP II007-2013
Zambia	Africa	CSP II001-2007	CSP II008-2013
Zimbabwe	Africa	Not existing	Not existing

Taking into account the nature of the CSP document, the analysis cannot cover all judgement criteria and indicators of the evaluation, but focus on very specific aspects, in particular EQ 6 and 7. The research question for the CSP review have been designed according to what information should be made available in the CSPs, based on the guidelines for a common framework for joint multiannual programming from 2000 and the update of 2006.[56] Even though general frameworks existed for both

[56] Commission staff working paper sec(2000)1049, Community co-operation: framework for country strategy papers. European Commission (2006): COM (2006) 88 final. increasing the impact of EU aid: Common framework for drafting country strategy papers and joint multiannual programming.

periods, the information available in the CSPs differs considerably. Thus, the questions have been tested in some CSP.

The following aspects have been eventually reviewed for all 24 countries:

- How and to which degree do the CSPs analyse the country situation, and is the outlined EC response strategies based on this analysis?
- How do the CSPs discuss issues of coordination between donors and with the partner government as well as complementarity with other donors' interventions? The findings of this section are directly related to the indicators of EQ6.
- To which degree do the CSPs discuss the choice made in terms of EC aid delivery methods, financial instruments and channels? The findings of this section are directly related to the indicators EQ7.

The CSP review does not aim to give an exhaustive picture of donor coordination mechanisms nor of aid delivery methods used in the countries, but focuses on how different aspects of these issues are discussed in the CSPs. Thus, some countries may show characteristics that are not depicted in the analysis as they are not clearly stated in the text of the CSP analysed.

3.2 Analysis

3.2.1 Country situation analysis and EC response strategies in comparison

All the CSPs under review provide a fairly detailed analysis of the health sector: the country's health situation at the time of the CSP, analysis of past years' evolutions and progress, the main future challenges (risks and constraints).

This chapter sums up the screening of the 47 CSPs on the following research topic:

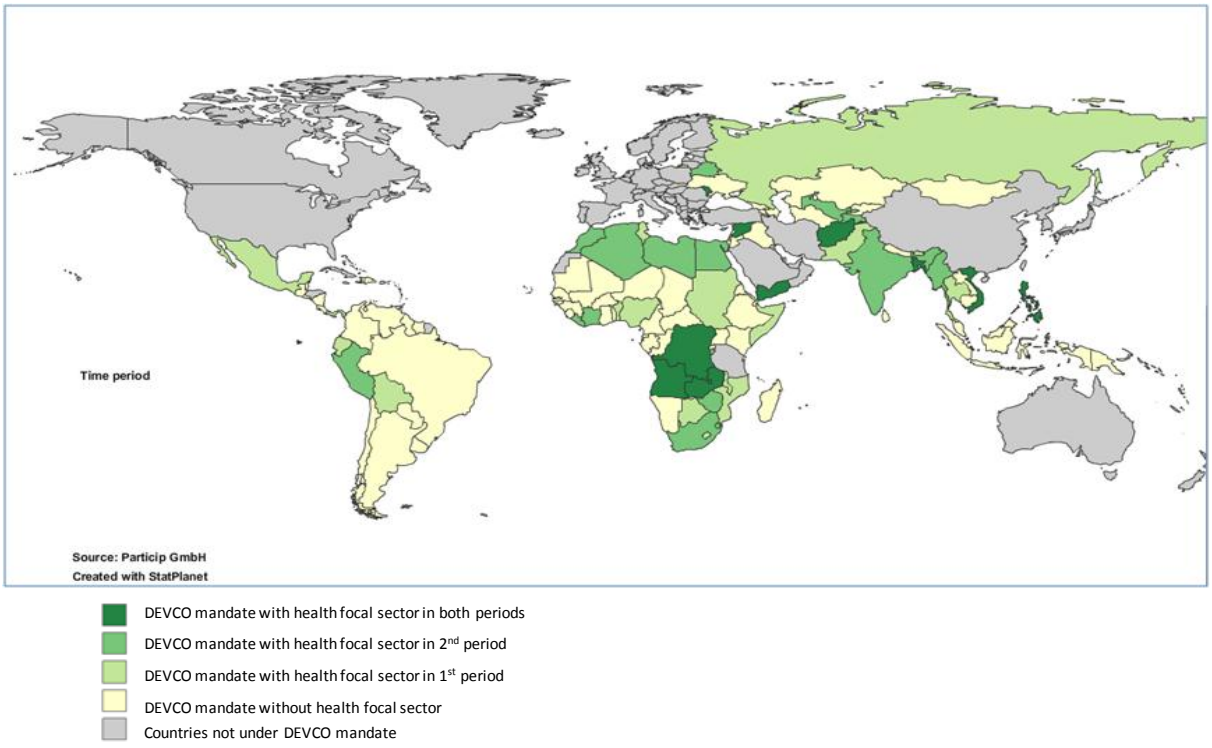
- EC planning documents for support to the health sector identify gaps, discuss means of filling them, and identify action to minimise overlaps (*former I 621*), focusing on the evolution of approach. Two separate research questions where asked:
    - Is health a focal sector?
    - Does the CSP provide an explicit response strategy in the health sector?

Health has been a focal sector in 10 CSPs and a sub-sector or non-focal sector with specific budget allocation to health in three countries in the first CSP period. In the second CSP period, 12 countries have health as a focal sector and four countries have health as a subsector or non-focal area.

The first map below shows all countries in which health has been a sector of concentration for the EC.

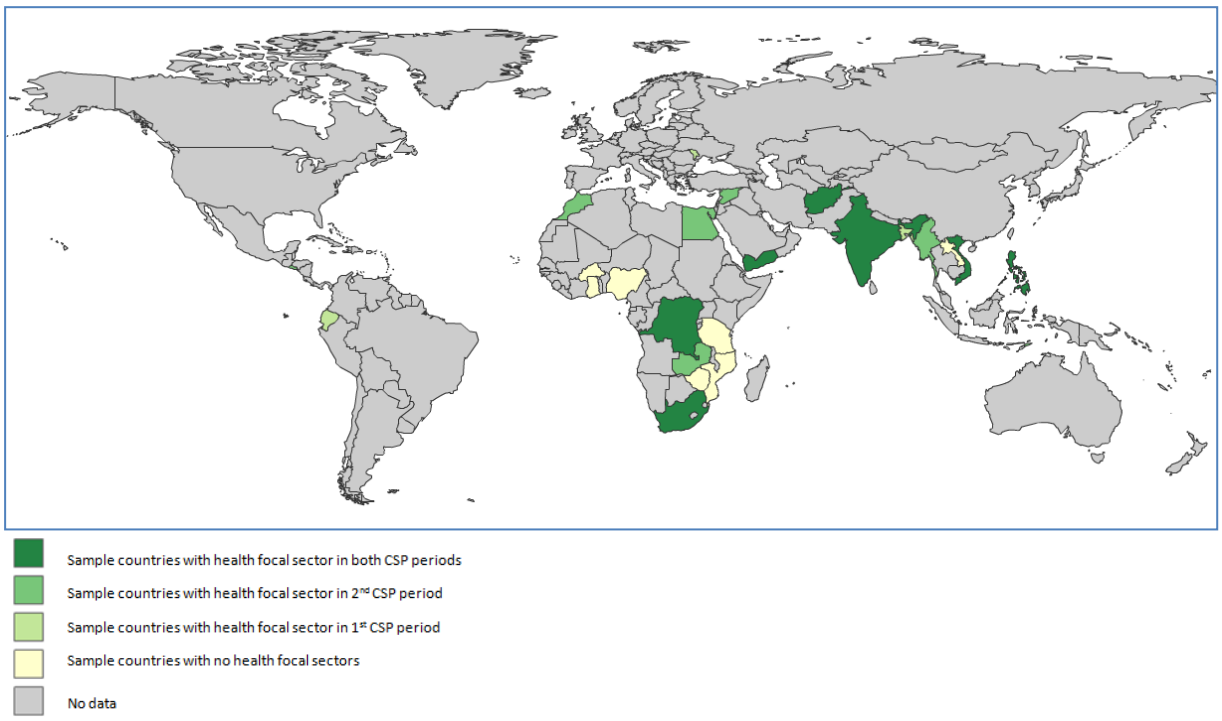
European Commission (2006): Common Framework for country strategy papers, adopted in April 2006, guidelines with examples and templates.

Figure 90: Health focal sector between 2002 and 2010 worldwide



The second map shows the distribution of focal sector for the sample of 25 countries in this analysis.

Figure 91: Health focal sectors in sample countries between 2002 and 2010 worldwide



3.2.1.1 Strategic continuity between CSP I and II in the health sector

Health being a focal sector in both periods

For half of the countries reviewed, there is a strategic continuity between CSP I and II in the health sector. In *Afghanistan*, *DRC*, *India, Philippines*, *South Africa*, *Vietnam* and *Yemen* health has been a **focal sector in both periods** (CSP I and II), mostly oriented around poverty alleviation and improved access to basic health services.

Figure 92: Health focal sector in sample countries in both CSP periods

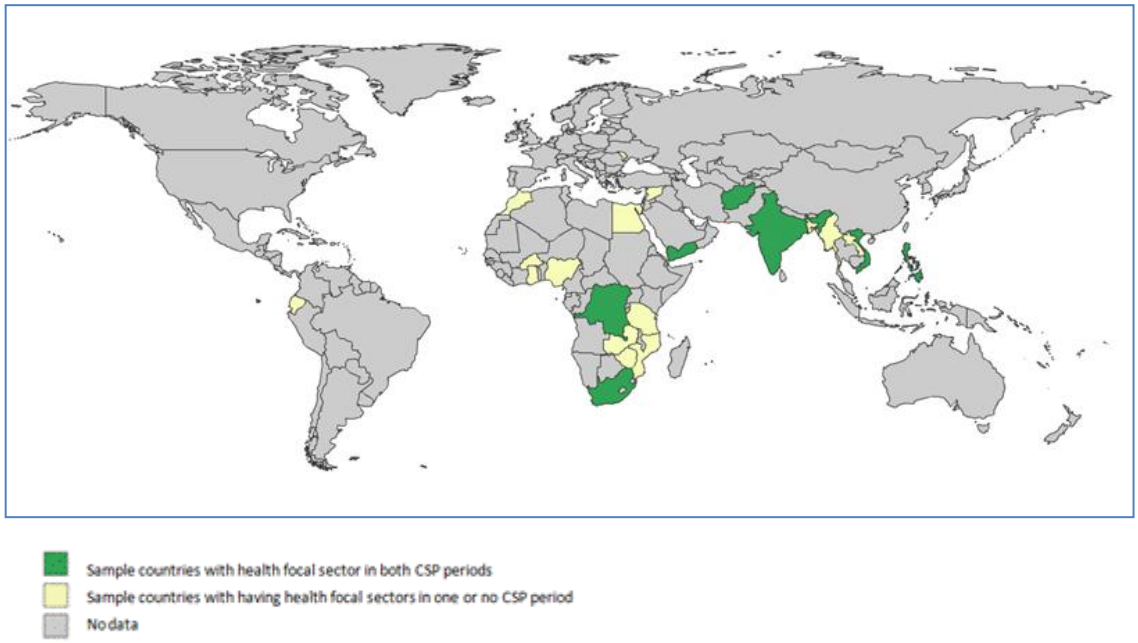


Figure 93 Health focal sectors in African sample countries between 2002 and 2010 worldwide

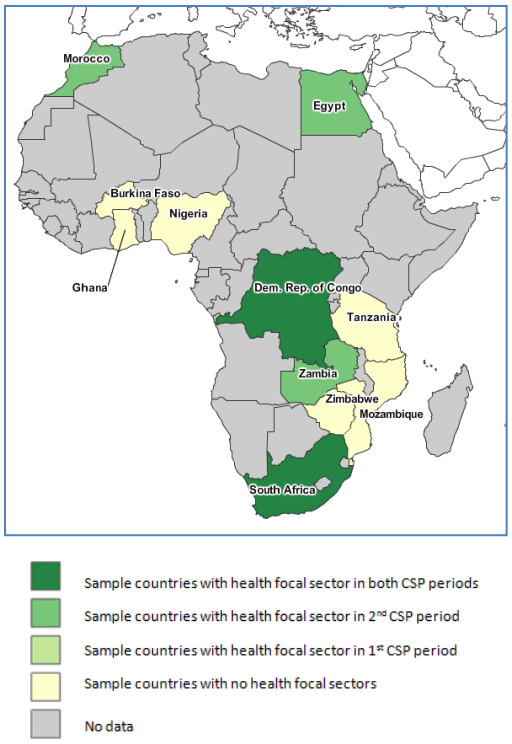
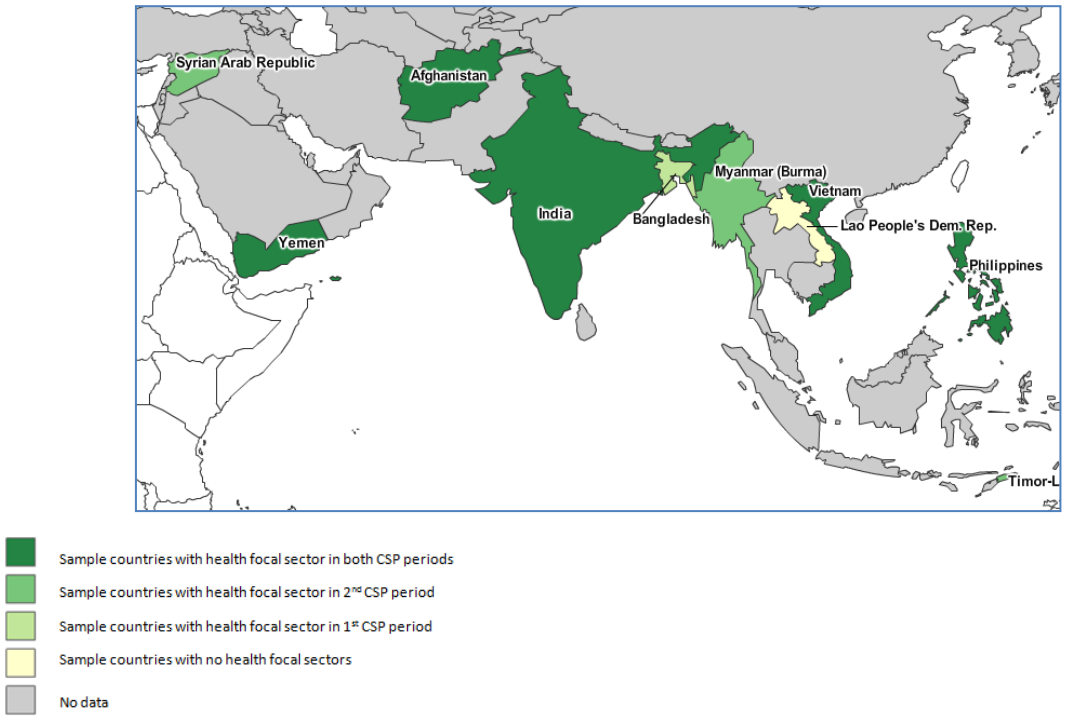


Figure 94: Health focal sectors in Asian sample countries between 2002 and 2010 worldwide



- ***Afghanistan*** CSP1: EC focal sectors include economic infrastructure and health, mainly focusing on reconstruction and rehabilitation as well as support to IDPs which also includes health, building on ECHO support. Overall aim is to improve **access to health facilities**. Initially a large proportion of EC funds supported NGOs active in the health sector.

  CSP II: Health is one of three focal sectors besides rural development and governance. Given the conflict and post-conflict situation in Afghanistan during the period of the two CSPs the EC strategy has evolved according to needs in the country and feasible options. CSP II states that despite the conflict, 238 health clinics and three hospitals are functioning through EC support. Health support made up € 12 million in 2002. CSP II refers to CSP I and the national development priorities and states that CSP II builds on the priorities in CSP I and concentrates on sectors where the EC has key expertise.

  CSP II mentions that there has been a DFID funded evaluation of the Basic Package of Health Services (BPHS) programme of which the EC has been a major donor together with the World Bank and USAID. The recommendations from this study, particularly for increasing the effectiveness of EC assistance, will be taken into account in the configuration of future BPHS programmes. But CSP II does not mention whether any evaluation recommendations have been used to write the CSP.

- ***Bangladesh*** CSP I: Health is included under the focal sector of improving Bangladesh's human development indicators as including health, population and nutrition. The EC's response strategy is **based on the PRSP** and the areas where the EC has significant expertise.

  CSP II: Health is included under the focal sector Human and Social Development and the EC supports the HPSP in order to improve the HDIs and Bangladesh's achievement of the MDGs and thus concentrates on public health sector management and health sector diversification. CSP II refers to CSP I as well as to evaluations of the EC's country strategy and refers to EC support to the health sector as having achieved significant progress in the health sector, which is reflected in **improved access to health**.

- ***DRC***: Both CSP have a detailed situation analysis and emphasis the specific and fragile situation of the country several times. The EC strategy has thus to be reactive to possible changes of country situations. This is made clear in both CSPs.

  CSP I: health is a priority in the focal sector. Support to the health sector is planned between 20%-30% of total budget.

  CSP II: health is one of the three focal sectors. The CSP II is in the continuity of CSP I (and previous support of the EC to the health sector) and is oriented around **poverty alleviation and the access to health services** and drugs as well as the affordability of health care as

one major pillar. It can be noted that the CSP II is more focussed on institutional support to the health sector than the CSP I.

- ***Yemen*** CSP I: Health is a focal sector under Priority 3 of **poverty reduction**. The reasons are clearly based on Yemen's requirements due to its poor health and development indicators and the fact that poverty had been on the increase at the time of the CSP. The focus is on strengthening **basic health services and improving access to health facilities**. The social fund for development is also used to support health-related interventions.

  CSP II: Health is a subcomponent of the strategic objective 2 of strengthening Yemens ability to fight poverty and contribute to the MDGs by supporting **reproductive health and strengthening the delivery of basic services**. CSP II mentions strategy and priorities of CSP I but no reference is made to any evaluations.
- ***South Africa*** CSP I: Health is within the area of cooperation 1 - **equitable access to and sustainable provision of social services** - aimed at increasing access and use of social services. Decentralisation of social services is also planned. Specifically addressing country needs and tackling the HIV/AIDS pandemic and the continuum of care needed.

  CSP II: One of three priorities is improving the capacity and **provision of basic services** for the poor at provincial and municipal levels and promoting equitable **access to social services**. Evaluations have shown some common trends in terms of strengths and weaknesses. In the public sector, importing international best practices has been the key to success. Activities supported by an EU partner have been successful when they have focused on three elements: the way services are delivered, the capacity to deliver them and the quality of operations. Finance has played a secondary role.
- ***India*** CSP I: long history of EC support informs response strategy; both achievements and gaps are clearly laid out.
- ***Philippines*** CSP I: health is included in the primary focal point: **assistance to the poorest sector of society**. The CSP also refers to a gradual reduction of EC Aid to the Philippines, and how the reduction will be implemented. CSP II: EC responds directly to the stated desire of the Government by supporting health through a SWAp, building on earlier interventions and the experience gained therein.

<u>Health being a focal sector in none of the periods</u>

On the contrary, health has not been identified as a **focal sector in none of the CSPs** *Tanzania, Mozambique and Burkina Faso*. For *Egypt, Moldova, Syria and Nigeria* health is a sub-sector in a focal area or a non-focal sector to which a certain amount of fund has been allocated. Thus, the health situation is analysed and the arguments against an involvement or a drop-out of the sector is given.

- ***Syria***: Even though earlier support to health is mention and its continuation promoted, health *per se* eventually does not receive focus in CSP I. Equally, health comes in under the CSP II but not as a focal sector, where earlier support is lauded for its contribution in capacity building but the complexity of the programme is lamented.
- ***Tanzania*** CSP I: HIV/AIDS is taken into consideration as cross cutting issue in the context of support to the education sector (p4). CSP II: health is included in the government's poverty reduction strategy (MKUKUTA and Zanzibar's MKUZA), which is supported by the EU. The EU has completely withdrawn from the health sector, including HIV/AIDS and is now delegating partner.
- ***Nigeria*** CSP I: Health issues are included only to a certain extent as a non-focal sector under the heading 'immunisation'. CSP II: Health and immunisation are still non-focal sectors but the limited role of only focusing on immunisation in CSP I has expanded to be expanded to additional states.
- ***Egypt****:* Even though no direct health strategy is designed in the CSP I, an analysis of the critical factors of the Egyptian health sector has been made. In CSP II sanitation emerges as an issue; critical reflection on what has been achieved in the past and chances of success if staying on same trajectory; public health has a specific programme.
- ***Moldova*****:** The CSP I gives a fairly good reflexion on the country situation including the health sector and the government's capacities to act in the sector. CSP I gives an explicit response strategy related to the health sector reform. But health is not a priority area thus, few detailed information can be found. The CSP II is less explicit on health issues and does not give any explicit response strategy as health as such is not a EC priority but a part of the poverty reduction strategy.

- ***Mozambique**:* In CSP I, health is not a focal sector but the EC responds specifically to the HIV/AIDS problem. The EC continues its support in the social sectors (health and education), particularly with a view to ensuring equitable access to social services. The EC uses PARPA as a framework for its development cooperation and addresses health in this context; the EC responds in those areas, within the limits of sector concentration laid down in the Cotonou Agreement and by the EC's own guidelines. The health sector receives 7.1% of the 7th & 8th EDF. A sector wide approach in the social sector is sought.

  CSP II: The EC supports the objectives of PARPA II, the support strategy is consistent to CSP I. However, due to the principle of concentration, the EU and its partner countries will select a limited number of priority areas of action, thus avoiding spreading efforts too thinly across too many sectors - health is not in the focus; HIV/AIDS is one of the non-focal sectors and is mainstreamed in the context of the focal sectors (agriculture and transport infrastructure). The decision on the strategy for CSP II has been taken based on the EC's former experiences.

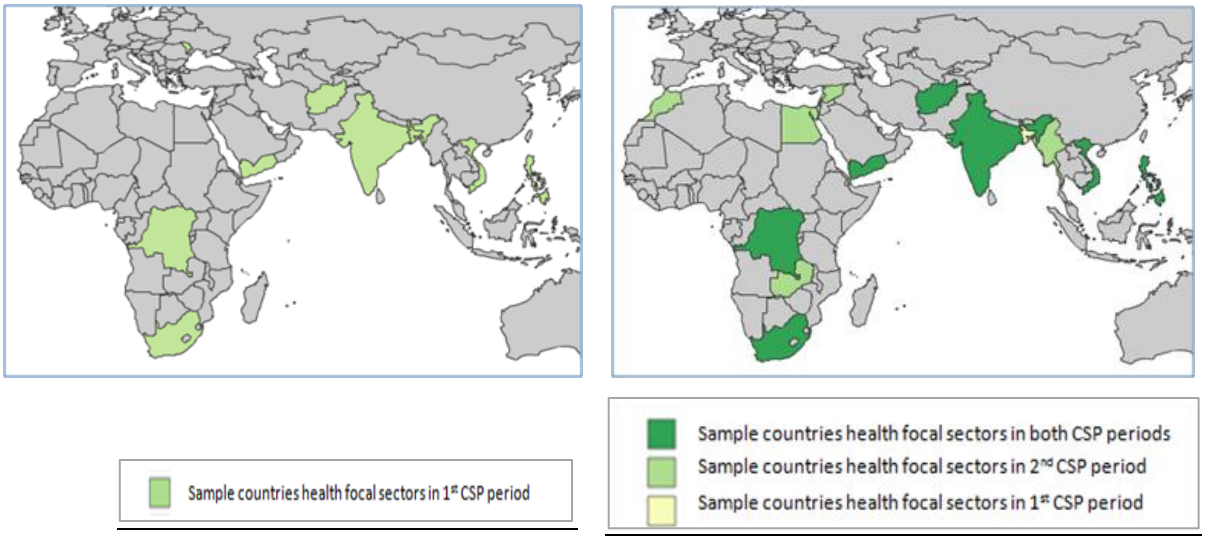
- In ***Burkina***, health is included in the GBS during both periods. CSP I: an important part of EC funds is channelled as GBS (40% for the period 2001-2006, p. 17), where the health sector is represented and included in performance indicators.

  CSP II: 60% of EC funds (i.e. € 320 million) go to a GBS for poverty reduction, including health issues. GBS performance indicators include health indicators.

3.2.1.2 Strategic changes between CSP I and II in the health sector

The analysis of the CSPs makes it possible to highlight strategic changes of the EC in the health sector. Five countries made health a new focal sector in the country during 2007-2013. Only twp countries of the sample had health as a focal sector during 2002-2007, but shifted priority for the CSP II period. The following map shows the focal sectors between 2002 and 2007 for the sample countries.

Figure 95 Strategic changes between CSP I and II in the health sector with a focus on Asia and Africa



Health being a focal sector only in the second period

In *Zambia, Timor Leste, Morocco, Egypt and El Salvador*, health became a **focal sector only in the second period (CSP II)**. In these countries, the EC decided to focus on this sector mainly because of the very bad health sector performance and EC support is concentrated on improving access to basic health care.

- ***El Salvador*** CSP I: health is not a focal sector for 2002-2006, but is somehow included in the focal area no 2 "Appui au développement local intégral et durable". Health topics are not prominent in the CSP I and are only mentioned together with social sector and education and post-disaster relief. The CSP mentions that for the period 2002-2006, 6.2% of the EC funds for the period are committed to the health sector. The CSP remains unclear how the funds shall be used. The MoU of 2001, annex to the CSP is much clearer: it dedicates 12% to 14% (depending on the sources) of € 60 million cooperation funds to the health sector and focus on preventive health, especially maternal and child health.

  CSP II: the CSP provides an explicit response strategy in the health sector. The EU intends to support the country in fostering social cohesion (including through investments in health);

health is included in one of the focal sectors (social cohesion). The EC support is aimed at health, water/sanitation and education, and the rule of law in continuation of previous cooperation. Specifically, EC cooperation will contribute to **improve access to basic social services** with a focus on health and water & sanitation EC support in the health (and W&S) sector is based on earlier experiences (PAPES). The first CSP is still being implemented, therefore there are no lessons learned so far, however, lessons from individual project evaluations are taken into account. The objectives from CSP I remain the same. Through a pre-programming mission, the national policy, the country situation, the interventions of other donors and the first CSP were analysed and taken into consideration, civil society was consulted in a workshop. EC cooperation will be guided by the MDG on health and water and sanitation, specific investment areas are mentioned; indicators are mentioned, based on earlier experiences. As social cohesion is set at the centre of the EU-LA relations, the EC health policy establishes the link between health and poverty, between health and well-being and development, including a reference to AIDS and other contaminating diseases.

- In ***Morocco***, the increased visible EC involvement in the health sector is explained by a **very bad health sector performance**.

  The CSP I does not mention health (only in a footnote a € 20 million support to health sector management is mentioned), but reading of the CSP II reveals that during 2000-2002 the EC financed health projects and also health BS.

  In the CSP II, health is the second priority in the focal sector "social policies" after the education component. The CSP gives a good overview on the past EC support to the health sector, the current needs of the Moroccan health sector and the EC response (in the NIP). The priority of EC support lays in the support the state reform of social protection (€ 4 million) and aid to **improve access and quality of the health system** through decentralisation of health services via a health sector budget support (€ 50 +36 M).

- ***Timor Leste***: After having stopped its support to the health sector in CSP I, health has again become a focus area in CSP II **in order to support the huge needs of the health sector** as outlined in the recently developed Health Sector Strategic Plan (HSSP) 2008-2012.

  CSP I does not provide any explicit response strategy in the health sector and health is not included specifically in the main objectives. Timor-Leste is a new ACP country, therefore eligible for EDF support, which will be focused on sound Public Finance Management, human rights and good governance. After 2002, health has been a focus area in EC support. EC contribution to health sector since 1999 is € 24.5 million The EC's approach to now has been a good example of linking relief, rehabilitation and development, lessons learned from implementation reports, EAMR & JARs (External Assistance Management Reports and Joint Annual Reviews) are taken into account. It is now proposed to exit from the health sector, as the Ministry of Health already has absorption problems with the funds available; no money is allocated to this sector under the present NIP.

  CSP II: Health is among the main objectives and intervention areas (one of three main areas): **improve the availability, accessibility and affordability of health services** to all people in Timor-Leste and the participation of the community and other stakeholders in the implementation of the National Health Plan. Indicative allocation: € 8 million and the recently developed Health Sector Strategic Plan (HSSP) 2008-2012. Policy planning and infrastructure rehabilitation went hand in hand in EC's support to the health sector in order to ensure a coherent development of a potentially long-lasting, sustainable health system. According to the CSP, there is a good deal of continuity in the approach of this country strategy and the previous strategy under the Asia-Latin America budget line. The areas of concentration of the ALA CSP-NIP (2002-2005) were food security, rural development and health. Lessons learned from the Trust Fund for East Timor, evaluations, implementation reports and EAMRs are taken into consideration. Local context, the government strategy and activities of other development co-operation partners is also taken into account. The principle of concentration will guide the Community country and regional programming. The fight against HIV/AIDS is one of 4 cross-cutting issues.

- ***Zambia***: CSP I identifies trends in a number of issues: thematic, strategic and institutional framework, modalities and their effect. For CSP II, a major evolution vis-à-vis CSP I is the inclusion of health as a focal sector, and as such (amongst others) a more thorough analysis is presented. Linkages to other measures/ sectors are more explicitly explored.

A specific situation can be found for Myanmar, which did not have a country strategy paper for the first CSP period. For the second period health has been made a focal sector, in order to build on the strong EC support in the past.

- In CSP II, health and education are the two focal sectors for EC support to Burma/Myanmar. The EC does provide an explicit response strategy. It has targeted health due to its **strong track record in the sector** and as a way of supporting the deprived population in reducing poverty, especially in relation **to basic health care**, malaria and HIV/AIDS.

Health being a focal sector only in the first period

For *Barbados* and *Ecuador* health was a **focal sector only in the first period** (CSP I). In these countries, the EC did not entirely drop out of the sector and still support the health sector, in particular the fight against HIV/AIDS, as a cross-cutting issue.

- ***Barbados***: The evolution of EC support (and focal sectors) is presented in both CSPs.

  In CSP I, health is a focal sector. The objective of the intervention in the health sector is to improve the effectiveness of the sector, **the quality of care** provided and the development of a pro-poor approach through a sector-wide approach. Barbados's first three NIPs (EDF 6 and 7) were devoted to conserve and improve the productive capacity in the more traditional sectors of agriculture, livestock and fisheries. The focal sector for EDF 8 was human resources development. It is proposed to concentrate 90% of the A envelope on the Health sector to support health sector reform in accordance with the strategic plan for health 2001-2010 through sector-wide budget support. The approach and the selection of this focal sector are justified.

  CSP II: the focus under the 10th EDF is on a Skills Development Sectoral Support Programme. **The fight against HIV/AIDS** is a cross-cutting issue and was sought to be addressed through contributing to the Global Fund to Fight AIDS.

- In ***Ecuador***, **changes in the support are based on situation analysis and consultation with the incoming Government**. Although only as one subsector of major focus areas, the health sector is addressed in CSP I; while in CSP II specific subsectors of health are pointed out (**HIV**). However, as the former EC health programme was still underway at the time of drafting the CSP, and after consultation with the Government, the latter was not prioritized during 2007-2010. CSP II refers to CSP I and mentions the programmes that are still ongoing.

  CSP I: One of several mentioned focus areas is the promotion of equitable access to social services, which include health service. It sought to be pursued through existing cooperation instruments particularly through decentralised horizontal programs. A new food security component has been added in 2000, which includes Health. It is the first programme implemented in Ecuador with a sector-wide approach, i.e. through the relevant Ministries (Social Welfare and Health).

  CSP II: Health is not a focal sector, although the Ministry of health is involved in the EC's food programme. **HIV/AIDS is one of the cross-cutting issues**. Health is taken into account in the context of the MDGs. the EC's food security programme involves the health sector.

In Laos and Ghana, the CSP reflects the drop out of the health sector in the second period of the CSP. It must be emphasised that in both countries, health was already not a priority area of the EC. In Laos, the CSP explain the sector drop out as a consequence of sector donor congestion and shift in aid modality.

- ***Ghana***: The early use of SBS is highlighted in CSP I; in particular CSP II provides an in-depth analysis of the sector, the gaps, the trends and the strategies to address challenges (as a donor community jointly with Government). The Donor matrix further reveals that the EC is withdrawing from the health sector and is from the CSP II on a delegating partner.
- ***Laos***: CSP I analyses the main gaps in the health sector and points out strategic developments both in terms of Government planning, developments in use of aid modality, as well as technical areas currently neglected.

  CSP II announces that the EC is pulling out of the health sector, and gives the reasons for this decision (**donor congestion, staffing bottlenecks and shift in aid modality**).

3.2.2 Coordination, complementarity and synergy *(related to EQ6)*

3.2.2.1 Joint efforts donor-government (I-612)

This chapter presents the outcome of the screening highlighting evidence on operational donor cooperation mechanisms led by the government: frequency of meetings, quality of discussion, level and quality of decisions etc., focusing on alignment with government's strategies and policies. The following research questions were asked:

- Are there evidences on existing coordination mechanism with the government such as:

- Alignment on governments health strategy or specific health policies (*also I-511*)
- Health sector policy dialogue
- Health sector performance monitoring

- Does the CSP mentions joint sector reviews with the government (also *I-521*)?

*3.2.2.1.1 Evidence of EC alignment on national government's strategy and policies (*also I-511*)*

Evidence of alignment with national government and the consideration of the particular needs/ alignment to national strategic plans is presented in a high number of CSPs. Alignment with national policies and strategies is underlined for most of the countries under review:

- For ***India***, CSP I indicates that coordination takes place at various levels; performance monitoring (evaluation) is mentioned as important, while CSP II specifies that EC support is directly in line with the national priorities, and addresses issues considered as priorities.
- In the ***Philippines***, CSP I indicates that EC support is in line with National MTDP prioritising basic social development services in areas such as health and nutrition. CSP II underlines that the SWAp enhances government ownership and coordination; EC support is thus fully aligned to the Governments own analysis of the situation in the sector and expressed desire for the EC to support the SWAp.
- **Barbados:** According to CSP I, the need for reform has arisen from increasing concern at the nation's capacity to sustain current levels of health care amidst rising costs and increasing demand for services, together with the phenomena of an ageing population and the increasing prevalence of non-communicable diseases; the Government recognises that there is need for investment in the health sector to improve managerial capacity and policy making; non-communicable diseases have gradually become the main source of burden of diseases; The prevalence of HIV/AIDS is of growing concern in the context of health sector reform. The Consistency with Government Policy is described; the EC supports the national strategic plan for health 2001-2010. "*Barbados is a signatory to the Caribbean Co-operation in Health (CCH), a joint framework for health action within the region. Eight priority areas have been identified under this initiative: health systems development, chronic non-communicable diseases, communicable diseases, human resource development, food and nutrition, family health, mental health and health and the environment. In addition to the above, the national strategic health plan for Barbados identifies a further two priority areas – institutional health services and HIV/AIDS"*
- ***DRC***: CSP II is based on the PRSP of DR Congo which has been elaborated together with other international donors in the "country assistance framework CAF". Mixed comities exist in the health sector. The EU strategy seems also to rely on the national health strategy "*Stratégie de renforcement du système de santé (SRSS)*" (p. 19).
- ***Ecuador***: The alignment with the government seems to have improved in CSP II. The EC sectors coincide with the Government's policy priorities; the Government's actions in social spending are encouraged (p.5, p.6). The good EU-Latin American relations are emphasized (meetings and visits) (p.10); EC plans to build on the achievements of current Government programme (p. 29) ""
- ***Morocco***: CSP II mentions a clear alignment to the government strategy "NHDI" National Human Development initiative" launched in 2005 which aim is to reduce poverty, insecurity and social exclusion. The reform of the health sector is a part of this strategy. But the CSP also notices that, in comparison with the education sector, a medium-term strategy for the health sector is not yet established. (p.7)

Evidence on specific coordination mechanisms such as policy dialogue, joint sector analysis and reviews, have been indicated for *Ghana, El Salvador, Moldova, Mozambique, Syria, Timor Leste, Zambia, Myanmar and Burkina Faso.*

Policy dialogue and working groups

- For ***Ghana***, CSP II gives a full review of the strengths and weaknesses of the national strategy; the review is however not sector-specific. A lot of effort in terms of coordination is evident in the document with a variety of matrixes being published. CSP II: "*Sector groups would operate according to a common standard, with transparent criteria for the selection of Government and DP sector leads. Civil society and private representatives would participate in core sector group activities, such as the annual sector review**. A joint Government-DP working group** reviewed and improved upon the original proposals, and forwarded its*

recommendations in December 2006 for consideration at the Ministerial level was shared with Government in June 2006 which proposed that the pillar and sector improved protocols and dissemination to MDAs for implementation would represent an important step towards a clearer division of responsibilities and increased coordination at sector level".

CSP I is less explicit but the **review process, policy reform and dialogue with GoG** suggest a coordinated effort. CSP I: "*The EC is supporting health policies and reforms through its macro-economic support and through its additional budgetary contributions into the common donor health account. It is therefore for this reason that sectoral policies in social sectors (primarily health and education) will be sustained in the dialogue with the Government within its medium-term expenditure framework*."

- ***El Salvador*** CSP II: a **regular political dialogue between the EC and El Salvador** coupled with new methods of partnership in the area of cooperation (budget aid) (p.8). The document states that there is a consensus with the Government that the programmes under CSP1 are in line with the needs and priorities of El Salvador (p.19). To establish a closer link between national policies and EC cooperation, a shift from the classic project approach to long-term sector programmes, implemented via budget support, is sought (p.19). The fight against HIV/AIDS is based on the government's policy agenda (p.25, 31).
- For ***Moldova***, the CSP II indicated that **consultation with the government** for the elaboration of the CSP took place.
- In ***Mozambique***, CSP I mentions that the EC approach is in close alignment with the situation in the country and with the Government's strategy. **Discussions with the Government** and MS are mentioned.

  CSP II mentions two EC objectives in the health sector: (i) support the Ministry of Health with implementing its Health Sector Strategic Plan (PESS) in line with the National Health Policy; (ii) support the National AIDS Council (CNCS) with coordinating HIV/AIDS activities across all sectors and leading implementation of the National HIV/AIDS Strategic Plan (PEN II).
- In ***Syria***, support is informed by **broad political dialogue** and aligned to what is considered the most pressing needs for CSP I (this does not include health). CSP II stresses national ownership and the EC support is aligned to the national policy agenda, and while coordination between donors appears to have improved since drafting CSP I, the Government leadership still appears weak. Health is not specifically mentioned in this context.
- In ***Timor Leste***, a continuous alignment with the government is noticed in both CSPs, whereas the health sector is only relevant in CSP II, where it is specified that both the Ministry and donors will have to cooperate within the health policy framework: there is a need for the Ministry to cut costs through improvements in efficiency and to seek retaining the involvement of donors for a longer period. The draft National Health Sector Strategic Plan (HSSP) and a Medium Term Expenditure Framework (MTEF) have **been elaborated by the Ministry of Health with the assistance of the ongoing EC** health sector programme.
- As for ***Zambia***, CSP I refers to the **Health Sector Support Steering Committee**. Coordination from the Gov's side is **considered weak**. CSP II refers to a defined agreement (PAF), defined channels of dialogue, co-funding arrangements with other donors and other EC budget lines. Mechanisms such as SAG are mentioned.
- ***Myanmar*** (CSP II): **Policy dialogue in relation to HIV/AIDS** is mentioned as being needed and possible and being able to lead to positive results, despite the constraints of military rule. **Full health sector dialogue** is aimed at for the future. But the support is implemented by NGOs or the UN due to the Common Position on Burma/Myanmar. The planned 'Humanitarian Fund for Communicable Diseases' was to provide a platform for EU, MS and other donors to engage in policy dialogue under the leadership of the UN. "*These two sectors (education and health) offer good potential to coordinate with other donors providing or considering support to the same areas, and to initiate a sectoral policy dialogue with the Government on the basis of National Plans that exist for both health and education. Benefits from providing assistance to these sectors will accrue directly to the deprived Burmese population and contribute to an improvement of key social development indicators.*"
- As regards ***Burkina Faso,*** there is no exclusive reference to alignment to the health sector, but the EC strategy is completely aligned to the PRSP (through GBS) which contains health priorities. The CSP II states an active participation of the GoBF in all coordination and harmonisation procedures. The coordination as a whole is centered around the PRSP (so called "*cadre fédérateur*", p. 16). The PRSP has six thematic working groups in which the

donors have an observatory status. Furthermore the CSP mentions a **concertation framework for sector programmes**. The health sector has such a coordination structure.

Joint situation analysis

It has only been specified in one CSP, in the case of *Burkina Faso*, that analysis of national context has jointly been carried out by donors and national government.

- In ***Burkina Faso***, the situation analysis for the current CSP II has been done together with the government and the donors: *"Une analyse de la situation du pays a été préparée conjointement par le ministère des finances et du budget et le ministère de l'économie et du développement du Burkina Faso et par les États membres de l'UE représentés au Burkina Faso, la CE, le Canada et la Suisse*".

Joint sector reviews

Joint sector reviews, mostly by means of JARs, are mentioned for *Ghana and Timor Leste*:

- ***Ghana*** CSP II: "*Sector groups would operate according to a common standard, with transparent criteria for the selection of Government and DP sector leads. Civil society and private representatives would participate in core sector group activities, such as the annual sector review. A joint Government-DP working group reviewed and improved upon the original proposals, and forwarded its recommendations in December 2006 for consideration at the Ministerial level was shared with Government in June 2006 which proposed that the pillar and sector improved protocols and dissemination to MDAs for implementation would represent an important step towards a clearer division of responsibilities and increased coordination at sector level*".
- ***Timor Leste*** CSP I draws on "*lessons learnt sourced mainly from implementation reports and EAMR and JARs*".

No evidence of alignment

However, in *Afghanistan, Bangladesh, Laos, Yemen, South Africa and Nigeria*, the CSPs do provide **no evidence** on existing coordination mechanism with the government in the health sector during the periods under review:

- ***South Africa***: CSP II states that *South Africa* does not have a PRSP and that there is much less dialogue between donors and the GoSA because aid is merely 1.3% of the government's budget.
- ***Laos*** CSP I: High-level dialogue with the Government is referred to but **no process for the health sector explicitly mentioned**; neither is any evidence of sectoral performance monitoring beyond the most basic indicators evident.

  As support to the health sector is diminishing in CSP II not much sector specific alignment is evident, but overall the processes seem to have been improved or are at least better depicted in the text.

3.2.2.1.2 Leadership of the government in the donor coordination (I-612/I-631)

It appears that government leadership for coordination has increased in the past years for various countries under review. It also appears that the EC support, as described in the CSPs has enhanced government capacity to steer and coordinate donor assistance.

:

- ***Burkina Faso***: The CSP II states that **the government is more and more taking the lead** of the above-mentioned thematic working groups (p. 16).
- ***Philippines***: "*A sector wide approach in health, with a contribution of € 33 million in support of the Health Sector Reform Agenda (HSRA) of the government, has been approved, enhancing government-led donor coordination in the health sector" and "Since May 2005* ***government-led donor coordination has indeed been significantly strengthened*** *in particular in the areas of education, health and the MTF*".
- ***Tanzania*** CSP II: "*The overall objective of the JAST is to contribute to sustainable development and poverty reduction by consolidating and coordinating Government efforts and DP support under a* ***single Government-led framework*** *to achieve results on the National Strategy for Growth and Reduction of Poverty (NSGRP/MKUKUTA) and the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP/MKUZA).* ***JAST should extend progress in enhancing national ownership and Government leadership*** *of the development process to all levels of society and Government: it should also shift Government accountability from*

donors to domestic stakeholders (p9). ***GoT has taken the lead*** *in defining its strategy at both the MKUKUTA and sector level. (p. 32)*"

The following examples infer that national governments already exert high leadership in the health sector:

- In ***Egypt***, it appears Government takes concrete measures to coordinate donors.

  CSP I: "*Education and health reform already benefit from considerable donor assistance and the government is now positioning the Social Fund for Development (already overwhelmingly donor funded) as the most effective instrument to articulate donor assistance and civil society delivery mechanisms. The Social Fund for Development as its preferred model for donor funded social programming*."
- ***Timor Leste*** CSP II: "*GoTL has taken* ***firm leadership*** *over the coordination of development activities and chaired the Timor-Leste and Development Partners Meeting (TLDP millionwith the assistance of the World Bank*".

The CSPs also discuss the problems induced by the lack of leadership by the government including:

- ***Zambia*** CSP I "*Donor co-ordination and co-operation are necessary since* ***Government has insufficient capacity to take the lead*** *in these respects (…). The health sector programme is based on a SWAp and is co-financed with Member States (basket funding). A recent appraisal report shows that a lack of transparency in procurement as well as the recording of expenditures within the Ministry of Health constitute major setbacks*" Notably, the subsequent Zambian CSP proactively addresses this problem "*The agreement aims to increase Government leadership of coordination by calling for the establishment of an external development assistance policy, with the Ministry of Finance and National Planning at the head, to provide guidelines and procedures to govern various areas including coordination and harmonization, ODA agreements, and technical assistance as well as financial and accounting systems. In addition, the WHIP agreement called for an Aid Management Capacity Assessment to be undertaken. Key element of the Memorandum is an annex with specific actions and associated deadlines in relation to: increased use of direct budget support, increased reliance on government systems for procurement, fund management and auditing, use of TA pools and preparation of a JASZ with an improved Division of Labour*". CSP I refers to "*Health sector reform started in 1991, with a vision to provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible. The reforms were founded on the* ***principles of leadership****, accountability and partnership and underpinned by a clear strategy, operationalised through national plans*".
- A very particular case is witnessed in ***Ecuador*****,** where the situation at the time of writing the CSP II is described as follows: "*Although Rafael Correa was elected President in the second round with a convincing 57% of the vote, his party Alianza País has no members elected to Congress and he will depend on the support of several other political parties. This means that the Correa Government, which takes office in January 2007, may struggle to implement effectively its policies on vital matters such as health, education and poverty reduction. If major political reforms are not achieved, the day-to-day activities of governance may continue to unfold in the atmosphere of constant social tension that has reigned during the past decade*". This **political situation affects all sectors** in which EC is involved, including the health sector.

3.2.2.2 Coordination mechanisms with other donors

In this chapter the following topics have been screened in detail:

- Level of co-ordination and consultation (e.g. for health sector or in relation to health conditions for budget support, Member States consultations, or on TA and capacity building) *2*, focusing on coordination mechanisms with other donors. Two separate research questions where asked:
  - Do the CSPs discuss coordination mechanisms with other donors in the health sector?
  - At which phase of the process are they used (elaboration of support or implementation)?
- Different kind of coordination mechanisms have been identified, such as:
  - Joint donor work in the health sector such as harmonised health assistance strategies and joint field missions
  - Health donor working groups

- Multi-donors trust funds

Donor co-ordination mechanisms are in place or being set up with the EC providing value added Coordination mechanisms with other donors are mentioned for most of the reviewed countries; taking the form of joint donor efforts, as for example joint health assistance strategies or field mission; health donor working groups or multi-donor funds.

3.2.2.2.1 Joint donor efforts (Joint and harmonised health assistance strategies, field mission etc) (I-623)

For some of the countries analysed, the CSP review 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 cooperation and efficiency.

Joint assessments and reviews

Vietnam, Tanzania and ***Zambia*** both give examples of such joint efforts; a "*EC-Vietnam Joint Commission*" prepares "*joint evaluations and assessments*" referred to frequently (CSP II), whilst both CSP I & II of Zambia speaks of "*joint reviews*" – CSP II referring to JAR's, and mention is made of "*Periodic progress reports and joint GRZ/CPs reviews, minutes of the Health Sector Support Steering Committee meetings*".

- ***Zambia*** (CSP II): The JASZ (Joint Assistance Strategy for Zambia[57]) 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, it 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.*"
- For ***Tanzania***, CSP I and II indicate that "*In accordance with Article 5 of Annex IV to the ACP-EU Partnership Agreement, the National Authorising Officer and the Head of Delegation shall annually undertake an operational review of the Indicative Programme and undertake a mid-term review and an end-of-term review of the Country Support Strategy and the Indicative Programme in light of current needs and performance*. *The mid-term review shall be undertaken within two years and the end-of-term review shall be undertaken within four years from the date of signature of the Country Support Strategy and the National Indicative Programme. Following the completion of the midand end-of-term reviews, the Community may revise the resource allocation in light of current needs and performance*."

  CSP II: "*Under the JAST [Joint Assistance Strategy for Tanzania], **DPs have committed to align their support to Government priorities**, with MKUKUTA and MKUZA and to facilitate domestic accountability by being transparent in the provision of their development assistance by making increasing use of Government systems in terms of financing, procurement, accounting, auditing, monitoring and evaluation, as well as by engaging in open dialogue with the Government and other domestic stakeholders. There are also expectations in terms of Technical Assistance in support of capacity development becoming more demand-driven and untied from the source of financing; and elimination of parallel Project Implementation Units. The JAST calls for increased aid predictability through enhanced reporting of three-year MTEF financing commitments. This will facilitate improved budget planning. While baskets and projects have a continued place in Tanzania's development, the Government has clearly stated its preference for general budget support. Work will be done on division of labour and JAST rationalisation also includes a move towards the Government's preferred aid modalities."*

A particular good example appears to be ***Mozambique***, which for CSP II benefitted from being one of the countries selected for the pilot initiative on coordination of policies and harmonisation of procedures.

- ***Mozambique*** CSP II: Ad-hoc technical assistance was mobilised from January 2005 to March 2007, and a **coordination and harmonisation roadmap** was agreed in February 2005; a **projects database for all donors** has been created as the first accurate global overview and forecast on cooperation activities in Mozambique. Concomitantly a Performance Assessment Framework (PAF) was agreed in 2004 between the Government and the EC. This PAF is the

[57] See e.g. http://www.synisys.com/zambia/index.jsp?sid=1&id=19&pid=1

basis for the dialogue on budget support and is assessed annually during **joint reviews** by the Government and the 19 budget support donors.

Joint field missions

Joint field missions including in the health sector have only been mentioned for *Timor Leste* in CSP II, even if they exist in other countries in the framework of GBS or JAS.

- In ***Timor Leste***, CSP II: Joint Assessment Mission and the joint donor sector missions are mentioned, including in the health sector.

Other joint efforts

Other initiatives reinforcing donor coordination are described:

- In ***Ecuador*****,** CSP I: The **guidelines** adopted by the General Affairs Council are mentioned as instrument to coordinate donor's actions. CSP II: Operations are planned to be coordinated and harmonised with the rest of international cooperation especially at the operational identification and formulation phases, with special emphasis on seeking complementarity with the EU Member States.

3.2.2.2.2 Health donor working groups (I-611/I-612)

According to the CSPs reviewed, donor working groups have been identified in several countries, as for example DAG - Donor Assistance Group - in Egypt, CG – Consultative Group, amongst other in Ghana, JDG (Joint Donor Group) in Mozambique, evolving into the DPG (Development Partners Group), etc.

An evolution towards the more frequent establishment and use of sectoral working groups, in line with the broader strategies of enhancing aid effectiveness, is witnessed in the CSP's II for :

- Burkina Faso, the DRC, Ghana, Mozambique and Tanzania
- Afghanistan, Philippines, Timor Leste, and Vietnam,
- Egypt,

where explicit reference to the existence and role of such fora is made.

The CSPs for Egypt, the DRC, Ghana, Philippines, Tanzania and Vietnam make reference to the existence of health sector working groups specifically.

- In ***Vietnam***, a consultative group and also a partnership group on health exist as mechanisms, as mentioned in CSP I; in CSP II the role of the EU in the mix is highlighted and coordination mechanisms and respective roles well defined.
- As for **Tanzania**, CSP II states that Health donor coordination group exists (DPG Health), but the EC has completely withdrawn from the health sector and thus does not play an active role in the negotiation. "*Joint Health Sector Reviews have been held for seven years, PERs are conducted annually and partners employ a common list of indicators. M&E and engagement of civil society are areas for strengthening. Sector dialogue and division of labour is facilitated by the DPG-Health and working groups within the sector, but DPs and the MOHSW (Mainland and Zanzibar) have committed to strengthening the role of working groups in facilitating sector dialogue and coordinating inputs. DPs provide technical support, policy analysis and system strengthening, technical and policy inputs through the Care and Treatment Task Force, support strengthening of capacity of districts in providing VCT services, STI screening and promoting condom use. DPs provide funding and technical support for the expansion of services including screening, treatment, antiretroviral drugs, social marketing of condoms, laboratory services. Prevention activities include VCT, PMTCT, and blood safety and injection safety interventions. DPs provide support to palliative care, and to the improvement of the health status and well-being of patients living with HIV/AIDS and other major diseases. (p. 40)*"
- In ***Timor Leste***, CSP I: Since December 1999, there have been six-monthly and, since 2004, yearly donor coordination meetings. Coordination has been increased among the EU Member States present in Timor Leste through the sharing and discussion of cooperation priorities, the sharing of cooperation data, the presentation of identified priorities during EC financed missions and workshops, the joint preparation of the common statement during the annual Development partners meeting and a series of other consultations jointly with other donors and agencies (Consolidated Support Programme; TFET; Sector meetings and working groups etc).

  CSP II of ***Timor Leste*** states that *"Joint donor-government sector working groups (SWG) were established under the previous administration for health care, agriculture and basic*

infrastructure, education and training." Continued yearly coordination meetings are mentioned, EC participates as observer in the Consolidation Support Programme (CSP), one of the main instruments of monitoring and policy dialogue between GoTL and its development partners; EC will be co-funding the World Bank funded Public Finance Management Programme which could further improve the basis for sector or budget support operations in the country. Under UNDP guidance the EC like many other donors was involved in the election observation, In the drafting process of the 10th EDF CSP-NIP a broad consultation took place among representatives of main donors. The National Development Programme and a series of Sector Investment Programmes operate as a framework for international assistance. A multi-sectoral forum to bring together all actors involved in the compact is sought. A definition of priorities, activities and the role of different partners should allow for a clear identification of any gap in the assistance needed.

- In the ***Philippines***, CSP I: a short run-down of the major donors (MS and others) is presented, but no further information (volume of support; distribution of labour amongst donors etc) is presented. For the proposed health support refer to I-3111 above CSP II refers to specific health sector working groups on which the EC take a leading role.
- In ***Mozambique***, CSP II: "*inside the Development Partners Group, EU participates in the working groups on different sectors, particularly in the working groups on agriculture, justice and legal reform, the private sector, roads, health and of course, general budget support. Furthermore, a donor working group on sector alignment and on implementation of the 2005 Paris Declaration was constituted in 2005*."
- In ***Egypt*****,** CSP II refers clearly to a thematic subgroup on health, CSP I speaks more of consultative groups. (CSP I): "Joint sector funding is common in Egypt; the Social Fund II Programme is a multi-donor funded and the EU both initiated and led the SFD multi-donor evaluation. With respect to non-MS donors, the EU is partnered by the WB in the EEP Programme and by the WB and USAID in the Health Sector Reform Programme. All main donors collaborate closely within the active Donor Action Group (DAG) based in Cairo and in the biannual meetings of the Consultative Group organised jointly by the WB and the Government of Egypt"; and CSP II: "All main donor collaborate closely within the active Donor Action Group (DAG) based in Cairo and in the biannual meetings of the Consultative Group organised jointly by the WB and the Government of Egypt".
- For ***DRC***, CSP II mentions that a health sector working group exists, but the coordination modalities are not detailed.
- As for ***Nigeria***, CSP II indicates that a Social Service Delivery Thematic Group exists of donors on HIV&AIDS, Health and Education but the CSP states that so far the group has not really had a global coherence.
- For ***Bangladesh***, CSP I: Local Consultation Groups are in place and the start of a sector-wide approach with regular coordination between donors active in the health sector. It is not clear at which phase of the process they are used.
- For ***Afghanistan***, CSP II: Since the end of 2002, the EC has acted as co-chair in 3 Consultative Groups, one of which is on health.
- ***Ghana****,* CSP II: "*Sector working groups are also in the process of being rationalised. The Ghana Aid Harmonisation and Effectiveness Matrix and Action Plan (including, in Pillar 2, the health sector) is an effort to combine the commitments reached at global level, in the Paris Declaration, at local level.*"

In some cases, health working group are not specifically mentioned but several sector working groups are in place, as for example in *Laos* and *Zambia*.

- ***Laos***, CSP II refers to "eight sectoral/ thematic Donor Working Groups (DWGs) with quarterly meetings and one overall yearly meeting".
- ***Zambia***, CSP II: "Donor co-ordination and co-operation are necessary since Government has insufficient capacity to take the lead in these respects. The annual CG meeting serves as a focal point for Government – donor dialogue. The CG dialogue is followed up at the sector level through working groups, which meet regularly".

Policy dialogue

Close dialogue, as described in *Ecuador* and *Egypt* is another way of improving donor coordination:

- ***Ecuador***, CSP I: projects funded by other donors in the health sector shall be taken into account for EC actions; the EC's food security programme is already implemented using a

sector-wide approach in collaboration with the World Bank. CSP II: since the inauguration of the EU Delegation in Ecuador in 2003, a dialogue with monthly meetings of team leaders and consultants, information exchange and selected coordination agreements in common sectors are taking place, especially with MS.

- In ***Egypt*****,** CSP I speaks of programming and operational dialogue; CSP II seek to rely on regular meetings of development councillors. Document review should investigate the contents of such meetings and how any conclusions and recommendations taken there feature in programming or implementation...

3.2.2.2.3 Multi-donor trust funds (I-624)

Mention of trust funds remains scant in the CSPs; where they appear, the issue of complementarity mostly remains vague.

Health related trust funds

Only the *Philippines* and *Vietnam* refer explicitly to trust funds in relation to the health sector *per se*.

- ***Vietnam*** CSP II "*The European Commission has several initiatives on-going or under preparation jointly financed with EU and other donors. These include the PRSC (with the Netherlands, UK, Denmark, France, Canada, the World Bank, Japan, and the ADB, and possibly, Spain, Belgium, and Germany), Targeted Budget Support for Education (with UK, Belgium, Spain, Canada, New Zealand and the World Bank), a Multi-donor Trust Fund for Public Financial Management (with the Netherlands, Denmark, Sweden, United Kingdom, Norway, Canada and Switzerland), institutional support to the National Assembly (with DK), support to the forest sector (with the World Bank, the Netherlands, Germany)*". The PRSC is a major modality for "pooled financing in different sectors (notably in the health sector) and budgetary support".
- ***Philippines*** CSP I mentions "*The ASE millionTrust Fund, where the EU is a key member, could assist in defining new strategies and reforms especially within the education and health sectors", and CSP II refers to the details of the CSP I period insofar "it was therefore envisaged to support the World Bank-administered Mindanao Trust Fund (MTF) and an amount of € 11-13 million was earmarked in the NIP 2005-2006*".

Other trust funds

Trust funds or common pool funds/basket funds that are not specific to the health sector are described for other countries:

- CSP I for ***Afghanistan*** refers to the "Afghanistan Reconstruction Trust Fund", of which the World Bank is a major contributor. How much the EC contributes to the fund is not specified further in the CSP; neither is the coordination mechanism nor the complementarity with other EC support. Afghanistan's CSP II mentions multilateral trust funds but provides no specifics, other than to justify its use as "*to date, the European Commission has channelled funds through a number of means. It has directly funded private contractors and NGOs, as well as channelled funds through the framework of the National Development Budget, and through the multilateral trust funds established to support the Government's recurrent budget and the National Priority Programmes. 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*"
- In ***Laos***, for CSP II, it is mentioned that the national government was setting up a Multi-donor Trust fund, but no additional details are provided (whether for instance this covers the health sector).

Complementarity with other EC support

Complementarity between EC support to trust funds or pooled funding with other EC support, directly managed and implemented by the EC, is mentioned as a target and discussed in the following countries.

- As regards ***Tanzania***, no trust fund or basket funding specific to the health sector is mentioned. The JAS shows a critical review of the use of basket funds and limit it to specific areas such as emergency relief. CSP II: "*Over the past decade, the structural design of aid has changed with the introduction of a large number of global programmes and private initiatives in response to the perception that not enough was being done to alleviate poverty, particularly in the social sectors. Tanzania is targeted by many of these initiatives as a pilot*

country: the consequence is a multitude of unpredictable aid inflows and external priority setting. Although sometimes clearly beneficial, there is a danger that global initiatives may be superimposed on existing country programmes, risking an increase in transaction costs and further challenges for the division of labour. Improved alignment of global initiatives with the JAS will be a priority. As pointed out in the IMG report 2005, Government should decline aid when necessary and reject initiatives which do not support country priorities. If possible, global funds should go through the exchequer. The amounts should also be integrated as far as possible into the MTEF. Addressing this issue implies a more systematic dialogue between country representatives of the Development Partners and their Headquarters, as well as firm encouragement of the organisations entrusted with the management of global initiatives to disseminate early information and participate regularly in sector dialogue. DPs commit to alert the GoT and the DPG early on when they see a global fund including Tanzania in a new initiative or program. The sponsoring DP also commits to working with the global fund to ensure to the largest extent possible that the new initiative or program fits within existing GoT processes, and is consistent with MKUKUTA/MKUZA and the JAST commitments and goals."

A clear statement in favour of using a trust fund for CSP I in *Timor Leste* is made:

- ***Timor Leste***: "*The Commission has followed a clear-cut strategy of financing the Trust Funds established to assist the UN missions and the multi-donor Trust Fund managed by the World Bank (TFET). This has facilitated implementation and coordination, and avoided fragmentation of aid whilst providing support for a new and weak administration, Programming jointly with other donors also ensures complementarity of aid (a total of 5 Member States and 5 international donors co-financed the TFET). The main reasons for the EC's participation in TFET were (i) better donor coordination; (ii) higher efficiency resulting from the use of uniform procedures (particularly in financial matters such as procurement and disbursement) and the elimination of the administrative burden to have a large ground capacity in Timor-Leste; and (iii) to have a voice in the mechanism in which most donors participate. The Commission continues to believe that our assistance is best provided in coordination with other donors and if possible through pooling mechanisms such as the TFET*" CSP II considers the lessons learnt and reflects favourably on the use of the TFET (based on an interim evaluation). Whilst he TFET had a primary, but not exclusive focus on rural development, the lessons may be applied sector-independently.

3.2.2.3 Complementarity with other donors (JC 62)

This chapter will provide insights on the following topics:

- EC programming and programme documents refer to other donors' policies, particularly that of Member States (*I-621*), focusing on donor coordination. Two separate research questions where asked:
  - Does the CSP analyse other donors' policies related to the health sector?
  - Does a donor matrix exist for CSP I and CSP II? If a donor matrix exists, does it mention which donor supports the health sector/subsectors? Is coordination with EU MS explicitly discussed?
- Complementarity between the interventions of the EC, the EU Member States and other donor agencies active in the health sector, and in GBS support related to health (*former I-624*). Two separate research questions where asked:
  - Does the CSPs discuss the complementarity between EC interventions and intervention of other donors, in particular EU MS interventions?
  - Added value compared to other donor or specific task allocation between donors?

3.2.2.3.1 Existence of a donor matrix

The level of detail depicting donor coordination varies from vague statements to detailed explanations of budget shares, specific thematic foci and institutional procedures allowing for effective exchanges between the EC and MS, between the EC and other donors, and the EC and the national Government, providing details of the role the EC takes in these, both at the political and/ or technical level.

Donor matrixes detailing all sectors, including health

Donor matrixes exist for most of the CSPs reviewed. For *Afghanistan, Bangladesh, Burkina* and *DRC,* they detail donor interventions in all sectors, including health.

- For ***Bangladesh***: CSP II highlights that sector-wide programmes have led to heightened coordination and alignment of approaches. Donor matrix exists and is very detailed on funding per sector.
- For ***Burkina***, both CSP I and II have a detailed donor matrix. CSP I: A detailed donor matrix per sector exists listing the amounts given per donor: between 1990 and 2000, EC contributed to the health sector with an amount of 15% over the period.
- As for ***DRC***, both CSPs have detailed donor matrix which shows the commitment of each donor in the health sector. CSP I: The donor matrix details information on which donor provides which support to the health sector (without budget). CSP II: the donor matrix details sectors in which the donors currently intervene and where they plan to intervene.
- In the case of ***Tanzania***, EC has withdrawn from the health sector, including HIV/AIDS and is acting as delegating partner, meaning: "DPs outside a particular sector/thematic area will be represented by those Partners that will assume the role of "delegating partners". They can nevertheless provide financial assistance to any sector/the delegated cooperation, as DoL does not concern the amount of distribution of DP funding." In the CSP II, there is a division of labour matrix to be found (p. 53).

  CSP I: "*To learn more about the environment for future EDF programmes, EC carried out a comprehensive data collection exercise among Tanzania's main development partners. All donors who have multi-annual programmes with Tanzania made their data available. The resulting matrix therefore covers most future interventions by Tanzania's development partners (only figures for Japan, ADB, EADB and some Arabic Funds have not been captured).(p14) The data collected are not only quantitative (expected commitments from 2001 per sector), but also of a qualitative nature (type of intervention – policy dialogue and institution building components, potential role by the donor in the sector, etc.) (...)As regards the sectors of co-operation, macro-economic support in form of budgetary aid has taken a clear lead, with 22% of total aid captured, followed by health with 10% (including population and HIV/AIDS). (...)Health support is massive (...) Close co-operation with the donor community, particularly EU member states, to ensure coherence, impact and efficiency of EC's aid form parts and parcel of this Strategy. Coordination will be active both in sector policy dialogue and around specific support actions.*" *(p20)*

<u>Donor matrixes where health is not specifically mentioned</u>

However, donor matrixes do not always indicate the respective roles, or even financial envelopes, in the sectors. In particular, the health sector has not been specifically mentioned in *Moldova*, *Yemen, Nigeria* and *Barbados* CSP II.

Examples of these type of matrixes are the CSPs of *Ecuador*, and CSP I of both *El Salvador*.

- ***Ecuador****:* CSP I mentions that a donor matrix is presented, but donors are not linked to specific sector; in CSP II the weak Government capacity is given as a reason for lack of information on other donor's actions: It mentions that coordination is sought especially during identification and formulation phases; there are efforts to improve coordination, but the punctual cooperation is still very weak.
- CSP I of ***El Salvador*** mentions that a matrix exists but despite "*other donors and MS are mentioned, but not related to sectors in the analysis*".

<u>No donor matrixes</u>

Some CSPs do not include any donor matrix, such as CSP I of *Laos* and *Nigeria*.

- For the ***Republic of Laos***, at the time of drafting the CSP I, no donor matrix was presented and coordination was considered weak, as the EUD had not yet opened in the country. Overall, it was considered that *"much progress in terms of coordination has been made" by the time of drafting CSP II, with "working groups established and other mechanisms in place to coordinate amongst donors and with GoL."*

<u>Discussion on the use of donor matrixes</u>

Equally, a donor matrix does not imply donor coordination *per se*, as pointed out, among others:

- In the CSP II of ***Barbados,*** which, despite a thorough matrix, states that *"Coordination so far has been on a limited ad hoc basis. There is a need for more systematic policy and operational coordination in the Eastern Caribbean"*.
- In ***El Salvador*** the observation is made that, whereas a donor matrix exists, "*the level of political dialogue and coordination 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 coordination 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*" (CSP II). However, the CSP does not give any indication on how this problem should be tackled.

Further to the list of donors and allocation of tasks, some CSPs discuss the distribution of tasks from a complementarity point of view. It is made clear that complementarity is sought, and goes beyond the sole coordination efforts. Synergies, especially with EU Member States is discussed, e.g. for the HPSP programme in Bangladesh.

- In ***Barbados***: CSP I indicates that consultations have taken place between the EU and the main donors working in the health sector - PAHO, IDB and the World Bank, so as to ensure maximum complementarity in the projects being undertaken.
- In ***Timor Leste***, CSP I: Complementarity among Member States and the EC has been achieved mainly in the common participation and financing of TFET; Coordination has been particularly active in the preparation of the Stability Programme and the Sector Investment Programs and Sector Working Groups; Donors in the health sector are mentioned to justify the exit from this sector by the EU. CSP II: Division of labour is well reflected, together with Australia and United States, the EC is a major donor in health; overlapping is being avoided; The importance of continuing the already close co-ordination with other donors, in particular with EU Member States, with other major donors such as Australia, USA, Japan, UN agencies, WB and IMF is highlighted; Complementarity among Member States and the EC has been achieved mainly in the common participation and financing of TFET.
- For ***Ecuador*:** according to CSP I, the main sectors of cooperation for the EU Member States and other multilateral donors are listed; sector-wide support by other donors is mentioned in the health sector, which should help the EC adopt this method. Complementarity is ensured, as health is identified not to be a focal sector for aid to Ecuador. In CSP II, other donor's actions are mentioned, including in the health sector; MS interventions are not explicitly coordinated with EC interventions, however there is no major inconsistency between them. MS manage cooperation funds through their own representatives or through NGOs.
- In ***Bangladesh***: in CSP I, there is a section of the CSP on complementarity with other donors and the CSP discusses the actions of other donors in the health sector. "*The major sectors of intervention by EU Member States are human development, including rural development, health and education. The development partners have promoted the sector-wide approach since the Paris meeting of the Bangladesh Development Forum in April 1999. The Netherlands, as well as other EU Member States such as Denmark, are committed to this approach as a general principle for their development co-operation. So far, the sector-wide approach has been applied only in the health sector, though the Government of Bangladesh is now considering developing sector-wide programmes with the development partners also in other sectors such as the education and water sectors. The new Council guidelines on operational co-ordination between EU Member States missions and EC Delegations of January 2001 have provided a new impetus. Member States and the Delegation have been discussing harmonisation of the next cycle of the programming exercises and have proposed to jointly start for the country strategies as of 2006. The Commission views this proposal favourable and will consider its feasibility at the appropriate time. The matrix on donor co-ordination (…) shows how EC actions relate to those of Member States and other donors. Duplication is avoided by ensuring consultations at various levels to improve coherence, in particular at the EU level. The process of establishing the CSP and the new multi-annual planning cycle should allow for an even more effective co-ordination*".

  CSP II explicitly discusses the synergies and complementarities of EC work and that of certain Member States such as Germany and UK DfID. Cooperation 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. The German development programme has also a strong focus on the social sector and on economic reform and market development. This has allowed the EC and German programmes to achieve a fair amount of synergies, notably in the health and trade sector programmes. The other EU donors represented in Bangladesh include the Netherlands, DANIDA/Denmark, SIDA/Sweden, Italy and France. With the exception of France, which has concentrated it's assistance on cultural issues, there has been co-operation in the social sector (health and education) with most of the donors*."

- In ***Mozambique*****,** complementarity with other donors seems to be continuously strong. CSP I: Interaction with other donors, including EU Member States, is intensive and comprehensive, including in the health sector, in the health sector, the EC has recently become a member of the donor core group, which is contributing to the Government's policy discussions on the development of a SWAp; complementarity with other donors' actions has been taken into account for the EU strategy. CSP II: Interaction with other donors, including EU Member States, is intensive and comprehensive, The DPG (Development Partners Group) meets once a month at Heads of Mission level; 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; Participation in Programme Aid Partners: The Union's collective influence on development issues has been enhanced by its collaboration with other non-EU partners in this forum; This harmonisation framework is quite advanced and may be considered one of the best practices.

3.2.2.3.2 Added value of EC compared to other donors

High added value of EC compared to other donors has been highlighted in the case of DRC:

- As for ***DRC***, CSP I: Through a long experience in the health sector of DR Congo (PATS I and PATS II - 1992-2002) the EC has a good knowledge of the sector. This can be perceived as added-value for the implementation of today's health support. CSP II: "*La coopération RDC - CE est néanmoins parvenue à obtenir de bons résultats en matière d'engagement et de déboursement, grâce au choix de partenaires institutionnels pour la mise en œuvre, tels que les agences des Nations unies, et du fait que le contexte a permis, dans certaines conditions, l'utilisation de procédures plus souples*".

In other cases, no added-value from EC interventions has been identified:

- In ***Vietnam****,* MS are very active at the time of drafting the CSP I and many have actions in the field of health. The EC's added value is not apparent, even though it is the second-largest donor. For the CSP II the added value is clearly spelt out and complementarity, or at least coordination with, MS is very prominent.

<u>Active lead of EC in enhancing donor coordination in the health sector</u>

In most cases, EC (intends to) take(s) an active lead in enhancing donor coordination in the health sector in the following countries:

- ***Mozambique*** (CSP I and II): *"As far as the main areas of intervention to achieve impact on poverty reduction are concerned, the EC is the lead donor in terms both of financial and policy input for macroeconomic/budget support"* (CSP I) & *"The European Commission's support in the focal sectors is complementary in areas traditionally covered by EU Member States and other development partners in Mozambique, even where the mere scale of the EDF implies assuming leadership among donors"* (CSP II).
- ***India*** (CSP I): *"EC programmes are designed and implemented in close coordination with EU Member states and the major multilateral donors. The Health sector programme in particular continues to benefit from a high degree of collaboration and joint action"*.
- In the ***Philippines***, CSP I: Donor coordination (overall, not sector specific) is implemented via a round table process and at a more sector-specific level at working group level. CSP II: EC takes a leading role in a well-elaborated coordination mechanism. CSP II: "*Since May 2005 government-led donor coordination has indeed been significantly strengthened in particular in the areas of education, health and the MTF. For education and health, there are to very active PDF sub-working groups, both of which the* ***EC*** *is a member of (and even co-chairs the one on health jointly with the German Development Cooperation). There is a Joint Appraisal Committee also in the health sector. On the MTF, coordination is done at the following levels: PDF working group on Mindanao and Project Steering Committee on the MTF (the EC is in the process of becoming a member). In addition, there is coordination of EC projects (and of other donors) working on the ground with the MTF*".
- In ***Tanzania***, CSP I states that was at the time "*active in a number of sectors that do not form an explicit part of this Response Strategy: agriculture, water & sewerage, tourism and natural resources conservation, HIV/AIDS. Although no new financial allocations are foreseen for these sectors within the framework of this CSP, EC will continue to take an active part in sector policy dialogue to promote sector-wide strategies and programmes, in donor co-ordination and through concrete project investments*". (p.25)

A rare mention of the EC taking the lead in the health sector working group is presented in the Afghanistan CSP II, where the EC co-chairs a consultative group on health but does not mention

which other Member States are involved. *"Since the end of 2002, cooperation between Afghanistan and donor countries has taken place within a Consultative Group (CG) framework. The structure is broken down into 14 consultative groups, 3 working groups and 5 advisory groups. The EC acts as co-chair in 4 CGs: public sector reform, health, rural livelihoods and social protection"*.

3.2.3 Choice of aid delivery methods (approaches, financing modalities and channels) and financial instruments - *related to EQ7*

The next chapter summarises the screening of the 47 CSPs on the following research topics:

- *Discussion on aid delivery methods related to the health sector focusing on approaches, financial modalities and channels*. In relation to this topic, two research questions were asked:
  - Does the CSP discuss different aid delivery methods and explain clearly the choice made for a specific approach/ financing modality/ channel?[58] *(This question relates to Indicator I-711)*
  - Is there evidence that the aid delivery methods used are chosen based on the partner country's need? (*This question relates to Indicator I-712)*
- *Discussion on the coherence between EC financial instruments.* In relation to this topic, one research question was asked:

Does the EC analyse the use of different financial instruments (geographic budget lines (EDF or DCI) and thematic budget lines (SANTE, FOOD, EIDHR, ...))? *(This question relates to Indicator I-732*As approaches, financing modalities and channels are often discussed together, the following chapter often refer to the general terms: 'aid delivery methods' (see also footnote 58).

3.2.3.1 Discussion on aid delivery methods used in the health sector (I-711)

The primary purpose of a strategy paper is to provide overall guidance for the cooperation strategy and not necessarily to discuss in detail the specific implementation modalities to be used. This explains why only a limited number of CSPs are actually discussing the financing modalities and channels to be used in the health sector.

In total, the analysis of the 47 CSPs revealed that 23 CSPs discuss the choice of aid delivery methods while 14 CSPs do not mention at all the financing modalities or channels. The CSPs discussing the choice of aid delivery methods are *Afghanistan, Bangladesh, Barbados, Burkina Faso, El Salvador, Egypt, India, Laos, Mozambique, Philippines, Timor Leste, Vietnam, Zambia*.The level of detail of discussion on and the analysis of different financing modalities and channels varies.

<u>From a project approach to a sector wide approach</u>

The discussion in the CSPs on aid delivery methods is mostly focused on the evolution from a project approach towards a sector wide approach and to a certain extent on the best combination between these two approaches. It is also noteworthy that the CSPs discussing this topic make it clear that the final aim is to deliver aid through sector or general budget support.

- The ***Afghanistan*** CSP II indicates that: "*Sector-wide approaches (e.g. health sector and rural development) and budgetary support will be explored. (..) The government's administrative capacity does not allow wide use of such decentralised implementation mechanisms at the moment. However, it is expected that government capacity will improve in the period covered by the CSP. As government capacity increases, decentralised implementation mechanisms will be phased in."*
- The CSP I of ***Laos*** reflects on the evolution of support modalities in the context of a reduction of EC support to the health sector. Although the main type of support used is the project

[58] The wording in this chapter is based on EC definition and classification of aid modalities: http://ec.europa.eu/europeaid/how/delivering-aid/index_en.htm.

- When referring to financing modalities we mean: 1) project approach, 2) sector approach/SWAP (including SBS, common pooled funds and national trust funds and EC procedures following contracting and procurement rules in the framework of a sector strategy), 3) Macro approaches (GBS and SBS)
- When referring to channels we refer to the contracting party receiving the fund (e.g. government, NGO)
- When referring to aid delivery method this includes both the financing modalities and the channel, as the review of the CSPs shows that they are often linked and discussed together.

Further information and the complete discussion can be found in the inventory of this evaluation.

approach with funds channelled mainly through NGOs (local and international ones), the discussion goes towards a future support via SBS.

- In comparison to other CSPs the CSP II of El Salvador provide a rather detailed discussion[59] of the use of different financial modalities and the need to ground the choice on the country situation, can be found in the CSP II of ***El Salvador***: Where possible, and whenever the necessary conditions are met, consideration will be given to sector programme support and especially sector budget support (p.6); Sector-wide approaches and SBS will be the preferred means of implementation (see p.19,25,30) in the medium to long term, especially in the social integration sector sector policies (notably health and education) (see p.25); A project approach will be considered in relation to regional integration and trade related assistance with technical assistance and training (see p.30) and support for increasing social cohesion will be provided through the country-level strategies, as will also be the case for sectoral initiatives including areas such as education, health, rural development and decentralisation (see p.62).
- Also the CSP II of **Morocco** mentions the shift from project to a sector wide approach funding mainly through SBS: *"In operational terms, programme implementation will move towards support for sectoral approaches where possible, turning away from ad hoc projects that are not in sync with national sectoral policies. This will improve the bilateral dialogue and the visibility of EC cooperation."*
- The same trend can be seen between the CSP I and II of ***India.*** CSP I : *"The early 1990s saw a significant change in the development co-operation portfolio with the introduction of Sector Support programmes (…)The two sector programmes provided an entry point for the EC's engagement with the country's macro policy agenda for two major social sectors. The EC's support to the Reproductive and Child Health (RCH) programme is aimed at helping States to make a "paradigm shift" away from a target-oriented family planning approach to a more holistic health care system for families, focusing in particular on women and children."*

  CSP II: "*In line with the resolutions adopted by the EU Council of Ministers (GAERC, 22/11/04) and with the aim to enhance the effectiveness of EU cooperation in India, a country-specific "*Roadmap*" consisting of a menu of options for actions (coordination of policies, joint-multi-annual programming, complementarity and common framework for aid implementation) will be explored together with the GoI and the EU Member States. This should also open-up further prospects in the shift from stand-alone projects towards a more sector-wide oriented approach of the EU cooperation in India, through identification of complementary actions.*"
- The **Zambian** NIP I of the CSP II discusses the pro and cons of different financing modality per sector. For the health sector the detailed financing modalities will be re-discussed according to the results of the programme identification process:

  "*A three-year initial direct sector support programme, followed by a subsequent two-year programme. Following the assessment provided by the identification process, the use of sector budget support modalities will be considered. In this case, the programmes will be labelled to support specific policy measures as per national planning priorities. This labelling, in combination with the existence of separate legal financing agreements, will empower the line Ministry in the resource allocation dialogue with the Ministry of Finance and National Planning, and ensure some degree of additionality. Alternatively, direct sector support to health could be in the form of support to the Health Basket managed by the line Ministry, on-budget through inclusion of the committed resources into the government budget and MTEF and through inclusion into Government budget execution reports. A nutrition programme targeting the most vulnerable (especially OVCs in schools), seeking to address root causes of HIV/AIDS, might be developed through an EDF project that will build decentralised implementation modalities within existing public service delivery systems and in collaboration with local authorities.*
- **Egypt** CSP I and CSP II allude to the complementary actions to make proper use of the modalities (such as TA, capacity building of NGOs, national bodies management capacity for trust funds, etc). The multi-donor basket funding mechanism for the Social Fund is yet a different approach. The EU is the major donor (and led the mid term evaluation) but the Social Fund itself has been almost entirely responsible for planning and executing its activities.

[59] This implies that aid modalities are discussed in a separate chapter and different aid delivery methods are compared to each other.

Common pooled funds to the health sector as a specific form of financing a sector approach

A few CSPs include in their discussion on aid delivery methods the funding through pooled funds, which are in most cases national trust funds. These trust funds can be health related, in some instances (Afghanistan and Timor Leste) they are general trust funds aiming at the reconstruction of the country and thus covering a whole range of sector, including the health sector.

- A clear statement in favour of using a trust fund in ***Timor Leste*** is made in the CSP I: "*The Commission has followed a clear-cut strategy of financing the Trust Funds established to assist the UN missions and the multi-donor Trust Fund managed by the World Bank (TFET). This has facilitated implementation and coordination, and avoided fragmentation of aid whilst providing support for a new and weak administration, Programming jointly with other donors also ensures complementarity of aid (a total of 5 Member States and 5 international donors co-financed the TFET). The main reasons for the EC's participation in TFET were (i) better donor coordination; (ii) higher efficiency resulting from the use of uniform procedures (particularly in financial matters such as procurement and disbursement) and the elimination of the administrative burden to have a large ground capacity in Timor-Leste; and (iii) to have a voice in the mechanism in which most donors participate. The Commission continues to believe that our assistance is best provided in coordination with other donors and if possible through pooling mechanisms such as the TFET."*
- The close link between a successful sector approach and coordinated aid delivery of donors is reflected in the CSP II of ***Barbados***: *"The EC will support the Government's Health, Nutrition and Population Sector Programme through contributions to a World Bank administered pool-fund, and through funding of projects on issues, where innovative strategies need to be developed. Using the pool funding and project approaches, the EC support to the health sector programme aims at attaining three specific objectives: Strengthening the Public Health Sector Management and Stewardship Capacity; Health Sector diversification, through development of new delivery channels for publicly and non-publicly financed services; Stimulating demand for essential services*."
- The difficulties that can arise while channelling EC funds through national trust funds led by other donors are outlined in the ***Bangladesh*** CSP II. Furthermore, the discussion on the CSP is a good example how external factors such as the donor landscape, impacts on the mix of EC financing modalities :

  While the CSP I still states: *"Co-financing, and in particular pool funding, should remain a major focus of EC cooperation in Bangladesh",* the picture in the CSP II is more differentiated, reflecting the previous experiences: "*EC joined the HPSP SWAp consortium in 1998, with a contribution of EUR 70m to a 2.9bUSD sector programme. This ended in 2003 (other donors continued funding until 2004) but because of the host country's inability to meet the EC condition to integrate the health and family planning cadres of the Health/Family Welfare Ministry, tested under the TFIPP, EC disbursed only 50%. Under the successor HNPSP, 2004 – 2010, EC will contribute EUR 108 million to a 4.3 billion USD sector budget. In addition to government implemented sector wide programme, EC's contribution aim to focus on the areas of particular challenges like, maternal and child health and Chittagong Hill Tracts (CHT) areas. Therefore, characterized by programme and project approach, larger proportion of EC contribution aims to spend on World Bank lead pool fund and the rest is on projects with particular challenges."*

The health sector as precursor of the use of SWAps in other sectors

While most of the CSPs discuss aid delivery methods on a strategic level with only little detail on the sectors, it appears in some CSPs that the health sector (along with the education sector) is often the sector spearheading SWAps and - in a next step - preparing a sector budget support.

- ***Bangladesh*** CSP I : *"The programme approach as opposed to the project approach has not yet gained a foothold with the exception of the Health and Population Sector Programme (HPSP). (..) Bangladesh is currently piloting a large sector wide programme in the health and population sector (HPSP). Provided the initial good results can be continued, the programme will serve as a model for other potential intervention sectors. The position of both government and the administration towards SWAps, however, has at best been hesitant, if not openly critical. It will therefore require a long preparation process to successfully extend the current pilot to other sectors, including the provision of appropriate technical assistance to develop government policy and planning in this regard. While the EC realises that sector wide interventions must not be donor imposed, and cannot be adopted in every intervention sector immediately, the EC's Country Strategy 2002 – 2006 for Bangladesh still emphasises that for*

certain core development co-operation sectors, such as the education sector, a turn to the sector wide approach and its full acceptance will be a necessary prerequisite for major EC assistance to the government owned projects and programmes."

- ***Zambia CSP I*** "*The health sector is in the lead in Zambia with regard to decentralisation and adoption of a SWAp."*

Discussion on aid delivery methods: General budget support

- **Mozambique's** CSP I assumes that general budget support is the preferred option. It must be noted that GBS finances indirectly the health sector in Mozambique and is thus relevant for the current analysis: "*As the objectives and results expected of PARPA* [=Mozambique's PRS] *in the medium term are particularly ambitious, in terms both of budgetary management and poverty alleviation, their implementation will require an unfailing commitment to financial regulation and management, and to the social services, particularly in rural areas. More concretely, budgetary support as a way of financing the fight against poverty implies making the accompanying structures in the technical ministries more functional, in terms of technical and financial aspects and the production of regular and reliable statistics on the different sectors."*

  The CSP II of **Mozambique** is in the same line than the CSP I but provides a little bit more detailed analysis on the choice of the financing modality. *"The variable tranche mechanism used in EDF budget support programmes is a way to focus the dialogue on results in predetermined areas based on Government-defined indicators and targets, while preserving predictability. Focusing on outcome indicators and targets in health and education has provided a means of addressing the performance of social sectors in the macro-level policy dialogue".*

- From the ***Burkina Faso*** CSP it is made clear that the choice of the EC in Burkina Faso is to deliver the aid through GBS and that this choice is still supported. The continuity of discussion between CSP I and CSP II can in this example clearly be seen. Furthermore the aid delivery question is discussed together with the cooperation of donors. Not only the EU but also some MS have more and more changed from project approach to a macro approach through GBS, as illustrated in both CSPs.
  - CSP I : *« Les bailleurs de fonds ayant validé cette stratégie, il convient de l'appuyer par une aide budgétaire qui soutienne la lutte contre la pauvreté dans un contexte de réforme. »*
  - CSP II : *"[La matrice des bailleurs de fonds] illustre bien le passage de l'aide projet vers l'appui budgétaire général, sur lequel se sont engagés différents bailleurs l'Allemagne, le Danemark, les Pays-Bas, la France, la Suisse, la Suède, la BM, la CE et la BAD." (..) Les appuis budgétaires soutiennent la mise en œuvre des priorités du CSLP dans leur ensemble. »*

- In ***Tanzania,*** GBS is seen as the preferred aid modality this in particular the health sector in the CSP I as well as CSP II. Even though evidences on the health sector can be found, it must be noted that the EC, in the framework of the division of labour policy, withdraw completely from the health sector in Tanzania and is today a delegating partner.

  CSP I: "*Tanzania's bilateral donors, primarily EC Member States, critically reviewed the PRSP prior to its adoption by the IMF/World Bank in December 2000. The donors recognised the participatory process and local ownership of the paper, as well as its links with ongoing poverty eradication actions. (…) and they welcomed the idea of triggering external budget support resources for priority sectors identified under PRSP."*

  CSP II: *"The Government has clearly stated its preference for general budget support. (…) GBS will also help realize key development targets for public service delivery including health, water, transport and education. Regular policy dialogue in these areas will be conducted through the GBS review process and the Public Expenditure Reviews (PERs) with a view to improving the quality of public expenditures and increasing the focus on outcomes of GBS programmes. In this way, emphasis on dialogue based on indicators should reinforce the link between policy, budgeting and monitoring and evaluation of outcomes."* The CSP II quotes paragraphs from the JAST which discusses the challenges of GBS specifically for the health sector: "T*he capacity of general budget support to impact on the quality of social services delivery will largely depend on the improvement of the policy dialogue at the sector level."*

The analysis of aid delivery methods discussion in the 24 countries reviewed reveals that the final decision of the mix of financing modalities is not to be taken at the time of the CSP drafting but at a later (programming) stage in order to be able to respond to the realities of the country.

- **Timor Leste** CSP II: *"The implementation modality - project support, co-financing or sector budget support - will be decided in light of coordination with other donors and assessment of needs and management capacities." The indicative programme does not provide for general budget support. "However, in the light of changing needs, it may be decided to reallocate funds from other implementation modalities in the NIP to this type of support."*
- ***Moldova*** CSP II promotes 'components with inbuilt flexibility'. *"While detailed implementation mechanisms will be worked out action by action, support for Sector or multi-Sector Programmes, including the use of pool funding and/or budget support, is encouraged wherever the necessary conditions are met".*

3.2.3.2 Aid modalities chosen on the basis of country needs (I-712)

A first observation is that the 47 CSPs reviewed for the two periods shows a lack of detailed analysis of the health sector including a description of the key issues in the sector and the various actors involved. In particular concerning aid delivery methods, 18 CSPs have no information whether the aid delivery method is chosen on basis of country needs while 26 CSPs discuss or mention them in relation to country needs.

While in most of the CSPs it is made clear that the EC strategy is based on a needs assessment and situation analysis of the country only few CSPs contain information whether the EC has chosen the financing modalities and the channels in the health sector according to the needs of the country.

The following quotations give an overview on the aims that inflect the choice for one or another aid delivery method. They are in short: to build on previous experience and achieving concentration, to achieve a more strategic and focused approach, to reduce administrative burden both on EUD and Government and to take into cognisance the limited national capacities.

- ***Afghanistan*** CSP II: "*The programmes will be implemented via mechanisms that empower the democratically elected government as far as possible. Sector-wide approaches (e.g. health sector and rural development) and budgetary support will be explored. The government's administrative capacity does not allow wide use of such decentralised implementation mechanisms at the moment. However, it is expected that government capacity will improve in the period covered by the CSP. As government capacity increases, decentralised implementation mechanisms will be phased in."*
- ***Myanmar*** CSP II: "*So far, EC interventions in the country were based on ad hoc assessments and financed from a variety of budget lines. In order to ensure a strategic and focused approach and to increase effectiveness of assistance provided to the population, the Commission will implement future interventions on the basis of this first EC-Burma/Myanmar Country Strategy Paper. Based on an in-depth needs assessment, assistance for the period 2007-2013 concentrates on two focal sectors: education and health. Flanking actions in support of sustainable livelihoods and uprooted populations will be financed from relevant thematic programmes*."
- The CSP II of ***Laos*** states to following reasons for the move towards a sectoral approach: "*The main lesson learned from past EC cooperation is that although the great majority of projects have been successful and have had a positive impact on the direct beneficiaries, their long-term structural impact on the country's economic and social development has been limited. Moreover, a large number of relatively small projects represents a disproportionately heavy administrative burden both on the Delegation and on the Government*"
- The same argumentation tackling the administrative burden induced by the management of small projects can be found in the CSP II of **Moldova**: "*If too many small, stand-alone measures were to be taken, this would result in administrative overload and delay implementation in general. Instead, programmes should contain a limited number of components with inbuilt flexibility. While detailed implementation mechanisms will be worked out action by action, support for Sector or multi-Sector Programmes, including the use of pool funding and/or budget support, is encouraged wherever the necessary conditions are met."*
- ***DRC*****,** CSP II : *« L'enveloppe B, d'un montant de 104 millions d'euros, a été essentiellement consacrée a la réhabilitation des infrastructures sociales et a la réintégrations des populations dans l'est du pays (Nord et Sud Kivu, Orientale, Katanga). (..) Le fait de disposer de cette enveloppe régie par des procédures plus souples que le reste des ressources du FED a permis à la Commission de commencer un processus de transition après urgence dans un*

délai adapte. Vu la situation d'instabilité dans laquelle se trouvent encore plusieurs régions du pays, il apparait fonde d'envisager la poursuite de ce type d'intervention adaptée aux situations d'après-conflit. Un nouveau programme de type après-conflit/LRRD de 75 millions d'euros est dans sa phase de mise en œuvre, dont environ 7 % (5 millions d'euros) sera geré par ECHO. Les principaux volets de ce programme sont: les infrastructures, ***la santé****, le renforcement des capacités, l'aménagement du territoire, la relance économique et la réponse aux situations d'urgence humanitaire qui persistent a l'est de la RDC. »*

- A single example of the financing modality discussion involving GBS can be found in the CSP II of ***Tanzania***. There, it is explained why GBS will be the preferred modality especially for the health sector and how many different external funds can lead to distortion in the sector.

  "The lack of resources during the first quarter of each fiscal year [in the health sector], the time required to process simple payments approved in the budget and the remaining challenges in procuring large consultancy contracts through government create disincentives to shift to [general] budget support, and creates incentives for DPs and the MOHSW to maintain special project accounts in order to protect delivery of critical health services. A critical challenge is the persistence of large, earmarked external funds (specifically for AIDS and malaria), which distort health sector spending and crowd out discretionary funding for health."

<u>Lack of capacity of the partner government can delay the introduction Sector Budget Support</u>

A recurrent discussion point in the CSPs is the capacity of governments to manage the sector budget support to the health sector or the constitution of a sector approach together with the partner government.

- The CSPs of ***Barbados*** give a good picture on the evolution of the discussion between CSP I and 2. CSP I states: "*In view of the funds available, we see an opportunity for the EC in participating with PAHO (Pan American Health Organization) to take a leading role in developing this sector wide approach. The strategic plan for health currently being developed will presently constitute a platform on the basis of which budget support can be channelled to the health system, because the overall quality of the management of public finance is satisfactory and transparent"*.

  The CSP II gives a little less optimistic summary of the evolution since the last CSP writing: *"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 problem is common to all donors (..). It results from a number of factors, including weak institutional capacity, aid governance problems and a lack of political will for reforms. 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, when, following the 2001 elections, the in-coming government back-tracked on reforms previously agreed"*
- The CSP I of ***Bangladesh*** discuss the hesitance of the partner government to go towards a SBS. There, the need of a thorough preparation (e.g. via TAs and other capacity building measures) of the Government of Bangladesh is needed: *"The position of both government and the administration towards SWAps, however, has at best been hesitant, if not openly critical. It will therefore require a long preparation process to successfully extend the current pilot to other sectors, including the provision of appropriate technical assistance to develop government policy and planning in this regard. While the EC realises that sector wide interventions must not be donor imposed, and cannot be adopted in every intervention sector immediately, the EC's Country Strategy 2002 – 2006 for Bangladesh still emphasises that for certain core development co-operation sectors, such as the education sector, a turn to the sector wide approach and its full acceptance will be a necessary prerequisite for major EC assistance to the government owned projects and programmes."*
- ***Afghanistan*****,** CSP II: *"The government's administrative capacity does not allow wide use of such decentralised implementation mechanisms at the moment. However, it is expected that government capacity will improve in the period covered by the CSP. As government capacity increases, decentralised implementation mechanisms will be phased in. (..) Sector-wide approaches (e.g. health sector and rural development) and budgetary support will be explored."*

  Philippines CSP II*: "Building upon and further consolidating this (sector) programme, an additional sector health programme will follow up and deepen the current one. Support for health through sector-wide approaches is relevant, as it enhances ownership, impact and sustainability, works at local and provincial level and reduces transaction costs. The DOH has been making substantial progress with the preparation of the Sector Development Approach*

for Health – SDAH. It aims to mainstream cross-cutting issues not explicitly addressed before, such as internal DOH management, public finance management and procurement, which are critical to the effective development of a SWAp and ongoing national health policy revision. These developments are conducive to a more cohesive and successful implementation of the HSRA and to a fully fledged SWAp. (…) EC support will take the form of a contribution to the Government-led Philippine Health Sector Programme. Indicators will include traditional health-related MDGs, indicators related to HSRA and PFM-related indicators; indicators will not only be gender sensitive but also sensitive to ethnicity. Consideration will also be given to maximizing synergies between EC support for health and support for the delivery of other social services, including education as well as extension of social protection coverage where possible.

3.2.3.3 Coherence between EC financing instruments – geographical and thematic budget lines (I-732)

Out of the 47 CSPs analysed, 13 CSPs provide information on the internal coherence of EC instruments, meaning between geographical and thematic budget lines, or in some limited cases other EC intervention and policies or other EC bodies (e.g. ECHO).

Overall, the analysis insofar thematic programmes add distinctive added value to geographic programmes is much improved for the second set of CSPs – eight out of the 12 CSPs are from the second set. In many instances a good overview and rationale is presented.

<u>At a strategic level complementarity of geographical and thematic budget lines is sought</u>

Especially the second round of CSPs discusses the use and complementarity of different financial instruments. But most of them stay on a rather general level, discussing neither the need of a good mix without going in details in specific sectors nor highlighting specific interventions which would be particularly fitting in the geographical strategy. Some examples:

- The CSP I of ***Bangladesh*** clearly states the general objectives to elaborate a country strategy that is based on the added value of a mix of modalities*:*

  "The EU/EC co-operation objectives and parameters which have been considered for defining the present EC co-operation strategy with Bangladesh (is) based on (…) the co-ordinated and complementary use of the EC funding mechanisms (budget lines) in order to target, in a more comprehensive way, the multi-faceted dimension of development, i.e. (humanitarian aid, rehabilitation, development, food aid, economic and trade co-operation, refugees etc)."

- The same statement can be made for the CSP II of ***Barbados*** where complementarity with the different thematic budget line is outlined, but not specifically detailed for the health sector. Furthermore the analysis of the respective purposes and complementarities to the EDF Envelopes is well presented

  "*Specific activities may be supported through the various Community budget lines, including, inter alia, NGO co-financing, decentralized cooperation, European Initiative for Democracy and Human Rights, food security and disaster prevention.. Approval of proposals and implementation of support measures under the available budget lines will be decided in accordance with the procedures in place for each respective financing instrument. They will also be subject to availability of funds and on the continuing existence of the different funding mechanisms in the period covered by this paper*".

- Also ***Vietnam*** uses the CSP I to outline the different possibilities of added value of different EC financial instruments. It is made clear that at this strategic programming stage no details about potential complementary actions is given.

- ***India***, CSP I: *"The EC has also implemented projects through a number of special budget lines, such as food aid, emergency aid, disaster preparedness, drugs, HIV/AIDS, human rights and decentralised co-operation. The co-operation strategy outlined in this paper builds on the lessons drawn from two decades of cooperation with India and carries it forward into a new phase that takes due account of the changing economic and political environment prevailing inside and outside India. The paper elaborates on the key perspective outlined in the Commissions' Communication on "an EU India Enhanced Partnership"*

The exception is the CSP II of ***Yemen***, which makes clear that a priori strategising is neither done nor sought:

- *"Yemen will also receive assistance for other projects under various special budget lines (NGO co-financing, humanitarian assistance, rehabilitation actions, human rights, etc.). These actions are not subject to programming, but are allocated to a country on ad hoc basis."*

Detailed references to thematic budget lines like "Santé", "Investing in people" and "NGO-co-financing"

Although references to the health sector are limited, some CSPs detail rather well the interaction of geographical and thematic budget lines. In short, it can be seen that the most used thematic budget lines to complement the health sector are the "Investing in people programme" and its predecessor the "human and social budget line", the santé budget line and the different NGO co-financing budget lines (*India, Bangladesh, DRC*). In some cases the research collaboration between developing countries and the Framework Programme for research is highlighted (*Moldova, Morocco, DRC*).

- The CSP II of ***Afghanistan*** is a little bit more concrete in actually describing the thematic budget lines (here "Investing in people) which will complement the geographical funding:

  "In the context of cooperation with Afghanistan, along with the interventions provided for in this CSP, the Commission could pursue actions under the following thematic programmes: Investing in people. *This programme could be accessed to build on interventions under the basic health programme of the CSP, in particular in confronting the major communicable diseases such as HIV/AIDS. Moreover, the programme could be used to extend the vocational and tertiary education elements of the CSP, highlighted for example in the social protection programme."*

- The discussion on the complementarity of geographical BL with the NGO-co-financing budget line can also be found in the CSP I of ***India***, although not specifically targeted on the health sector: *"The The EC's NGO co-financing budget continues as a useful instrument to promote civil society actions in a range of sectors. The EC has financed a large number of projects through this budget line and there are about 150 NGO projects currently under implementation in different parts of the country"*

- CSP I ***DRC****: « Entre 1993 et 2002, la ligne budgétaire cofinancement ONGs a alloué 21,8 ME a la ROC. Actuellement,* ***16 projets*** *sont en cours concernant* ***essentiellement le secteur de la sante*** *et le capacity building. ».*

  The CSP II of ***DRC*** is even more explicit on the complementarity with the NGO co-financing budget line: *«Les différents lignes du budget ('aide et sécurité alimentaire', 'cofinancement des ONG', 'initiative européenne pour la démocratie et les droits de 'Homme, EIDHR', 'mines anti-personnelles', 'coopération décentralisée', 'VIH-SIDA' et 'migration' ont permis à la Commission de financer à hauteur de quelque 30 millions d'euros par an au total plusieurs actions ponctuelles (micro et macro - projets) à travers le pays et dans des secteurs aussi varies » (dont la santé). Ces divers instruments présentent l'avantage de permettre à la coopération RDC - CE de travailler plus directement avec la société civile et les ONG pour des initiatives qui peuvent compléter utilement les appuis."*

  The **DRC** is also the only CSP mentioning complementary EC funding of the SANTE budget line directed to the GFATM in its CSP II: *« Enfin, plusieurs initiatives complémentaires sont venues appuyer les programmes finances par Ie FED, dont les lignes budgétaires ou thématiques ou les financements du Fonds mondial de lutte contre Ie SIDA, la tuberculose et la malaria). »*

- ***Lao,*** CSP I : *« Further support to the health sector will be considered within the established areas where the EC already supports projects, namely Malaria control, Sexually Transmitted Diseases and Reproductive Health – all terminating in 2002. (…) Health initiatives implemented by European NGOs will continue to be financed by the appropriate budget lines."*

Only the CSP II of *Zambia and Tanzania* mention one of the problems that occur with thematic budget lines, which is still centrally (Brussels-) managing a lot of these budget lines:

- ***Zambia***, CSP II: *"After devolution, the current budget lines project portfolio managed by the Delegation comprises 14 NGO projects for a total amount of EUR 10 million in the following sectors: Food aid/Food Security, Water supply and Sanitation, Basic Health, Social Services and Rural Development. As much as possible, these projects are coordinated with 9th EDF activities in the respective areas. But it has to be emphasised that only the follow-up of the funded projects has been devolved. The selection is still centralised in EuropeAid Brussels, except for the NGO component of the Food Aid and Food Security budget lines."*

- ***Tanzania,*** CSP II: *"In the second semester of 2006 the Delegation was managing 29 contracts amounting to a total of € 3 million. Budget-line projects have been better aligned with Government priorities and are in closer contact with local government authorities contributing to district planning and budgeting. Nevertheless, budget-line/project alignment remains a challenge in the context of JAS and the division of labour agreed between development partners and government."*

As like funding of thematic budget lines, also other EC funds, here the EC contribution to the GFATM, the alignment and coordination with other EC funds and national strategies and policies remain challenging: *"The Global Fund for AIDS, Tuberculosis and Malaria is also supported by the European Commission which contributed € 432.5 million to the initiative. At country level, Tanzania has been successful in three out of six rounds of proposals where a total amount of approximately € 115 million has been disbursed supporting Malaria, TB and HIV/AIDS interventions. A challenge remains in integrating Global Fund support into national systems aiming at overall health systems strengthening, although a lack of qualified health staff in particular in rural areas continues to be a key restraint."*

Research collaboration in the health sector

- Due to its geographical location, ***Moldova*** can participate in the EU's Framework Programme activities, in particular INCO-Copernicus, as well as in INTAS projects in which health components are found. " *With regard to the European Research Area and the new Framework Programme, the objective for the Newly Independent States (NIS) will be twofold: stabilise their research potential and tackle problems of mutual interest where research can provide appropriate solutions and responses (i.e. non-proliferation, health and environmental safety related to industrial changes)*"
- CSP I ***DRC****:* « *Enfin, des opportunités de financement seront offertes au niveau du 6eme programme-cadre de recherche et développèrent pour des actions de mobilité de scientifiques et des projets de collaboration scientifique Nord-Sud en vue de la réintégration des scientifiques congolais dans des programmes avances ciblant les besoins urgents de ce pays en* ***matière de sante et de sécurité alimentaire*** *ainsi que de gestion de l'eau. Ces activités compléteront les actions prévues dans le domaine de la sante dans le présent document de stratégique*. »

Complementarity with financing instruments under the neighbourhood policy

The countries benefiting from the neighbourhood policy (in our sample: Moldova, Morocco, Syria and Egypt) benefit from specific funding instruments (e.g. TAIEX) that are also tackling health issues. This is for example the case in Moldova which benefits from specific assistance (mostly workshops and punctual technical assistance) to reform its procurement system for medicines.

- Furthermore ***Moldova*** benefits from the TACIS and TAIEX assistance in the framework of the neighbourhood facilities: "Tacis will provide assistance in order to organise the system of procurement of medicines in the most cost-effective manner and will support other administrative reform in the health sector as necessary" (CSP I). 'Further it is stated in the CSP I:

  "*Interaction between the Food Security Programme and Tacis is essential to obtain the expected results. In view of the ongoing very difficult financial and social situation of the country the EU considers Food Security Programs such as outlined above as an efficient instrument to contribute to poverty reduction*"
- Also ***Morocco*** can benefit from the various thematic instruments, including the neighbourhood facilties. While most of the funds go to the education sector (especially TEMPUS), some TAIEX activities financed under TAIEX or the 'Investing in people programme' might be targeted to the health sector. This is nevertheless not made explicit in the CSP II.

Interaction with ECHO interventions

Even though the ECHO interventions are not part of this evaluation, it can be noticed that the CSPs highlights in the relevant countries the interaction with ECHO funds. This interaction is especially important in the transition phase from ECHO to general EC funding. A particular detailed example is DRC where the shift between EC funds to ECHO funds and back is well explained and the need for a close coordination is highlighted.

- ***DRC*****,** CSP I: *"L'aide humanitaire et l'exercice de LRRD en RDC. Le pays reste l'un des principaux bénéficiaires de ECHO, qui lui a alloue 38 ME en 2002 et prévoit 35 ME en 2003 sur la base d'une stratégique orientée a soutenir, surtout dans les zones hors contrôle du gouvernement de Kinshasa,* ***prioritairement la fourniture des soins de sante de base****, la sécurité alimentaire et la nutrition. La répartition entre les actions humanitaire et celles humanitaires-plus/réhabilitation a été clairement définie selon la classification des zones faite par ECHO en terme de différents degrés d'urgence (..). Le premier passage des consignes a eu lieu lors du premier semestre 2002 par la reprise d'un ambitieux programme de réhabilitation/réinstallation entrepris par ECHO dans la région du Masisi. Un deuxième*

*transfert de dossiers s'est effectue dans le domaine de la **sante ou la coopération communautaire a progressivement pris la relève de l'aide humanitaire sur différents instruments financiers pour environ 31 zones de sante dans le Nord Kivu et dans la Province Orientale**. (..) Le volet appui aux zones de sante : L'attention sera variable en fonction des priorités identifiées sur base régionale et locale. En effet, elle se fera en priorité au niveau des centres de sante et consistera en la mise en couvre d'un paquet minimal d'activités, et, lorsque les conditions le justifient, au niveau des hôpitaux de référence, par exemple pour les activités de sécurisation de la transfusion sanguine et dans la chirurgie de première urgence, notamment obstétrique, La répartition géographique se fera prioritairement dans les zones qu'ECHO classifie comme vertes et jaunes et dans la mesure du possible dans les zones bleues et rouges en étroite collaboration avec ECHO et lorsque les conditions de sécurité et d'accessibilité le permettront. »*

Shift between geographical budget lines

An interesting, but singular event is the shift between different geographical instruments. This is the case of ***Timor Leste*** which shifted from the ALA funding to an EDF funding in 2005 by ratifying the ACP-EC Partnership Cotonou Agreement on 19 December 2005. This means benefiting from an amount of € 18 million for the two years remaining under the 9th EDF. The new resources had been committed within the framework of the present Country Strategy Paper and Indicative Programme upon the entry into force of the 10th EDF multi-annual financial framework for the period 2008-2013. The eligibility to funds of the Pacific RIP had nevertheless only been possible under the 10th EDF. The same is applicable for the specific funds allocated to the ACP group of countries using Portuguese as official language (PALOP).

- ***Timor Leste*****,** CSP I: *"On 16 May 2003, the EU Council of Ministers approved the accession of Timor-Leste to the ACP-EC Partnership Agreement, the Cotonou Agreement. Timor-Leste duly ratified that Agreement on 19 December 2005. An amount of € 18 million has been allocated to Timor Leste for the two years remaining under the 9th European Development Fund (EDF). Timor Leste will also be included in the programming previsions for the 10th EDF. Hitherto, Timor Leste has been receiving development assistance provided under the Council Regulation 443/92 (Asia-Latin America Regulation) This present strategy paper has been designed to provide a framework for a two-year bridge (2006-2007) out of the 9th EDF to cover Timor-Leste's transition from Asia-Latin America budget line to cooperation assistance under the 10th EDF. As such, there is a good deal of continuity in the approach of this strategy and the previous strategy under the Asia-Latin America budget line. The framework is based on EU-ACP co-operation objectives (notably the reduction of poverty and integration of developing countries into the world economy), the Government of Timor-Leste's (GoTL) own development policies, an analysis of the political, social and economic situation in the country, and an assessment of past co-operation programmes with the EC and other donors.*

Quality judgment on the mix of financial instruments used

Eventually, the CSPs are confined on describing the future or existing interaction between the different EC financial instruments. It is thus worth mentioning the CSP II of ***DRC*** in which a quality judgment of the interaction between the different financial instruments can be found:

- ***DRC***, CSP II : *« Dans les secteurs où les différents instruments mis à la disposition de l'Union européenne dans son ensemble ont été réellement coordonnes et utilisés de manière créative, voire harmonises, on a pu observer une différence en matière d'efficacité et d'impact. Cela est particulièrement vrai dans le domaine sécuritaire (police et armée) mais aussi dans celui de l' assainissement par exemple. »*
- ***DRC***, CSP II : *« Les différents lignes du budget (..) ont permis à la Commission de financer à hauteur de quelque 30 millions d'euros par an au total plusieurs actions ponctuelles (micro et macro - projets) à travers le pays et dans des secteurs aussi varies » (dont la santé). Ces divers instruments présentent l'avantage de permettre à la coopération RDC - CE de travailler plus directement avec la société civile et les ONG pour des initiatives qui peuvent compléter utilement les appuis. »*