

***Thematic evaluation of
the European Commission support
to the health sector***

Final Report
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This report has been prepared by Particip GmbH. The opinions
expressed in this document represent the views of the authors, which
are not necessarily shared by the European Commission or by the
authorities of the countries concerned

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Thematic evaluation of the European Commission support to the health sector

Final Report

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Volume II: Annexes

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AFGHANISTAN

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1.1 Introduction

1.1.1 Country context of EC support

While on-going efforts are contributing to some progress in improving health status, the overall health situation remains very grim in Afghanistan. The under-five mortality rate was 172 per thousand and the infant mortality rate was 115,000 in 2006. These indicators have significantly decreased but remain the highest in Asia. The maternal mortality ratio, estimated at 1,600 per 100,000 live births is also very high and reflects the low status of women, poor infrastructure, and a barely functioning maternal health care system. The rate of chronic malnutrition (moderate and severe stunting) remains around 50% reflecting a combination of poor caring practices, micronutrient deficiency and chronic food insecurity. Most of the burden of disease results from infectious causes, particularly among children where diarrhoea, acute respiratory infections and vaccine preventable illnesses account for 60% of deaths. Among adults, tuberculosis accounts for an estimated 15,000 deaths per year with 70% of detected cases being women. Most of the Afghan population does not have access to even basic health services. For example, routine immunization coverage (DPT3) was estimated to be only 54% and 66% in 2003 and 2004 respectively and even this may overstate the reality. 40% of existing health facilities do not have female staff, which means that women are very unlikely to access those facilities. More than 80% of existing services were provided by NGOs.¹

Although largely city-, hospital- and doctor-based, prior to the war that started with the Soviet invasion in 1979 Afghanistan's health system was relatively well developed. However, the protracted war from 1979 to 2001 not only caused serious dilapidation of most health care that used to be available but also caused the country to miss out on the 1978 Alma Ata Declaration inspired primary health care (PHC) movement in bringing primary care services to more peripheral, mostly rural populations. Nevertheless, some PHC services were introduced during this period through NGOs who operated from Pakistan across the border. The war itself, the collapse of health services, the virtual lack of any central health policy making and war-induced increased poverty resulted in Afghanistan having one of the poorest arrays of health indicators in the world by 2001.

At the time the Taliban regime was ousted at the end of 2001, the EC had already a longstanding presence in the health sector in Afghanistan through its support to a range of NGOs operating cross-border health programmes. Also the EC itself, under the DG Relex budget line programme for uprooted people, operated from Peshawar, Pakistan. The health programmes were of a LRRD-like nature, scattered over much of Eastern and Southern Afghanistan.

The January 2002 "Afghanistan Recovery and Reconstruction Conference" in Tokyo, of which the EC was one of the co-chairs, concluded with massive pledges from the international community to rebuild Afghanistan, including a pledge from the EC of EUR 1 billion for the following five years. The EC then decided to target its aid to three sectors: Rural Development, Public Sector Reform and Health.

Initiated by the World Bank and soon adopted by the Afghan Ministry of Health (MoH), the core of the country's new health policy became the roll out of a Basic Package of Health Services (BPHS) to all Afghans, mainly through a contracting-out approach to not-for-profit non-state providers, i.e. national and international NGOs. The three main donors for health, World Bank, USAID and EC, aligned behind this policy, divided the country by each supporting a number of Provinces, and started to contract NGOs to deliver the BPHS, whereby each donor used its own institutional arrangements. For instance, while all NGOs implement health services on behalf of the government according to government policies and are monitored by the government, the actual contracts and flows of money to the NGOs differ between donors. The EC continues to pay the NGOs directly, while the money from the World Bank flows through the Ministries of Finance and Health.

¹ Regional Health Systems Observatory - EMRO, Health Systems Profile Afghanistan, 2006, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Afghanistan/Full%20Profile.pdf>.

Figure 1: Seven Elements of the BPHS

Box 1. Seven Elements of BPHS
1. Maternal and newborn health (ANC, PNC, delivery, family planning, care of the new born)
2. Child health and immunization (EPI and IMCI)
3. Public nutrition (prevention, assessment and treatment of malnutrition)
4. Communicable disease treatment and control (TB, malaria, and HIV/AIDS)
5. Mental health (education, awareness, case detection, identification and treatment of mental illness)
6. Disability services (awareness, prevention, education, assessment and referral)
7. Regular supply of essential drugs
ANC, antenatal care ; EPI, expanded program for immunization; IMCI, integrated management of childhood illness; PNC, postnatal care; TB, tuberculosis.

Source: *PloS Medicine*,

<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001066>

The BPHS for Afghanistan consists of a package of well-proven, low-cost health interventions addressing key health issues, like maternal and newborn health, child health, major communicable diseases (HIV/AIDS, TB, Malaria) and malnutrition. The interventions can be delivered through a network of health facilities, i.e. health posts, basic health centres and first-referral hospitals. Mental health and disability were later added to the package. In 2005, a complementary package for hospitals was developed, the EPHS (Essential Package of Hospital Services).

The EC used a two-pronged approach in its support to the health sector, with direct support to service delivery and strengthening the stewardship role of the health system at central and provincial level.

The service delivery component consists of funding NGOs to deliver the BPHS, from 2002 onwards till today, in ten provinces, to almost 5 million people (about 20% of the total population). The provinces covered by the EC are those that received aid prior to 2002, supplemented by some areas where activities are a follow-up to ECHO projects. Although initial bidding rounds allowed bids for entities smaller than provinces, the tendency over the years has been to contract a single provider covering a full province. In a couple of years all provinces (and most areas within those provinces) became covered by contracts from either the EC, World Bank or USAID, a situation still in place by 2011. Service delivery is contracted out to the NGOs, on behalf of the government, which gives the NGOs full responsibility and authority, including hiring and firing health staff, to deliver the BPHS.

The EC provides BPHS and, from 2005, also EPHS activities in ten out of Afghanistan's 34 provinces. These ten provinces are Kunduz, Nooristan, Kunar, Laghman, Nangarhar, Logar, Zabul, Ghor, Uruzgan, and Daikundi. Outside the major BPHS component, some other activities were supported, mainly in the field of disability, mental health and nutrition.

The component to strengthen MoH's stewardship role materialised through the provision of TA through local and international experts. Over time, and ongoing, the EC has been supporting a range of departments/directorates (Mental Health Unit, Disability Unit, Public Nutrition Department, Grant and Contract Management Unit (GCMU), Planning and Policy General Directorate, Provincial Liaison Directorate, Provincial Health Directorates (PHD), Preventive and Curative General Directorate, etc.).

The EC's presence is predominantly in the East and South of Afghanistan, where quite a few areas soon after 2002/03 became increasingly insecure, a trend that only got worse over time and over a much larger area. Nevertheless, the contracted NGOs manage to keep activities going in all provinces, be it not in all areas within the provinces. The insecurity has not helped to strengthen the reportedly weak performance monitoring capacity of the EC of its programme (CSE, 2007).

A Balanced Scorecard (BSC) has been introduced in Afghanistan to monitor BPHS and EPHS progress at national and provincial levels. Based on a sample of 600 facilities, scores for 29 indicators, divided in six domains, are annually measured by an independent third party for 28 provinces, excluding six provinces due to security concerns. Annual reports are available for five consecutive years (2004-2008) and constitute an important source of information for this case study.

1.1.2 EC funds between 2002-2010

Full details of EC support are given in Annex.

From 2002 to 2010 the EC contributed a total of EUR 150 million (planned amount) to the health sector in Afghanistan. By far the largest share, EUR 123 million, went to the provision of the BPHS through contracts with NGOs. Of the remaining EUR 32 million, mostly allocated in the second half of this period, a good share did go to the EPHS, again through contracts with NGOs. So, of the EUR 150 million, EUR 136 million were channelled through NGOs, while another EUR 15 million were channelled through consultant firms. Virtually no funds were channelled directly through the

government. Attempts to decentralise in this context the handling of funds through the central MoH instead of the EC Delegation, failed for various reasons related to financial management concerns².

The bulk of allocations comes from annual, later bi-annual decisions, initially labelled “Reconstruction Programmes for Afghanistan” and “Support to the Afghan public health sector” from 2005 onwards. This is reflected in the aid modality statistics in the evaluations inventory with a gradual shift from “projects” to “support to sector programmes”. However, underneath are largely the same grant contracts with individual NGOs to deliver services. These grant contracts the EC used are based on input financing, unlike the contracts issued by the two other main donors in the health sector, World Bank and USAID, who use performance based elements.

The service delivery activities (BPHS and EPHS) in the 10 provinces supported by the EC are totally dependent on EC finance, as are the provinces supported by USAID and World Bank, with alternative domestic resources not expected to be available in any substantive way in the near future³.

1.2 EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services?

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

Indicators

- I-111 National health policies guarantee access to drugs, officially recognised as essential
- I-112 Average availability of selected essential medicines in public and private health facilities, incl. pharmacies

1.2.1.1 Findings per indicators

I-111 There is no evidence of EC interventions supporting national government and ministries in formulating and implementing policies guaranteeing access to drugs to be found in relevant documents.

Afghanistan has a National Medicines Law that is designed to put policy into practice concerning policy areas that require regulation. A survey reveals that it does not cover several regulatory areas that would normally be included under a national medicines law. Provisions for medical devices are not specified. In addition the law covers a number of topics that normally would not be covered by a medicines law. Then two regulations are in place: Regulation on “import and production of medicines and medical devices” (2005) (a number of weaknesses and areas of confusion appear to exist in this regulation); and Regulation on “pharmacies” (2006) (quite comprehensive, however its provisions have largely not been implemented).⁴

The Afghanistan Pharmaceutical Sector Identification Mission Report⁵ summarises the pharmaceutical market situation as following: i) the private sector accounts for over 70% of total pharmaceutical consumption with the balance provided by donors through the BPHS / EPHS system; ii) approximately 95% of the Afghanistan pharmaceutical market consists of imported medicines; iii) the proportion of sub-standard medicines on the market may be as high as 80% of medicines sold in the private sector; iv) illegal medicine imports are estimated to account for greater than 50% of the Afghanistan pharmaceutical market; v) the pharmaceutical market is chaotic; vi) the number of players is larger at every point in the supply chain compared to other economic markets in Afghanistan; vii) pharmaceutical regulation and medicines quality control in particular is considered to be extremely inadequate; viii) drug usage in Afghanistan is highly irrational; and ix) drug pricing control concerning importer, wholesale and retailer margins is extremely weak. It concludes that “Afghanistan has a very serious public health and trade problem concerning medicines.”

The core of Afghanistan’s national health policy since 2003 has been the roll out of a Basic Package of Health Services (BPHS) to all Afghans. The BPHS covers seven domains one of which is the “regular supply of essential drugs.” Throughout the period under study, all providers, including the NGOs who run major, province-wide BPHS delivery programmes, purchase and distribute drugs and other medical supplies directly, in a way best suited to them, mostly through direct imports. There is no

² CSE, 2007, page ii.

³ Health Care Finance Policy, 2007.

⁴ Afghanistan Pharmaceutical Sector Identification Mission Report, Intervention Scenarios for EC, November 2007 – January 2008, EuropeAid / 119860/C/SV/multi – Lot 8 – Health, pp. 28-29.

⁵ Ibid, p.13.

central drug store or similar facility. Unlike USAID that pools drug purchases for the NGOs they contract, the EC and World Bank require the NGOs under contract to acquire the drugs. The EC, through its TA, aimed to provide input in developing a national pharmaceutical programme, and a contract has been approved in 2010. However, implementation will not take place before 2011.

The EAMRs between 2008 and 2011 give insight into EC support to the Pharmaceutical Affairs unit of the MoPH. At the end of 2007 three identification missions started in order to support the pharmaceutical sector, inclusion of groups at risk in the health system and overall healthcare delivery including support to MoPH and decentralization in the management of contracts. The results have been fed into the financial agreements. The EAMR records show that unfortunately due to overload, the support to pharmaceutical affairs could not start before 2011.

International drug purchasing is still a problem and calls for co-ordinated manner between all EC funded NGOs, as the BPHS in Kunduz Province highlights. The biggest problem associated to internationally purchased drugs is the custom clearance in Kabul – a time consuming procedure because of poor management.⁶ The ROM report of the BPHS monitoring in the Nangarhar Province highlights the lack of available medicine in the country and the need to rely on international drugs, wrong population estimates (too low), too low estimates for drug distribution and need and a higher service uptake than estimated. To buy on the local markets includes additional expenses.⁷

To summarise, policies are in place to ensure access to essential medicines. The EC has contributed, through TA and through support for NGOs, to the access to essential medicines, however, serious gaps remain and steps identified during the evaluation period could not be implemented.

I-112 Given the chaotic nature of the pharmaceutical distribution sector, not to mention the quality of medicines being sold, it is not reasonable to think in terms of pharmacy stock-outages per se. However, the EC, through its contracts with the NGOs which allowed them to purchase and distribute drugs, has contributed significantly to this increased availability of essential drugs in Afghanistan.

The Afghan Health Sector Balanced Scorecard (BSC) reports on drug availability as one of its indicators. Nationwide, the drug availability index rose from 65% to 85% between 2004 and 2008.

Figure 2: Drug availability index

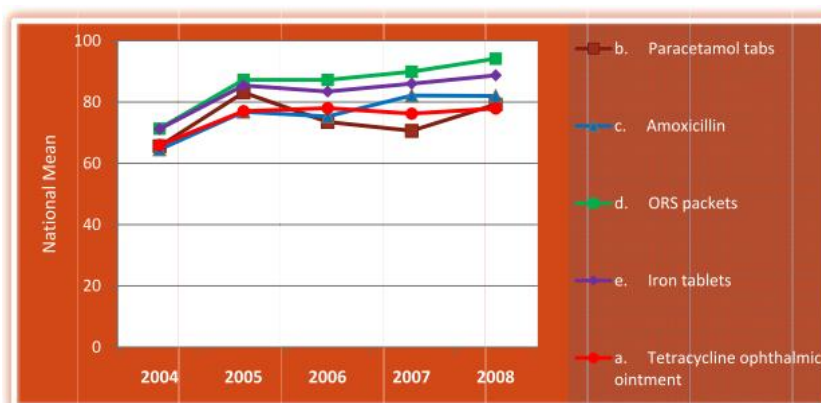


Figure 7b: Mean scores of the individual items for drug availability index

Source: Afghanistan Health Sector Balanced Scorecard 2008, p. 25

While there is variation in performance between provinces, all provinces do reasonably well (or better), including the provinces supported by the EC. The roll-out of the BPHS to all provinces, supported by all three major donors in health, from 2002/03 to 2011 has meant a substantial increase in availability of essential drugs at a substantially increased network of public health facilities.

The evaluation of BPHS in the Kunduz province and the monitoring reports of the Nangarhar province illustrate two different situations of availability of essential drugs and very different problems that have been faced:

⁶ Extraction of the External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

⁷ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

The BPHS Services in Kunduz province, BPHS financed by the EC and implemented by Merlin-CAF stated that in the past year drug availability has been an area of concern as highlighted in the Balanced Score Card “Drug Availability Index,” as well as in the WHO HMIS survey, with a high proportion of health facilities reporting stock out. In the BSC 2008, the Drug Availability Index reached the upper bench mark and the health facilities reporting stock out (through HMIS) decreased during the project period.⁸ HMIS data nevertheless are difficult to interpret as they do not inform about the type of stock out and the kind of drugs that are lacking. All the facilities of evaluation mentioned that they were receiving regular drug supplies according the Essential Drug List. Distributed drugs corresponded to the recommended BPHS list plus an additional 30%. Moreover, a higher quantity of specific drugs is supplied in order to respond to seasonal diseases e.g. Acute Respiratory Infections (ARIs). The 2009 BPHS revised list of Essential Drugs is being introduced in Kunduz Province. The project has been facing important difficulties as regards to drug procurement, as international procurement takes a very long time.⁹

The ROM report of the Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province highlights the phenomenon of over-distribution and over-consumption as a new challenge that comes along with a better drug provision. One of the problems associated to it is the patient overload which allows no time for health education. Furthermore, co-operation with the private sector is lacking resulting in believes that drugs from pharmacies are better than from BPHS, and users are still keen to incur extra cost. Common procedures are needed.¹⁰

In conclusion, by supporting the BPHS package, the EC has significantly improved the availability of essential medicines in Afghanistan.

1.2.1.2 Resume of the JC

EC support clearly improved availability of essential drugs in Afghanistan, in particular in the 10 provinces that receive support from the EC. Essentially, this works through direct provision by the NGOs in those provinces who receive funds from the EC to purchase and distribute drugs. While EC aims to give support to the development of a longer term strategy for the pharmaceutical sector, this did not materialise yet in the reported period. As of 2011, it appears that the context of Afghanistan does not allow for any alternative to donor supported drug imports for years to come. The EC was not involved in national health policies that guarantee access to essential drugs.

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

Indicators

- I-121 Improvement in the mix of primary and secondary health facilities
- I-122 Increased proportion of health facilities with appropriate equipment
- I-123 Increased proportion of health facilities with adequate budget for maintenance and recurrent expenditures

1.2.2.1 Findings per indicators

I-121 Health services in Afghanistan operate at three levels. At the community or village level there are health posts (HP) and community health workers (CHWs). In larger villages or communities of a district Basic Health Centres (BHC), Comprehensive Health Centres (CHC) and District Hospitals exist. The third levels are the provincial and regional hospitals. In urban areas, for the time being and due to a general lack of facilities offering basic curative and preventive services, urban clinics, hospitals and specialty hospitals provide the services that in rural areas are provided by the HPs, BHCs and CHCs.¹¹

The emphasis on the roll-out of the BPHS all over Afghanistan since 2002, including the 10 EC supported provinces, has meant an enormous increase in the number of primary care facilities,

⁸ The Afghan Health Sector Balanced Scorecard (BSC) report, 2008.

⁹ Extraction of the External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

¹⁰ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

¹¹ WHO. Regional Health Systems Observatory- EMRO, Health Systems Profile- Afghanistan, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Afghanistan/Full%20Profile.pdf>, p.35.

support to first-referral basic hospitals, and a more limited support to some other more specialised hospitals. Afghanistan, with its pre-war emphasis on (urban) hospitals, has now a much improved mix of primary and secondary health facilities, and EC support deserves a significant part of the credit.

A 2002 report, based on scanty data available at the time, stated that the ratio of basic health centres to population ranged from approximately one per 40,000 in the central and eastern regions to approximately one per 200,000 in the south.¹² The MoH HMIS office reported in 2009 around 1,500 primary care facilities in all of Afghanistan, which would amount to about one for every 17,000 population, and a much better spread over the various regions, including the areas supported by the EC. So, the EC contributed to the improved mix of health facilities by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS with its emphasis on a sufficient number of primary care facilities in all areas.

As an example, the EC was successful with the BPHS in the Laghman Province project in health infrastructure improvements to BPHS standard, which involved construction, rehabilitation and maintenance.¹³ Furthermore, IbnSina organised the take-over of facilities from MoPH and NGOs and rationalised the facilities, the staffing and the services in accordance with BPHS. The community health care was completed with 111 health posts installed, comprising of both female and male health workers. The reports on neonatal and maternal deaths were found to be most encouraging.¹⁴ BPHS Services in Kunduz province was successful during the project period (2007-2009) with a set of upgrading and downgrading of hospitals. These health facilities became operational in the last quarter of 2008. Altogether renovation works were undertaken and about to be completed in 20 health facilities. Five BHCs do not have their own building, one is rented and the other ones have been provided by the community. These buildings are functional but are not fully up to MoPH standards. In some health facilities there are additional rehabilitation needs in order to provide quality services.¹⁵ Findings of the End of project evaluation: Health Programme Qarghayee and Alingar Districts, Laghman Province, Afghanistan 2007, are equally positive.¹⁶

Although infrastructure improved in the provinces where the EC is active, the main problem remains the lack of qualified staff. The different target groups which were supposed to profit from the project actually benefit from it, and in most cases also actively participate in it. Unfortunately, due to worsening security and poor access, the most remote and needy communities often remain inaccessible.¹⁷ Second, although the "Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province" is considered to be successful, the major problem remains the registry system: All the facilities use registries but none uses a proper recording system to keep track of the medical history of patients. Individual files for out-patients are not available which makes it virtually impossible to follow the evolution of the patients and the records of in-patients or children under the age of five are only kept for one month before being moved to a store-room.¹⁸

The EC was, considering the political situation in Afghanistan, successful as stated in the EAMR 01/2008 report "Support to Provincial Public Health set up continues with a combination of international and national TA, supply contracts and training. The programme has a positive impact on the capacity of the provincial public health and as an example, other donors started to replicate the same format late in 2007."

Altogether, the EC was successful with the out-contracted NGO projects in improving the mix of primary and secondary health facilities in the 10 provinces of action.

I-122 The Balance Scorecard (BSC) reports show a gradual increase in equipment availability, with nationally around 80% of facilities having basic equipment. The EC supported provinces show a similar picture. So, the EC contributed to the increased proportion of health facilities with appropriate

¹² Waldman, 2002, AREU report: The Public Health System in Afghanistan.

¹³ EAMR 01/2010, and Conclusion of the effectiveness of the BPHS in the Laghman Province.

¹⁴ Conclusion of the effectiveness of the BPHS in the Laghman Province.

¹⁵ External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

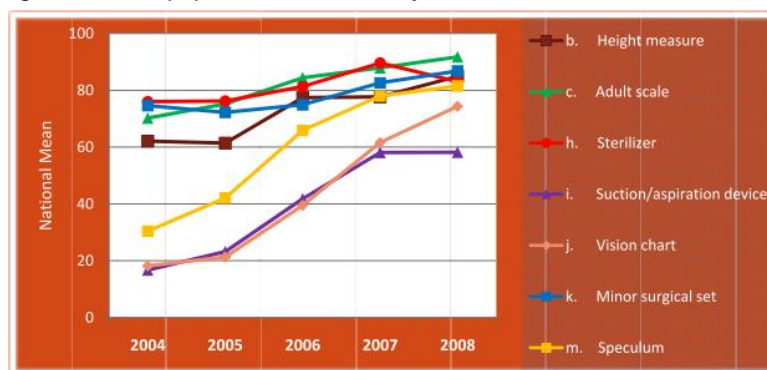
¹⁶ Findings of the End of project evaluation: Health Programme Qarghayee and Alingar Districts, Laghman Province, Afghanistan 2007.

¹⁷ ROM report MR 136904.01, 2010: Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services for Ghor Province Afghanistan.

¹⁸ ROM report MR 136904.01, 2010: Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

equipment by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which included provision of equipment to the expanding network of health facilities.

Figure 3: *Afghanistan Equipment Functionality Index*



Source: *Afghanistan Health Sector Balanced Scorecard 2008*, p. 24.

Anyhow, there are remaining problems in equipping the health centres. For instance, an X-ray machine may be delivered but the slides and other elements to use it may be still missing. Similarly, a physiotherapist has been found, but equipment is still missing for him to carry out his activities. One recurrent issue has been the difficulty to find technical staff and especially female staff to work in remote areas.¹⁹

I-123 The contracts to NGOs to deliver the BPHS include funds for maintenance and recurrent expenditures. With the increase of BPHS coverage over the past years, this indicator has also improved. As made also clear in other parts of these case studies, the system is entirely dependent on external aid.

1.2.2.2 Resume of the JC

The number of basic health facilities has increased substantially since 2002 resulting in a much improved mix of primary and secondary health facilities.²⁰ The BSC annual reports (2004-2008) have a range of quality of services indicators all showing improvements compared to the very low baseline situation in 2002, nationally as well as in the provinces supported by the EC. So, the EC contributed to the improved availability of quality health infrastructure by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which included ensuring expansion of the number primary care facilities towards the prescribed ratio of facilities, and rehabilitation of (mostly pre-existing) first-referral hospitals. The EC contracts allowed for investments in infrastructure, equipment and maintenance. Staff and other running costs are also provided by the EC through the NGOs.

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

Indicators

- I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 inhabitants
- I-132 Improved availability and standards of health worker training
- I-133 High health worker attrition and absenteeism rate addressed

1.2.3.1 Findings per indicators

I-131 The EC contributed to keep medical staff in the country and incentives are created to educate the next generation. However, staff shortages and high turn-over persist being problematic.

The number of doctors in Afghanistan is reported to be around two per 10,000 inhabitants in both 2001 and 2009, with slightly less in the years in between, so rather a reversed decrease than an

¹⁹ ROM report MR 136904.01, 2010: Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services for Ghor Province Afghanistan.

²⁰ See also EAMR 01/2010: *Major Achievements and examples of impact achieved*: increased coverage of health service delivery over the country.

increase during our period of interest. The same for nursing and midwifery personnel: five per 10,000 in 2005 and 2009, with somewhat lower numbers in years between (see Table below).

Table 1: Human Resources for Health per 1,000 inhabitants

	2001	2005	2006	2007	2008	2009
Physicians	0.19	0.20	0.14	0.15	0.15	0.21
Pharmaceutical personnel	0.02	0.03	0.03	0.03	0.03	0.03
Dentistry personnel	0.03	0.03	0.01	0.01	0.01	0.03
Nursing and midwifery personnel	n/a	0.50	0.37	0.42	0.41	0.50

Source: WHO Global Health Atlas, <http://apps.who.int/globalatlas/>.

The “External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan” gives interesting insights on the link between quality of health care provisions and the health worker situation in the provinces:²¹ “The project has managed to recruit a large number of female workers particularly midwives with particular efforts in the deployment of the trained community midwives. The recruitment of female doctors remains the main challenge despite the fact that project endeavours to look for several alternatives. One-third of the drop-out concerns female staff. Insecurity is one of the reasons for women to stop working in health facilities but among the drop-out a large proportion of vaccinators stopped their activities, often for further studies or for family reasons. The fact that the project has been posting female vaccinators and female guards is very conducive for female attendance of the health facilities. Insufficiencies in the number of male doctors are compensated through filling positions with male nurses.”

The “Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services for Ghor Province Afghanistan” addresses the difficulty to find technical staff and especially female staff to work in remote areas. The remoteness of the sites, the isolation, the low temperature and lack of communication continue to be the main reasons for high staff turn-over. The most striking indirect impact is certainly the fact that the perceived need for trained medical personnel has encouraged communities to send their children to school.²²

The ROM report of the “Support to the Afghan Public health sector” programme found that there has been an increase in qualified female health staff. The proportion of health facilities with at least one trained female health worker increased from 25% in 2002 to 76% in 2007. A major increase of in-service training occurred. Several of the NGOs contracted by the EC train young rural women to become nurses or midwives.²³

I-132 The EC contributed with its NGO projects clearly to health personnel training, both in pre-service and in-service education.

In considering training, one has to keep in mind the high illiteracy rate in Afghanistan (78% among women and 48% among men). The status of Afghan women is one of the lowest in the world, and during the Taliban years many health workers were killed or fled the country and only a few poorly trained remained in the country. Furthermore, no standardised health training programmes are existent, and there is a continued severe shortage of female health workers in remote areas.²⁴

The EC has not been involved in the formal education of new health staff, which takes place at universities and mid-level health worker training institutes. An exception is the support to NGOs that have initiated community midwife training courses, with a shortened curriculum of 2 instead of 3 years. Training of this, for Afghanistan new, but now recognised health care cadre was piloted by the INGO HealthNet/TPO in Nangahar province, supported by EC funds and later replicated by other NGOs.

Several initiatives in EC supported provinces have focused on increased training of community midwives. Otherwise there is no proper, consolidated information available about formal health workers training and its standards. However, from the various project reports it is clear that a plethora

²¹ External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province.

²² ROM report MR 136904.01, 2010, Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services for Ghor Province Afghanistan.

²³ ROM report 104420.01 – 2008: Support to the Afghan Public health sector.

²⁴ Country Cooperation Strategy for WHO and Afghanistan 2009–2013; and JR Acerra, K Iskyan, ZA Qureshi, and RK Sharma. 2009. Rebuilding the health care system in Afghanistan: an overview of primary care and emergency services. *Int J Emerg Med.* 2009 June; 2(2): 77–82.

of on-site on the job training activities have taken and continue to take place by the NGOs in charge of the health facilities, in the context of EC support to the 10 Afghan provinces.

Project staff i.e. pharmacists, supervisors and health facility staff were trained in Management of Drug Supply by CAF. A pharmacy consultant was hired by Merlin for three months in order to review the drug management system and the ware house management, and to train project staff. A system is developed allowing the inclusion of morbidity patterns and previous consumption in the calculation of the drugs needs of each health facility.²⁵

The BPHS Services in Kunduz province project managed to conduct many trainings for a large range of personnel in a very short period. However considering the need for introducing new BPHS components such as mental health, disability, VCCT and reinforcing the other BPHS components, individual training needs may not have been fully addressed. The last BSC (2008) shows that Kunduz scores for health workers knowledge (about vaccination, IMCI and reproductive health) are among the lowest provinces. On-the-job training is considered by the project as a part of regular supervision. Since health facilities are supervised two to three times in average, supervisors have the opportunity to provide on the job training. Comprehensive training management for Kunduz Province is lacking and will be essential in the second phase of the project to respond to the reinforcement needs.

Findings of the end of project evaluation of the Health Programme Qarghayee and Alingar Districts, Laghman Province (2007) stated that there has been a large number and variety of trainings provided by IbnSina, well as by the WHO, MoPH, the Global Fund, USAID Reach and ICRC. In 2006 alone records indicate 55 different trainings with in total 249 female and 360 male participants. In 2007 to date 16 trainings have been provided. Further, IbnSina with support from Oxfam Novib implemented a community midwife training, which is attended by 21 female students from different districts of Laghman, also in 2007.²⁶

The pre-service training of community midwives in the Community Midwife Education (CME) School is a strong component of the project as it provides a high quality and practical education to its trainees. The recent assessment of the National Midwifery Education Accreditation Board highly rated Kunduz CME School on the classroom and practical teaching quality and the management of the school. The main area to improve concerns the clinical teaching and the teaching skills of clinical preceptors in the Regional Hospital and other practical sites. This last area can be strengthened through an improved coordination between the two teams.²⁷

In summary, the EC, as well as other donors, have supported massive training efforts for health workers at all levels. In the face of enormous challenges, not the least of which being attrition and other problems related to the security situation, there has been significant improvement in this Indicator as a result of these efforts.

I-133 Health workers are hired by NGOs, on contracts that are likely to be as long as the NGO itself has a contract (only a few years). This makes it difficult to put retention schemes in place.

The EC funded programme in Nangarhar Province faces problems such as the fact that, although dissatisfaction and drop-outs continue to be common amongst community health workers. Insufficient attention has been given so far to setting up a bonus system which is simple, feasible and transparent enough to be followed through. Retention of community health workers (CHW) remains a problem since, in the long run, they are not willing to keep working as volunteers. Delays in payment and inconsistencies in the tracking of the number of referrals made by each CHW led to dissatisfaction with the performance based pay system. Despite their involvement in the selection process of the CHWs, some communities believe that the CHWs already receive some sort of payment and are therefore reluctant to support them in any way. In other areas, facilities or electricity are provided to them in recognition of their work.²⁸

The deployment of local health workers, either doctors or nurses and community midwives, who are posted in their own village, undeniably adds to the sustainability of the system. The demonstration of the feasibility of female health professionals posting and of its effect upon services utilisation by

²⁵ External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

²⁶ Findings of the End of project evaluation: Health Programme Qarghayee and Alingar Districts, Laghman Province, Afghanistan 2007.

²⁷ External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

²⁸ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

women is a factor for continuity as well. The strong participation of community Shuras in health facilities affairs and support have developed a valuable community ownership of their health facilities which is a strong element to ensure the continuity of health services. Involving them further in local health services planning would reinforce their ownership.²⁹

High attrition rates appear to be still a problem when looking at the constant numbers of health personnel per 10,000 inhabitants over the last years. No human resource management seems to be in place.

1.2.3.2 Resume of the JC

The main contribution of the EC to health worker availability in Afghanistan has been the training of community midwives that has been implemented by the NGOs under contract of the EC. These midwives, although recognised by the government, do not follow the standard curriculum which used to be in place to graduate as a “regular” midwife in Afghanistan. Many of these trained community midwives, recruited from the community where the training takes place, have been posted to the NGO-run (and therefore EC-supported) health facilities. Despite the emphasis on training of community midwives within various EC supported NGO programmes, available figures do not show an increase in number of midwives. A possible cause may be that this new cadre of community midwife is not taken into account when collecting these health worker statistics. However, implementing retention schemes, in particular in remote areas, are of need to address attrition.

1.2.4 JC 14 Increased or maintained quality of service provision

Indicators

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)
- I-142 Clinical treatment guidelines available, disseminated and applied
- I-143 Client satisfaction with the quality of health care services

1.2.4.1 Findings per indicators

I-141 The BSC is a novel quality assurance mechanism that covers all provinces, including the ones supported by the EC, as far as they are accessible. Initially, they only covered primary care facilities, but more recently hospitals are covered as well. Other mechanisms in place include Lot Quality Assurance, which is practised in a number of (USAID sponsored) provinces. Contracted NGOs will be responsible for quality assurance in the facilities supervised by them. The EC puts less emphasis on monitoring of performance of the NGOs under contract than other key donors in health, due to a lack of resources and staff capacity.³⁰ Occasional site visits by EC Delegation staff to programme areas remained a key M&E tool. In the years thereafter this has not substantially improved. On the contrary, the ability of EC staff, in particular expatriate staff, to do site visits was further reduced by increased insecurity in more and more areas supported by the EC.

Most health facilities report functioning referral system to the upper facilities but the proportion of cases referred to district hospitals remain uneven. An initial set of standard health indicators is currently under discussion, for measuring: the immediate and concrete consequences of the measures taken and the resources used (outputs); the effects of the changes introduced by the action at beneficiaries' level (outcomes A); the effects of the changes introduced by the action on socio-economic conditions affecting poverty (outcomes B); and the overall mid-term impact (in line with GoA I-ANDS benchmarks). The new Terms of Reference of the EC-extended contracts (to be signed mid-June) will contain a set of standard measured information to be provided on a quarterly basis.³¹

I-142 The BSC provides some indicators on patient treatment, like a ‘patient history and physical exam’ index and a ‘patient counselling index’. While the first indicator has gradually increased, the second one’s improvement is still meagre. This also applies to the 10 provinces that receive support from the EC through the contracts with NGOs.

²⁹ The External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan.

³⁰ Particip (2007): Evaluation of the European Commission’s Support to the Islamic Republic of Afghanistan, November 2007.

³¹ EAMR 07/2006.

I-143 The BSC, in its 2008 report, concludes: “Although the BSC shows that very substantial progress has been made in BPHS implementation, progress has not been demonstrated in several important areas since 2004 — these include patient satisfaction and perceptions of quality, on-time salary payments, health worker satisfaction, and facility infrastructure.”³² This also applies to the provinces supported by the EC.

The EC Afghan Public Health Sector project contributed to the overall client satisfaction. The ROM report states that overall patient satisfaction at national level had remained stable until 2007, when it saw a decrease. This may also be due to increasing expectations. With regard to patient perceptions of quality, nationally this remained rather stable with a somewhat higher score in 2006. In general patients report high levels of satisfaction with the courtesy and respect shown by staff and the lowest level is with convenience of travel to the health facility.³³ One has to consider that security issues remain a big problem in the country, and in particular for the projects implemented by the NGOs through EC funds.³⁴ Concerning psychosocial care, which has been introduced recently and which is of need for population traumatised after a war, it will take time as far as behaviour and mental changes are concerned. One remaining problem will be overcrowded health facilities, so that patient satisfaction will remain proportionately low.³⁵

1.2.4.2 Resume of the JC

Improvements in quality of services shows a mixed picture, with some aspects, like patient satisfaction and patient counselling clearly lagging behind improvements in many other domains. Assessment of quality of services in the EC supported areas primarily depends on the surveys done for the BSC. Site visits by EC delegation staff were initially another tool to assess the quality of services, but lack of staff and in particular increased insecurity hamper regular visits.

However, the infrastructure improvements of health facilities and health personnel training funded by EC, implemented by NGOs, as described in the previous JCs, are a first step towards improvements of client satisfaction. No information has been obtained to date about how far the EC funds contributed to quality assurance mechanism and treatment guidelines available being implemented and disseminated.

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

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

Indicators

- I-211 Change in proportion of health spending out of pocket
- I-212 Change in share of health expenditure financed by social security schemes
- I-214 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

1.3.1.1 Findings per indicators

I-211 Private expenditure (virtually all “out of pocket”) on health as a percentage of total expenditure on health remained largely unchanged over the past decade, declining from 79.6% to 77.7% between 2002 and 2009 according to WHO.

Although government health services are officially free of charge according to the Afghanistan Constitution, informal fees are paid for MOPH health services. In the MOPH there appears to be considerable discussion about the potential for user fees as a source of increased revenue for the sector. NGOs, who provide healthcare to the largest share of the population, have been charging user fees for years. It is estimated that user fees currently contribute about one tenth of total health

³² The Afghan Health Sector Balanced Scorecard (BSC) report, 2008.

³³ ROM report 104420.01 – 2008. Support to the Afghan Public health sector.

³⁴ EAMR 1/2008.

³⁵ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

spending in Afghanistan. Recently MOPH in co-operation of partners developed formal cost sharing and user fee policy which has not been approved by the Afghan Cabinet yet.³⁶

The high out-of-pocket statistic should be interpreted in light of the fact that most basic health services are, in fact, provided very cheaply through the BPHS. That is, the bulk of household health spending is concentrated in curative and hospital care. The EC is supporting BPHS programmes in 10 provinces through the contracts with NGOs, which leads to increased availability and uptake of basic health services. These services are provided for free, and should have a lowering effect on out of pocket payments. However, this does not show up yet in the statistics collected to measure out of pocket payments.

One concern raised in one of the ROM reports is that an apparent negative indirect effect of the cancellation of service fees is that free services seem to be less valued.³⁷

There is no evidence so far that, despite having increased the availability of health care, EC support has reduced the share of health spending that is out of pocket. According to the MoH, it will not be possible for the government to sustain the health sector alone, and the future focus should be on how the private sector can contribute to a more efficiently functioning health sector.

I-212 There are no social security schemes set up in Afghanistan.

I-213 No health insurance is set up yet in Afghanistan. A pilot community health insurance scheme failed and at the moment no other forms of insurances are being considered. Also under SuCop, a social health insurance system should have been implemented, but is still not operational (nor conceptualised) due to delays in funding.

1.3.1.2 Resume of the JC

Virtually all spending on health is out of pocket in Afghanistan, a situation that did not change over the second half of the evaluation period. However, out of pocket spending is not so much for basic health care services, but rather for hospital care and private care; the high statistic reflects the fact that most health spending is, in fact, for higher-level services. Basic health services (the BPHS) are free, following a government decision to formally abolish user fees at the primary care level. These services are largely paid for by the international community, including the EC in the provinces the EC supports.

A pilot community health insurance failed and at the moment no other forms of insurances are being considered.

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

Indicators

- I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs, such as children, the elderly, persons living with HIV/AIDS, and the disabled
- I-222 Health care financing schemes result in additional health care consumption by households

1.3.2.1 Findings per indicators

I-221 The BPHS are provided free of charge and have the following focus areas: maternal and newborn health, child health and immunisation, nutrition, communicable diseases, mental health, disability and pharmaceutical supply. The EC supports the BPHS implementation in 10 of Afghanistan's 34 provinces through its contracts with NGOs and is therefore financing this level of care.

The EC continues to support the BPHS in 10 provinces for a population of almost 5 million Afghans through contracts with health NGOs. During the most part of H1 the old contracts (both grants and services) came to an end. EC initiated a more coherent provincial approach through continuous development of the Provincial Public Health Offices (under the Ministry of Public Health) and through contracting each province to one NGO. The new contracts for healthcare delivery address the BPHS

³⁶ WHO, Regional Health System Observatory – EMRO, Health Systems Profile Afghanistan, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Afghanistan/Full%20Profile.pdf>, p.28.

³⁷ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services for Ghor Province Afghanistan.

component in all 10 provinces and the EPHS (Essential Package of Hospital Services) in four provinces.³⁸

None of this is entirely relevant to the issue of cost-waiver schemes for the most vulnerable. BPHS is heavily slanted towards the health needs of women and children, which are closely related.

I-222 Basis health services in Afghanistan are directly financed by the three main donors in health, the EC, USAID and World Bank. As from 2008, when the government formally abolished user fees that were in place in quite a few NGO managed health services, these basic services are now free. Next to increased availability this has led to substantially higher uptake of out-patient services, all over Afghanistan, including the provinces supported by the EC. The EC has thus contributed to additional health care consumption in parts of Afghanistan, primarily at the basic health care level. Secondary and tertiary health services need to be paid for, with very little protection for the poor. There has not been a specific EC activity to address this issue.

The External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan (EuropeAid/124832/C/ACT/AF) provides the following figures concerning the outpatient (OPD) attendance in Merlin-CAF run health facilities by quarter for the total evaluated period:

Table 2: Outpatient visits in Kunduz province

OPD	July-Sep 2007	Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	July-Sep 2008	Oct-Dec 2008	Jan-Mar 2009	Total
Below 5	39,396	27,867	37,662	47,429	50,654	33,307	55,997	292,312
Above 5	11,0974	79,527	115,287	137,911	136,815	81,051	151,182	812,747
Total	150,370	107,394	152,949	185,340	187,469	114,358	207,179	1,105,059
Coverage	72%	52%	73%	89%	90%	55%	99%	NA

Women's attendance is higher than men's, an indication that women seek reproductive health services. Moreover, the fact that the proportion of girls is nearly equivalent to the proportion of boys, among the children below five, is a very good signal that young children receive equal care regardless their gender. It is practically certain that without the EC BPHS support, women would be less likely to seek care than men and girls would be disadvantaged against boys. This is some evidence that EC support The Balance Scorecard (BSC) 2008 highlights that non-poor people were somewhat more likely than the poor to use outpatient services.³⁹

According to province-wide national indicators, the EC support has been very effective in the "Support to Afghan Public Health Sector." For example between 2003 and 2007, the number of consultations per capita per year increased from 0.3 to 0.8, and for the EC provinces to 0.9; antenatal control increased from 5% to 41% and to 40% for the EC provinces; institutional deliveries increased from 3% in 2004 to 23% in 2007, and to 22% for the EC provinces; Family Planning (FP) increased from 5% in 2003 to 16% in 2006; the coverage of BPHS has steadily been increasing to the current 66% and measures are put in place to increase the coverage further. Data from the HMIS show that overall utilisation of health services has been steadily increasing. The BSC shows that the quality of the performance of the BPHS has been increasing very well. Geographical coverage of health facilities has been increasing steadily as a result of rapid expansion of health services in rural areas through the partner agreements with the NGOs. The largest improvement is not so much in the number of health facilities, but in making the health facilities functional again. Progress reviews show that full coverage of the population is still an issue. Measures are underway to address this.⁴⁰

These figures provide dramatic evidence of highly significant EC impact on consumption of health care services.

1.3.2.2 Resume of the JC

The main sources of finance for the public primary care services come from the international community, and at this level there is protection for the poor and special vulnerable groups. However, for secondary and tertiary care there are no mechanisms in place to ensure availability for special

³⁸ EAMR 07/2007, and EAMR 01/2008

³⁹ The Afghan Health Sector Balanced Scorecard (BSC) report, 2008

⁴⁰ ROM report 104420.01 – 2008. Support to the Afghan Public health sector

groups. The EC, through its support to 10 provinces, is the main financing source for these primary care services in the areas its supports. There has been dramatic increase in health care service consumption in areas supported by the EC.

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

Indicators

- I-231 EC supported technical assistance provides expertise on health care finances
- I-232 EC supports enhanced communication, cooperation between MoH and MoF/planning

1.3.3.1 Findings per indicators

I-231 The EC did not finance any TA related to health care finances. A first National Health Accounts report was produced by the MoH (paid for by USAID) for the year 2008/09. The EC has supported various studies around health financing, including a “Cost-Efficiency Study of Two Alternative Mechanisms for Delivering BPHS in Afghanistan: Contracting-Out and Public Sector Strengthening Mechanisms (SM)” and a “Study Of Healthcare Financing In Afghanistan (2003-2008).”

Provision, not financing, is the core concern of donors in the Afghan health sector. According to the MoH interview, this is now changing and the EC is actively involved in the debate on the future health financing, discussing also the current contracting approach.

I-232 According to the interviews with the ministry of health, the communication related to EC support between the two ministries changed. Before, EC financing agreements were signed with the MoF, with no or only scarce involvement of the MoPH. Today, the MoPH is involved in the writing and discussion process. Through this budgeting process, communication has improved a little bit between these two ministries.

1.3.3.2 Resume of the JC

Although the EC supported a number of health finance related studies, there is no direct, deeper involvement in the development of health finance policies in Afghanistan. However, the EC is championing the development of a SWAp approach and gets involved in the discussion on the future health financing. A first step was the commissioned study on Study Of Healthcare Financing In Afghanistan (2003-2008) by Maryse Dugue. In general, donors including the EC have, during the evaluation period, concentrated on acute problems of health care provision, rather than the higher-level issues of financing.

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

Indicators

- I-241 Evidence of EU supported dialogue between major stakeholders and pharmaceutical industry to encourage R&D targeted at diseases of poor countries
- I-242 North-South medical and public health research partnerships supported by EU to produce new medicines and treatments

1.3.4.1 Findings per indicators

I-231 Not applicable to country cases.

I-232 Not applicable to country cases.

1.3.4.2 Resume of the JC

JC is not applicable to country case.

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

1.4.1 JC 31 Increase in availability of primary health care facilities due to EC support

Indicators

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

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

1.4.1.1 Findings per indicators

I-311 The emphasis on the roll out of the BPHS all over Afghanistan since 2002, including the 10 EC supported provinces, has meant an enormous increase in primary care facilities, in particular in the rural areas and smaller towns.

A 2002 report, based on scanty data available at the time, stated that the ratio of basic health centres to population ranged from approximately one per 40,000 in the central and eastern regions to approximately one per 200,000 in the south.⁴¹ The MoH HMIS office reported in 2009 around 1,500 primary care facilities in all of Afghanistan, which would amount to about 1 for every 17,000 inhabitants, and a much better spread over the various regions, including the areas supported by the EC. This is still below the threshold of at least 1 unit for every 10,000 inhabitants. In particular people in geographically remote areas are difficult to reach.

The EC has contributed support to this substantial expansion of primary care facilities in the 10 provinces in Afghanistan through contracts with NGOs, which included the obligation to expand the number of health care facilities in their area of operation.

According to EMAR 01/2007 and EAMR 07/2006, the EC is supporting 226 health facilities in the 10 provinces⁴² and has significantly contributed to the expansion of basic primary health services into remote district areas and underserved provinces such as Nooristan and Dai Kundi, in particular since the end of 2005. Compiled overall consultation rates indicate around 3 million consultations since 2002. Most health facilities report a functioning system of referral to the upper facilities but the proportion of cases referred to district hospitals remain uneven. An initial set of standard health indicators is currently under discussion, for measuring: the immediate and concrete consequences of the measures taken and the resources used (outputs); the effects of the changes introduced by the action at beneficiaries' level (outcomes A); the effects of the changes introduced by the action on socio-economic conditions affecting poverty (outcomes B); and the overall mid-term impact (in line with GoA I-ANDS benchmarks). The new Terms of Reference of the EC-extended contracts (to be signed mid-June) will contain a set of standard measured information to be provided on a quarterly basis.

It is very difficult to establish the impact achieved through this specific project since most of the activities have already been running for several years. Overall however the persons interviewed mentioned that they have observed changes at the following levels: a) increased use of the facilities, b) falling of barriers previously preventing women and children access to the services which has directly led to reduced maternal/child mortality and morbidity, c) the increased presence of female staff/midwives has led to an increase in the number of safe deliveries, d) better understanding of the referral system, e) increased acceptance of family planning, f) increased services in remote areas and g) increased understanding of the need to vaccinate and much better coverage of vaccinations. As this province borders Pakistan, it is also interesting to hear that people now seek health care locally while not so long ago they were very keen to cross over to Pakistan.⁴³

I-312 The 2008-2013 Health and Nutrition Sector Strategy claims 65% of the population having nearby access to primary health care facilities by 2006, against a baseline of 9% in 2000. Nearby access is defined as two hour walk from the facility.

⁴¹ Waldman, 2002, AREU report: The Public Health System in Afghanistan.

⁴² Kunduz (north), Nuristan, Kunar, Laghman, Logar and Nangharar (east), Zabul and Oruzgan (south), Ghor and Dai Kundi (central Afghanistan).

⁴³ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

Table 3: Travelling time to the nearest health facility

	Avg. time required to travel from home using usual mode of transportation (%)	Cumulative (%)	Avg. time required to walk from community (%)	Cumulative (%)
Travel time to nearest facility	n=7959		n=397	
< 1 hour	35.5	35.5	32.1	32.1
1 to < 2 hours	25.6	61.1	26.4	58.5
2 to < 3 hours	18.1	79.2	14.4	72.8
3 to < 4 hours	7.5	86.7	6.7	79.5
4 to < 6 hours	7.2	93.9	8.7	88.2
≥ 6 hours	6.1	100.0	11.8	100.0

Source: Afghanistan Health Survey 2006,

<http://www.humanitarianreform.org/humanitarianreform/Portals/1/cluster%20approach%20page/Afghanistan/Afghanistan%20Health%20Survey%20Report%202006.pdf>, p.22

The average time required to travel from home using usual mode of transportation is a household-level variable, while the second is a community-level variable (either a village or an urban block).

The major barriers in going to health facility were: illness or disability not severe enough (27.5%), facility too far (26.9%), and financial constraints (23.5%), cannot afford transport cost (11.1%), lack of transport (5.9%), quality of services is low (2.6%), and no drugs available (1.4%).⁴⁴

The EC has contributed to this substantial increase of access in the 10 provinces in Afghanistan it supports through contracts with NGOs. One of the requirements in the contracts was to increase the number of primary health care facilities in their area of operation.

1.4.1.2 Resume of the JC

Afghanistan has seen a dramatic increase in primary health care facilities since 2002, including the provinces that receive EC support. The roll out of facilities was primarily targeted at previously underserved areas all over Afghanistan, mostly poor, rural areas. The EC has contributed to this substantial expansion of primary care facilities in the 10 provinces in Afghanistan through its support to NGOs, which included the obligation to expand the number of health care facilities in their area of operation. Clearly the EC has had a significant positive impact on the geographic proximity to care, although remote and mountainous regions remain a challenge.

1.4.2 JC 32 Increase in availability of secondary health care facilities due to EC support

Indicators

- I-321 Change in number of hospital beds per 10,000 inhabitants (to >10 per 10,000 inhabitants)
- I-322 Change in the proportion of population living in a radius of two hours of a secondary health care facility
- I-323 Increased number of Caesarean Sections

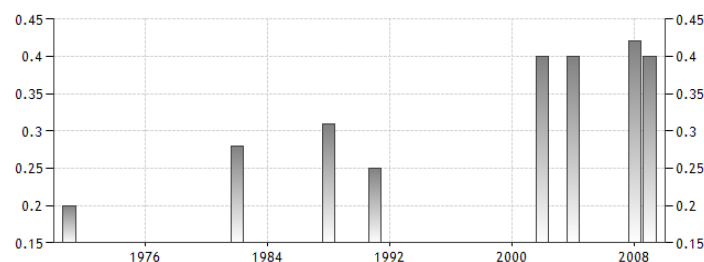
1.4.2.1 Findings per indicators

I-321 Only a "snapshot" figure of four beds per 10,000 inhabitants for 2009 is known in the WHO Health statistics. This is likely to be similar to the years before, with a low priority being given to the hospital sector and the need to rehabilitate existing but poorly functioning hospital prior to extending current capacity. Since 2005 the EPHS is in place, which is incorporated in the work done by the NGOs that are under contract of the EC in 10 provinces. So, in most of the areas support is being given to the basic hospitals. However, this would normally not lead to increased number of hospital beds. Secondary and tertiary hospitals are not supported by the EC

⁴⁴ WHO, Department of Making Pregnancy Safer, 2006. Afghanistan Country Profile, p.3.

Based on World Bank indicators, we can see in the following figure that the number of hospital beds per 1,000 inhabitants increased slowly, but still is very low.

Figure 4: Hospital beds per 1,000 inhabitants, Afghanistan 1967-2008



Source: <http://www.tradingeconomics.com/afghanistan/hospital-beds-per-1-000-people-wb-data.html>

According to the MoH, the focus of the EC (as well as of all other donors), is on rural areas. The MoH emphasised that there is a non-met need for specialised health care in Kabul.

I-322 No information available, but likely to have improved to some extent with the emphasis on the BPHS and EPHS bringing some functioning first referral hospitals nearer to where people live and will also be the case in the areas supported by the EC through its contracts with the NGOs. Some EC contribution can be assumed.

I-323 Only a figure of 3.5 % births by Caesarean sections is known (WHO Statistics), for 2008, which is well below the international good practice minimum level of 10%. No time trend data are available, but the rate may have gone up somewhat over the past years, with the emphasis within the BPHS/EPHS on maternal care, which was specifically supported by the EC through its contracts with the NGOs in 10 provinces.

1.4.2.2 Resume of the JC

While data are scarce for the hospital sector, the emphasis on the primary health care sector over the past years has precluded much progress in the hospital sector, which is still a huge task ahead. The BPHS and EPHS roll out, however, will have brought some functioning hospital closer to people, including the capacity to do Caesarean sections. Overall, EC support to 10 provinces has contributed to bringing essential hospital care, including Caesarean sections, within reach of more rural Afghans in the areas it supports.

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

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

Indicators

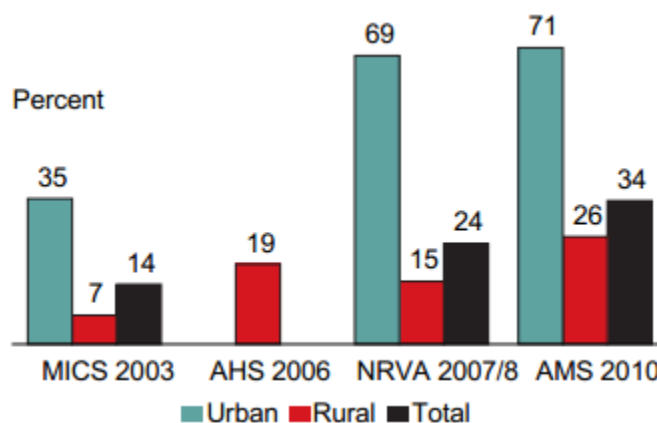
- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving four or more ante-natal check-ups
- I-413 Increased proportion of women using modern family planning

1.5.1.1 Findings per indicators

I-411 The Afghanistan Mortality Survey 2010 report⁴⁵ found an increase in the proportion of Skilled Birth Attendant supervision. The 2010 figure of 34% for 2010 is still low, but shows the influence of the introduction of the BPHS when compared with the 14% for 2003.

⁴⁵ Afghan Public Health Institute, Ministry of Public Health (APHI/MoPH) [Afghanistan], Central Statistics Organization (CSO) [Afghanistan], ICF Macro, Indian Institute of Health Management Research (IIHMR) [India] and World Health Organization Regional Office for the Eastern Mediterranean (WHO/EMRO) [Egypt]. 2011. Afghanistan Mortality Survey 2010. Calverton, Maryland, USA: APHI/MoPH, CSO, ICF Macro, IIHMR and WHO/EMRO.

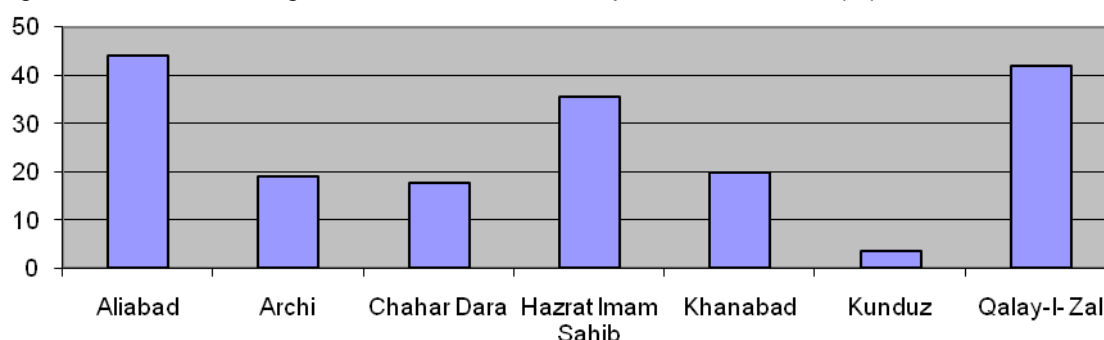
Figure 5: Trends in Delivery Care from a Medically Skilled Provider, Various Surveys, 2003-2010



Source: Afghanistan Mortality Survey 2010

The trends in attended deliveries increased, for instance, in the BPHS in Kunduz Province project. Normal deliveries are performed in all BHCs during clinic opening hours and after opening hours in 12 BHCs where midwives are on call and can attend delivery.

Figure 6: Coverage of institutional deliveries per district in 2008 (%)



Source: Afghanistan Mortality Survey 2010

Figure 7: Coverage of institutional deliveries per quarter for each district

Percentages %	July-Sept 2007	Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	July-Sept 2008	Oct-Dec 2008	Jan-Mar 2009
Imam Sahib	19	24	24	33	36	31	43
Qalay-i-Zal	27	32	37	52	31	35	50
Chahar Dara	16	22	27	23	19	11	18
Khan Abad	11	13	15	22	19	15	23
Kunduz	2	2	3	5	2	3	4
Ali Abad	16	18	19	45	40	39	52
Archi	13	13	14	14	18	18	26

Source: HMIS Kunduz - Calculation of targets done on Population data CSO 2005

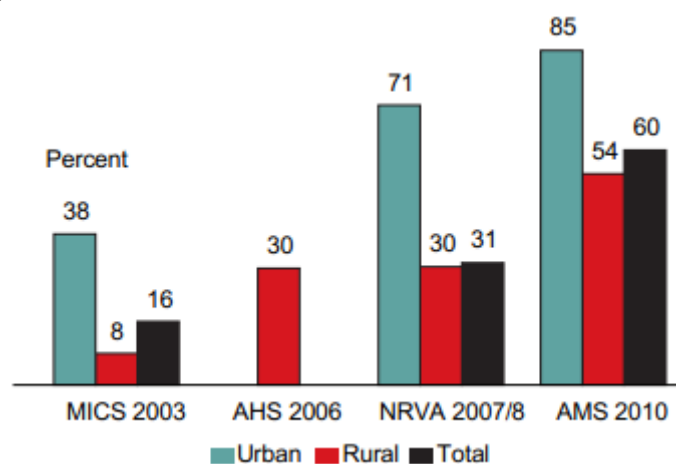
The ROM report MR 136904.01, 2010, states that persons interviewed mentioned that they have observed changes such as: a) increased use of the facilities, b) falling of barriers previously preventing women and children access to the services which has directly led to reduced maternal/child mortality and morbidity, c) the increased presence of female staff/midwives has led to an increase in the number of safe deliveries, d) better understanding of the referral system, e) increased acceptance of

family planning, f) increased services in remote areas and g) increased understanding of the need to vaccinate and much better coverage of vaccinations.⁴⁶

There has clearly been a significant EC contribution to improvement in this Indicator.

I-412 Data are only data available for “at least one ANC visit,” not on “4+ visits.” The Afghanistan Mortality Survey 2010 reports 60% “at least one ANC visit,” a steep increase compared to a MICS figure of 4.6% from 2003, and arguably influenced by the roll out of the BPHS, to which the EC contributed. The EC contributed to the increased number of ANC visits by contracting NGOs in 10 of Afghanistan’s 34 provinces to roll out the BPHS which includes expansion of facilities where ANC is being offered.⁴⁷ However, some caution in interpretation of this and the other graphs from the Afghanistan Mortality Survey 2010 is necessary. These graphs are based on a survey with national coverage. But due to security reasons some parts of Afghanistan, in particular in the South and South-east, could not fully be covered and are thus underrepresented. And it is likely that indicators in these areas, including several provinces where the EC funds activities, are below national averages.

Figure 8: Trends in Antenatal Care from a Medically Skilled Provider, Various Surveys, 2003-2010



Source: Afghanistan Mortality Survey 2010.

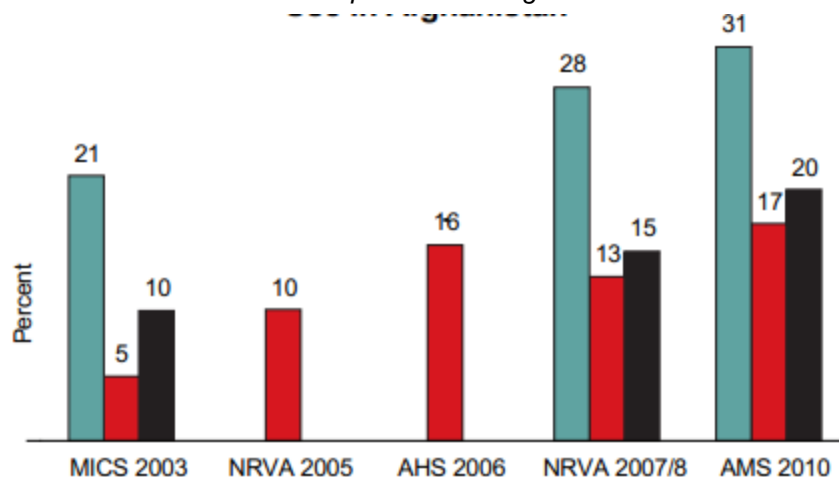
I-413 A similar influence of the BPHS is visible in contraceptive use, which increased from 5% in 2003 to 20% in 2010.

The EC contributed to increased prevalence of family planning by contracting NGOs in 10 of Afghanistan’s 34 provinces to roll out the BPHS which includes expansion of facilities where Family Planning is being offered.

⁴⁶ ROM report MR 136904.01, 2010 : Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province.

⁴⁷ See also The evaluation of the EC funded project ‘Provision of Basic Package of Health Services (BPHS) in Kunduz Province’.

Figure 9: Trends in Modern Contraceptive Use in Afghanistan



Source: Afghanistan Mortality Survey 2010

Family Planning (FP) services are in place in all the facilities. MICS 2003 shows that 93% of married women under the age of 50 years were not using any contraceptives and the Afghanistan Health Survey 2006 shows that 18.6% were using one contraceptive method. Kunduz HMIS data show an increasing trend in prevalence (20%) in the last quarter. This is explained by the project team by a special emphasis put upon the importance of spacing births throughout the health services after they realised that FP indicators were very low. The HMIS FP indicator is not very useful for monitoring the situation as all the methods are mixed and it does not indicate whether these are continuous users or new users and thus may be used with caution. The health professionals, CHWs and even the Health Shura members seem to be very comfortable with promoting child spacing and family planning. Nevertheless in some areas the environment may not be so conducive to talk freely about Family Planning or even Birth Spacing. Contraceptive methods were available in the health facilities and with CHWs at the time of the evaluation. But it was not possible to assess the quality of FP counselling.⁴⁸

1.5.1.2 Resume of the JC

Support by the EC to the roll-out of the BPHS resulted in a rapid increase in a number of MCH related indicators, like Skilled Births attendance, ANC use and contraceptive use. The EC contributed to the increased number of ANC visits and contraception by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which includes expansion of facilities where ANC and Family Planning is being offered.

In particular the Support to Afghan Public Health Sector, and the Provision of BPHS and EPHS according to MoPH policy in Lagham Province contributed to all three indicators (measured through reduced maternal and child mortality,⁴⁹ antenatal and postnatal consultations, and family planning showed result above the target. 28,000 women were reached instead of 17,000⁵⁰).

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

Indicators

- I-421 Percentage of children under five receiving regular growth monitoring
- I-422 Immunisation rate

⁴⁸ External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

⁴⁹ ROM report 104420.01 – 2008. Support to the Afghan Public health sector.

⁵⁰ Rom report MR 136903.01-2010: Provision of BPHS and EPHS according to MoPH policy in Lagham Province.

1.5.2.1 Findings

I-421 Growth monitoring is not an indicator reported on (yet) for Afghanistan. However, increases in child attendance at BPHS centres, especially of girls, is likely to have improved child nutritional monitoring in Afghanistan.

I-422 There is – as is often seen – a discrepancy to reported immunisation rates (e.g. WHO) and rates found in a community based survey. The former reports for DPT3 a rise from 31% in 2000 to 83% in 2010, while in the Afghanistan Health Survey 2006 DPT3 is reported as 20% in 2003 and 35% in 2006. At least both sources suggest that there has been a substantial improvement. The latter report also has a disappointing 27% overall immunisation rate (so the full EPI: BCG, measles, DPT3 and OPV3). While OPV and measles are partly covered by campaigns, DPT depends more on the fixed health facilities, and thus on the BPHS. The EC contributed to the increased immunisation rate by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which includes immunisation as one of its key priorities.⁵¹

The evaluation of the BPHS project in Kunduz showed following achievements against targets calculated on total population per quarter.

Table 4: Achievements of the BPHS project in Kunduz

Services	July-Sept 2007	Oct-Dec 2007	Jan-Mar 2008	Apr-Jun 2008	July-Sept 2008	Oct-Dec 2008	Jan-Mar 2009
DPT3	102%	117%	58%	121%	125%	91%	77%
TT2+	89%	78%	60%	114%	89%	77%	84%

Source: HMIS Kunduz - Calculation of target done on Population data CSO 2005

EPI coverage has been increasing although with seasonal decrease during the winter when access to services is difficult. Integrated Management of Childhood Illnesses (IMCI) training of health personnel started from December 2007 and the IMCI approach was introduced in Kunduz in all the Merlin-CAF run health facilities. IMCI charts could be observed on the walls in CHCs as well as in BHCs. The use of IMCI chart requires time and in a context of high attendance health workers may have difficulties in flowing the full process. This was recognised during the evaluation by some health workers. In general the introduction of IMCI through one initial training is not sufficient in order to ensure that health workers are fully familiar with the chart approach and thus for quality IMCI services and a close follow-up is usually needed. Merlin-CAF is planning to recruit a focal point for IMCI, what is very relevant in order to reinforce IMCI services.

1.5.2.2 Resume of the JC

Despite data that may over-estimate the immunisation rate, there is clearly a tendency for improved immunisation rates, to which the roll out of the BPHS contributes. The EC contributed to the increased immunisation rate by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which includes immunisation as one of its key priorities. Growth monitoring is not an indicator reported on (yet) for Afghanistan. However, increased attendance of children at EC-supported primary health care centres probably contributed to addressing the very high rates of stunted and underweighted children in Afghanistan.

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

Indicators

- I-431 Increased proportion of children sleeping under a bednets
- I-432 Reduction in rate of child deaths from diarrhoeal disease
- I-433 Improved household management of diarrhoea based on oral rehydration salts (ORS)

1.5.3.1 Findings per indicators

I-431 While a 6% is reported for 2008, this indicator is not really applicable to Afghanistan, where malaria is seasonal and restricted to certain geographical areas. Bednet use in these areas is being implemented at scale, initially supported by the EC by support to malaria and leishmaniasis control

⁵¹ External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

programme implemented by HealthNet/TPO, in 2003, as a follow-up to funding to similar activities in the years before 2002. When the EC support ended, activities including large scale distribution of bednets became part of Global Fund / World Bank activities. Bednet use in the affected areas is most likely substantially.

One of the reasons mentioned increased coverage is that since free bednets are distributed to pregnant women for her first visit many of them went to different clinics to get other bednets.⁵²

I-432 Under-five mortality is slowly dropping, in which reduced deaths from diarrhoea may play a role, but no cause-specific data is available. The EC contributed to the reduced deaths from diarrhoea in children by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which includes an emphasis on primary care facilities that are capable of dealing with diarrhoea, primarily through treatment with ORS.

I-433 No information available

1.5.3.2 Resume of the JC

Under-five mortality dropped from 222 in 2000 to 199 in 2009; so it is still very high, but with some decline. The roll out of the BPHS may have played a role here, but more refined data like specific reduction in diarrhoea death rates are lacking. The EC contributed to the decreased under-five mortality by contracting NGOs in 10 of Afghanistan's 34 provinces to roll out the BPHS which has an emphasis on treatment and prevention of conditions affection under fives.

1.6 EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

1.6.1 JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support

Indicators:

- I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators)
- I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector
- I 513 EC contributed to decentralized capacity building to strengthen health policy capabilities at provincial, district, and local levels

1.6.1.1 Findings

I-511 No evidence of EC interventions. However, the EAMR 01/2008 mentions that in *institutional development* a EUR 3 million contract was signed with EPOS reinforcing the capacity of the different departments and the MoPH in general to ensure its stewardship of the sector. The areas addressed through international TAs are: (i) policy and planning; (ii) human resources; (iii) administration and procurement; (iv) healthcare financing; (v) hospital reform and (vi) monitoring and evaluation. The support to the Disability Unit of the MoPH continued during 2007.

I-512 No information could be obtained up to today.

I 513 There are many plans for the decentralised activities in various field of health services delivery in Afghanistan but the only one that has materialized in some provinces is decentralized planning. There is no autonomy in the public hospitals running by the government. Contracting with NGOs for delivering health services is one of the decentralised processes in the health system. The main problems in this approach are: 1) there will be a very challenging phasing out strategy for the government to take over from NGOs; and 2) monitoring and evaluation of the programs that are running by different NGO will be full of problems.⁵³

⁵² External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF.

⁵³ Regional Health Systems Observatory- EMRO, Health Systems Profile- Afghanistan, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Afghanistan/Full%20Profile.pdf>, pp.20-21

The EAM 01/2008 further states that the support to Provincial Public Health set up continues with a combination of international and national TA, supply contracts and training. The programme has a positive impact on the capacity of the provincial public health and as an example, other donors started to replicate the same format late in 2007. The Grant and Contracts Management Unit was supported throughout 2007, by which it is regrettable that from EC side it was not yet possible to come to an agreement on the decentralization of at least the operational expenditures for this unit.

The “Health Management Training to the General Directorate of Provincial Public Health, Ministry of Public Health” (2006-2009), implemented by BRAC Afghanistan, strengthened the managerial and administrative capacity of the Afghan Ministry of Public Health for providing an efficient, accessible and equitable health services to the Afghan population at large and specifically in rural and remote areas.⁵⁴

The EC clearly contributed to decentralised capacity building in the ten regions out of Afghanistan’s 34 regions with its NGO contracted projects.

1.6.1.2 Resume of the JC

Services are delivered on the basis of contracting-out to NGOs.

1.6.2 JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

Indicators:

- I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc) in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing)
- I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

1.6.2.1 Findings

I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc). However, unlike the World Bank, the EC does not channel money for BPHS delivery through the MoF, but directly to the NGOs. Also, procurement for BPHS activities is still directly done by the EC, according to the MoH. Attempts to work more through the government (MoF/MoH) so far failed because of accountability concerns.

According to the MoH, transparency of services have increased, but, as the EC, compared to other donors, there is less follow-up on expenditure and budget flow.

I-522 No information could be obtained on this aspect.

I 523 No information could be obtained on this aspect.

1.6.2.2 Resume of the JC

No assessment can be made.

⁵⁴ Final Progress Report on Health Management Training to the General Directorate of Provincial Public Health, Ministry of Public Health

1.7 EQ6 Coordination, complementarity and synergy: To what extent and how has the EC contributed to strengthening government-led co-ordination, complementarity and synergies with Member States and other donors in the health sector, in line with the Paris Declaration? (national, regional and global levels)

1.7.1 JC 61 Level of health sector-related coordination in place with active role/contribution of the EC

- I-611 Evidence of EC participation and value added in functioning coordination mechanisms between donors
- I-612 Evidence of partner government leadership and EC value added in functioning coordination mechanisms between government and donors
- I-613 Change in number of project implementation units running parallel to government institutions within the health sector

1.7.1.1 Findings

I-611 According to the interviews with donors, the EC is an active member and on occasion the rotating chair of the donor coordination forum. This forum holds regular meetings, initially weekly, now bi-weekly. In addition to this general forum there are several committees where donors meet for coordination purposes, e.g. around MCH, pharmaceutical issues, the Afghan Trust Fund, etc. As main donor the EC has a strong voice in this coordination mechanism.

I-612 According to the interviews with donors, for years, the key coordination mechanism between the government and other stakeholders in the sector, in particular donors, UN agencies, is the Consultative Group on Health and Nutrition (CGHN). The EC is active member in this bi-weekly meeting, which is chaired by the MoH. All policy and strategy for the sector has to be discussed and passed in this forum. Besides the main CGHN there are several, sometimes ad hoc committees dealing with specific topics. The EC is often part of those committees.

I-613 The Grants and Contract Management Unit is seen by some as a project implementation unit. Others consider it as an integral part of the MoH, but with relatively high influence because of the important role contracts play in the health sector. It was set up in 2003 and is increasingly involved in managing and monitoring contracts in the health sector, including those with the NGOs to deliver health services, paid for by the various donors. Next to other staff, the Unit has more than 10 people, paid for by the EC, who are specifically monitoring EC projects.

1.7.2 JC 62 Increased complementarity of EC support and between EC support and support of other donors

- I-621 EU programming and planning process related to health has been co-ordinated with other (EU) donors (as e.g., evidenced by EC programming documents such as CSPs, NIPs)
- I-622 Evidence of joint activities enhancing complementarity
- I-623 Degree of complementarity of EU supported health-specific global trust funds, national trust funds and contribution agreements with other EC support to the health sector in the country.

1.7.2.1 Findings

I-622 Donor operations are divided by province. So, at provincial level there are not much joint activities between donors. At national level there is quarterly joint review of the BPHS/EPHS process, and there is an annual retreat with all major stakeholders. The EC fully participates in these joint activities and is in particular seen as the donor who actively promotes a SWAP approach, according to the interviews with donors.

1.8 EQ 7 Financing modalities, funding channels and instruments: To what extent have the various financing modalities (GBS, SBS, other sector support, projects), funding channels and instruments and their combinations, been appropriate, thus contributing to improving access to, equity of and policy-based resource allocation in health?

1.8.1 JC 71 Aid delivery methods (incl. modalities and channels) adapted to national context

- I-711 Alternative aid modalities and channels explicitly considered/analysed during project formulation stage
- I-712 Appropriateness of aid delivery methods used with regard to capacities of implementing partner
- I-713 Evidence that aid delivery methods were aligned to national systems and procedures and adjusted to evolving contexts

1.8.2 Findings

I-711 From the EAMR 2010 it is made clear that a shift to budget support is the preferred option for future support. *“Afghanistan is not yet eligible for BS and no ministry was ready for sector policy support programmes in 2010. Policies, programming and budgeting are often deficient. Core budget execution low, monitoring weak; and sector coordination remains poor. Donors are still reluctant to use government systems, while providing much substitution technical assistance. Only 20% of donor funds flow through government system and half of that is not earmarked.”*

According to the interviews with donors, the EC is the imitator of the SWAP approach in the health sector and provides technical and financing support. Support to this process is seen by the donors as the EC most important contribution. This could lead to an increased coordination in the health sector.

I-712 According to the MoH, the use of NGOs as main service providers is seen to have a high cost. On the other hand, it provides flexibility and the capacity of the MoH to directly be involved in service delivery is very limited.

The EAMR of 2007 highlights : “Major obstacles encountered in the period are: 1) the severe understaffing of the section: one PO dismissed because of breach of confidence and study, essential as programmatic document, is delayed (5) little progress on the conceptualisation one PO left disagreeing to the demanded levels of performance. (2) Limited progress on formulation mechanisms to pool funds among major health donors, (3) the “health sector review” for a SPSP in the institutional aspects of the health sector.

1.9 Annex

1.9.1 Key documentation used for the analysis

1.9.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
Reconstruction Programme for Afghanistan (2002, 2003, 2004) (ASIE/2002/003-024 ASIE/2003/004-847 ASIE/2004/006-095 ASIE/2004/016-775)		End of project evaluation : Health Programme Qarghayee and Alingar Districts, Laghman Province , Afghanistan 2007 (under ASIE/2003/004-847)	ROMs available,		(ASIE/2002/003-024: available not used yet ASIE/2003/004-847: (ASIE/2002/003-024: available not used yet ASIE/2004/91648 available not used yet ASIE/2004/006-095 several end of project reports available.
(ASIE/2005/017-681 & ASIE/2006/018-370) Support to the Afghan public health sector		External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF	3 ROMs available,		several end of project reports available.
(DCI- ASIE/2008/019-898) Support to the Afghan Public Health and Nutrition Sector			Done (2 ROM reports		several end of project reports available.
(ASIE/2006/018-300) , Contract 144737 Technical assistant to the disability Unit of the Ministry of public health			No ROM		available. -

1.9.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	done
EAMR	done
Country note from old health evaluation	Not available
Other Evaluations	External Evaluation Provision of Basic Package of Health Services (BPHS) in Kunduz Province of Afghanistan, EuropeAid/124832/C/ACT/AF
	Study Of Healthcare Financing In Afghanistan (2003-2008)
	Evaluation of the HealthNet TPO: Reproductive Health Outreach Pilot Project in Nangarhar province aiming at innovative approached to increase the number of supervised deliveries
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EAMR 01/2008

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Journal	article	PloS	Medicine:
http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001066			

Kunduz (north), Nuristan, Kunar, Laghman, Logar and Nangharar (east), Zabul and Oruzgan (south), Ghor and Dai Kundi (central Afghanistan)

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ROM report MR 104420.01 - 2008: Support to the Afghan Public health sector

ROM report MR 136903.01 - 2010: Provision of BHPS and EPHS according to MoPH policy in Laghman Province.

ROM report MR 136904.01 - 2010: Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services and Prison Health Services in Nangarhar Province

ROM report MR 136904.01 - 2010: Decision: Support to the Afghan Public Health and Nutrition Sector Project - Provision of Basic Package of Health Services for Ghor Province Afghanistan

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WHO, Department of Making Pregnancy Safer. 2006. Afghanistan Country Profile

1.9.1.4 Weblinks

<http://www.tradingeconomics.com/afghanistan/hospital-beds-per-1-000-people-wb-data.html>

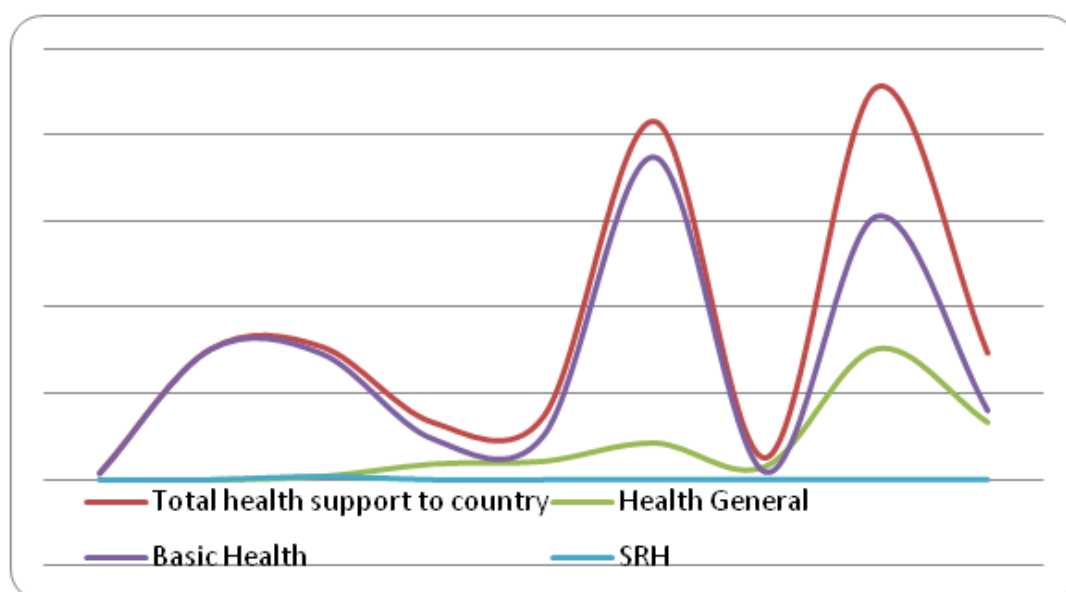
WHO Global Health Atlas, <http://apps.who.int/globalatlas/>

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1.9.2 EU funds between 2002-2010 – detailed listing

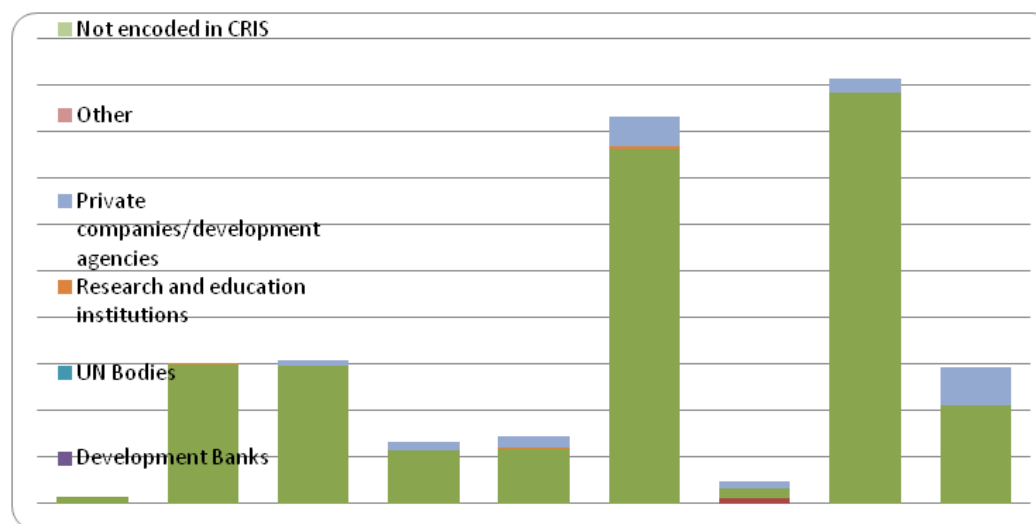
1.9.2.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to the country
2002	-	712,000	-	712,000
2003	-	15,118,162	-	15,118,162
2004	389,713	14,613,287	392,164	15,395,164
2005	1,829,914	4,749,829	-	6,579,743
2006	2,133,918	5,137,277	-	7,271,195
2007	4,245,449	37,359,994	-	41,605,443
2008	1,549,582	902,534	-	2,452,116
2009	15,088,897	30,505,290	-	45,594,187
2010	6,435,164	8,209,868	-	14,645,032
Total	31,672,637	117,308,242	392,164	149,373,043



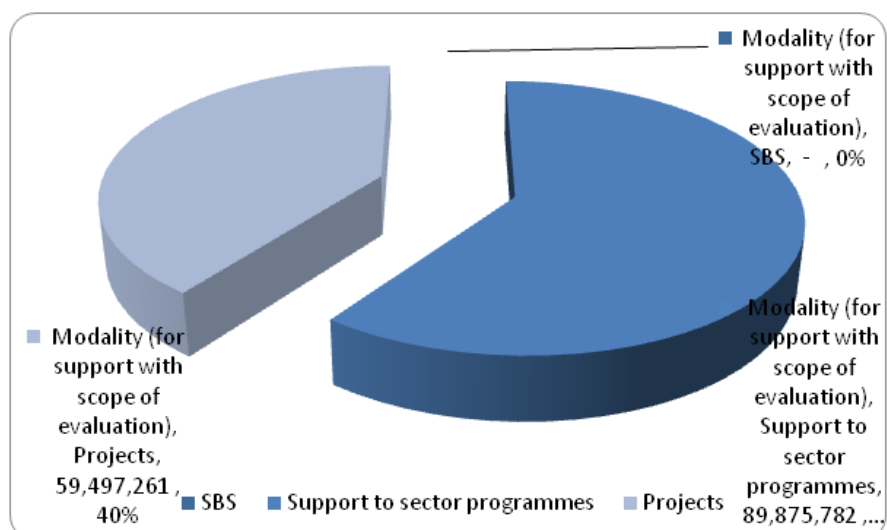
1.9.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	712,000	-	-	-	-	-	-	712,000
2003	-	15,018,662	-	-	99,500	-	-	-	15,118,162
2004	-	14,846,793	-	-	-	548,372	-	-	15,395,164
2005	-	5,774,823	-	-	-	804,920	-	-	6,579,743
2006	-	5,809,042	-	-	262,749	1,199,405	-	-	7,271,195
2007	-	38,058,488	-	-	326,426	3,220,528	-	-	41,605,443
2008	524,129	1,068,534	-	-	-	859,453	-	-	2,452,116
2009	-	44,203,120	-	-	-	1,391,067	-	-	45,594,187
2010	-	10,545,227	-	-	-	4,099,805	-	-	14,645,032
Total	524,129	136,036,689	0	0	688,675	12,123,549	0	0	149,373,043



1.9.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	712,000	-	712,000	-
2003	-	-	15,118,162	-	15,118,162	-
2004	-	-	15,395,164	-	15,395,164	-
2005	-	-	6,579,743	-	6,579,743	-
2006	-	4,533,715	2,737,480	-	7,271,195	-
2007	-	27,854,619	13,750,823	-	41,605,443	-
2008	-	1,399,491	1,052,625	-	2,452,116	-
2009	-	45,327,762	266,425	-	45,594,187	-
2010	-	10,760,194	3,884,838	-	14,645,032	-
Total	-	89,875,782	59,497,261	-	149,373,043	-



1.9.3 Overview of funds committed to the country's health sector

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention, contracted between 2002-2010</i>
ALA/02/0360 - Initial Recovery Programme for Afghanistan	ASIE/2002/003-149	2002	811.500€
Fifth Reconstruction Programme for Afghanistan	ASIE/2004/006-095	2004	17.180.994€
Fourth Reconstruction Programme for Afghanistan	ASIE/2003/005-645	2003	31.819€
Framework Contract AMS/451 - Dev. Coop. - Brussels	ASIE/2003/005-030	2003	55.573€
Global commitment for global in-country calls for proposal - Objective 1- PVD Projects - Non State Actors	DCI-NSAPVD/2007/019-615	2007	701.625€
Horticulture Project for Afghanistan	ASIE/2004/016-882	2004	334.332€
LRRD-FOOD SECURITY THEMATIC PROGRAMME FOR AFGHANISTAN 2009	DCI-FOOD/2009/021-086	2009	763.917€
N/A	MULTI - AFG/2002/0523	(blank)	355.407€
	N/A	(blank)	13.804.539€
OPERATIONAL SHORT TERM TECHNICAL ASSISTANCE RELATED TO THE FINANCIAL AND TECHNICAL COOPERATION WITH DEVELOPING COUNTRIES IN ASIA	ASIE/2005/016-885	2005	189.183€
Operational short-term TA related to Financial and Technical Co-operation with Asian developing countries	ASIE/2006/018-300	2006	278.236€
Operational Short-Term Technical Assistance Related to the Political, Economic, Cultural, Financial and Technical Cooperation with Developing Countries in Asia	DCI-ASIE/2008/019-770	2008	58.352€
pré-engagement dont dépendront les contrats PVD projets	ONG-PVD/2006/018-227	2006	300.000€
PROMOTING INNOVATIVE APPROACHES TO ADDRESS FOOD INSECURITY IN AFGHANISTAN	DCI-FOOD/2009/021-087	2009	1.909.441€
Removing obstacles to Afghan refugees return and challenging regional migration issues	ASIE/2005/017-608	2005	788.282€
Second Reconstruction Programme for Afghanistan	ASIE/2002/003-024	2002	10.466.758€
Sixth Reconstruction Programme for Afghanistan (GN)	ASIE/2004/016-775	2004	386.869€
SOCIAL PROTECTION IN AFGHANISTAN: STREET WORKING CHILDREN AND PEOPLE WITH DISABILITIES	ASIE/2005/017-658	2005	103.000€
"Support measures for FSTP AAP 2009".	DCI-FOOD/2009/021-078	2009	79.845€
Support to the Afghan Public Health and Nutrition Sector	DCI-ASIE/2008/019-898	2008	56.573.181€
SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR	ASIE/2005/017-681	2005	19.966.178€
SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR	ASIE/2006/018-370	2006	14.547.902€
Third Reconstruction programme for Afghanistan	ASIE/2003/004-847	2003	9.686.108€
Grand Total			149.373.043€

1.9.4 Overview of main programmes/funds and sectors

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the interventions</i>
Second Reconstruction Programme for Afghanistan	ASIE/2002/003-024	2002	9.686.108€
Third Reconstruction programme for Afghanistan	ASIE/2003/004-847	2003	10.466.758€
Fifth Reconstruction Programme for Afghanistan	ASIE/2004/006-095	2004	17.180.994€
SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR	ASIE/2005/017-681	2005	19.966.178€
SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR	ASIE/2006/018-370	2006	14.547.902€
Support to the Afghan Public Health and Nutrition Sector	DCI-ASIE/2008/019-898	2008	62.007.586€

1.9.5 Description of main EC intervention

1.9.5.1 Intervention no 1

Title: Second Reconstruction Programme for Afghanistan

Budget: 10.466.758€ to the health sector

Start and end date: 2002

Objectives and expected results:

Overall objective:

- The Project covered by this agreement entitled 'Support to the Public Administration Reform' will assure that the Second Reconstruction Programme makes a significant contribution to its overall objectives of 'stabilisation of the country by contributing to basic governance and meeting basic needs'.
- This project feeds into the good governance, which is one of the priority areas of the European Commission's reconstruction strategy in Afghanistan. The overall objectives of this priority are to build the capacity of the government as it re-establishes, stabilise and strengthen the budgetary process and to foster and support reform of the administration.

Specific objective:

- The specific objective of this project is to build the capacity of the government in both centre and provinces, and specially to strengthen the planning and capacity of the Ministry of Public Health (MoPH). This will be done by providing Ministers with the resources necessary to begin the restoration of a functioning government in Kabul and throughout Afghanistan.
- While this project addresses a government wide problem of capacity building, the state of health administration in Afghanistan is particularly weak in policy and management at ministry and provincial levels and so will receive particular attention in this project.

Expected results:

- Core ministries and provinces will have stronger implementation and policy making capacities, especially in core EC areas of health, rural development and public works.
- Centralised training capacity will be established and operational in Kabul.
- Basic information will be produced to guide future civil service reform.
- Central customs revenue collection system will be designed and accepted, covering also main customs revenue centres of Kandahar, Mazar, Herat and Jalalabad.

Activities:

Civil Works

- Rehabilitate the buildings of the ministries and provincial centres, both core rooms for CBGs and other parts of buildings where appropriate. There will be a priority on Ministry of Public Health and Ministry of Rural Rehabilitation and Development;
- Refurbish and fit out central training facility in Kabul.

Capacity-Building

- Develop cabinet training and seminars using distance learning centre;
- Improve existing training programmes for:
 - English Language Training (including training of trainers and establishment of English Language Institute);
 - Computer Skills;
 - Project Design/Project Management/Procurement;
 - Modern Public Administration;
 - Develop more tailored and advanced courses (e.g. audit);
 - Establish medium term TA Fund to contract qualified Afghans and other TA;
 - Integrate formal training with practical hands-on work

Procurement

- Procure equipment and supplies for Ministries and provincial CBGs

Improve AACA Coordination

- Recruit staff and advisers;
- Support the establishment and develop the CBG teams

1.9.5.2 Intervention no 2

Title: Third Reconstruction programme for Afghanistan

Budget: 10.126.708€

Start and end date: 2003

Objectives and expected results:

Overall objective:

The project covered by the related Financing Agreement will contribute to the following overall objective:

- To improve the managerial and administrative capacity of the Afghan Ministry of Health to provide efficient, accessible and equitable health services to the Afghan population at large.

Specific objective:

To enable and strengthen the decentralisation process of the Ministry of Health by providing support to the Provincial Health Liaison Office and selected Provincial Health Directorates in EC-funded provinces.

Expected results:

- The Provincial Health Liaison Office is fully functional and fulfils its roles and responsibilities effectively.
- Provincial Health Teams manage the Provincial Health Directorates proficiently
- Health care is delivered in an equitable and efficient manner in selected provinces.
- Information Technology is installed and functioning

Activities:

1. The Provincial Health Liaison Office is fully functional and fulfils its roles and responsibilities effectively

- With the support of long term EC and national TA,
 - to sustain and strengthen the daily management and functioning of the PHLO,
 - to establish and build capacity of the Project Task Force at central level, responsible for the development of an Overall Work Plan and Disbursement Schedules.
- to initiate and institutionalise organisational relations between provincial and central levels by ensuring a continuous and improved communication flow in both directions.
- to ensure that the information provided by the PHD's is appropriately used for defining new strategies and policies, and shared among other departments.
- to identify and respond to immediate capacity building needs of PHLO-staff.

2. Provincial Health Teams manage the Provincial Health Directorates proficiently

- to support PRR-ed Provincial Health Directorates in the fields of:

- organisational management of the directorates in order to ensure proper functioning (including the provision of support to the advancement of an organizational development plan)
- provision of tailor-made training of Provincial Health staff following needs assessments (encompassing management, financial planning, organizational theory, gender, monitoring and evaluation, public health issues, policy development and implementation skills).
- to assist Provincial Health Teams in identifying priorities in the sector and developing, in collaboration with other stakeholders, plans and strategies to address them, through a.o.:
 - the enhancement of the functioning of the Provincial Health Coordination Committee (PHCC)
 - continued monitoring and evaluation of ongoing projects and processes (specifically the implementing of the Basic Package of Health Services by NGOs) by the strengthening of the Health Management Information System (HMIS).
- to, where appropriate, support the implementation of the short- and mid term capacity building plan developed by the MoH Public Administration Capacity Building Working Group.
- to provide follow-up and supervision of the Provincial Health Teams in the implementation of acquired planning and management skills.
- to produce and disseminate technical and financial reports to the appropriate departments and (senior) management
- to regularly disseminate and share information on lessons learned and experiences gained with respective forums at central MoH, with institutionalised feedback to the provinces.

3. Health care is delivered in an equitable and efficient manner in selected provinces.

- to improve and strengthen the public/private partnership in the implementation of the Basic Package of Health Services, through:
 - regular communication
 - exchange of information and feed-back
 - joint planning, including participatory planning at community level
 - monitoring and supervision
 - institutionalised reporting on quality of services to central MoH for feedback and decision-taking
- to support the implementation of cost-sharing initiatives currently defined at central level, with special focus on continued accessibility and equity for the most vulnerable in society.

4. Information Technology is installed and functioning

- to procure IT equipment according to EC rules and regulations
- to distribute and install IT equipment, in identified training sites
- to develop adequate IT training modules for proper use and maintenance
- to train PHO staff to use and maintain IT equipment

1.9.5.3 Intervention no 3

Title: Fifth Reconstruction Programme for Afghanistan

Budget: 17.180.994€b (*only health component*)

Start and end date: 2004

Objectives and expected results:

Overall objective:

- Political stability is established and the public administration has resumed basic functions. Rule of law and human rights including those of women are respected. Progress in terms of economic recovery is made particularly in view of reducing poverty and dependence on the opium economy.

- The Overall Objective comprising all six sectors of the programme is as follows: The living conditions of the ordinary Afghan population including returnees are enhanced through better access to basic services, continuous economic recovery reducing dependency on opium production and a more secure environment.

Specific objective:

- **Rural Development:** Local governance is improved and community projects benefit each village in three districts per province.
- **Infrastructures:** The Kabul - Sarobi section of the Kabul - Jalalabad -Torkham road is rebuilt making transport more efficient and reliable.
- **Health:** The national health care system is enabled to provide a Basic Package of Health Services (BPHS) to the under-served population of selected provinces.
- **Institutional Strengthening of ATA:** Budgetary constraints and problems regarding information management are reduced and a better functioning of the public administration is ensured.
- **Demining:** The threat deriving from mines and UXO will be reduced in selected regions and former militias are socially reintegrated into their communities.
- **Applied research:** The ATA and the International Community have a better understanding and knowledge of the complex Afghan environment.

Expected results:

Rural Development:

- Local governance is improved at village level in three districts per province.
- Social and economic situation is improved at village level in three districts per province.
- Community micro-projects are completed (these projects will be as various as irrigation schemes, social buildings, village banks, micro-power plants...)

Infrastructures:

- The Kabul-Sarobi section road is rehabilitated to international standards

Health:

- Number of population having a fair access to good quality BPHS provided through NGOs is increased.
- Capacity of the Ministry of Health and other health providers to ensure proper management of malaria and leishmaniasis is improved.

Institutional Strengthening of ATA:

- The Trust Funds (ARTF and LOTFA will provide to donors a possibility to pool resources together ensuring a co-ordinated support to the reconstruction programme and reform process of the ATA.
- The ATA capacity on information management (standardisation and data collection, and mapping) is strengthened.

Demining:

- Priority areas are selected and surveyed for protection.
- Priority areas in particular road reconstruction sites and locations for large scale investment projects are cleared of mines and UXO.
- Vulnerable groups are aware of mine dangers reducing risk of self-injury.
- Capacity of UNMAPA in terms of co-ordination and supervision of partners is improved reducing the risk of de-mining and make it more cost-effective.
- Government is enabled to set overall policy and to make sure that Afghanistan complies with the Mine Ban Treaty recently signed.

Applied research:

- Quality applied research studies are carried out on water management (irrigation and water social management), opium economy and livestock. Results are properly disseminated.

Activities:

Rural Development:

- Mobilise communities in order to elect village councils.
- Identification of community projects.

- Block grants managed by communities.
- Community projects implemented.
- Monitoring carried out by the overseeing agency

Infrastructures:

- Improvements such repair and reconstruction of bridges, culverts and Irish crossings, as well as of retaining walls.
- Pavement reconstruction, mainly consisting of milling and reclaiming existing asphalt, preparation of sub-base/base and asphaltic concrete layers.
- Existing structures repaired/reconstructed made of concrete, brick masonry or stone masonry.

Health:

- Agree with MoPH on geographical priorities for the delivery of the BPHS.
- Identify, negotiate and sign contracts with NGOs with full involvement of MOPH at all stages of project cycle.
- NGOs run health facilities and deliver BPHS in chosen geographical areas under the overall responsibility of MOPH or their provincial offices.
- The NGO HealthNet International builds the capacity of MoPH and other health providers in managing and implementing the malaria and leishmaniasis control programme.

Institutional Strengthening of ATA:

- Contribution to ARTF: No activities have been defined for this component due to reasons mentioned above.
- Standardization of data collection.
- Production of maps.
- Training of line ministries and specialized governmental offices in Management Information System.

Demining:

- Survey of mine fields and UXO contamination.
- Clear humanitarian Mine/UXO, expand the use of community based de-mining and use former combatants where appropriate.
- Survey and clear major infrastructure projects, including Kabul-Jalalabad-Torkham road and development of a new contracting mechanism that serves requirements of works contractors to clear roads during reconstruction.
- Conduct awareness education on Mine Risk and appropriate behaviour.
- Implement quality assurance system to underpin quality of de-mining activities.
- Improve capacity of relevant government entities in view of mine action management
- Co-ordinate and manage support, including support to operation of UNMAPA regional offices that oversee provincial level co-ordination and management.
- Identify, train and monitor ex-militia becoming community-based deminers.

Applied research:

- For the main issues to be studied, liaise closely with other donors and the ATA to drawn up the TORs.
- Plan and conduct research work on the selected topics.
- Dissemination of the research results to the ATA and the international community

1.9.5.4 Intervention no 4

Title: SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR, 2005
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Budget: 20.226.013€**Start and end date:** 2005**Objectives and expected results:****Overall objective:**

To contribute to the significant reduction of the burden of morbidity and mortality among the Afghan population especially women and children.

Specific objective:

Public health services are enabled to provide quality and equitable care to the Afghan population, especially women and children, in ten EC-supported provinces.

Expected results:

- The Basic Package of Health Services, with a special focus on reproductive and maternal & child health care is successfully implemented.
- District and Provincial Hospitals are able to provide the EPHS complementing the BPHS,
- The Ministry of Public Health is enabled to serve as steward of the health system at central and provincial level.

Activities:**The Basic Package of Health Services, with a special focus on reproductive and maternal & child health care is successfully implemented.**

- health system delivery and its management are contracted out to not-for-profit organizations in order to guarantee efficient and timely delivery of services,
- service contracts are designed and introduced using (province adapted) National Health Indicators
- an ongoing third party evaluation of the BPHS-approach and BPHS contracts in EC supported provinces is carried out
- Quality of Human Resources in BPHS projects, with a special emphasis on skilled female health professionals, is improved

District and Provincial Hospitals are able to provide the EPHS complementing the BPHS.

- A comprehensive provincial referral system is implemented, with a special focus on Comprehensive Emergency Obstetric Care
- Quality of hospital care in BPHS contracted health service delivery systems is upgraded.
- Integrated public hospital administration reform is introduced and supported

The Ministry of Public Health is enabled to serve as steward of the health system at central and provincial level.

- procurement of health services, contract management, and regular monitoring and evaluation to be carried out by the Ministry of Public Health Grant
- Contract Management Unit (GCMU) through decentralized management institutional reform needs, with a special emphasis on policy, planning, budgeting and financial management, identified and successfully addressed
- decentralized structures designed and institutionalised
- capacity building institutionalised through a targeted Capacity Building Group Approach
- stimulation of policy dialogue amongst various partner ministries and other relevant stakeholders

1.9.5.5 Intervention no 5

Title: SUPPORT TO THE AFGHAN PUBLIC HEALTH SECTOR, 2006
--

Budget: 14.548.902€

Start and end date: 2006

Objectives and expected results:**Overall objective:**

To contribute to the significant reduction of the burden of morbidity and mortality among the Afghan population, especially women and children.

Specific objective:

Public health services are enabled to provide quality and equitable care to the Afghan population, especially women and children, in ten EC-supported provinces.

Expected results:

- The Basic Package of Health Services, with a special focus on reproductive and maternal & child health care is successfully implemented.
- District and Provincial Hospitals are able to provide the EPHS complementing the BPHS,

- The Ministry of Public Health is enabled to serve as steward of the health system at central and provincial level.

Activities:

The Basic Package of Health Services, with a special focus on reproductive and maternal & child health care is successfully implemented.

- To guarantee efficient and timely delivery of health services by not-for-profit organisation based on the contracting-out model;
- To replace the last grant contract agreements with partners by competitive tendering for services;
- To support human resources development aiming at improving quality of care in BPHS-project, with a special focus on skilled female health professionals ;

District and Provincial Hospitals are able to provide the EPHS complementing the BPHS,

- To establish comprehensive provincial referral systems in EC-supported provinces, with a special focus on Comprehensive Emergency Obstetric Care;
- To upgrade the quality of care in District Hospitals that are part of BPHS-contracts;
- To continue support to the integrated public hospital administration reform strategy;
- To renovate hospitals in need of renovation or upgrading.

The Ministry of Public Health is enabled to serve as steward of the health system at central and provincial level

- To continue support to the Ministry of Public Health in general and the Grant & Contract Management Unit in particular, in order for the MoPH to assume responsibilities for decentralised procurement of health services, contract management, and regular monitoring and evaluation;
- To continue support to institutional reform;
- To strengthen decentralized structures, i.e. Provincial Health structures;
- to stimulate policy dialogue amongst various partner ministries and other relevant stakeholders.

1.9.5.6 Intervention no 6

Title: Support to the Afghan Public Health and Nutrition Sector
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Budget: 62.007.586€

Start and end date: 2008

Objectives and expected results:

Overall objective:

Better health for all Afghans in order to contribute to economic and social development.

Specific objective:

- to support institutional and capacity development of the MoPH at central and provincial level towards improved sector stewardship and a sector-wide approach (policies and strategies, planning and budgeting, health financing, regulation, oversight including M&E, donor co-ordination);
- to provide aligned and harmonized support to quality health care service delivery in 10 provinces based upon the BPHS and EPHS

Expected results:

- The institutional capacity of MoPH, instrumental for effective HCS delivery and for acting as a steward of the sector, is strengthened. Indicative areas for EC support/activities have been identified. The final package of EC capacity and institutional development support will be refined in function of the outcome of the sector review and follow a harmonised approach with the other donors (WB, USAID).
- The BPHS is effectively implemented in the 10 EC-supported provinces and the EPHS is effectively implemented in at least 5 EC-supported provinces. More selected EPHS-support is implemented to support the Orthopaedic and Rehabilitation wings of the regional hospitals in Herat and Kandahar and the national Mental Health Hospital in Kabul.

- Groups at risk for ill health are effectively integrated in the BPHS and EPHS schemes. Activities will be specific studies, a TA component at the central level, and the inclusion of the target groups in the grants to Implementing Partners (IP).

Activities:**1. The institutional capacity of MoPH is strengthened:**

- To effectively assist the Grant and Contract management Unit (GCMU) and the Directorate for Policy and Planning;
- To convey the stewardship role at provincial level and vis-à-vis development parties;
- To develop and enforce policies / guidelines instrumental for the effective integration of groups at risk of ill health in the BPHS-EPHS schemes;
- To backstop and guide the implementation of the EPHS, the core functions of GD Pharmaceutical Affairs, GD of Administration and Finance and Human Resources.

2. The Basic Package of Health Services (BPHS) is effectively implemented in 10 provinces.**3. The Essential Package of Hospital Services (EPHS) is effectively implemented in at least 5 Provinces and a selected number of regional/national hospitals:**

- To guarantee efficient and timely delivery of health services by not-for-profit organisations based on the contracting-out model;
- To support human resources development aiming at improving quality of care in the BPHS-project, with a special focus on skilled female health professionals;
- To support appropriate referral schemes inside the province and in full complementarity with BPHS-EPHS;
- To continue support to the integrated public hospital administration reform strategy;
- To renovate hospitals in need of renovation or upgrading;
- To streamline weaker areas such as disability and mental health.

4. Groups at risk for ill health are effectively integrated in the BPHS and EPHS schemes

- To streamline disability (including Mental Health), nomadic Kuchi and IDP (Internally Displaced People) assistance in the BPHS-EPHS schemes.

2 Annex 13: Country case study Bangladesh

***Thematic evaluation of
the European Commission support
to the health sector***

Thematic case study
BANGLADESH

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2.1 Introduction

2.1.1 Country context of EC support

Bangladesh has been a longstanding partner in the Commission's development co-operation and is still one of the largest recipients of Community assistance in Asia.

Densely populated, Bangladesh has 140 Million people. Bangladesh is a so-called 'least developed country', but has shown marked improvement in the recent past, including a considerable decline in both the birth rate and death rate. Nutrition and childhood infections remain key challenges for the health sector.

The EC CSP 2002 states that donors generally agree that most programmes aiming at poverty reduction, including major NGO programmes, have pre-dominantly benefited the moderate poor, but failed to reach the poorest of the poor. To address this structural poverty, a key area to be addressed is 'good governance'. Next to other important donors like DFID, UNDP and World Bank, the EC has therefore decided to concentrate on improving human development indicators, with in-built good governance and institutions building elements. The largest share of the CSP 2002-2006 (with EUR 560 million) is therefore focusing on improving Bangladesh's human development indicators, in a limited number of sectors, including the Health, Population and Nutrition sector.

Following on from the EC's earlier involvement in the field of primary health care, culminating in its participation as the largest bilateral donor in the sector-wide Health and Population Sector Programme (HPSP) project, the EC CSP 2002 then aimed to contribute to supporting a second phase of the sector-wide programme.

The Health, Nutrition and Population (HNP) Sector Programme (HNPS), launched in 2003 and revised in 2005, aims to reform the health and population sector with the long-term vision of creating a modern, responsive, efficient and equitable HNP sector. The programme entails provision of a package of essential and quality health care services responsive to the needs of people, especially those of children, women, the elderly and poor.

Several donors, including the EC, contribute to the HNPS through a World Bank administered trust fund. The total amount adds up to EUR 3,375 million for 2005-2010 of which the EC contributes 105 M. Other partners include: Government of Bangladesh, World Bank, DFID, RNE, SIDA, CIDA, KFW, USAID, Japanese Government, ADB and UN Agencies. HNPS is by far the largest programme supporting the health sector and its 38 operational plans account for around 90% of budgeted Government development expenditure on health (APR09)

The next EC CSP (2007-2013) reaffirmed the EC support to the health sector, essentially through the support to the HNPS.

The HNPS is annually reviewed by an independent review team reported in an Annual Programme Review (APR), available for the year 2006, 2007, 2009 and 2010. In 2008 the same team performed a more extensive mid term review (MTR08).

2.1.2 EU funds between 2002-2010:

Between 2002-2010, the EC allocated EUR 113 million to Bangladesh, EUR 105 million of this being for the EC- Support to the national Health, Nutrition and Population Sector Programme (HNPS).

Key activities under this EUR 105 million decision were a contribution of EUR 76 million to a World Bank administered HNPS pool fund, in 2006 and a total of EUR 26 million for contracts with various UN agencies in 2008, i.e. EUR 10 million to UNFP for 'Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction'; and EUR nine million to UNDP for 'Improving Health, Nutrition & Population in the Chittagong Hill Tracts'. The Urban Health Component of the programme has been replaced by three different activities: a national food safety project with FAO/WHO EUR seven million, the continuation of the country Immunisation Surveillance network with WHO 1.4 Million EUR and the expansion of maternal vouchers scheme monitoring and supervision system with the Government of Bangladesh EUR 0.7 million. The rest of the money going to a number of support and monitoring missions, including work on health finance options. Further information on the HNPS can be found in Annex 2.9.4.

Table 5: Overview of contracts financed under the EEC support to the national Health, Nutrition and Population programme between 2002 and 2010

Decisions Title	Decision #	Contracts Title	Ctrct #	Ctrct year	Total
EC- Support to the national Health, Nutrition and Population Sector Programme	ASIE/2005/017-585	Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction	149350	2008	10.000.000€
		Continuing monitoring and supervision system for a pilot project on Demand Side Financing (Maternal Voucher Scheme)	170512	2008	250.000€
		EC Support to the National Health Nutrition and Population Sector Programme	124833	2006	76.000.000€
		HNPSP - UN Collaborative Health Initiative in the CHT - Assessment of Project Proposal and development of alternative options	140664	2007	93.128€
		Improving food safety in Bangladesh - Appraisal of a project proposal by FAO	143305	2007	70.895€
		Improving Food Safety, Quality and Food Control in Bangladesh	164234	2008	7.108.218€
		Improving Health, Nutrition & Population in the Chittagong Hill Tracts	165839	2008	9.000.000€
		Innovative approaches to Health Financing in Bangladesh : HNPSP - Identification of options	140301	2007	-€
		Innovative approaches to health financing in Bangladesh: HNPSP - Identification of options	142938	2007	83.301€
		Joint Appraisal Mission for Accelerating Progress Towards Maternal and Neonatal Mortality and Morbidity Reduction	128403	2006	34.740€
		Monitoring and supervision system for a pilot project on Demand Side Financing (Maternal Voucher Scheme)	170241	2008	450.000€
		Monitoring the EC-UNDP Health Project in the Chittagong Hill Tracts	169145	2008	134.339€
		Monitoring the UN collaborative project on maternal and neonatal health	169257	2006	123.510€
		Support for defining Health Financing Options in HNPSP	169284	2007	154.375€
		Support Ministry of health in designing a proposal for a monitoring system for a Demand Side Financing Scheme	164116	2007	37.183€
		Supporting the preparation of a successor programme to the ongoing Health, Nutrition, and Population Sector Programme, Bangladesh	169290	2008	168.198€
		Supporting WHO field surveillance network	169073	2008	1.400.000€
		Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction	149350	2007	10.000.000€
Continuing monitoring and supervision system for a pilot project on Demand Side Financing (Maternal Voucher Scheme)	170512	2007	250.000€		

Source: CRIS database, Particip GmbH analysis

Table 6: Overview of all EU funds committed to the health sector in Bangladesh between 2002-2010⁵⁵

Decisions Title	Decision #	Dec Year	Contracts Title	Ctrct #	Ctrct year	Total
ALA/00/09 - Primary Health Project Cox's Bazaar Phase 3	ASIE/2000/02-583	2000	Final Evaluation of Primary Health Care Project, Cox's Bazar 3rd Phase	102663	2005	45.733€
DCI-NSA Support measures 2008 - Allocation AIDCO/F	DCI-NSA/2008/019-819	2008	Financial Audit for the project ""Capacity Building for Tuberculosis Control and Leprosy Elimination û Bangladesh""	163956	2008	29.041€
	DCI-NSAPVD/2009/021-105	2009	Early Childhood Care and Development in Disaster Prone Areas	210435	2010	847.688€
EIDHR 2007 AAP - COUNTRY BASED SUPPORT SCHEMES	(blank)		Treatment and Rehabilitation of Adibashi (Tribes) Victims of Torture and Organised Violence in Bangladesh	155247	2008	159.875€
Framework Contract AMS/451 - Dev. Co-operation - Bangladesh	ASIE/2003/005-009	2003	Appraisal - EC support on Quality Management to the Health, Nutrition, Population Sector Programme	85591	2004	60.975€
Global commitment for in-country and multi-country calls for proposals - Objective 1 - PVD projects - Non State Actors - AAP 2009	DCI-NSAPVD/2009/021-105	2009	Affordable and sustainable health care for vulnerable people	208612	2010	1.000.000€
	(blank)	2009	Early Childhood Care and Development in Disaster Prone Areas	210435	2010	847.688€
	DCI-NSAPVD/2009/021-105	2009	Improving Maternal and Newborn Health through Public-Private Partnership	208367	2010	325.392€
Health workers : call for proposal	(blank)	2009	TARSAN - CSO Towards sustainable quality healthcare delivery at grassroots level through active participation of civil society organisations	230203	2010	1.217.476€
N/A	(blank)	(blank)	Bangladesh - Birth Registration	110772	2005	999.000€
Operational short-term TA related to Financial and Technical Co-operation with Asian developing countries	ASIE/2006/018-300	2006	Mid- term review of thematic project SANTE/2004/80420: Working towards Safe Motherhood in South Asia: Increasing Access to Maternal Health Services for Poor Women in Rural Bangladesh	139062	2007	51.112€
	ASIE/2006/018-300	2006	Mid-term review of thematic project SANTE/2006/120-021: Adolescents and Women's Reproductive and Sexual Health Initiative (ARSHI)	144566	2007	44.005€
Operational Short-Term Technical Assistance Related to the Political,	DCI-ASIE/2009/0	2009	Costing of the next Health Sector Programme	248565	2010	4.023€

⁵⁵ The overview reflects the contracts related to the health sector available in the CRIS database between the period 2002-2010.

Decisions Title	Decision #	Dec Year	Contracts Title	Ctrct #	Ctrct year	Total
Economic, Cultural, Financial and Technical Cooperation with Developing Countries in Asia	21-502					
pré-engagement dont dépendront les contrats PVD projets	ONG-PVD/2004/006-239	2004	Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts	112170	2005	743.877€
pré-engagement P1 dont dépendront 190 contrats en faveur de pays en développement	ONG-PVD/2002/001-092	2002	INTEGRATED RURAL PROGRAMME TO PROMOTE ACCESS TO INCOME, EDUCATION AND HEALTH FOR KHASI MINORITY IN SYLETH DIVISION, BANGLADESH	20044	2002	240.890€
Small Initiatives by Local Innovative NGOs SMILING	ASIE/2000/002-464	2000	Advocacy for Poor's Access to the Local Public Health Services.	158701	2010	142.499€
	ASIE/2000/002-464	2000	Households` Enhanced Access to Local Treatment and Health Services (Health Services) project	253728	2010	148.009€
Thematic Lines Support Expenditure Programme 2005	(blank)	2005	External Audit of 'Urban Community Health Programme	104657	2005	21.412€
Thematic lines support expenditures programme 2006.	(blank)	2006	Audit for Urban Community Health Project	128233	2006	10.060€
Health and FW Action Research Project (BHARP)	ASIE1997/002-656	(blank)	Bangladesh Health and FW Action Research	81660	2004	27.852€
	ASIE1997/002-656	(blank)	Post Implementation Peer Review of BHARP Project implemented by International Centre for Diarrhoeal Disease Research, Bangladesh	110413	2005	4.957€
Grand Total						111.231.762€

Source: CRIS database, Particip GmbH analysis

2.2 EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services?

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

Indicators

- I-111 National health policies guarantee access to drugs, officially recognised as essential.
- I-112 Average availability of selected essential medicines in public and private health facilities, including pharmacies.

2.2.1.1 Findings per indicators

I-111 Bangladesh is known for its championship, in the 1980s, in the promotion of (generic) essential drugs, partly in response to known shortages at primary health level facilities. However, still in 1997, a sample of health facilities in remote areas revealed that only 8% of essential drugs needed at those levels were available. There is no concrete information whether the EC has contributed to national health policies guaranteeing access to drugs, officially recognised as essential.

I-112 In the 2008 Mid Term Review, the following is noted on procurement in the public sector: "Lengthy procurement processes are associated with poor advance planning, over-centralisation, inadequate coordination mechanisms, and lack of a standardised procurement monitoring system. As a consequence, stock-outs occur." And the APR (2009) remarks: "Less positively, there has been no improvement in the low utilisation of curative health services, especially by the poor. Utilisation is strongly associated with the availability of drugs, but provision for drugs at lower levels of the system has long been insufficient and even in decline." However, the latest APIR (2010) states that "essential drugs have been supplied in all Upazilas of the country and logistics supplied. Drawing on the findings of the report, the supply of medical equipment and drugs increased from 226 Emergency Obstetric Care Facilities in 2009 to 237 in 2010.

Figure 1: Performance-based financing indicators for 2009

Name of Indicators	Status 2008	Target		Status	
		2009	2010	2009	2010
i) National					
Availability of Essential Drugs	96%	100%	100%	97%	98%
ii) OP level					
Availability of Essential Drugs		96%	100%	100%	97%

Source: HNPSP APIR 2010

Besides these statements of the HNPSP APR, the old health evaluation of 2007 provides a positive picture regarding EC contribution to this indicator. The report noted that medicines for the directly observed treatment short courses (DOTS) program are provided by the MOH through their part of the global fund (GF) grant. Malaria medicines and rapid diagnostic test kits are also provided by the MOH through their part of the GF grant. The procurement of medicines, contraceptives and other medical inputs, affected by stock outs in the last two years (2005-2007), has been streamlined and seems to be working better now. Essential drugs and contraceptives are funded through the SWAp trust fund with an emphasis of maintaining the Upazila level well supplied.

Furthermore smaller projects such as the Primary Health Care Project (PHC) Cox's Bazaar; of which 80% has been funded by the EC, included a component which focused on pharmacies and stock of essential drugs and seemed to be successful in this respect⁵⁶.

2.2.1.2 Resume of the JC

No recent quantitative data about drug availability at public health facilities was available. Qualitative statements in various reports indicate that in particular in the more remote areas and for the very poor drug shortages are frequently noted, however, the documents reviewed did not provide a consistent picture regarding the achievements of the EC under HNPSP. Whilst the APR (2009) of the HNPSP saw no improvement, the latest APIR (2010) and the old health evaluation (2007) were more

⁵⁶ Final Evaluation of the Primary Health Care Project Cox's Bazaar, 2005

optimistic. Thus, it can be assumed that there has been an improvement, at least regarding the average availability of selected essential medicines.

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

Indicators

- I-121 Improvement in the mix of primary and secondary health facilities
- I-122 Increased proportion of health facilities with appropriate equipment
- I-123 Increased proportion of health facilities with adequate budget for maintenance and recurrent expenditures

2.2.2.1 Findings per indicators

I-121: Bangladesh is administratively divided in Divisions (7), Districts (64), Upazila/Thana and Union Parishods (UPs). Out of 476 Upazilas, 400 rural Upazilas have health complexes, and are functioning with 31-50 beds. At the next level of 4,484 Unions, 1362 Union sub-centres are functioning and 3,648 Health & Family Welfare Centres run by the Family Planning (FP) Department. Besides, there are 671 hospitals with total number of 35,500 beds and 91 Maternity and Child Welfare Centres. No trend data on the mix of facilities is available. The number of hospital beds (WB and WHO data) in 2002 was 0.34/1,000 and in 2004 and 2005 0.4/1,000, which are very low rates.

Regarding the documents reviewed the 2nd ROM report MR-130903.02 (2011)⁵⁷ of the “Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction” project which has been financed under HNPSF noted that the quality of the maternal and neonatal health (MNH) district and Upazila 2010-11 plans has improved compared to 2008-09. Fifteen Comprehensive and ten Basic Emergency Obstetric and Newborn Care (CEmONC and BEmONC) facilities have been upgraded/established, thus contributing to an increased number of health facilities.

Likewise, the APIR 2010 noted that the pace of progress of Community Clinic (CC) construction and renovation is significant. Till 2001, 10,723 CCs have been constructed, of which till date, 7,522 CCs have been repaired or renovated and remaining 3,201 CCs are in the process of repairing plan. By end of 2010 year another 2,876 CC were planned to be constructed.

I-122 There was a 2008 survey of equipment in health facilities, but it was not possible to assess from this survey whether the equipment found represented an improvement in facilities as this survey was not repeated nor levels of equipment monitored since.⁵⁸ The APR2009⁵⁹ refers to absence of basic equipment when discussing low utilisation: “Low utilisation also reflects lack of staff (especially in the more remote facilities), and absence of basic equipment.”

It is also notable that for listed indicators in the APR2009, like “% health facilities that provide quality services according to National Standard”, “% health facilities with functional ComEOC/Basic EOC”, and “% hospitals achieving and maintaining three to five star rating under IHMS accreditation scheme” no data are entered in the tables.

However, even though the APR2009 noted a lack of equipment, the EC has provided support for equipment for instance under the Gender, Equity and Voice component under HNPSF. The APR2009 noted that in the period from July 2007 to June 2008, as part of the “Strengthening of Baby and Women Friendly Hospital”, a number of hospitals have been selected and assessed; orientation has been provided to the service providers and community; additional monitoring carried out and supply of medicine, instrument & equipment for strengthening of the Women Friendly Hospital activities at district hospital has been provided. In addition, the APIR2010 stated that the number of EmOC Facilities supplied with medical equipment and drugs has been increased from 226 in 2009 to 239 in 2010.

I-123 According to the Annual performance reports 2009⁶⁰ and the performance indicators “APIR captures development budget expenditures for 5 largest Ops at the district level” and “Improved

⁵⁷ European Commission(2011): MR-130903.02 Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction

⁵⁸ Interview with Bangladesh EUD

⁵⁹ Annual Programme Review(2009): Bangladesh Health, Nutrition and Population Sector Programme (HNPSF) Volume I, Main Consolidated Report, 10th May 2009

⁶⁰ Annual Programme Implementation Report (APIR), Operational Plan (OP)

Budget Management”, the provided support in order to increase the proportion of health facilities with adequate budget for maintenance and recurrent expenditure. The progress between 2005 and 2008 in budget management was apparent between 2006 and 2007, showed by an increased from 45% to 52%. In 2008-2009 this figure reached 54.5% according to the APR2009. However, for 2009 the targeted 3% increase of budget going to Upazila and below has not been achieved.

2.2.2.2 Resume of the JC

While the EC supports the HNPS, being the government’s health sector programme, which should include assistance to facilities etc, there is no information easily available on these specific indicators. This may partly be explained by the frequently mentioned highly fragmented health services with a high degree of vertical organisation of the Bangladeshi health services and the lack of data available.

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

- I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population
- I-132 Improved availability and standards of health worker training
- I-133 High health worker attrition and absenteeism rate addressed

2.2.3.1 Findings per indicators

I-131 The number of physicians per 10,000 inhabitants is given as 2.95/10,000 for the year 2007, but no trend data available. Nurses/midwives are 2.7/10,000 in the year 2007 (WHO), but again no trend data available. However, for both cadres, the APR reports the risk of unemployment of doctors and nurses, since the system is not able to absorb the new graduates. The number of physicians and in particular the number of nurse/midwives is well below the regional average.

Health workforce shortage is a chronic problem in Bangladesh. A concluding remark in the APR2009 is: “All chapters in this report show that there is a crisis in the human resources of the health sector in the country, both in quantity and in quality” which adversely affects the whole health sector. For instance, low utilisation of drugs is highly associated with lack of staff and based on “poor prioritisation of spending, and pervasive problems of management and coordination.” Ministry of Health and Family Planning (MOHFW) has not yet tackled the internal reforms to address these problems, nor has it exploited the potential to improve the contribution of non-public sector service providers. Similarly, the old health evaluation provides information in this regard by stating that in 2007 that there are 50% vacancies at the lower levels for family planning (FP) services and 40% vacancies for primary health care (PHC) community services (filling these positions has been estimated to take only 6% of the recurrent budget of the MOH but, at the core, is the problem that this personnel was hired on the development and not the recurrent budget).

In the LFA⁶¹ the EC included “Strengthen the MoH&FW’s capacity in the areas of financial management, procurement, human resource management, provision of pharmaceuticals, and in general aid management” to its activities under HNPS. Thus, through EC support under HNPS the issue of human resources has been addressed. The APR2009 noted good progress and positive changes are taking place: (1) A dedicated Task Group on HR was set up following the MTR, which has a large number of interested development partners (DPs) as members. The TG is working as a forum for co-ordinating different HR initiatives: e.g. a preparatory study on a Health Master Plan and the launching of the incentive study for retention of HR in hard-to-reach areas; (2) Personnel management authorities seem to be making moves for overcoming long pending personnel issues e.g. Directorate General for Health Services (DGHS) has completed the graduation list of doctors and put the list on a website; Personal Data Sheets have been updated and are accessible online for addition/alterations by the employees. Improved system and software in MIS is yielding better access to HR data, including gender-disaggregated ones; (3) Energetic steps have been taken to meet critical shortages both in DGHS and Directorate General of Family Planning (DGFP) involving doctors, paramedics, technologists and field-level workers. Moves are towards successful resolution of the problem around appointment of some 2000 nurses. The Government has also announced its intention to recruit more doctors and create additional post for nurses; (4) A new transfer and posting policy for doctors has

⁶¹ European Commission(2005) LFA, Health, Nutrition and Population Sector Policy Support Programme Bangladesh

been issued which provides a rational instrument for needs-based deployment and offers career paths – which are necessary conditions for improved retentions. (5) A Midwifery Strategy has been developed and approved, a step in the right direction towards filling the serious gap in addressing MNH problems.

Furthermore, projects such as “Improving Health, Nutrition & Population in the Chittagong Hill Tracts” (MR-139261.01/2011)⁶² contributed to an increased number of key health workers. Accordingly the planned 15 Upazilas are now (by 03/2011) covered by 16 mobile teams of 6 health workers each, and about 1,000 Community Health Service Workers (CHSW).

I-132 Again the statement from the APR2009 applies: “All chapters in this report show that there is a crisis in the human resources of the health sector in the country, both in quantity and in quality.”

However the HNPSP seemed to have started to address this issue and positive changes are evident, for instance (1) a recent study showed that large training investments being made under HNPSP funds are being managed better with evidence of good practices across the training spectrum. (2) A policy on training Community Paramedics in the private sector with curricula developed and supervised by National Institute of Population Research and Training (NIPORT) has been developed for service in the community and in the private sector (APR 2009). In addition, the APR2010 noted that during the reporting period, a significant number of health service providers including Nurses and managers were trained in country and abroad, which ranges from Master Course to short training.

Figure 10: Findings in Gender Equity and Voice since the start of HNPSP 2009

July 2008 to June 2009	July 2009 to June 2010
<p>Training</p> <p>26 Medical Officers received training on Obs & Gynae</p> <p>25 Medical Officers received training on Anesthesia</p> <p>104 SSN received training on EmOC</p> <p>83 MT (Lab) received training on Safe Blood Transfusion.</p> <p>905 Health Workers (HA & FWA) received training on Community Skilled Birth Attendant (CSBA)</p>	<p>Training</p> <p>528 participants received training on ANC, PNC and ENC</p> <p>95 participants received training on Incubators</p> <p>42 participants received ToT on LSS</p> <p>109 participants received training on Life Saving Skill on LSS</p> <p>1313 Health Workers (HA/ FWA) received training on CSBA</p>

Source: APR 2010

Furthermore projects such as the Primary Health Care Project Cox’s Bazaar⁶³ contributed through curricula development and trainings to some extent to an improved availability and standards of health worker training (evaluation, 2005).

I-133 Although vacant posts are frequent, this is not primarily a result of high attrition, but rather due to other shortcomings in the HR system to fill the posts. In addition, high absenteeism is a reported issue in the Bangladesh health system. Related to this issue, the APIR2010 noted that specifically retention of key positions is a concern. In Emergency Obstetric Care (EOC), retention of trained doctors at district and below level particularly at the District hospital, maternal and child welfare centre (MCWC), and Upazila health complex (UHC) must be ensured for guaranteeing 24 hour services availability. The APIR2010 mentioned as a possible option to incorporate adequate non-practicing allowances for doctors to avoid absenteeism during duty hours. Also, the presence of both, Gynaecologist and Anaesthetists in expanded EOC should be ensured. However, it is not mentioned whether this already happens or whether there are actual plans for implementation.

2.2.3.2 Resume of the JC

There are major issues, both in terms of quantity and quality of health workers in Bangladesh. Workforce planning and other human resource management issues encounter major problems which are only slowly addressed by the Ministry of Health, in the context of the complex civil service reform.

⁶² European Commission(2011) MR-139261.01 Improving Health, Nutrition & Population in the Chittagong Hill Tracts

⁶³ Final Evaluation of the Primary Health Care Project Cox’s Bazaar, 2005

Human resources were included in the EC LFA of HNPSP, although the situation is improving very slowly, the EC seemed to have contributed to improved availability of human resources for health.

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

Indicators

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)
- I-142 Clinical treatment guidelines available, disseminated and applied
- I-143 Client satisfaction with the quality of health care services

2.2.4.1 Findings per indicators

I-141 As noted earlier, indicators that are mentioned in reports like the APR2009/APIR2010, like “% health facilities that provide quality services according to National Standards”, and “% hospitals achieving and maintaining three to five star rating under International Health and Medical Service (IHMS) accreditation scheme” which could shed some light on quality assurance, are not reported on.

There is no clear indication whether the EC has provided support to quality assurance mechanisms under HNPSP. However it seems that the indicator has improved to some extent. According to the figure below they are in progress of putting an accreditation and regulatory system in place and implementing Standard Operating Procedures (SOP).

Figure 11: Indicators for HNPSP regarding quality assurance, 2009

INDICATORS	SIP / HEALTH NUTRITION POPULATION SUPPORT PROGRAMME (HNPSP)				
	Baseline	APR 2007	MTR 2008	APR 2009	HNPSP
	2004	2006	2007	2008	2010
YEAR	Target	Result	Result	Result	Target
Decentralisation + Hospital Autonomy expanded + Feasibility study Fin decentralis.	Legal devt Starting		Being approved Not started	Not done Not done	30 Hospitals Scaling-up
Diversifying Service Provision: + Regulatory framework in place + Accreditation system in place + MSA established + PMA established			In progress Draft developed In place Selection in progress	In progress In progress In place Draft contract issued	Enforced 40% NS

Source: APR 2009⁶⁴

Figure 12: Indicators for HNPSP regarding quality assurance, 2010

SI	Name of Indicators	Status 2008	Target		Status	
			2009	2010	2009	2010
1	Awareness Workshop (AW) on QA Managers & Service providers	11 health facilities	5 districts	5 districts	--	--
2	TOT on QA and SOP	5 district hospitals and 40 Upazila hospitals	4 district hospitals and 25 Upazila hospitals	4 district hospitals and 30 Upazila hospitals	3 district hospitals and 20 Upazila hospitals	3 district hospitals and 27 Upazila hospitals
3	Training of service providers Of District Hospital & Upazila Health Complexes	5 district hospitals and 40 Upazila hospitals	4 district hospitals and 25 Upazila hospitals	4 district hospitals and 30 Upazila hospitals	3 district hospitals and 20 Upazila hospitals	3 district hospitals and 27 Upazila hospitals
4	Service Provider of Health Facilities Practicing SOP's	5 district hospitals and 40 Upazila hospitals	4 districts and 25 Upazilas	4 districts and 30 Upazilas	3 districts and 20 Upazilas	3 districts and 27 Upazilas

Source: APR 2010

⁶⁴ Annual Programme Implementation Report (APIR), Operational Plan (OP)

Besides the vague evidence under HNPSP there has been EC contribution through the project “Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction”⁶⁵. The 03/2011 ROM report noted that the quality of the MNH district and Upazila 2010-11 plans has improved compared to 2008-09. Fifteen Comprehensive and ten Basic Emergency Obstetric and Newborn Care (CEmONC and BEmONC) facilities have been upgraded/established. The improved Management Information System (MIS) integrates data from the private sector. A Technical Working Group (TWG) on Quality Assurance promotes quality care.

I-142 There has been evidence of EC contribution to this indicator under the project “Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts”. According to the ROM report of 2009⁶⁶ the training of staff, the management system of the clinics, clinical guidelines and protocols for SRH are according to Marie Stopes International (MSI) standard and are of good quality.

I-143 No information available

2.2.4.2 Resume of the JC

The indicator has been assessed by three indicators. Only for the first two indicators there was information available. EC has contributed to these indicators through some smaller projects; however, there is limited information available which directly focused on the issue of quality of services. More generally, however, both some positive and less positive results of the HNPSP, which is support by the EC, can be stated according to the 2009APR: “Vertical programmes under HNPSP have continued to record good progress, reflected in improved coverage, with reduced gaps between rich and poor, and continued progress in health outcomes – lower child mortality, reduction of some communicable diseases, continued reduction in chronic malnutrition (stunting) and some improvements in maternity services from a low base. Overall contraceptive prevalence has not improved. Little progress has been made in improving utilisation of public sector health services, especially by the poorest segments. Major problems affecting utilisation are lack of sufficient drugs, staff shortages (especially in remote facilities), poor prioritisation of spending, and pervasive problems of management and coordination.

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

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

Indicators

- I-211 Change in proportion of health spending out of pocket
- I-212 Change in share of health expenditure financed by social security schemes
- I-213 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

2.3.1.1 Findings per indicators

I-211 Government accounts for only about one third of total health expenditure, with out of pocket spending on pharmacies and on a diverse range of private sector practitioners accounting for most of the rest (APR2009). Per capita total health expenditure in Bangladesh increased from USD ten (current) in 2002 to over USD 18 in 2009. Private out of pocket expenditure, as a percentage of total expenditure increased from 60% to 67% for these same years. So, some increase over the years, but still below the average for least developed countries. However, out of pocket expenditure as percentage of private health expenditure has also slightly increased over the evaluation period.

⁶⁵ European Commission (2011) Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction

⁶⁶ European Commission (2009) MR-020590.02 Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts

The 38 HNPSP operational plans account for 91% of budgeted 2008-9 Government development expenditure on health, and about 38% of total Government health expenditure including the revenue budget. While HNPSP is without doubt the largest programme to support the health sector, it is not the only one. There are – according to the Annual Development Programme (ADP 2007-08) – a total of 23 projects included in the MOHFW sector (13 investment and ten TA projects) of which four are under the responsibility of other Ministries, but operate within the HNP sector (e.g. Urban health programme under Ministry of Local Government).

According to the HNPSP APR2009 Government and donor spending of USD five per head accounts for 30% of health spending; the rest largely consists of out of pocket expenditure on a diverse range of mostly small scale private providers of modern and alternative services of variable efficacy. Direct household expenditure on purchasing drugs from pharmacies accounts for private spending of USD four per head – dwarfing public expenditure of much less than USD one per head on drugs. Curative services offered by MOHFW reach a far lower proportion of the population, they are little used by the poor and coverage is not improving. If current plans are left unchanged, there will be little improvement in coverage of curative care or in equity by 2010-11. The recently revised operational plans (OPs) are not planning for an increase. A resource group on health financing has been established, and has begun to define a work plan. A number of important studies have been recently completed or are in preparation, including the public expenditure review, health facility and facility efficiency surveys, and Sida stock takes, while new national health accounts are being prepared.

Table 7: Health financing health expenditure ratios, Bangladesh 2002-2009

USD/%	2002	2003	2004	2005	2006	2007	2008	2009
Health expenditure per capita (USD)	10,01	10,58	11,59	12,07	13,18	15,04	16,52	18,43
Health expenditure private (% of GDP)	1,87	1,89	1,91	2,09	2,16	2,27	2,28	2,29
Health expenditure, public (% of GDP)	1,23	1,14	1,21	1,12	1,24	1,19	1,04	1,06
Health expenditure, public (% of government expenditure)	8,23	7,86	8,17	7,46	8,44	8,41	7,38	7,52
Health expenditure, public (% of total health expenditure)	39,68	37,65	38,78	34,90	36,49	34,39	31,44	31,73
Health expenditure, total (% of GDP)	3,09	3,04	3,12	3,21	3,40	3,46	3,32	3,35
Private prepaid plans as a % of private expenditure on health	0,10	0,10	-	0,10	0,10	0,00	0,30	0,10
Social security expenditure on health (% of general government expenditure on health)	0,0	0,0	0,0	0,0	0,0	0,0	0,0	0,0
Out-of-pocket expenditure (% of private health expenditure) Bangladesh	96,00	95,72	95,92	96,22	96,31	96,52	96,52	96,52
Out-of-pocket expenditure (% of private health expenditure) South Asia	91,29	90,98	89,00	87,67	83,29	77,68	76,45	76,94

Source: WHO Global Health Observatory 2011⁶⁷,

I-212 Bangladesh does not have any social security scheme

I-213 Not applicable to Bangladesh

2.3.1.2 Resume of the JC

The EC contributes to the HNPSP which is the main contributor to the public health sector, which provides services free at point of use. Social security system coverage is limited to civil servants workers in the formal sector, representing a distinct minority of labour force. Out of pocket payments

⁶⁷http://databank.worldbank.org/ddp/editReport?REQUEST_SOURCE=search&CNO=2&country=&series=SH.STA.BRTC.ZS&period=

as a percentage of total health expenditure have not been reduced over the reported period, but rather show an increase.

The old health evaluation (2007) noted that an improvement towards a fair and equitable financial access to health is clearly not evident, despite the Delegation's (and other DPs) constant advocacy for it. In 2007 there were no data to show the access for the poor has become any better three years after the start of the HNPSP. The Delegation brought in a special consulting team on this, but their report was judged to be sub-standard (not reviewed). Since the SWAp is a key component of the national health policy and encompasses most of the issues pertaining to the financial access to health of the population, it is fair to say that an equitable health care financing system remains a core unresolved issue in Bangladesh -- despite the good intentions of the 2003-2010 Strategic Investment Plan for Health, Population and Nutrition.

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

Indicators

- I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs, such as children, the elderly, persons living with HIV/AIDS, and the disabled
- I-222 Health care financing schemes result in additional health care consumption by households

2.3.2.1 Findings per indicators

I-221 Regarding the documents reviewed there seems to be some cost waiver and subsidies schemes in place, especially targeting women. For instance, the old health evaluation mentioned that in 2007 a roughly one year old 'voucher system' project under the SWAp in 33 Upazilas is providing free care and transport to poor pregnant women to seek needed obstetric care; the system has resulted in marked increases in access to obstetric and other reproductive health services.

The 2009 ROM report for Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisa districts underlined the same findings by stating that the clinics are accessible and used by the target population. Patients pay a generally judged reasonable service fee, and there is a subsidy system in place for those who can't afford to pay. All beneficiaries of the subsidy system are carefully screened and belong to the poorest of the poor. An average of 7% of the income of the clinics is subsidised. The voucher system provides free delivery in the hospital and includes transport to and from the hospital. Of a total of 2,181 voucher patients, 1,324 voucher women delivered in the hospitals till February 2009.

The reason for the rather limited availability of data for cost waiver and subsidies schemes in place may be found in the fact that in Bangladesh, the primary health care services provided by the Government are free for all. Thus, it does not necessarily require specific cost waiver schemes for vulnerable to be in place.

I-222 Not applicable to Bangladesh

2.3.2.2 Resume of the JC

Vertical programmes under HNPSP have continued to record good progress (HNPSP APR2009), reflected in improved coverage, with reduced gaps between rich and poor, and continued progress in health outcomes. The reform programme aims to extend user-centred and effective services. However, the only significant progress in this context has been the scaling up of the maternal voucher scheme, but the contracting of non-public providers and decentralisation has not advanced.

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

Indicators

- I-231 EC supported technical assistance, provides expertise on health care finances
- I-232 EC supports enhanced communication, cooperation between MoH and MoF/planning

2.3.3.1 Findings per indicators

I-231 The EC supports HNPSF which also deals with health care finance issues, as in the HNPSF LFA⁶⁸ the EC also included strengthening the MoH&FW's capacity in the areas of financial management. In this context the HNPSF APR2009 noted that a resource group on health financing has been established, and has begun to define a work plan and a number of important studies have been completed such as the public expenditure review. In addition the APR2009 and APIR2010 noted activities in terms of conducting workshops on different health economics and health financing issues.

However, in the field of health finance, the EC has also developed some direct initiative and technical assistance. For instance in 2008, a report was produced to support the Ministry of health in designing a proposal for a monitoring system for a Demand Side Financing Scheme.

I-232 The EC support the HNPSF, but it is not clear from the available documentation if the HNPSF play a role in enhancing communication and cooperation between MoH and MoF.

2.3.3.2 Resume of the JC

Apart from through its support to the HNPSF, the EC has provided some direct technical assistance to health care financing issues.

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

Indicators

- I-241 Evidence of EU supported dialogue between major stakeholders and pharmaceutical industry to encourage R&D targeted at diseases of poor countries
- I-242 North-South medical and public health research partnerships supported by EU to produce new medicines and treatments

2.3.4.1 Findings per indicators

I-241 For this indicator there was no information available

I-242 For this indicator there was no information available

2.3.4.2 Resume of the JC

No information available.

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

2.4.1 JC 31 Increase in availability of primary health care facilities

Indicators

- I-311 Change in number of primary care facilities per 10,000 population (towards >1 per 10,000 population) ; disaggregated by rural/urban and income level, where feasible
- I-312 Change in the proportion of rural population living in a radius of 1 hour of a primary health care facility.

2.4.1.1 Findings per indicators

I-311 While Bangladesh will work towards a more integrated 'Upazila health service', where the various services will get a place within primary care facilities, the current system is still highly virtualised, not only in terms of the 'classical' vertical programmes, such as TB Control, Malaria, EPI or Vitamin A distribution, but also in its overall management structures, through the various Directorates. This makes a calculation of primary care facilities per 10,000 population not really feasible. Some indication is given by these figures: out of 476 Upazilas (sub districts), 400 rural Upazilas have health complexes, and are functioning with 31-50 beds. At the next level of 4,484 Unions, 1,362 Union sub-

⁶⁸ European Commission(2005) LFA, Health, Nutrition and Population Sector Policy Support Programme Bangladesh

centres are functioning and 3,648 Health & Family Welfare Centres run by the Family Planning (FP) Department. No substantial change in terms of number of facilities is reported over the last decade.

Table 8: Table workload at outpatient department (OPD) by type of facilities at the various administrative levels (April 2009)

Administrative division	Average population	Type of facility	Number of facilities functional	Average out-patients / month (% female)	Remarks
Divisions: 6 (excl. Dhaka city)	25 million	Tertiary and teaching hospitals			
Districts: 64 (DGHS)	2.3 million	District hospital	60	8,855 (39%)	not in Dhaka; 100-300 beds (average 147 beds)
Districts: 64 (DGFP)	2.3 million	Mother & Child Welfare Centre (MCWC)	97		obstetric care + clinical contraception; (average 14 beds)
Upazilas 481 (DGHS)	270,000	Upazila Health Complex (UHC)	413	4,597 (64%)	30-50 beds (average 40)
Upazila 481 (DGFP)	270,000	Mother and Child Welfare Centre	74		0-26 beds (average 15)
Union: 4,403	25,000	health and family welfare centre ("upgraded" if with medical officer)	1,300 (est.)	661 (61%); 704 if upgraded	No beds; 128 not contracted out to NGOs through MSA
Wards (DGHS) (roughly 20,000)	6,000*	Community Clinic (Health Assistant)	10,775 (or: 8,000?)	1,052* (48%)	378 not contracted out (MSA)
Wards (DGFP) (roughly 20,000)		Community Clinic (FW Assistant)	approx. 23,000	1.052* (48%)	

* sampled together (both services are provided in the same facility).
Source: Tulane & ACPR, Bangladesh Health Facility Survey, April 2009; various other sources
Note: Some of the available figures are conflicting; MOHFW is requested to update the information provided here before the next APR.

Source: HNPSP APR 2009

However, the EAMR07/2010 noted that the monitoring/evaluation Mission in CHT health confirmed the strong impact on the health population improving quality service delivery in remote areas, but sustainability remains an issue for the three projects

I-312 Most facilities are in rural areas, where the great majority of people in Bangladesh reside. No specific data are available regarding the proportion of rural population that lives within the one hour radius of a primary care facility. Over the past year, this proportion will not have changed. However through various projects the EC has provided support to achieve a change in the proportion of rural population living in a radius of one hour of a primary health care facility. In the draft final report⁶⁹ assessment of a project proposal and development of alternative options it is noted, that minorities belong to the key target groups of the programme. An amount of some EUR 30 million is earmarked for complementary actions to the pool funding, especially for areas difficult to reach through the overall programme. The "UN Collaborative Health Initiative in the Chittagong Hill Tracts (CHT)" may be one of the key complementary programmes, to be implemented in an area of specific geographical, socio-economic and political conditions. The initiative has been created through the 1997 Peace Accord, may open the door to a tailor made decentralised approach to health care delivery in coordination with the national Ministry of Health and Family Welfare and in liaison with key strategies following by the ongoing HNPSP.

The Paris Declaration evaluation of Bangladesh (2010)⁷⁰ noted in this context, that the HNPSP transformed 126 vertical projects into one programme and functional integration of health and family planning activities and staff at Upazila level and below was initiated under the Programme. The main focus of HNPSP was to decentralize the delivery of essential service package (ESP) in 'one stop

⁶⁹ HNPSP EC support to Health, Nutrition and Population Sector Programme and UN Collaborative Health Initiative in the Chittagong Hill Tracts, 2008

⁷⁰ Evaluation of the Implementation of the Paris Declaration, Phase II, Country Evaluation Bangladesh, Final Report, December 30, 2010

service' model through the involvement of the private sector and the NGOs. Around 135,000 Community Clinics (CC) were planned to be set up throughout the nock and corner of the country to provide essential health and reproductive health service, one CC to serve 6,000 people. Regarding achievements the HNPSP APR2009 mentioned as results and achievements under the gender and equity component; four District Hospitals and three Upazila Health Complexes have been accredited under the women friendly hospitals scheme and about 8,000 community clinics are set up with local committees.

Likewise, the APIR2010 noted that the pace of progress of Community Clinic (CC) construction and renovation is significant. Till 2001, 10,723 CCs have been constructed, of which till date, 7,522 CCs have been repaired or renovated and remaining 3,201 CCs are in the process of repairing. By the end of 2010 another 2,876 CCs were planned to be constructed.

2.4.1.2 Resume of the JC

Bangladesh health policy is highly focused on primary health care. The EC supports the HNPSP, which is a main component of the public health system. Under component two "UN supported special interventions to strengthen HNPSP performance in areas with particular challenges" and component three "Urban Primary Health Care Programme" of the HNPSP the EC addressed this indicator, however, no trend data are available. While coverage with primary care facilities should probably be increased, it is currently difficult to properly assess due to the fragmentation and verticalisation of services, which together produce relatively good results.

2.4.2 JC 32 Increase in availability of secondary health care facilities

Indicators

- I-321 Change in number of hospital beds per 10,000 population (to >10 per 10,000 population)
- I-322 Change in the proportion of population living in a radius of 2 hours of a secondary health care facility
- I-323 Increased number of Caesarean Sections

2.4.2.1 Findings per indicators

I-321 In total, 35,500 hospital beds are being reported, which would amount to about four beds per 10,000 population. However, the 400 Upazila health complexes also have 30-51 beds each, which would raise this ratio to six per 10,000. No trend data are available.

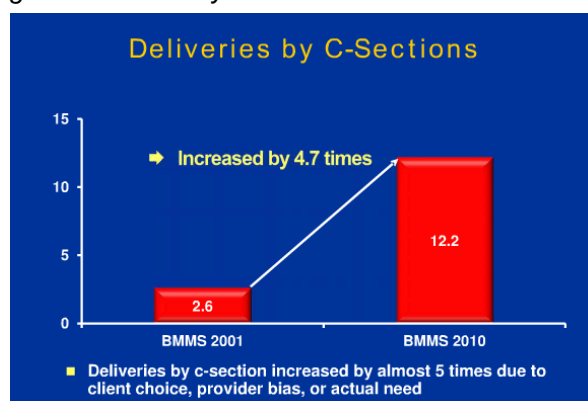
I-322 There is no information available as to the distances to hospitals.

I-323 For 2007, a figure for caesarean sections of 7.5% of all births is given (WHO), which is well up from the 3.5% reported for 2004. A recently published Bangladesh Maternal Mortality survey reports an ongoing positive trend with a 12.2% caesarean section rate for 2010 (see figure below).

According to the 2007 DHS survey⁷¹ caesarean sections are more common among first births (13%), births in urban areas (16%), and especially among births in the private sector (67%). Education and wealth are associated with caesarean section deliveries; more than one-quarter of women who have completed secondary or higher education and women in the highest wealth quintile delivered by caesarean section, compared with less than 2% of women with no education and women in the lowest wealth quintile.

⁷¹ National Institute of Population Research and Training (2009) Bangladesh Demographic and Health Survey 2007

Figure 13: Percentage of deliveries by Caesarean Sections 2001-2010



Source: BMMS 2010 (Bangladesh Maternal Mortality Survey)

Table 9: Percentage of caesarean deliveries by background characteristics⁷²

Background characteristics	DHS 2007
Place of delivery	
Public sector	34.6
Private/ NGO sector	67.3
At home/don't know/missing	na
Urban-rural residence	
Urban	15.4
Rural	5.4
Education	
No education	1.1
Some primary	2.2
Primary complete	3.7
Secondary incomplete	11.2
Secondary complete / higher	25.7
Wealth index	
Lowest	1.8
Second	1.9
Middle	3.3
Fourth	8.5
Highest	25.7
Total	7.5

Source: Bangladesh Demographic and Health Survey 2007

There is no clear indication whether the EC has contributed towards increased number of caesarean sections in the documents reviewed. However it can be assumed, that the EC has indirectly contributed under HNPSP and the various projects explicitly addressing maternal health.

2.4.2.2 Resume of the JC

There are no proper trend data available for primary care facility and hospital bed availability for Bangladesh. And due to the high degree of verticalisation of services, the number of primary care facilities is a less meaningful indicator than for most other countries. Overall, it seems that these two indicators did not change in any substantial way over the reported period.

The caesarean section rate has substantially increased, with an almost four-fold increase, from 3.5% in 2004 to 12.2% in 2012. One of the key objectives of the HNPSP, which is supported by the EC, is a focus on reduction of maternal mortality, of which an increase in the number of caesarean section is one of the strategies. The reported increase seems a marked success.

⁷² Id.

2.5 EQ4- Health service utilisation related to MCH: To what extent has EC support to health contributed to improving health service utilisation related to MCH?

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

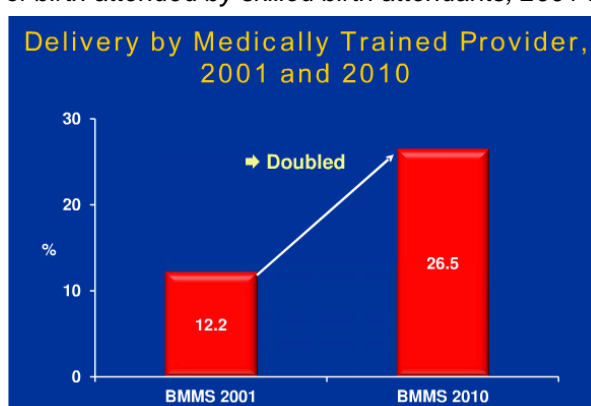
Indicators

- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving four or more ante-natal check-ups
- I-413 Increased proportion of women using modern family planning

2.5.1.1 Findings per indicators

I-411 The BMMS report shows an increase in deliveries attended by a skilled birth attendant from 12.2% in 2001 to 26.5% in 2010; a marked increase, be it from a low base.

Figure 14: Number of birth attended by skilled birth attendants, 2001-2010



Source: BMMS 2010 (Bangladesh Maternal Mortality Survey)

The EC has thematic budget line projects in the country with both M. Stopes and CARE. They both provide access to a full range of reproductive and sexual health care services and products (including family planning) and also work on reproductive health (RH) issues of the youth. Both projects show an increase in deliveries by skilled attendants and have worked on improving the referral system to access emergency obstetric care. These projects fall outside the government's (GoB) budget (old health evaluation 2007).

Under HNPSP the EC has directly contributed to the achievements. However, the marked increase still does not match HNPSP target for 2010. The HNPSP 2009 noted that skilled attendance at birth has increased slightly since 2004, largely due to increased use of private sector by the wealthier quintiles. The gap between the highest and lowest quintiles has increased. About 82% of women deliver at home and the programme has tried to increase access through trained community skilled birth attendants (CSBAs). As yet, available data does not enable an analysis of how effective this intervention has been. Only about 43% of the estimated requirement of 15,000 CSBAs has been trained, but the pool of eligible candidates from the public sector is almost exhausted.

Figure 15: Core Performance Indicators

INDICATORS	Baseline and results over the years				
	2004/05	2006/07	2007/08	2008/09	2009/10
YEAR	Baseline	Results	Results	Results	Target
5. Percentage of births attended by skilled health personnel					
Average	Av: 13.5	Av: 18.8	Av: 18.0	Av: 21.4	43
Lowest quintile	LQ: 3.3	LQ: 5.2	LQ: 4.8	LQ: 5.1	
Second quintile	SQ: 4.3	SQ: 10.1	SQ: 6.7	SQ: 11.1	

Source: HNPSP, APR2009

Figure 16: Findings in MNCH and Family Planning since the start of HNPSP

Major expected outputs and results in HNPSP	Indicators and Targets	Progress during 2005 – 2008
1. Reducing IMR and U5M to achieve MDG 4	IMR 33.1/1000 and U5M of 48/1000 by 2015	1. Bangladesh is on track to achieve MDG 4 with impressive declines in infant and under-five mortality). 2. IMR declined from 65 (2004) to 52 (2007); 3. U5M declined from 88 (2004) to 65 (2007)
2. Reducing maternal mortality to achieve MDG 5. (reduction by three fourths of the 1990 level to reach 120 per 100,000 live births by 2015)	1. To increase the proportion of births by skilled attendants from 13% (2004, BDHS) to 43% by 2011 (APIR, 2009) 2. To decrease Maternal Mortality Ratio from 320 per 100,000 live births (BMMS, 2001) to 270/100,000 in 2011.	1. Births with skilled attendance has increased from 13% (2004) to 18% (2007).. 2. An accurate estimate of progress on maternal mortality is possible only with a MMR survey, and this has been commissioned to be done in the next year.

Source: HNPSP, APR2009

I-412 For 2007 a figure of 21% for ANC4+ is provided by WHO. The APR2009 reported on 'at least one ANC visit' and quotes 48.8% for 2004 and 51.3% for 2008. This is a very modest increase, where this indicator is usually higher in comparable countries.

Figure 17: Core Performance Indicators

INDICATORS	Baseline and results over the years				
	2004/05	2006/07	2007/08	2008/09	2009/10
YEAR	Baseline	Results	Results	Results	Target
5b. Any ANC from medically trained provider:					
Average					
Lowest quintile	48.8	46.3	51.7	51.3	ANC not mentioned
Second quintile	24.9	23.4	30.8	30.9	
	38.2	37.7	36.3	40.7	

Source: HNPSP, APR2009

Comparison of the 2004 and 2007 DHS shows that there has been some narrowing of the gap between the richest and the poorest in ANC coverage.

Figure 18: Coverage basic health, nutrition and population (HNP) services by wealth quintile

RFW No	Indicators	BDHS 2004		BDHS 2007	
		Wealth Quintile		Wealth Quintile	
		Lowest	Highest	Lowest	Highest
1	% deliveries attended by skilled personnel	3.3	39.4	4.8	50.9
23	% ANC Coverage	10.4	61.1	30.8	83.6

Source: APR2009 citing DHS2004/2007

It is likely that under HNPSP and its various projects the EC has contributed to the improvement of the indicator. The APR2009 underlined in this context that there were some improvements in maternity services from a low base. For instance the EC financed the project "Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal". For this project the ROM report (2009) noted that the increased use of family planning methods, better health during pregnancy and professional assistance for deliveries have already an impact on the maternal and child mortality and will also have an impact on the poverty level of the population of the target area.

I-413 Contraceptive prevalence is given as 56% for 2007 (WHO), with the APR2009 indicating a steady state between 2004 (47%) and 2008 (50%). Likewise the DHS2007 survey provides a steady picture during the evaluation period.

Figure 19: Trends in ever use of family planning methods

Percentage of currently married women age 10-49 who are currently using specific family planning methods, selected sources, Bangladesh 1975-2007										
Method	1975	1983	1985	1989	1991	1993-1994	1996-1997	1999-2000	2004	2007
	BFS	CPS	CPS	BFS	CPS	BDHS	BDHS	BDHS	BDHS	BDHS ¹
Any method	7.7	19.1	25.3	30.8	39.9	44.6	49.2	53.8	58.1	55.8
Any modern method	5.0	13.8	18.4	23.2	31.2	36.2	41.5	43.4	47.3	47.5

Source: DHS2007

Over the years, the MOHFW has played a key (and quite successful) role in bringing down the very high fertility rates in the country. The total fertility rate currently stands at 2.7 children per woman (2007). Unfortunately, the official goal of replacement level fertility (meaning a TFR of 2.2) by 2010 will therefore not be met. This will have serious consequences for Bangladesh's socio-economic development in the long term. Therefore, the ultimate aim should be to bring down the fertility rate to replacement level as soon as possible and certainly not later than by 2015.

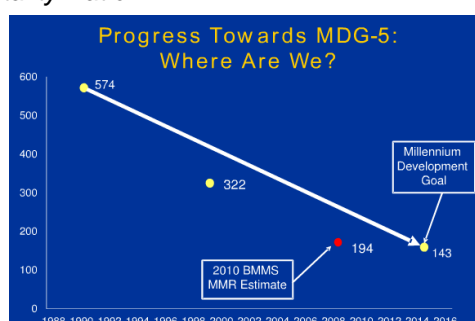
Even though the HNPSP APR2009 noted some improvements in maternity services from a low base, the overall contraceptive prevalence has not increased. However, it should be noted that the information extracted from the documents reviewed is inconsistent to some extent. For instance, the ROM report (2009) of the project "Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts" noted that family planning (FP) was one of the sectors of health care where significant achievements have been made. The project combines service delivery with a strong awareness raising and service promoting strategy and with strong linkages with Government structures and other organizations involved in SRH and Essential Services Package (ESP). Furthermore EC has contributed to this indicator through the "Primary Health Care Project, Cox's Bazaar Bangladesh" and "Adolescents and Women's Reproductive and Sexual Health Initiative (ARSHI)". The EAMR 01/2011 noted that ARSHI has been successful in generating knowledge and awareness within the community to break down many of the socio-cultural barriers that prevent women and adolescents from accessing maternal, family planning and sexual reproductive health (SRH) services.

Although the EC has implemented programmes aimed at improving sexual and reproductive rights there has been little dialogue related to this issue within the health sector SWAp. This is due to the fact that it hasn't been a priority for the group as most of the focus has been on the MDGs. This has led to the EC addressing the issue through its own programmes rather than through dialogue⁷³.

2.5.1.2 Resume of the JC

In 2007 the old health evaluation noted that Bangladesh still has one of the highest maternal mortality ratios in the world 320-400 per 100,000 live births and maternal morbidity remains a serious concern in Bangladesh. About 75% of the children born to these women also die within the first week of their life.

Figure 20: Maternal Mortality Ratio



Source: BMMS 2010 (Bangladesh Maternal Mortality Survey)

⁷³ EUD interview

The EC supports the HNPSp which has reduction of maternal mortality as one of its key targets. Maternal mortality has substantially been reduced (see figure above) and primarily due to improved health service availability and utilisation. This will be due to the reported HNPSp supported increases in a number of maternal services (see below), like number of births by skilled birth attendants and rate of caesarean sections. But some of the other maternal health related services, like ANC visits and use of contraceptives have not seen any substantial improvement.

Figure 21: Progress in implementation of maternal, child and reproductive health component

July 2008 to June 2009	July 2009 to June 2010
<p>Training: 13 Doctors trained on EOC (One year), 29 FWVs trained on EOC (Six month), 235 FWVs trained on Midwifery (Six months).</p> <p>83 Doctors & 167 FWVs trained on VIA & CBE methods.</p> <p>Services: ANC- 3,71,974 PNC- 77,226 Delivery- 47,791 C. Section- 10,938 <5 Child Care- 3,46,229 CSBA – 955</p> <p>Others: 28 MCWCs upgraded from 10 to 20 beds.</p>	<p>Training: 07 Doctors trained on Emergency Obstet year), 16 FWVs trained on Emergency OI (Six month), 18 FWVs trained on M months).</p> <p>37 Doctors & 119 FWVs trained on methods.</p> <p>Services: ANC- 3,68,459 PNC- 84,068 Delivery- 51,797 C. Section – 12,673 <5 Child Care- 2,54,801 CSBA – 1224</p> <p>Others: UH&FWC: 500 centers upgraded (under MCWC: 28 centers upgraded from 10 to :</p>

Source: APIR2010

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

Indicators

- I-421 Percentage of children under five receiving regular growth monitoring
- I-422 Immunisation rate

2.5.2.1 Findings

I-421 No data are available on the percentage of children receiving growth monitoring. However, the HNPSp APR2009 noted that Bangladesh has continued to make good progress in reducing stunting in children of six to 59 months, an indicator of chronic malnutrition, which fell from 46.5% in 2004 to 38.5% in 2007, an acceleration in the rate of improvement. There was some increase in wasting between the 2004 and 2007 DHS surveys, although this indicator of acute malnutrition may be influenced by the combined impact of the floods and of the 60% increase in food prices in 2007. This would also explain the slower progress in reducing the MDG indicator of weight-for age (underweight), which reflects both chronic and acute effects.

Although some progress is being made, the case study in nutrition, undertaken as part of the HNPSp APR2009 and APIR2010, highlighted the urgent need for: (i) mainstreaming nutritional activities in all health facilities, (ii) special centres to treat acute malnutrition cases and (iii) gradual merging of nutrition activities undertaken by NNP, IPHN, ICDDR, B under the overall coordination and guidance by the MOHFW. Consequently about 46% of children from 6 to 59 months are still underweight (APIR2010) and 38% are stunted (APR 2009)

Figure 22: MDG1A – Reducing childhood malnutrition

MDG	Indicators	Progress till 2008	Targets 2015
MDG 1A: Reducing childhood malnutrition	(i) % of underweight children age 6 to 59 months	(i) Declined from 51.7% (2004) to 49.7% (2008)	(i) 33%
	(ii) % of under-five children with moderate or severe stunting (Ht/Age)	(iii) Declined from 46.5% (2004) to 38.5% in 2007	(iii) No target set

Source: HNPSP; APR2009

Figure 23: MDG1A – Reducing childhood malnutrition

HNPSP Priority Objectives	Units of Measurement	Benchmark (with Reference Period and Source)	Achievement with reference period & source	Projected Target Mid-2011
Reducing Malnutrition	% of underweight children age 6 to 59 months (weight-for-age Z-score < - 2)	50.9% (Child Nutrition Survey of Bangladesh 2000)	46.3 (BDHS 2007)	36%
	% of severely underweight children age 6 to 59 months	12.9% (Child Nutrition Survey, Bangladesh 2000)	10.9 (BDHS 2007)	<2%

Source: APIR2010

I-422 The APR2009 reported a substantial increase of fully immunized children from 73% to 83% between 2004 and 2008. Children are being protected effectively against vaccine preventable diseases in childhood (for example, 81% coverage of measles immunisation, and the country has maintained polio-free status). There is no gender or wealth disparity in immunization rates. There is good quality surveillance and outbreaks are promptly and well investigated. The number of vaccines in the routine programme is being expanded with GAVI support. The EPI programme also delivers Vitamin A and achieves good coverage. Similarly the old health evaluation (2007) noted that control and prevention of diseases, such as measles, poliomyelitis, and diphtheria have greatly reduced childhood mortality and morbidity. Bangladesh is on the verge of polio eradication.

Figure 24: Coverage basic HNP services by wealth quintile related to immunization ratios

RFW	Indicators	BDHS 2004		BDHS 2007	
		Wealth Quintile		Wealth Quintile	
		Lowest	Highest	Lowest	Highest
2	Percentage of DPT3 coverage	70.7	91.1	92.4	94.7
3	Percentage of Measles immunisation	59.5	90.5	80.2	89.2
NS	Percentage of fully vaccinated children	57.5	85.7	79.9	88.4
4	Percentage of Vit A Coverage	77.2	87.5	88.8	90.0
NS	ORS for Diarrhoea	74.9	94.4	78.7	88.2
NS	ARI treatment	10.8	45.3	23.6	73.0

Note: Wealth quintiles in this table are derived from household ownership of assets (BDHS 2004 and 2007).

Source: HNPSP APR 2009 citing BDHS 2004 and 2007

Accordingly it is safe to say that the EC under HNPSP contributed to the improvements of this indicator.

2.5.2.2 Resume of the JC

The EC supports the HNPSP, which supports the various (vertical) health programmes within the public health sector including immunisation. Over the past few years a further increase, from a relatively high base, has been achieved. Consequently the figures for childhood mortality ratios (see figure below) have experienced a continued decrease. No data are available on growth monitoring, but other figures do indicate a persistent problem in child nutrition with about 50% of children being underweight and stunted.

Figure 25: Childhood mortality ratio

Childhood mortality	2005	2006	2007	2008	2009	2010
Under 5 Mortality Rate	66,20	62,30	58,70	55,20	52,00	48,00

Source: 2005-2009 WHO Global Health Observatory 2011

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

Indicators

- I-431 Increased proportion of children sleeping under bednets
- I-432 Reduction in rate of child deaths from diarrhoeal disease
- I-433 Improved household management of diarrhoea based on oral rehydration salts (ORS)

2.5.3.1 Findings per indicators

I-431 No figures are available for children sleeping under bednets. However, for most of the country this is not a relevant indicator since it is largely malaria free, apart the south-east.

Regarding the documents reviewed, the 80% EC funded project Primary Health Care Project Cox's Bazaar, 2005⁷⁴ provided some information for this indicator. Accordingly through promotion activities with community groups 6,213 mosquito nets have been purchased by households.

I-432 Diarrhoea is still a common cause of death among children, as expected and in par with deaths due to Acute Respiratory Infection (ARI). No specific trend data as to the reduction in child deaths due to diarrhoea exist. However, overall under five mortality has improved substantially over the last decade, from 86 per 1,000 in 2000, to 64 in 2004, to 48 in the year 2010. These reductions can only have been achieved by a reduction in the number of child deaths due to diarrhoea.

I-433 Household management of diarrhoea with ORS has gradually improved, at 50% in 2004 to near 70% in 2008.

Even though according to the HNPSP APR2009 the use of oral rehydration for diarrhoeal disease has wide coverage and reaches the poor, Zinc supplementation with ORT as treatment of diarrhoea has reached only 23% of children.

2.5.3.2 Resume of the JC

The EC supports the HNPSP, which had reduction of child mortality as a key target. HNPSP will have been instrumental in reducing childhood mortality, from 86/1000 to 48/1000 in just 10 years. Improved treatment of diarrhoea with ORS, at household and facility level, will have contributed significantly to this reduction.

2.6 EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

2.6.1 JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support

- I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators)
- I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector
- I-513 EC contributed to decentralized capacity building to strengthen health policy capabilities at provincial, district, and local levels.

⁷⁴ Final Evaluation of the Primary Health Care Project Cox's Bazaar, 2005

2.6.1.1 Findings

I-511 The documents reviewed do not provide information whether the EC has contributed to this indicator. It can just be assumed that under the HNPSP and the World Bank administered trust fund the EC has played a role to overall policy strategy processes. In this context the old health evaluation (2007) noted that development partners (DPs) have also started reviewing and submitting comments on GoB policy documents jointly, which is also a departure from the previous practice.

I-512 The documents revised make clear that there has been increased attention to PFM, accountability and capacity building measures. The EC LFA (2005) for HNPSP included as one of the results "The MoH&FW is efficient in managing the public health services", indicating that the EC policy dialogue probably also incorporated PFM, accountability and capacity building measures to some extent. The HNPSP APR2009 provides more information on that. Consequently the key reform areas in HNPSP were (1) Strengthening of public health sector management and (2) stewardship capacity. The old health evaluation (2007) also highlighted capacity building. Accordingly donors' are providing support to capacity building activities through TA under various Operational Plans of the HNPSP. At the time of the evaluation the TA had not proved effective because of lack of adequacy in terms of duration and content and context of the training courses. In addition, due to frequent turnover of GoB officials, the value of the trainings could not be utilized fully. However, coordinated and comprehensive TA for human resources development of the next sector program is receiving due priority in the next HNPSP and a positive move in this direction is already evident from the coordinated TA provided to the MHFW for the preparation of the draft PIP of the next sector program. As highlighted under I-131 the APR2009 noted good progress and positive changes are taking place (1) A dedicated task group on HR was set up following the mid-term review (MTR), which has a large number of interested development partners (DPs) as members.

I-513 Achieving the required improvements in the efficiency, effectiveness and equity of health services (and sustaining progress towards the MDGs) will need significant reform to decentralise decision-making, reduce fragmentation and increase accountability to users. A fully effective health system is not possible through a system in which management within the 64 districts and nearly 500 Upazilas is split between the two Directorates General and the smallest decisions are taken in Dhaka through a structure involving two budget systems, 38 line directors, numerous projects and programmes, and the involvement of several Ministries. Increased delegation of management and financial responsibility to Upazila and district level will help to alleviate the problems, and will be more effective, if accompanied by some streamlining of management in Dhaka (APR2009). Minorities belong to the key target groups of the programme. An amount of some EUR 30 million is earmarked for complementary actions to the pool funding, especially for areas difficult to reach through the overall programme. The "UN Collaborative Health Initiative in the Chittagong Hill Tracts (CHT)" may be one of the key complementary programmes, to be implemented in an area of specific geographical, socio-economic and political conditions and new opportunities created through the 1997 Peace Accord, which may open the door to a tailor made decentralized approach to health care delivery in coordination with the national Ministry of Health and Family Welfare and in liaison with key strategies following by the ongoing HNPSP.

In the 2005 LFA the EC noted as one of their achieved results "Three districts in the CHT have an improved capacity for the management and delivery of health services." Accordingly the EC probably has addressed the issue of decentralized capacity building. There has been some progress as the APR2009 noted that programme managers from Directorate General for Health Services (DGHS) and Directorate General for Family Planning (DGFP) sat together and agreed on the need for more integrated services at the Upazila level and below. However, from the figure below it gets clear that the level of progress under HNPSP for decentralisation and local level planning has been low. Consequently the APR2009 suggested to strengthen processes and mechanisms to address important issues in the remaining two years of HNPSP, being: 1. The elaboration of the new Health Policy and Strategy for the coming 5-10 years, including (i) decentralised planning and budgeting, (ii) setting of local priorities in consultation with local communities and the (iii) development of an Upazila Health System, managed by Upazila Health Management Committees (UHMC).

Besides the information found in the APR, the EAMR 07/2010 provided information. Accordingly the ROM assessment confirmed the results of the Mid Term Review, conducted during the last quarter 2009 to the UN MNHI project, namely the substantial progress in the service delivery and the positive impact of the decentralised decision making process.

Figure 26: Is HNPSP achieving its objectives?

IS HNPSP ACHIEVING ITS OBJECTIVES?				
HNPSP Objectives	SIP Objectives	IRT Rating of progress by March 2008 (MTR): HP = High level of progress (= on target); MP = Moderate level of progress; LP = Low level of progress; NP = No Progress; Unclear		Indicators HNPSP / SIP
Component 3: Implementing key reform areas. OR: Advancing sector modernisation (see AM, p. 13-15)	<p>Policy responses:</p> <p>A. Public sector management and stewardship</p> <p>B. Decentralisation</p> <p>C. Demand Side Financing (DSF)</p> <p>D. Diversification</p>	<p>3.1. Improving Financial Management (incl. planning, budgeting, accounting and auditing)</p> <p>3.2. Improving sector management & stewardship</p> <p>3.3. Decentralisation and local level planning (LLP)</p> <p>3.4. Improving aid management</p> <p>3.5. Expanding / stimulating demand-side financing initiatives for ESD (Vouchers etc);</p> <p>3.6. Diversifying service provision (Institutional / PPP)</p>	<p>3.1. NP: Audit contract delayed, FMAU and LDs not strengthened in reporting</p> <p>3.2. No focus on strategic issues</p> <p>3.3. LP: LLP produced for 6 districts</p> <p>3.4. LP: TGs has broadened the involvement of both MOHFW/DPs</p> <p>3.5. HP: Vouchers implemented according to plan; showing increased utilisation. Evaluation underway.</p> <p>3.6. NP: Outsourcing of CC cancelled</p>	<p>+ Proportion of contracts awarded within initial bid validity period: DGHS: XXX% DGFP: 100%</p> <p>+ HS, FP and P-MIS delivering mgmt information according to specifications: NO + DSF pilots on schedule as per results framework: FINE</p>

Source: HNPSP APR2009

2.6.1.2 Resume of the JC

Governance in the country is weak with poor delivery of services to the neediest (many systemic problems in the delivery of the same) despite the EC being active in supporting these weaknesses now for years. From 2002 to 2006, the country had low absorption capacity, i.e., disbursements of foreign aid in health was low. This was attributed to a lack of political will for needed reforms especially for the first EC-funded HPSP where 50% of the funds had to be cut.

Through the SWAp, the EC has tried hard to support the restructuring of health systems leading to more efficiency in the management of the MOH and the use of its resources to address these priority problems. Institutional strengthening is the core of the SWAp but results are according to the old health evaluation of 2007, so far, mostly poor.

2.6.2 JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

- I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc).
- I-522 EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing)
- I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

2.6.2.1 Findings

I-521 Under HNPSP it is likely that EC has addressed the issues of accountability and transparency of the health system, even though it is not explicitly mentioned. In this context the EAMR 01/2009 noted that the Ministry of Health and Family Welfare (MoH&FW) has become a pioneer in addressing systematic weaknesses through implementing the first management audit carried out by a professional external auditor. The HNPSP APR2009 highlighted the key reform areas in HNPSP, which are amongst others, strengthening of public health sector management and stewardship capacity, including functions like planning and monitoring, Information management, Reform management, Aid management and the management of contracts. The APR2009 concluded that the reform agenda has only partially been addressed (see figure below) during the last year, due to the changes in government (elections in December 2008) and the ambitious but poorly operationalised objectives set out in the project appraisal document (PAD). According to the APR2009 the Audit Committee has been active in managing the resolution of observations arising from both internal and external audit. Tripartite meetings have been held to discuss the finding of the Foreign Aided Projects Audit Directorate (FAPAD) and task groups in both MOHFW and FAPAD have been constituted to assist in this process. MOHFW has continued to meet its target for production of claims for reimbursement through preparation of Financial Monitoring Reports (FMR) within 45 days of the end of each quarter

Figure 27: Status on Action Plan Aide Memoire 2008 for M&E

Area	Targets 2009	Status
1. Revise results framework with mini assessment of data sources (together with DGHS, DGFP, NNP, NIPORT, HEU, BBS)	June	Done and shared with LDs, OPs and concerned stakeholders. Revised RFW was finally discussed in the M&E Task Group June 2008 and included in the RPIP and HNPS
2. Link OP to results framework with specific time bound indicators		A 2-day workshop was conducted May 2008 for this purpose: Linking Results Framework with Operational Plans of HNPS under the responsibility of the JC (Planning) and carried out with technical support from M&E Unit. Report with the same title is available. Main OPs have RFW indicators included.
3. Comprehensive Plan for M&E system, including coordination of MIS for DGFP, DGHS, NNP, Urban Health and others, which outlines roles and responsibilities of different actors with time bound activities is endorsed by GOB and started to be implemented. Put in place transitional arrangements including data management centre	March	A comprehensive plan for M&E system has not been prepared yet. First steps have been taken to strengthen the M&E Unit (MEU) of MOHFW: the MEU was provided with renovated premises in a new location. Except for 1 staff member who seconded from DGFP no other government personnel operates the MEU. The rest of staff is hired by GTZ. Also support staff is not paid by the government. First design steps for DMIS have been made. In addition, a workshop was held July 2008 on DMIS.
4. Facility Survey for HF outputs and pro-poor performance		Done. Preliminary findings shared
5. Maternal Mortality Survey	April	NIPORT initiated, outsourcing for data collection is in process
6. UESD Survey	April	Conducted by NIPORT, ACP with support from GTZ. Provisional findings already available and shared

Source: HNPS APR2009

I-522 There is scope for significant improvement in the planning and budgeting processes. This includes adopting a coordinated approach to the revenue and development budgets, linking operational plans (OP) more clearly to the budget, synchronising their review and updating with the budget cycle, and providing MOHFW with flexibility to reallocate resources within the overall programme. Resolving the shortage of planning staff in the Planning Wing of MOHFW and within the Line Directorates will also contribute to improved planning processes (APR2009). Many of the comments made regarding the weaknesses in financial management at the Mid-Term Review (MTR 2008) remain true one year further on (APR2009). Some action has been taken in response to the action plans arising from both the Annual Programme Review (APR) and MTR processes, but gains have been offset by continued shortages of staff, frequent staff transfers and delays in progressing contractual arrangements. The Programme Implementation Plan (PIP) for HNPS was revised in 2008 to provide a better allocation of resources between the various operational plans (OPs).

Furthermore the APR2009 highlighted that monitoring and evaluation of HNPS has gained some ground (see figure for I-521 and figure below), but there is scope for significant improvements, especially with respect to the effectiveness - the use of quality health information at peripheral and central levels for planning and decision making, and the efficiency and reliability of the system. In this context the EAMR 07/2010 still expressed criticism as GOB has still not put in place requirements to start activities for the monitoring and supervision system for the Maternal Voucher Scheme pilot project on Demand Side Financing, in spite of a close follow up by the EUD. Furthermore little progress has been achieved in the context of developing Annual Operational Plans with output based budget.

It is likely that the EC has addressed this issue under HNPS as the LFA (2005) incorporated the development of Programme Implementation Plans (PIP) and synchronised Operational Plans (OPs) under its activities.

Where the EC has most successfully supported planning and budgeting has been at local level through a project to strengthen local level planning. This has been successful, as the local level planning process developed by this programme has now been included as part of the HNPS/national planning process, as EC activities convinced donors and the Government of Bangladesh of their usefulness.⁷⁵

⁷⁵ Interview EUD Bangladesh

Figure 28: *Actions undertaken regarding annual operational planning and planning, budgeting and monitoring of the health sector*

Table 2-10: Actions AND decisions taken as a follow-up on MTR / AM.

Actions to be undertaken	Immediate	Short term	Comments
	(before June 2008)	(in next OP 2008/09)	
1. Develop Annual Operational Plans with output based budget	Take formal decision to ask the BMC to develop single, MOHFW-wide annual plan and budget for next year. Involve MOF/MOP	Budget Management Committee led by the secretary to develop single, MOHFW-wide annual plan and budget	Little progress: No single MOHFW-wide annual plan with budget has been developed. The elaboration of a development and revenue budget by two different LDs continues. IRT has been told that no authority from MOF is needed to go ahead and bring the two budgets together under MBTF
2. Planning, Budgeting and Monitoring of the health sector	Support relevant LD in drafting their new OP (incl budgets + revised Result Framework).	Include in the next OP the prioritised activities for the next year of each LD	Good progress: Support has been provided to LDs to revise their OPs and budgets, as reported in section 2.5. Many OPs did include suggestions from the IRT team in their 2008 action plan.

Source: HNPSP APR2009

I-523 In the 2008 Mid Term Review, the following is noted on procurement in the public sector: "Lengthy procurement processes are associated with poor advance planning, over-centralisation, inadequate coordination mechanisms, and lack of a standardised procurement monitoring system." The APR2009 noted the taking place of various important developments since the MTR 2008. A computerised procurement tracking software has been installed at central medical stores depot (CMSD) while the MOHFW has initiated the development of a web-based procurement tracking system. Training sessions have been organised for procurement officers, Line Directors and members of the Technical Evaluation Committee (TEC) and Bid Evaluation Committee (BEC). This training covered important aspects and was organised internally, in-country and abroad. The MOHFW has also reiterated its need for reinforcement of its procurement capacity and has produced a short list of candidates for Procurement, Logistics and Monitoring Cell (PLMC) candidates. A procurement status review meeting has been initiated to address procurement issues on a regular basis. The communication between the procurement agencies and the World Bank has clearly improved and another year has gone by without post-review issues. Implicitly the Project Appraisal Document (PAD) and the revised Programme Implementation Plans (R-PIP's) procurement objective is an increase in efficiency of the procurement process. The procurement improvement plan in the PAD lists a number of activities that are expected to strengthen the system and therefore increase efficiency. Although the timeline has changed, some of the seven conditions are in process of implementation (PLMC, TA, MIS, training, QC laboratory). However, the DDA capacity study has not yet been initiated and others are yet to start (pre-qualification, pre-shipment inspections). Although there has been a considerable delay in the implementation of these actions, due the fact that the PLMC has not yet been created, the performance of the procurement agencies has improved. This is measured using the three result framework indicators as mentioned in the PAD: Percentage of the contracts awarded within bid validity: this has increased, mis-procurements: there have been zero mis-procurements; Only the opening of letter of credits L/C's within 14 days still poses a problem. Whether the performance of the sector procurement has improved in terms of value for money or expediency in processing packages (in other words, whether the client has benefited) has not been monitored. However, this is unlikely, as the functioning of the MOHFW has not improved and they play an important role in the overall procurement process.

Regarding EC contribution to these improvements, it is likely that the EC has addressed this issue as they mention in their LFA (2005) that all activity groups will require combinations of procurement, training, Technical Assistance in varying quantities. This could not be verified as the interview with the EUD in Bangladesh indicated that there probably had been a programme related to procurement, but there was no institutional memory that could be drawn on. Currently the EC is not active in the area of procurement as the World Bank and USAID have tended to focus on this.

2.6.2.2 Resume of the JC

This judgment criterion has been assessed by three indicators. (I) EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc) (II) EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing) (III) EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement. The information found the direct EC contribution to these indicators is quite limited in scope, apart from support to planning and budgeting at local level which has been successful. However it can be assumed that the EC has contributed under HNPSP and the World Bank administered trust fund.

2.7 EQ6 Coordination, complementarity and synergy : To what extent and how has the EC contributed to strengthening government-led co-

ordination, complementarity and synergies with Member States and other donors in the health sector, in line with the Paris Declaration? (national, regional and global levels)⁷⁶

2.7.1 JC 61 Level of health sector-related coordination in place with active role/contribution of the EC

- I-611 Evidence of EC participation and value added in functioning coordination mechanisms between donors
- I-612 Evidence of partner government leadership and EC value added in functioning coordination mechanisms between government and donors
- I-613 Change in number of project implementation units running parallel to government institutions within the health sector

2.7.1.1 Findings

I-611 The EC has been very active in donor coordination and has been Chair and Vice-chair of the donor group twice. They have been active in the dialogue itself and have often brought lessons learned from their projects into the dialogue. This has been helpful as these lessons have then been incorporated into the next health sector strategy.

Examples of EC value added are in the area of health financing which the EC has championed with a group of other like minded donors. This has led to the development of a revenue allocation formula for budget allocations to the local level which is now being piloted by the Government of Bangladesh and a health financing strategy. Also lessons from an EC project which focused on planning and budgeting at local level have now been integrated into national planning and budgeting processes.

I-612 A Joint Cooperation Strategy was signed in 2011 by the Government of Bangladesh and donors. This has led to more Government leadership as they now chair the health sector working group, with a donor acting as vice-chair. The EC has been active in supporting this process and is a key member of the group.

I-613 The EC now has four projects as well as their main support to health which is the HNPSP. This is a reduction compared to the past when there were more projects. Projects do have a useful function however, as they allow the EC to focus on areas which they view as important, but are not government priorities (e.g. food safety and hard to reach communities).

2.7.2 JC 62 Increased complementarity of EC support and between EC support and support of other donors

- I-621 EU programming and planning process related to health has been co-ordinated with other (EU) donors (as e.g., evidenced by EC programming documents such as CSPs, NIPs)
- I-622 Evidence of joint activities enhancing complementarity

2.7.2.1 Findings

I-621 All EC programmes are joint with other donors. They provide funding to the HNPSP through a World Bank Trust Fund and work through the SWAP which has been developed. The four EC projects are implemented by UN agencies.

I-622 As noted in I-611 the EC has worked with other like-minded donors to develop initiatives that have then been adopted by the government. By channelling the majority of their funding to the health sector they have also enhanced the complementarity of activities.

2.7.3 Resume of the JC

The EUD in Bangladesh has made a strong contribution to enhancing coordination and complementarity in the health sector. This has been through chairing the HNPSP working group, being actively engaged in dialogue and ensuring joint working with other donors for all their activities both inside of and outside of the SWAp.

⁷⁶ Evidence for this JC comes from the EUD interview.

2.8 EQ 7 Financing modalities, funding channels and instruments: To what extent have the various financing modalities (GBS, SBS, other sector support, projects), funding channels and instruments and their combinations, been appropriate, thus contributing to improving access to, equity of and policy-based resource allocation in health?⁷⁷

2.8.1 JC 71 JC 71 Aid delivery methods (incl. modalities and channels) adapted to national context

- I-711 Alternative aid modalities and channels explicitly considered/analysed during project formulation stage.
- I-712 Appropriateness of aid delivery methods used with regard to capacities of implementing partners
- I-713 Evidence that aid delivery methods were aligned to national systems and procedures and adjusted to evolving contexts

2.8.1.1 Findings

I-711 As the HNPSP is the main source of funding the health sector, the EUD only considered funding through this mechanism and through projects if they were complementary to HNSPS activities.

I-712 Aid delivery methods were appropriate in terms of funding through the SWAp and using the World Bank trust fund to undertake this. This reduced transaction costs for the government. There have been issues with their projects implemented through UN agencies as these projects have been very delayed (by one and a half to two years) due to the lack of capacity of these agencies.

I-713 All EUD support is channelled through government systems (for the SWAp and projects).

2.8.2 JC 72 JC 72 Contribution of EC GBS and SBS to policy based resource allocations and inclusive objectives in the health sector

- I-723 Evidence of the contribution to improved budgeting and policy processes (including policy based resource allocations, inclusive objectives in sector strategies, MTEF) (induced output)

I-723 For disbursement of funds for the SWAp there are five EC performance indicators. One indicator is related to increased resource allocation for the health sector. Although the absolute level of funding for the health sector increased, the percentage of the budget allocated to health did not increase.

2.8.3 JC 73 JC 73 Increased cost-effectiveness and internal consistency of EC support

- I-731 Disbursement rates by aid modality and channel
- I-732 Evidence that the thematic programmes provide distinctive added-value from programmes of geographic nature
- I-733 Evidence that the choice of specific aid modalities has led to reduced transaction costs (both on donor and partner country side)

2.8.3.1 Findings

I-731 The World Bank trust fund has had the best record for disbursement, although the programme will be extended for one year. The projects implemented by the UN have had a worse record with serious delays in disbursement. This has led to the projects being delayed by a year and a half to 2 years.

I-732 Thematic programmes are not always completely complementary to geographic programmes as they are run out of Brussels, so are not always tailored to the context. On the other hand, the thematic programme related to sexual and reproductive rights was complementary as it was not addressed in the HNPSP. Often geographic programmes have a better impact as they are implemented by local organisations who understand the local context better. EUD involvement with geographic programmes also means that they can bring lessons learned to the joint donor-government dialogue and ensure they are included in future activities.

⁷⁷ Evidence for this section is from the EUD interview

I-733 Funding through a SWAp has not led to an increase/decrease in transaction costs for the EUD. There are two staff dealing with health so they have had sufficient capacity to run the SWAp and projects effectively.

2.9 Annex

2.9.1 Key documentation used for the analysis

2.9.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction 2011			2011 MR-130903.02		
Improving Health, Nutrition & Population in the Chittagong Hill Tracts			2011 MR-139261.01		
Bangladesh Health, Nutrition and Population Sector Programme (HNPSP)	LFA (2005)			Annual Programme Review (APR) Main Consolidated Report, 2010 Annual Programme Implementation Report (APIR) 2010	
Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts			2009 MR-020590.02		
Primary Health Care Project, Cox's Bazaar Bangladesh		Final Evaluation of the Primary Health Care Project Cox's Bazaar, 2005			
Adolescents and Women's Reproductive and Sexual Health Initiative (ARSHI)				Mid-term Review of Thematic Project SANTE/2006/120021, Final Report, December 2007	

2.9.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	Not available
EAMR extractions	DONE
Country note from old health evaluation	DONE
Other Evaluations	
Paris Declaration Evaluation	Done

2.9.1.3 Bibliography

Annual Programme Implementation Report (APIR), Operational Plan (OP)

Annual Programme Review(2009): Bangladesh Health, Nutrition and Population Sector Programme (HNPSP) Volume I, Main Consolidated Report, 10th May 2009

Annual Programme Implementation Report (2010): Health, Nutrition and Population Sector Programme (HNPSP)

European Commission (2009) MR-020590.02 Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts

European Commission (2009) MR-020590.02 Improved access to and utilisation of affordable, quality sexual reproductive health (SRH) services and information among under served and low income women, men and young people of the hard to reach areas of Shariatpur, Bhola and Barisal districts

European Commission (2011) Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction

European Commission(2005) LFA, Health, Nutrition and Population Sector Policy Support Programme Bangladesh

European Commission(2011) MR-139261.01 Improving Health, Nutrition & Population in the Chittagong Hill Tracts

European Commission(2011): MR-130903.02 Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction

Evaluation of the Implementation of the Paris Declaration, Phase II, Country Evaluation Bangladesh, Final Report, December 30, 2010

Final Evaluation of the Primary Health Care Project Cox's Bazaar, 2005

HNPSP EC support to Health, Nutrition and Population Sector Programme and UN Collaborative Health Initiative in the Chittagong Hill Tracts, 2008

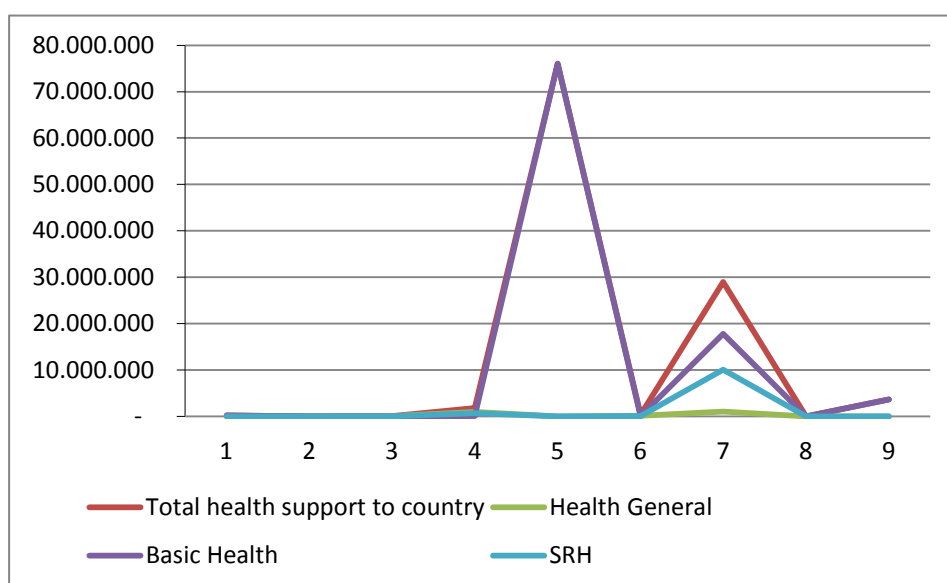
National Institute of Population Research and Training (2009) Bangladesh Demographic and Health Survey 2007

Worldbank:http://databank.worldbank.org/ddp/editReport?REQUEST_SOURCE=search&CNO=2&country=&series=SH.STA.BRTC.ZS&period=

2.9.2 EC contribution per sector, modality and channel

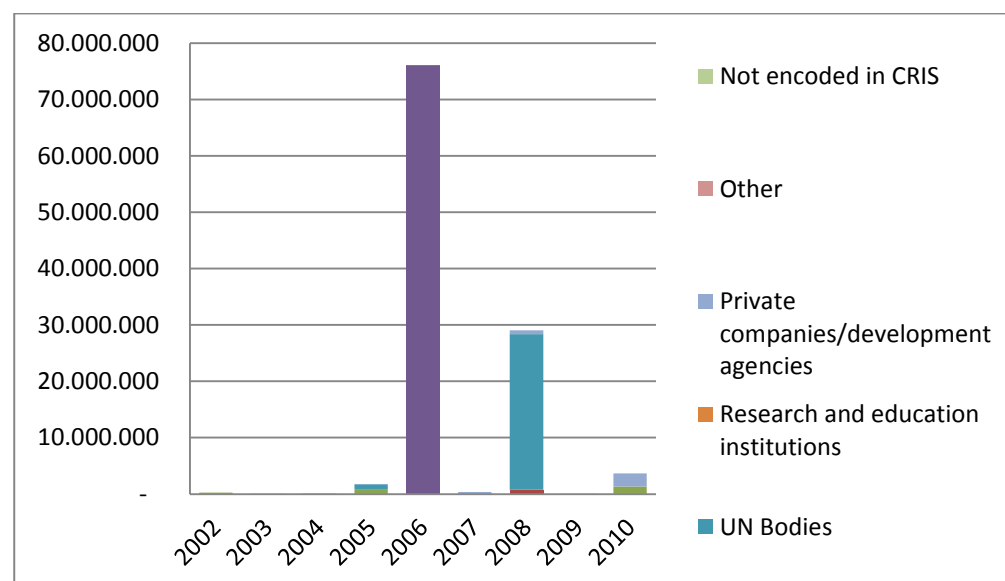
2.9.2.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to the country
2002	-	240,890	-	240,890
2003	-	-	-	-
2004	88,827	-	-	88,827
2005	1,003,957	67,145	743,877	1,814,980
2006	-	76,010,060	34,740	76,044,800
2007	176,429	70,895	95,117	342,441
2008	1,080,474	17,810,755	10,123,510	29,014,739
2009	-	-	-	-
2010	4,023	3,681,064	-	3,685,087
Total	2,353,710	97,880,809	10,997,244	111,231,762



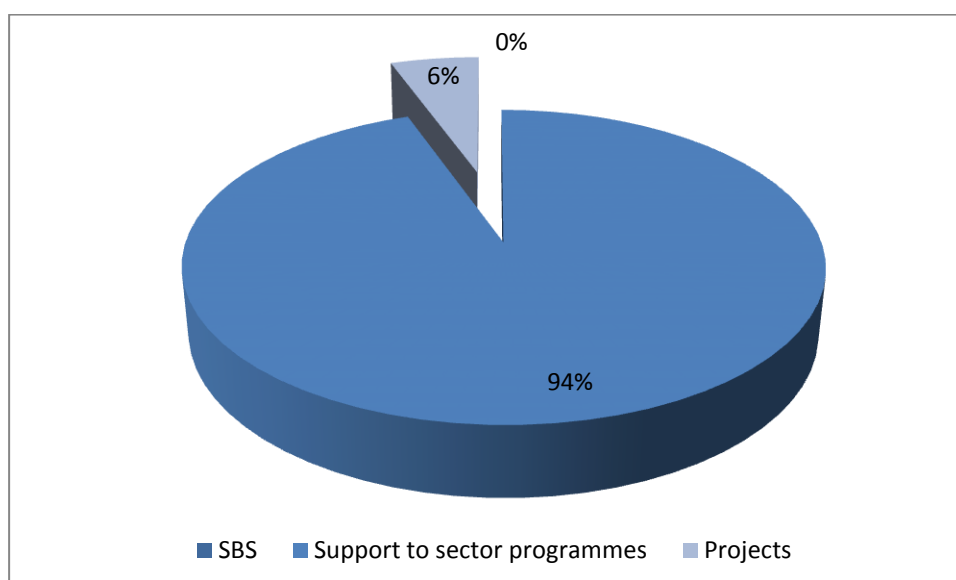
2.9.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	240,890	-	-	-	-	-	-	240,890
2003	-	-	-	-	-	-	-	-	0
2004	-	-	-	-	-	88,827	-	-	88,827
2005	-	743,877	-	999,000	-	72,103	-	-	1,814,980
2006	-	-	76,000,000	-	-	44,800	-	-	76,044,800
2007	-	-	-	-	-	342,441	-	-	342,441
2008	700,000	159,875	-	27,508,218	-	646,646	-	-	29,014,739
2009	-	-	-	-	-	-	-	-	0
2010	-	1,325,392	-	-	-	2,359,695	-	-	3,685,087
Total	700,000	2,470,034	76,000,000	28,507,218	0	3,554,510	0	0	111,231,762



2.9.2.3 per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	240,890	-	240,890	-
2003	-	-	-	-	-	-
2004	-	-	88,827	-	88,827	-
2005	-	-	1,814,980	-	1,814,980	-
2006	-	76,034,740	10,060	76,034,740	76,044,800	-
2007	-	247,324	95,117	247,324	342,441	-
2008	-	28,825,823	188,916	28,825,823	29,014,739	-
2009	-	-	-	-	-	-
2010	-	-	3,685,087	-	3,685,087	-
Total	-	105,107,887	6,123,875	105,107,887	111,231,762	-



2.9.3 Overview of funds committed to the country's health sector

Title of the intervention	Decision number	Decision starting year	Committed amount/contract
ALA/00/09 - Primary Health Project Cox's Bazaar Phase 3	ASIE/2000/00 2-583	2000	45.733€
DCI-NSA Support measures 2008 - Allocation AIDCO/F	DCI-NSA/2008/01 9-819	2008	29.041€
EC- Support to the national Health, Nutrition and Population Sector Programme	ASIE/2005/01 7-585	2005	105.107.887€
EIDHR 2007 AAP - COUNTRY BASED SUPPORT SCHEMES	(blank)	2007	159.875€
Framework Contract AMS/451 - Dev. Co-operation - Bangladesh	ASIE/2003/00 5-009	2003	60.975€
Global commitment for in-country and multi-country calls for proposals - Objective 1 - PVD projects - Non State Actors - AAP 2009	DCI-NSAPVD/2009/021-105	2009	1.325.392€
	(blank)	2009	847.688€
Health workers : call for proposal	(blank)	2009	1.217.476€
N/A	(blank)	(blank)	999.000€
Operational short-term TA related to Financial and Technical Co-operation with Asian developing countries	ASIE/2006/01 8-300	2006	95.117€
Operational Short-Term Technical Assistance Related to the Political, Economic, Cultural, Financial and Technical Cooperation with Developing Countries in Asia	DCI-ASIE/2009/02 1-502	2009	4.023€
pré-engagement dont dépendront les contrats PVD projets	ONG-PVD/2004/00 6-239	2004	743.877€
pré-engagement P1 dont dépendront 190 contrats en faveur de pays en développement	ONG-PVD/2002/00 1-092	2002	240.890€
Small Initiatives by Local Innovative NGOs SMILING	ASIE/2000/00 2-464	2000	290.508€
Thematic Lines Support Expenditure Programme 2005	(blank)	2005	21.412€
Thematic lines support expenditures programme 2006.	(blank)	2006	10.060€
Grand Total			111.231.762€

2.9.4 Description of main EC intervention

2.9.4.1 Intervention no 1

Title: EC- Support to the national Health, Nutrition and Population Sector Programme (The Commission Decision PH(2005)2078 has been amended under addendum no^o1 in order to extend by 18 months the operational implementation phase and execution period of the programme.

Budget: 105.107.887 EUR

Start and end date: 2005⁷⁸

Objectives and expected results:

Overall objective:

- The EC' s support to the health sector in Bangladesh aims at contributing to an "Improved health status of the population in Bangladesh - particularly of poor and vulnerable groups". This objective is in line with the Bangladesh Government's Poverty Reduction Strategy, which attributes to health three distinct kinds of importance - intrinsic, instrumental at personal and social levels, and relating to empowerment.
- The objective of the EC-programme is harmonised with the strategies of the other international donors currently involved in the health sector in Bangladesh.
- The purpose of the EC's Programme is that "The population - particularly poor and vulnerable groups - makes adequate use of Health, Nutrition and Population (HNP) Services of good quality".

Specific objective:

- Improving the access to and quality of preventive and curative health services through supply and demand side interventions.

Expected results:

The EC support programme consists of three components, which are to achieve three distinct but interlinked sets of results:

Component 1- HNPSP Pool Funding:

- Health interventions for achieving the *MDG/PRSP* outcomes and the targets of the population policy are effectively implemented.
- An effective response to the emerging challenges in the HNP sector is in place.
- The MoH&FW is efficient in managing the public health services and overseeing the service provision by non-public providers.

Component 2 - UN supported special interventions to strengthen HNPSP performance in critical areas:

- In the Chittagong Hill Tracts (CHT), women have increased access to pre-, postnatal and obstetric services including Emergency Obstetric Care
- The population in the CHT has increased access to curative services for Malaria, TB, acute respiratory infections and diarrhoeal diseases
- The population in the CHT has increased access to preventive services
- Three districts in the CHT have an improved capacity for the management and delivery of health services
- In Maternal and Child Health Pilot Districts (MCHPDs), the capacity for co- operation between the public Health System and the civil society has increased
- In MCHPDs, a larger proportion of women has skilled support during delivery

⁷⁸ The Commission Decision PH(2005)2078 has been amended under addendum no^o1 in order to extend by 18 months the operational implementation phase and execution period of the programme.

- In the MCHPDs, the access to EOC has improved sufficiently to make the approach a successful model to be expanded to all districts in the country

Component 3 - Urban Primary Health Care Project Phase II⁷⁹

- A sufficient number of adequately qualified Non-Government Organisations are under contract
- Planned infrastructure (Health facilities, waste disposal sites, community toilets) in place and functional
- The involved Government Institutions on all levels and the participating NGOs have adequate capacity to fulfil their respective roles in the UPHCP II
- Results of operational research on priority issues available
- The inclusion of UPHCP II into the HNPSP PIP is further advanced

Activities:

The EC support to the GoB's Health Nutrition and Population Sector Programme (HNPSP) will consist of three components:

Component 1:

- **A contribution to the World Bank administered HNPSP pool fund (EUR 76.000.000).** The EC will conclude an administration agreement for a trust fund with the World Bank (WB), which accepts the fiduciary responsibility for the pooled funds. In addition, the WB will assure that the utilisation of the pool fund is in line with the strategic priorities of the GoB's Strategic Investment Plan 2003-2010, to which the international donors have agreed during the appraisal process. Out of the total pool finances,
 - 60% will be available to finance the core activities of the sector programme;
 - 15% will be dedicated for contracting services from non-public service providers;
 - another 25% of the pooled donor support will be linked to programme performance and be disbursed against the programme meeting yearly targets.

Component 2:

- **UN supported special interventions for strengthening HNPSP performance in critical areas.** (EUR 9 million, EUR 10 million and EUR 7 million)

The EC will conclude a contribution agreement with the UN for the implementation of projects on

- i) Effective and cost efficient approaches to improve Maternal and Child Health and
- ii) Strengthening the health services in the Chittagong Hill Tracts.
- *The project for improving Maternal and Child Health* will be implemented in collaboration with and based on a concept of UNICEF and UNFP A and financed by one or more DPs. Given the project's objective of piloting innovative approaches, financing through the UN system seems to offer more liberty for testing innovative strategies and tools, without being overly restricted by public service rules. However, this managerial arrangement is regarded as transitional. At the latest in 2010 the management of activities for promoting maternal and child health are expected to be fully integrated into the GoB's administrative system.
- *Strengthening the health services in the Chittagong Hill Tracts.* The EC will support UN agencies in implementing a project for strengthening the Health Services in the Chittagong Hill Tracts (CHT), which will be financed by one or more DPs. While the special challenges in the CHT justify a project approach at this point in time, the intervention is regarded as an integral component of the national HNPSP and the EC's Sector Policy Support Programme. The EC will therefore work towards fully integrating the support to the health services in the Chittagong Hill Tracts into the MoH&FW's management system until the end of HNPSP in 2010.

⁷⁹ Urban Health Component 3 of the programme has been replaced by three different activities under addendum no°1 to Commission Decision PH(2005)2078

Component 3 before addendum no°1 to Commission Decision PH(2005)2078:

- **Urban Primary Health Care Project, Phase II (UPHCP II).**

Through a **trust fund arrangement with the Asian Development Bank**, the EC will co-finance the second phase of the Urban Primary Health Care Project. The EC contribution will allow an expansion of the ongoing project in 2006 to four additional municipal towns. Contributing to both, the HNPSP pool fund and the special project for urban areas, the EC aims at accelerating the process of getting better services to the urban poor, and at promoting the increasingly closer integration of urban health care into the national health, nutrition and population sector programme.

Activities under Component 3 after addendum no°1 to Commission Decision PH(2005)2078:

- National Food Safety Project with FAO/WHO
- Continuation of Immunisation Surveillance Network with WHO
- Expansion of maternal vouchers scheme monitoring and supervision system with the Government of Bangladesh

Contracted Services for special support measures.

- To support the smooth implementation of the above three components, the EC will contract services for monitoring purposes, to maintain some capacity for generating technical information, when needed by the group of pool funding agencies or specifically by the EC. The contracted services will also be available to provide additional technical assistance, which the MoH&FW or other involved Government institutions may sometimes require. In case the need arises, the EC may also contract services to carry out audits, which the EC may require in addition to the respective activities of the Development Banks and the UN partners.

3 Annex 14: Country case study Philippines

***Thematic evaluation of
the European Commission support
to the health sector***

**Country Case study
PHILIPPINES**

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3.1 Introduction

3.1.1 Country context of EC support

Ongoing reforms in health service delivery are aimed at improving the accessibility and availability of basic and essential health care for all, in particular for the poor. Public primary health facilities are perceived as being low quality and thus are frequently avoided. The result is that secondary and tertiary facilities are crowded with patients that are in need of primary health care. Private providers are predominantly located in highly urbanised areas. The private sector consists of a wide range of privately operated facilities, such as pharmacies, physicians in solo or group practices, small hospitals and maternity centres, diagnostic centres, employer-based outpatient facilities, secondary and tertiary hospitals, traditional birth attendants and indigenous healers.

The power of the DOH diminished significantly with the transfer of responsibility for health to about 1600 Local Government Units (LGUs) under the Local Government Code of 1991. With the devolution of health services to LGUs, fragmentation of services became evident. The provincial governments now oversee provincial and district hospitals, while the municipal governments manage rural health units (RHUs) and barangay (village) health stations. The Department of Health, however, maintains specialty hospitals, regional hospitals and medical centres. Sub-national Department of Health offices or "centres for health development" are located in 16 regions. Local Chief Executives, for whom health is often a low priority, have a great deal of authority in the allocation of budget resources.

The Philippine Department of Health's vision is to be "The leader of health for all in the Philippines". Its mission is to "guarantee equitable, sustainable and quality health care for all Filipinos, especially the poor and to lead the quest for excellence in health".⁸⁰ The differences in health status among different groups and regions in the country have increased through the years. These disparities indicate deficient economic and social policies, showing the need to reprioritise interventions to promote equity, fairness and immediate action. The strategic thrusts to achieve the health goals are anchored in the current programme of health reform, "FOURmula ONE for Health", a medium term plan covering 2005-2010. It was designed to undertake critical reforms with speed, precision and effective coordination, with the end goal of improving the efficiency, effectiveness and equity of the Philippine health system. In 2010 F1 has been replaced by Universal Health Care by the new administration. The "FOURmula One for Health" was structured around four pillars: (1) health financing; (2) regulations; (3) service delivery; and (4) good governance.⁸¹

The "EC Philippines Strategy Paper 2007-2013" indicates that the main area of concentration for cooperation will be support for the Government to deliver basic social services with a particular focus on improving equitable access to quality health. This thrust is in agreement with the Medium-Term Philippine Development Plan (MTPDP) where the importance of social services such as health and education is recognised and reflects the EC's commitment to the MDGs and ensures strategic continuity of EC interventions.⁸²

The Table 1 in the following section 1.3. provides an overview of EC funds committed to the country's health sector. In terms of financial volume, the biggest EC programmes were the SBS funds for the "Philippines Health Sector Policy Support Programme" (HSPSP) (ASIE/2005/017638) (project period 2006-2011) and the SSP funds for the "Mindanao Health Sector Policy Support Programme" (MHSPSP, ASIE 2006/018016) (project period 2007-2012).

- The first programme's objective was to contribute to the overall improvement of the health status of the population especially the poor, the women and other vulnerable groups and to achieve health-related Millennium Development Goals (MDGs). The Programme utilises a sector-wide approach that supports the health service delivery, health care financing, regulatory and governance pillars of the Department of Health's (DOH) FOURmula for Health Initiative (F1).
- The second programme has a twofold objective of further supporting the health sector reform process in some conflict-affected areas in Mindanao and at the same time contributing to confidence and peace building in the region. **The programme objectives do not differ significantly from HSPSP**, but are on a much lower scale, doable in Mindanao's current institutional context.

⁸⁰ DOH, http://www.doh.gov.ph/about_doh/profile

⁸¹ <http://www.scribd.com/doc/13885214/The-Fourmula-One-for-Health-DOH>

⁸² The EC Philippines Strategy Paper 207-2013, http://www.eeas.europa.eu/philippines/csp/07_13_en.pdf

The two NGO health sector projects selected for this case study are

- "Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao"(REH/2005/017-108, Contract 111156) and
- "Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health" project (EMPHASIS-RH) (DCI-NSAPVD/2007/019-404, Contract 172232).

More details on those programmes are summarised in the Annex.

3.1.2 EU funds between 2002-2010:

According to the evaluation of European Commission's cooperation with Philippines⁸³ which has covered the period from 2002-2009 (with an extension to 2011) support to the health sector was a key component of the EU cooperation strategy. In absolute terms public funds have increased but relative to overall spending it has declined. Furthermore, health financing is characterised by large gaps, resulting in substantial out-of-pocket payments.

The Health Sector Policy Support Programme (HSPSP) started on 26 May 2006, when the EC signed a €33 million support with the Government of the Philippines (GoP). The operational phase will end at 31 December 2011, while the final date for closing the books of the Financial Agreement (FA) is set at 31 December 2013. The HSPSP is a 4-year programme of assistance to the Philippine government by the European Union to strengthen the delivery of health services and help the country attain its Millennium Development Goals (MDG). The Programme utilises a sector-wide approach that supports the health service delivery. Technical assistance to the HSPSP was contracted to support GOP efforts in implementing health reform and aligned itself with the four pillars of F1.

The programme was designed in the decentralised context, including the choice of mixing two financing modalities to provinces, based on the results of the EU- and WB-financed diagnostics: the sector analysis undertaken by the EU with a start up TA, concluded that significant progress was achieved in the areas of sectoral policy and strategy and donor coordination (strong donors-Department of Health cooperation on SWAp) and that PFM systems were strengthened along the lines of an overall PFM reform encompassing the improvement of medium term financial planning, public finance management and procurement. The two complementary modalities are:

- Budget support (BS) to 10 provinces amounting to € 12.5 million and managed by the DOH and DBM and an amount of € 1 million for oversight PFM reforms led by DBM; and
- Trust Fund (TF) arrangement administered by the World Bank (WB) to support 6 provincial local government units (PLGUs) amounting to € 6.75 million out of which € 1 million for reforms in the Department of Health (DOH).

As of December 2010, the 10 budget support CBS provinces received about 82% of fixed tranche CFT) and earned variable tranche (VT) for 2007-2009. It should be noted that the 6 trust fund (TF) provinces also received the similar tranches including the earned VT3 for 2009. For the BS provinces, fund release request was received from DoH late November 2010 and the assessment has been submitted to DEVCO D on 10 December. No funds for VT3 have been released so far. Major obstacles encountered in the period include cumbersome requirements of DoH and GoP procurement procedures, coupled with a lack of know-how in the provinces, have continued to hinder timely fund releases to the LGUs, specifically with regard to civil works.

Further EU support to the reform process through the Mindanao Health Sector Policy Support Programme (MHSPSP) was signed in February 2007 covering some of the poorest, conflict affected and most unstable regions in Mindanao, comprising 13 provinces and two cities: Zamboanga del Sur, Zamboanga del Norte, Zamboanga Sibugay, ARMM provinces (Basilan, Tawi-tawi, Sulu, Maguindanao, Lanao del Sur), Sarangani, Compostela Valley, Lanao del Norte, Davao Oriental, Sultan Kudarat, Marawi City and Isabela City (Basilan), which are part of the second phase "roll-out" provinces that joined the health reform. MHSPSP forms an integral part of the government's sector programme which has been supported by an increasing number of donors. The EU regards the MHSPSP as a very strategic programme since it has the two-fold objective of supporting the health sector reform and at the same time contributing to confidence and peace building in Mindanao. MHSPSP commenced in January 2008 and activities will conclude in 2012. The project consists of 2

⁸³ European Commission(2011) Evaluation of the European Commission cooperation with the Philippines, Final Report, June 2011

elements, a TA component and a grant contribution implemented through an Administration Agreement with the WB.

The following tables give an overview of EC funds provided to the Philippines during the evaluation period (2002-2010). Only contracts signed between the 1/1/2002 and 31/12/2010 have been taken into account for elaboration of inventory and for the evaluation. A detailed overview of contracts, namely of the HSPSP and MHSPSP, can be found in Annex 3.7.3.1. A description of the objectives and activities carried out under the interventions selected for this evaluation can be found in Annex 1.1.1.

Table 10: Overview of funds committed to the Philippines health sector between 1/2002 and 12/2010 – main interventions in the health sector⁸⁴

Decision title	Decision number	Decision starting year	Contracted amount until 2010 (contract level)
Philippine Health Sector Policy Support Programme	ASIE/2005/017-638	2005	31.195.374€
Mindanao Health Sector Policy Support Programme (MHSPSP)	ASIE/2006/018-016	2006	10.674.734€

Table 11: Overview of funds committed to the Philippines health sector between 1/2002 and 12/2010 – small interventions⁸⁵

Contracts Title	Decision Number	Contract number	Contract year	Contracted amount until 2010 (contract level)
Health programme Philippines - pre-identification mission	ASIE/2000/002-965	59751	2003	159.857€
Identification Mission Health Programme-Philippines	ASIE/2000/002-965	64056	2003	62.082€
Health Sector Reform Programme - Public Finance Management start up TA	MULTI	97010	2004	162.638€
Philippines: Formulation Mission Health Sector	ASIE/2003/005-022	96849	2004	143.071€
Preventing HIV/AIDS among adolescents in the Philippines by building capacity of youth councils to engage in local decision-making processes on the rights of adolescents to sexual and reproductive health	ONG-PVD/2004/006-239	110816	2005	638.494€
"Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao"	REH/2005/017-108	111156	2005	996.258€
Developing a local monitoring system on the Millennium Development Goal 5, Target 8: Increase access to reproductive health services to 80% by 2010 and 100% by 2015	ASIE/2002/002-472	112064	2006	146.335€
Health sector support - Procurement and warehousing, phase 2	ASIE/2005/016-885	120455	2006	183.540€
Support to the Formulation of the EC Supplemental HSPSP in the PH	ASIE/2005/016-885	123037	2006	4.900€
Audit of ChristianAid's ONG/PVD Programme for Rehabilitation & Development in Mindanao	DCI-NSA/2007/019-144	141917	2007	42.378€

⁸⁴ Only contracts committed during this period are taking into account. For a detailed overview see Annex 3.7.3.1

⁸⁵ Only contracts committed during this period are taking into account

Contracts Title	Decision Number	Contract number	Contract year	Contracted amount until 2010 (contract level)
Support to government's capacity development for the appraisal of Provincial Investment Plans for Health in reform roll-out provinces	ASIE/2006/018-300	145390	2007	126.438€
South-Eastern Philippines Health and Economic Alternatives (HEAL) Project	DCI-NSAPVD/2007/019-406	172224	2008	700.000€
Enhancing maternal health services to selected underserved sectors in Eastern Visayas through the Cooperative Enterprise System	DCI-NSAPVD/2009/021-105	231290	2010	580.860€
Strengthening Local Response for Improved Access to family Planning	DCI-NSAPVD/2009/021-105	226790	2009	791.860€
Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH)	DCI-NSAPVD/2007/019-404	172232	2008	990.000€
Integrating Population, Reproductive Health and Coastal Resources Management Actions in Tawi-Tawi, Mindanao, Philippines	(blank)	226549	2009	850.000€
A FINANCIAL & SYSTEMS AUDIT CONCERNING ""SOUTH-EASTERN PHILIPPINES HEALTH AND ECONOMIC ALTERNATIVES (HEAL) PROJECT""	DCI-ASIE/2009/021-502	248167	2010	28.886€
Early Recovery and Rehabilitation for Central Mindanao	(blank)	256456	2010	4.000.000€
Total EC support to the country between 2002-2010				52.599.090€

3.2 EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services?

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

Indicators

- I-111 National health policies guarantee access to drugs, officially recognised as essential.
- I-112 Average availability of selected essential medicines in public and private health facilities, incl pharmacies.

3.2.1.1 Findings per indicators

I-111: The "Universally Accessible Cheaper and Quality Medicines Act of 2008" was signed by the President in June 2008; the Cheaper Medicines Act is an amendment to the Generics Act. The main focus of the Act is the amendment to trade related Intellectual Property Rights (IPR) for medicines to improve access to cheaply priced drugs. It should be noted that while the act does include IPR related aspects, this is not the main focus. It provides amendment for several legal issues (An Act Providing For Cheaper And Quality Medicines, Amending For The Purpose Republic Act No. 8293 Or The Intellectual Property Code, Republic Act No. 6675 Or The Generics Act Of 1988 and Republic Act No. 5921 Or The Pharmacy Law and For Other Purposes). The purpose is to provide policy options and "appropriate measures to promote and ensure access to affordable quality drugs and medicines for all". "Pursuant to the attainment of this general policy, an effective competition policy in the supply and demand of quality affordable drugs and medicines is recognised by the State as a primary instrument." The act also does not necessarily prescribe voluntary and mandatory price reductions. However it opens the possibility to do so "in the event that full competition is not effective, the State recognises as a reserve instrument the regulation of prices of drugs and medicines." This act prescribes Maximum Retail Price of five active drug ingredients and the voluntary price reduction of 16 others in 2009 and a

further 97 others in 2010. The impact needs to be evaluated. Private and public systems need to submit their prices to DoH and generic drugs are promoted. The TA contributed by producing technical papers on various policy options for the drafting of the cheaper medicines act as well as the drafting of the amendment to trade related Intellectual Property Rights for medicines.

Passing of the Republic Act 9711 or “The FDA Act of 2009”. RA9711 is aimed at strengthening of Food and Drug Administration of Philippines through various reforms affecting its organisational structure, legal and fiscal management systems and enforcement capacity. The implementing rules and regulations for RA9711 are under development. Implementation expected to start in April 2010.

According to the CSE Philippines from 2011⁸⁶ there are two programs of the central Government for cheap drugs, namely the Botica ng Barangay (BnB) and P100. The P100 scheme has a limited list of medicines and is limited to few outlets (public hospitals) to have a significant impact. Schemes, like BnB, face problems with re-supply from PITC Pharma. Some LGU hospitals are buying branded generics at 13-40 times of the international reference prices and originator brands at 60-70 times the reference prices.

The DOH “Complete Treatment Pack Program” (DOH ComPack) is the response of the national government to the need for essential medicines especially of poor Filipino families with meagre income to afford even basic medicines for common ailments. ComPac is a rather new measure introduced by the new administration under Universal Health Care (UHC) (not yet under F1) to replace the P100 programme. The Program provides free medicines for hypertension, diabetes, diarrhoea, pneumonia and other common infections to patients included in the National Household Targeting System of the Department of Social Welfare and Development (DSWD) on the condition that they consult a doctor at the rural health unit (RHU), adhere to their treatment regimen and comply with follow up.

Near the end of the evaluation period, the DoH also launched the Philippine Medicines Policy 2011-2016 which sets out the directions and strategies of the Department in collaboration with the Food and Drug Administration (FDA), PhilHealth, other government agencies and stakeholders in the pharmaceutical and health care sector to improve access to essential medicines.

After a review of the impacts of the Cheaper Medicines Act of 2008 or Republic Act 9502, the DoH recognised that there are major steps that need to be fulfilled to improve access to quality essential medicines such as implementing the FDA Strengthening Act and the provision of outpatient drug packages which is already being studied by PhilHealth.⁸⁷

The European Commission (EC) Health Sector Policy Support Program (HSPSP) supports the Health Sector Reform Agenda (HSRA) and FOURmula One (F1) for Health within the Sector Development Approach to Health (SDAH). The HSPSP does not attempt to address the whole Health Sector Reform Agenda (HSRA) but to focus on key reform targets in the areas of good governance, health financing, health services delivery and regulation, specifically of drugs and medicines.

Under the F1 for health initiative, the regulation pillar secures access to quality and affordable health products especially for the poor. The HSPSP supports this objective: At national level by enhancing the capacity of the Bureau of Food and Drugs (BFAD)⁸⁸ and the Department of Health (DoH) to perform their licensing, accreditation and certification functions. In addition, the HSPSP Final Report (2010) noted that in Regulation and management at central level the EC-TA was heavily involved with the newly created FDA (Food and Drugs Administration) in the production of the Implementing Rules and Regulation (IRR) of „The Affordable and Quality Medicines Act (RA9502) and the IRR of the FDA Act, assisting in the internal re-organization needed for the transition from BFAD into FDA and in the cascading training for the FDA and CHDs on pharmacovigilance, The TA also supported the production of technical specifications and an operations manual for medicine warehouses and stockrooms. A process map analysis of the Philippine International Trading Corporation (PITC) Pharma Inc. concluded that the corporation.

Consequently, among the most important milestones have been those accomplished in the regulation pillar with the passing of major pieces of legislation and taking steps to strengthen the newly established Food and Drugs Administration (FDA).⁸⁹

⁸⁶ European Commission, Particip (2011) Evaluation of European Commission cooperation with the Philippines, Final Report, Volume I

⁸⁷ DOH, <http://www.doh.gov.ph>

⁸⁸ BFAD was restructured and renamed as FDA

⁸⁹ Extracted from the: Interim Report 5 v3 (1st August 2009 - 31st January 2010), Report to the Delegation of the European Commission of the Philippines. Contract No. 2006/132479, TA to the Health Sector Policy Support

The EU-TA supported in the last year of the evaluation period (2010) the preparation of a Philippine Health Insurance Cooperation (PHIC) Board resolution increasing premiums and benefits, the development of a pro-poor budgeting scheme for drugs for retained hospitals and the support to the preparation of the legislative agenda that will accommodate the new policy frame. Improved financial protection through PHIC inpatient package should lead to decreased % of out-of-pocket (OOP) (see I-211) as a source of total hospital income in the 10 pilot hospitals. Some progress has been made as PhilHealth is reimbursing the P100 drugs in provincial hospitals and only if the patient is admitted, but with the knowledge that stock-outs and very slow-moving (low consumption of P100 drugs) are identified.

Besides providing support at national levels, further achievements have been identified in the CSE Philippines through EU-TA support at local level by helping local governments adopt Good Procurement Practices in Pharmaceuticals (GPPP) and by promoting the establishment of community-based pharmaceutical outlets (Botica ng Barangay). Drug Management Systems are enhanced at the local level to improve efficiency and performance of pharmaceutical supply management systems at LGU level starting from more focused selection of essential medicines through transparent and cost efficient procurement to effective, rational use through training in GPPP (see also I-523).

Under MHSPSP, a short term expert was engaged to review the public procurement mechanisms, review LGU application of procurement regulations and processes identifying key areas of impact on health services delivery, health planning and health financing at Provincial and Municipal level. As a result a report has been produced that includes a synthesis of the current baseline situation. In addition, the TA reviewed pharmaceuticals regulations, supply systems, outlets and access to affordable pharmaceutical products in CAA. The results have been presented in a report.⁹⁰

In summary, EC support has contributed strongly to putting in place policy structures that guarantee access to essential medicines, however the HSPSP Final Report (2010) also expressed the reservation that any future developments in this pillar would need a new National Medicine Policy in place in order to tackle issues on access to essential medicines in a systematic and comprehensive manner.

I-112: No data have been found on percentage of public health facilities experiencing stock-outages of selected essential drugs over the evaluation period.

The WB⁹¹ report confirms that the availability of essential medicines in the public sector is low and procurement prices in most LGUs are too high.

Both HSPSP and MHSPSP have included access to essential drugs among their anticipated results and, as described above, there have been improvements in the legal and regulatory framework. After reviewing the qualitative information available such as the CSE Philippines and the MTR of HSPSP, it can be said, that EC contribution to improvement in the Indicator is likely.

According to the CSE Philippines, pharmaceutical procurement and management at the local level is inefficient. There is an increasing market share of generic drugs, though it is not possible to attribute this to Government action and prices remain high. TA support to Drug Management Systems at the local level is meant to improve efficiency and performance of pharmaceutical supply management systems at Local Government Unit (LGU) level starting from more focused selection of essential medicines through transparent and cost efficient procurement to effective, rational use through training in GPPP. EU TA has contributed to Good Drug Management Systems and procurement (GPPP) at the local level.

More specifically, under MHSPSP the objective was to assist the Field Implementation Management Office (FIMO), DoH-ARMM and DoH-CHDs to undertake targeted responses to pharmaceutical supply issues. The training course conducted in 2010 included Simple Accounting and Bookkeeping for BnB Coordinators in all ARMM provinces⁹². In 2011 further trainings of BnB Municipal Coordinators

Program; and Interim Report 2 (1st January - 1st July 2008), Report to the Delegation of the European Commission of the Philippines. Contract No. 2006/32479, TA to the Health Sector Policy Support Program; and Mid-Term Review Of The Health Sector Policy Support Programme (ASIE/2005/017638) In the Philippines, Final Report, January 2009

⁹⁰ MHSPSP Progress Report, 2009

⁹¹ 2.Human Development Sector Unit East Asia and Pacific Region, WB Philippines' Health Sector Review, Draft May 2010

⁹² MHSPSP 6th six month report July 2010- February 2011

completed in all municipalities to develop strategies or mechanisms to address pharmaceutical supply issues,⁹³

Besides these positive aspects, some issues have been identified as well, which might mitigate EC contribution to the indicator, for instance where the TA package was introduced, the MTR Team observed inadequacies in design and implementation of the Good Procurement Practices in Pharmaceuticals (GPPP): i) over-reliance on the General Services Office (GSO) of the province to manage the procurement process; ii) minimal involvement of the provincial public finance team in the provision of oversight to the procurement process; iii) absence of a reliable local price monitoring system; and iv) no follow-through by the EU-TA Team or by the CHD after the GPPP training to provide continuing guidance to local staff, especially in critical stages of the procurement process.

Generally the Village and municipal drug outlets (Botika ng Barangay, Botika ng Bayan) have been revived and are growing rapidly in number (see WB report), however, the situation of drug procurement continues to be alarming. According to some interviewees, drugs account for 67% of costs, staff for 19% and investment 5%. According to the WB report, availability of essential and generic medicines in the public sector is still low and procurement prices are too high in most LGUs. Some LGU hospitals are buying branded generics at 13-40 times of the international reference prices and originator brands at 60-70 times the reference prices. Proper demand management could reduce consumption. Furthermore ill-served regions need more outlets; turnover is low, re-supply is still difficult, record-keeping is poor and pharmacy supervision is infrequent in most BnBs. Historically deprived regions continue to be ill-served, such as ARMM with only 1 BnB per 14,900 population; Bicol with only 1 BnB per 14,000 population; and SOCCSKSARGEN⁹⁴ with only 1 BnB per 10,700 population.

3.2.1.2 Resume of the JC

The legal and regulatory environment for access to essential medicines has improved, in part because of EC sector support. HSPSP explicitly listed as a monitoring indicator, at the local level and when possible disaggregated by gender, the drug availability and drug pricing and particularly for the poor. Similarly the Mindanao Health Sector Policy Support Programme (MHSPSP) also promotes drug availability to the poor on Mindanao Island including the Autonomous Region of Muslim Mindanao (ARMM), regions facing armed conflict, economic disadvantaged, having poverty and health indicators below national average, by including enhanced pharmaceutical supply in terms of location, type and number of pharmaceutical outlets as an objective and focusing on Botika ng Barangay (BnB) training. However, no data on the Indicator most directly connected to availability, the proportion of facilities experiencing stock outages, has been found and the procurement situation is still reported to be bad. Additionally, according to the CSE PHL the BnB and P100 programs are a limited answer to the problem of access to medicines as generally drugs in these programs are still paid out of pocket. The programs try to improve replenishment mechanisms by decentralising procurement and allowing some retained hospitals and local drug manufacturers to participate as wholesalers in addition to PPI.

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

Indicators

- I-121 Improvement in the mix of primary and secondary health facilities
- I-122 Increased proportion of health facilities with appropriate equipment

3.2.2.1 Findings per indicators

I-121 In 2006, the total number of health infrastructure of public health facilities consisted of 90 general hospitals, 21 specialised hospitals, 282 district/first-level referral hospitals and 331 primary health care centres. The private health facilities consisted of 1,068 hospitals in total with 44,296 beds.⁹⁵ No time-series data are available.

The National Center for Health Facility Development (NCHFD) has defined three cycles of rationalisation of health facilities based on need: first, rationalisation planning, second, implementation

⁹³ MHSPSP 7th six month report February 2011 – July 2011

⁹⁴ Acronym that stands for Mindanaos four provinces and one of its cities: South Cotabato, Cotabato, Sultan Kudarat, Sarangani and General Santos City

⁹⁵ WHO. 2010. Western Pacific Country Health Information Profiles: 2010 Revision. Geneva: WHO.

planning and third, systems development. After completing the first two cycles in 20 provinces, NCHFD is now ready to transfer the technical support role for the first two cycles to field implementation management office (FIMO). This will mean that NCHFD will be able to focus on the third, developmental cycle of rationalisation of health facilities starting in 2010. This effort has been supported by the HSPSP.⁹⁶ Furthermore the 2009 mid-term evaluation of the HSPSP⁹⁷ also provided recommendations to this process, for instance it recommends that the health facilities rationalisation plan should not just focus on eliminating redundancies in lower level facilities, but should also cover quality improvements needed to raise tertiary care capacity in provinces where no facility meets the tertiary care standards. Instead of immediately downgrading provincial hospitals, DOH and PhilHealth should collaborate in mobilising technical and financial assistance to prioritise upgrading of provincial hospitals to the level that will pass accreditation requirements, so as not to deprive the provincial PhilHealth members of access to quality tertiary care.

The MHSPSP supported catchment and case flow analysis.⁹⁸ This activity endeavours to increase the capacity of LGUs to review their Barangay Health Stations' role and scope of services by analysing access, demand and utilisation of Barangay Health Stations services. It also aims to respond to equity concerns by assessing the present geographic configuration of services and human resource allocations. The information derived from this activity resonated strongly with local health planners who wish to make important decisions regarding their human resource requirements and the number and types of facilities that may need to be increased, relocated or reduced.

Though, the NGO "Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao" a project which started on April 2006 and ended on March 2009, project's accomplishments are the construction of 15 community clinics and simple laboratories in the 14⁹⁹ project provinces on Mindanao¹⁰⁰.

In summary, through HSPSP, the EC contributed significantly to ongoing efforts to rationalise health infrastructure.

I-122 No information on time trends has been found for the indicator "Increased proportion of health facilities with appropriate equipment". Similarly the information found in the reviewed documents regarding EC support remains very vague, without stating any concrete numbers. However availability of equipment seems to be an important issue. In this regard the WB report¹⁰¹ stated that asset management remains a major problem area for the health sector. Annual audit reports of the Commission on Audit document the millions worth of defective and unutilised medical equipment in various DOH retained hospitals and centres for health development (CHDs) nationwide including waste water treatment, ventilators, fetal heart monitor and cardiac monitor, unused anesthesia machines, neonatal ICU and pediatric ICU machines and air-conditioning units.

Likewise the CSE Philippines emphasised the importance of addressing lack of appropriate equipment particularly regarding reproductive health as one conclusion of the CSE Philippines points to the requirements like procurement of equipment and other goods and commodities which influence programme implementation to build the capacity of health staff to fulfil quality standards of reproductive health services.

EC seems to have addressed this issue to some extent as one indication of EC contribution has been found in the CSE Philippines, where it is mentioned that a good development of maternity facilities at high pace, with equipment provided by EU-funds under MHSPSP (Mindanao Health Sector Policy Support Programme) and UNFPA with increasing basic emergency obstetric and neonatal care (BEmONC) recognition.

⁹⁷ Mid-Term Review Of The Health Sector Policy Support Programme (ASIE/2005/017638) In the Philippines, Final Report, January 2009

⁹⁸ Extracted from the: Mindanao Health Sector Policy Support Programme (MHSPSP) Mid-Term Review, EC ref n°: 2010/244731 Final Evaluation Report. Philippines, November 2010.

⁹⁹ The provinces are: Camiguin, Misamis Oriental, Bukidnon, Lanao Del Norte, Lanao Del Sur, Agusan Del Sur, Agusan Del Norte, Surigao Del Norte, Surigao Del Sur, Sarangani, South Cotabato, Davao Del Norte, Compostela Valley, Davao Del Sur, Zamboanga del Norte, Misamis Occidental

¹⁰⁰ Council for Health and Development (2009) Bringing Health into the People's Hands – Aid to Uprooted People (Philippines), April 2006-March 2009

¹⁰¹ Human Development Sector Unit East Asia and Pacific Region, WB Philippines' Health Sector Review, Draft May 2010

Besides providing equipment, the EU-TA also looked into strengthening procurement functions in LGUs. The TA has stepped up assistance to the provinces in the preparation of the different plans (APs, Training plans, Procurement plans, Rationalisation plans) and advocating for closer communication between DOH – LGUs. The EU-TA also looked into the logistics and supply chain management to improve both central and local level procurement, logistics and warehousing to guarantee the availability and assured quality of essential health products along the supply chain.

Until now, no EU budget under MHSPSP has been released through the WB TF, resulting in delays of equipment supply for services. The first two tranches have been released in late 2010 (November/December).

The rationalisation plans provided the basis for fund transfers from central government to local government under the Health Facility Enhancement Programme. Also EU funds (BS and TF) were utilised to support infrastructure and equipment.

3.2.2.2 Resume of the JC

This JC has been assessed by three indicators (1) I-121 Improvement in the mix of primary and secondary health facilities, (2) I-122 Increased proportion of health facilities with appropriate budget. Basically information on EC contribution was available for all of the three indicators and it is likely that the EC funded projects improved the situation, however it still remains difficult to assess to what extent the EC has actually contributed to an improvement, as for none of the indicators was it possible to find a time trend.

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

Indicators

- I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population
- I-132 Improved availability and standards of health worker training
- I-133 High health worker attrition and absenteeism addressed

3.2.3.1 Findings per indicators

I-131 The Philippines is the leading exporter of nurses to the world and the second major exporter of physicians. There are shortages of physicians and fast turnover of nurses in the country, particularly in rural areas. A high proportion of vacancies in the health sector – especially in rural areas - cannot be filled despite the high unemployment rate among health professionals. The human resources for health (HRH) information system are very weak in the Philippines and in the process of construction.

In order to address these complex and multifaceted issues of human resources for health (HRH) development in the country, a master plan for HRH development has been developed in. A high-level body and multispectral working group have been established in 2006. Called the “Human Resources for Health Network” (RHN), this group works on mobilising the political commitment, donor/partner support and funding needed to accomplish the priority activities of the master plan. The strategies include sustaining incentives mechanism for HRH distribution; development of HRH policies and strategies to address out-migration; and making education, training and skills more appropriate to local needs.¹⁰²

However, as for human resources, the HSPSP TA supported the preparation of HR components in the rationalisation plans. After human resources for health (HRH) Summit, three bills were presented: the Institutionalisation of the HRH, a bill on residency training and a wages bill. The MHSPSP developed plans to assist centres for health development (CHDs) and relevant ARMM health officials to strengthen HRH management and to develop HR plans. The entire process contributing to the quality of the planning process. In general, the result may be fewer but better equipped facilities operated by fewer but more qualified staff, an overall improvement in efficiency.

The CSE Philippines also concluded that MHSPSP plans strengthened health human resource management and developed HR plans, with attention to retention strategies and focusing on basic emergency obstetric and neonatal care (BEmONC) and comprehensive emergency obstetric and neonatal care.

¹⁰² WHO. 2010. Western Pacific Country Health Information Profiles: 2010 Revision. Geneva: WHO.

Another important activity undertaken under the MHSPSP is the conduction of catchment and case flow analysis. The information derived from this activity resonated strongly with local health planners who wish to make important decisions regarding their human resource requirements and the number and types of facilities that may need to be increased, relocated or reduced. This is a highly relevant intervention and according to the MHSPSP 2010 Mid-Term Review Report should be supported and pursued.

The EC funded NGO project “Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao” which started on April 2006 and ended on March 2009. trained almost 900 community health workers, The terminal report of the project¹⁰³ stated in this respect that the project accomplished to complete 43 batches of Basic Health Skills Level I, II and III Trainings where 893 community health workers acquired basic skills on higher level of health skills on anatomy and physiology, common diseases and pharmacology; and formation of 43 community health committees and 143 community health teams.

The HSPSP does not address explicitly the HR question. However the EC also addressed the issues of migration via policy dialogue with the GoP. Accordingly the 2nd CSP states that the EC introduced themes of migration into the policy dialogue with the Philippines at the 4th EC-SOM meeting of 2005 and agreed with the Government of the Philippines on further consultations and on the exploration of enhanced dialogue and co-operation. As the Philippines is an important country of origin of legal migration, related aspects such as information programmes on the rights and duties of migrants and the promotion of the best use of remittances will also have to be addressed.

Judging from the above, the EC might have contributed to an increased number of health workers in different ways, including policy dialogue with GoP on migration issues and contributing to policies which aim to strengthen HRH management and to develop HR plans, but also through training of health workers. However, no specific numbers and time trends are available.

I-132 Again there is no time trend and no other relevant quantifiable data available to assess this indicator. Training of health workers has been a component in several EC programmes and projects. However it is not always easy to differentiate between simply providing training in order to increase the number of health workers and an actual improved availability and standards of key health worker training.

Health human resource development is given recognition in FOURmula One (F1) provincial plans, with training as the main strategy for capacity development and national guidance for local health service delivery. Human resources for health (HRH) measures are included as part of rationalisation plan implementation in the draft 2009 annual operation plans (APs). Also the instalment of HRH unit is included as an activity in the 2009 annual operation plan (AOP). Local reform implementation coordinators (Lyrics) continued to provide support for the “Support to Human Resource Management in Local Health Systems” through the implementation of rationalisation plans which had been incorporated into the 2010 annual operation plans (APs); these include support for HRH unit activities at the provincial level. The rationalisation plan implementation guidelines include the local response to the impact of the rationalisation plan on local health human resources, with the identification of an HRH unit in the priority provinces with consistent support from the provincial, city and municipal human resource units.

According to the CSE Philippines, the HSPSP provided valuable support to conducting training courses related to continuous quality improvement based on the PhilHealth Bench book to ensure accreditation of health facilities. The aim was to strengthen the skills of service providers, this could also include the skills of health workers, however, it is not clearly stated in the CSE. In addition, according to the CSE Philippines the ERP-CASCADE project (Economic Self Reliance Programme, Caraballo and Southern Cordillera Agricultural Development) also provided health worker training. The project has trained 361 health workers and 300 barangay nutrition scholars. The 2003 progress report records a 30% decrease of infant mortality and a 42% reduction of moderate and severe malnutrition among pre-school children, but it is not clear to which extent these changes can be attributed to the project's action. Accordingly, there has been an increase of maternal mortality later on, which the project completion report attributed to the abandon of some donors of their programs in the area.

There seems to be clear contribution to improved standards under MHSPSP TA through competency based licensure exams for all 11 health professions in the context of preparation of HR components in the rationalisation plans. MHSPSP also contributed to facility accreditation. The CSE Philippines

¹⁰³ Council for Health and Development (2009) Bringing Health into the People's Hands – Aid to Uprooted People (Philippines), April 2006-March 2009

mentioned that, after a human resources for health (HRH) summit, three legislative bills were presented: the institutionalisation of the HRH network, a bill on residency training and a wages bill. All have been filed in the House of Representatives. Also as a consequence of the summit, the Professional Regulations Commission adopted a resolution to have competency based licensure exams for all 11 health professions. More specifically, in 2009 a review and mapping of health human resources in the CAA was conducted which led to the publication of a report that included the synthesis of the then-current baseline situation¹⁰⁴. In 2010, the 6th Progress Report noted that the MHSPSP STE provided technical assistance through training of CHDs, DOH ARMM and provinces on Human Resources for Health Management and Development System (HRHMDS) installation and institutionalization. With the conduct of the training-workshop on HRH planning for the rationalized health care facilities provinces, the participants were able to participate in the entire process of how to develop their HRH plan to respond to the requirements of rationalization of health care delivery systems. However, whilst the targeted participants from Non-ARMM attended the training workshop, only the Human Resource Development Unit (HRDU) head from ARMM attended. In 2011 several results has been achieved under this indicator. The 7th six month progress report¹⁰⁵ noted that a)Support to Human Resource (HR) component of the Rationalization Plan completed; b)Training module developed for M&E of HRH at MLGU level; c)Component HR plan Rationalization completed in the provinces of Sarangani, Sultan Kudarat provinces; Compostela Valley and Davao Oriental; Lanao Norte and in the Zamboanga Peninsula provinces; d)HRH situation report available; e) HRHMDS Installation report developed available; f)In ARMM HRH component endorsed for integration into ARMM rationalization plan.

Furthermore the Mid Term Consultation of the Philippines CSP 2007-2013¹⁰⁶ emphasised the importance of health worker training. Capacity-building for Barangay Health Workers (BHWs) was seen to be of utmost importance since they are the front-line health providers for poor people. Since LGUs are not investing enough in capacity-building for health workers and most of the training programmes for BHWs are conducted by NGOs,

In this regard the EC funded NGO project “Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao” which started on April 2006 and ended on March 2009 trained almost 900 community health workers (already mentioned for I131). The terminal report of the project¹⁰⁷ stated in this respect that the project accomplished to complete 43 batches of Basic Health Skills Level I, II and III Trainings where 893 community health workers acquired basic skills on higher level of health skills on anatomy and physiology, common diseases and pharmacology; and formation of 43 community health committees and 143 community health teams.

3.2.3.2 Resume of the JC

The “Improved availability of qualified human resources for health due to EC support” was assessed by four indicators. Even though only for two indicators (I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population and I-132 Improved availability and standards of health worker training) information was available, the EC probably contributed to an improvement. Some of this was due to policy dialogue on migration, some was due to support for policy making and some was due to direct training of skilled health workers.

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

Indicators

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)
- I-142 Clinical treatment guidelines available, disseminated and applied
- I-143 Client satisfaction with the quality of health care services

¹⁰⁴ MHSPSP TA 2009 Progress report

¹⁰⁵ MHSPSP 7th six month report February 2011 – July 2011

¹⁰⁶ EUD Philippines (2009) Mid-Term Consultation of the Philippines Country Strategy Paper 2007-2013 with civil society and local development partners

¹⁰⁷ Council for Health and Development (2009) Bringing Health into the People's Hands – Aid to Uprooted People (Philippines), April 2006-March 2009

3.2.4.1 Findings per indicators

I-141 The National Health Insurance Program (NHIP), as established by Republic Act 7875 in 1995, is not only about universal social health insurance coverage, it is also about promoting the quality of health care services. The law's Guiding Principles explicitly mandates the Philippine Health Insurance Corporation (PhilHealth) to “*promote the improvement in the quality of health services through the institutionalisation of programs of quality assurance*”.¹⁰⁸ PhilHealth accredits health care providers for them to participate in the programme. The report “Promoting Quality Health Care in the Philippines” (no date, probably ca. 2005) stated that 90% of all health care institutions and professionals are accredited by PhilHealth. PhilHealth implements a National Quality Assurance Program (NQAP) applicable to all accredited providers for the delivery of health services nationwide¹⁰⁹. In 2010 PhilHealth has accredited a total of 1,602 healthcare providers and 21,338 healthcare professionals nationwide. Aside from this, there are now over 813 Tuberculosis – Direct observed treatment strategies (TB-DOTS) and around 742 Maternity Care Clinics providing quality healthcare services to members nationwide¹¹⁰. The figures allow hardly any conclusion on the accreditation status. According to LGU scorecard (2010) 66% of RHUs are accredited to provide outpatient benefits, 24 % for Maternal Care Package and 43% for TB DOTS. However, this reflects only public service providers and does not take into account the private sector accreditation.

PhilHealth implements a National Quality Assurance Program (NQAP) applicable to all accredited providers for the delivery of health services nationwide. This ensures that the health services rendered to the members by accredited health care providers are of the quality necessary to achieve the desired health outcomes and member satisfaction.

The documents reviewed provide evidence that the EC supported quality assurance mechanisms in its programmes. For instance the CSE Philippines mentioned that EU support under HSPSP to the health service support project (HSSP) at national level, EU contributed to the capacity of the BFAD and the DoH to perform their licensing, accreditation and certification functions. But besides this, the PHIC adopts another accreditation and licensing not in line with the Bureau of Food and Drug (BFAD).

The EU-TA under HSPSP also organised pilot training on PhilHealth Benchbook Standards for Outpatient Facilities in 2 regions, to build the capacity of the centres of health development (CHDs) in providing technical support to LGUs in guiding the rural health unit (RHU/HC) staff in preparing and sustaining its quality assurance efforts.

Likewise, EC provided support to the implementation of LGU scorecards (according to CSE Philippines), an initiative launched by the DoH to increase LGU accountability for health sector results. It is implementing minimum service standards and using LGU scorecards to track progress. The Local Government Unit (LGU) Scorecard is one of the scorecards in the Monitoring and Evaluation for Equity and Effectiveness (ME3). It is a performance assessment of the combined efforts of stakeholders within the province-wide health system (PWHS), which include the clients and public private providers within the municipalities, cities and provinces¹¹¹. It measures and tracks the performance of the LGUs in implementing and achieving results desired for health sector reforms and it assesses progress in meeting national health targets. The LGU scorecard, along with other F1 scorecards, was the subject of support by the EU-TA under clear DOH direction. The MTR proposed to revise the HSPSP log frame indicators in relation to the monitoring evaluation for equity and effectiveness (ME3) and LGU scorecard indicators to be able. This aimed at better assessing HSPSP achievement of results, expanding data collection for M&E beyond the LGU Scorecard and at developing a set of progressive LGU-specific performance targets. This was the basis for service level agreements (SLAs) and clearly lead to the program objectives using the monitoring evaluation for equity and effectiveness (ME3) Framework and LGU scorecard to determine the variable tranche (source DoH). Ownership of the LGU scorecard by provinces and centres for health development (CHDs) has increased, both using the scorecard in program reviews for annual planning. The local reform implementation officers (LRICs) within the EU-TA have been instrumental to reach this and continue to be in the EU roll-out provinces.

Under MHSPSP the programme provided support to CHDs and the ARMM to assist municipalities in the development of PhilHealth Accreditation Plans, which in turn facilitated access for PhilHealth

¹⁰⁸ DOH Philippines, National Health Insurance Act of 1995, [Republic Act No. 7875] <http://www.doh.gov.ph/ra/ra7875.html>

¹⁰⁹ <http://www.asean-ssa.org/cs/groups/public/documents/document/mdaw/mda1/~edisp/wcm001408.pdf>

¹¹⁰ http://www.philhealth.gov.ph/about_us/statsncharts/snc2010.pdf

¹¹¹ <http://www.doh.gov.ph/content/what-lgu-scorecard>

members. The MHSPSP worked with DOH-ARMM and PhilHealth in the design of the Accreditation Inception Plan. The STE for Accreditation coordinated the design of the profiling framework with DOH-CO and PhilHealth in ARMM. The profiling framework was approved and training of LRICs as interviewers for the profiling was conducted in Manila. The roll out orientation on the application of profiling framework was completed for the DOH-ARMM and PHO during the visit of the STE in the provinces where the profiling activity was conducted. As an output support was provided to DOH-ARMM, IPHO and the MLGUs in the development of accreditation plans. The self-guided assessment tool and mock accreditation assisted them in the assessment of the facilities' readiness for accreditation. Three Rural Health Units and one municipal hospital were included in the profiling while the mock accreditation was conducted at Ramain RHU. The results of the profiling and mock accreditation were presented on December 10, 2010 in Davao City¹¹². Support to selected municipalities to have PhilHealth Accreditation Plans has been further implemented in 2011¹¹³.

I-142 The Philippines has a number of national guidelines for treatment of diseases. However, there exists no information on the percentage of patients correctly treated. Nevertheless, the public primary health facilities are perceived as being of low quality.

The EU TA under HSPSP¹¹⁴ contributed to the reform of the outpatient packages through a) conducting a cost study of OPB, presented and approved by PHIC at the end of August 2008 and b) preparing the implementation phase, designing the contract, targets, monitoring schemes and capitation fund for the pilot phase, concluded in November 2008, to the reform of the outpatient packages. The pilot is conducted in four sites: Dagupan City (Pangasinan), two municipalities in Mountain Province (Sagada and Besao), the entire Biliran province and one DO Plaza inter-local health zone LHZ in Agusan del Sur. According to the MHSPSP MTR (2010) Orientations on Health Quality Assurance guidelines were supposed to be conducted to increase the LGU's understanding of accreditation requirements and guide the development of appropriate implementation approaches. It was recommended in an earlier HSPSP assessment that the maternity care package of PhilHealth be used as the birthing facility standards for RHUs since the basic emergency obstetric and neonatal care (BEmONC) standards are not practical in many municipalities where there are not enough doctors to provide 24-hour oncall service. No further information is available whether this has been successful.

Moreover, the HSPSP Final Report (2010) saw further TA outputs under this indicator by referring to the development of the PhilHealth Benchbook Standards for Out-patient Services, the guidelines for hospital providers in handling stakeholders' concerns on patient safety, the guidelines for multi-level reporting and feed backing of adverse events and a „Rapid assessment on the delivery of health related MDG essential packages“.

A five-year development plan for patient safety is currently in the process of being developed with DOH-retained hospitals and other stakeholders. DOH-retained hospitals have established a mechanism for adverse events. The NCHFD pilots a mechanism for adverse events in a DOH-retained hospital. The short term expert (STE) during the time of the CSE was in process to develop the guidelines for handling patient complaints and reporting and feed backing of adverse events. No further information in the final report of Technical Assistance to the Health Sector Policy Support Programme is available whether the development of guidelines has been successful or not.

I-143 No information available on client satisfaction with the quality of health care services.

The EC probably has contributed indirectly to an improvement of client satisfaction through its TA described in I-142. For instance by addressing patient needs under MHSPSP efforts to strengthening catchment and patient flow analysis. Furthermore MHSPSP tried to combine innovative approaches and focusing beliefs and traditions especially to reduce maternal and neonatal mortality. This probably has affected client satisfaction, but there is no quantifiable data on that to provide more evidence. While catchment and patient flow analysis has been done and service delivery gaps identified, innovative approaches to service delivery still have to be implemented.

3.2.4.2 Resume of the JC

This JC has been assessed by three indicators. (I) I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities), (II) I-142 Clinical treatment guidelines available, disseminated and applied and (III) I-143 Client satisfaction with

¹¹² MHSPSP 6th six month report July 2010- February 2011

¹¹³ MHSPSP 7th six month report February 2011 – July 2011

¹¹⁴ Interim Report 3 (Final – April 09): Contract No 2006/32479 Technical Assistance to the Health Sector Policy Support Programme

the quality of health care services. Generally there was no statistical information available which indicates how the indicator has developed over the evaluation period. However, particularly for indicator I-141 it is safe to say that the EC contributed to a large extent to an improvement of quality assurance mechanisms. Regarding availability of guidelines and client satisfaction the information available at least supports that the EC contributed to some extent and it can be assumed that EC contribution affected the development of the indicators indirectly.

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

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

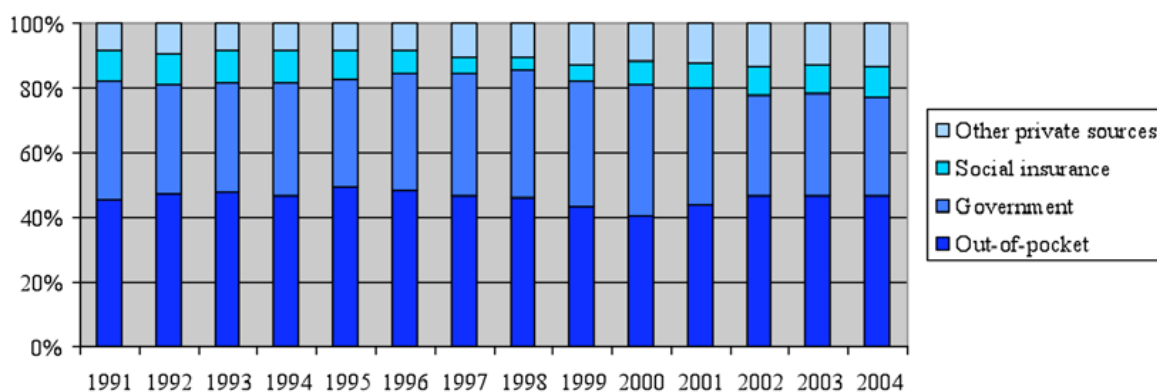
Indicators

- I-211 Change in proportion of health spending out of pocket
- I-212 Change in share of health expenditure financed by social security schemes
- I-213 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

3.3.1.1 Findings per indicators

I-211 According to WHO 2011 data, the share of out of pocket spending in total health expenditure rose from 46.8% in 2002 to 53.6% in 2009. According Evaluation of the European Commission's Cooperation with the Philippines' Final Report (2011), the out of pocket share of total health spending has increased while the public share is decreasing. Support to the health sector was a key component of the EU cooperation strategy. But still, public funding for health in the Philippines has declined over time and health financing is characterised by large gaps, resulting in substantial out-of-pocket spending. It should be noted that public funding as share has declined not necessarily in absolute terms (DoH budget increased considerably over the last years).

Figure 29: Distribution of health expenditure by source of funds, 1991-2004¹¹⁵



Source: WHO

According to the Philippines CSE 2011, while there has been some progress since 2008 in terms of income retention in health facilities (hence securing some extra budgetary resources) and Philippine Health Insurance Corporation or PhilHealth coverage and while Government allocation slowly increases, there is no progress in reducing out of pocket expenditures, or in the provision of financial protection and/or access. In addition, the 2011 World Bank Health Sector Review noted that there is

¹¹⁵ Source: Philippine statistical yearbook 2006. National Statistics Office, quoted in: Ronaldo D. Ico. 2007. Catastrophic Health Care, Poverty and Impoverishment in the Philippines, A paper submitted to the University of the Philippines School of Economics in partial fulfilment of the requirements for the degree of Master of Arts in Economics, p.21.

still a lack of income retention in most health facilities¹¹⁶. Data indicate an even higher burden on household out-of-pocket spending at the provincial level, which, at 63% of total health expenditure, is over three times the targeted 20% under health sector reform for health financing.

High out-of-pocket expenditures of Filipinos are a result of the insurance underutilisation by insured patients. Underutilisation suggests ineffective distribution of public funds, failing to reach a significant proportion of households which are by and large poor.¹¹⁷

The EC addressed the increasing OOP numbers through the HSPSP and MHSPSP. Through HSPSP the EC strengthened Philippine Health Insurance Cooperation under the Health Financing Pillar. The three major areas of health care financing reforms identified in the programme Logical Framework, namely: a) Securing social health insurance for the poor; b) Providing greater access to cost-effective primary care through reforms in the Philippine Health Insurance Corporation or PhilHealth Out-Patient Benefit (OPB) package; and c) Strengthening national level health financing analysis and policy implementation support. The HSPSP mid-term review (2010) mentioned as HSPSP achievements in health financing the core technical assistance support for health financing which is anchored on a long-term consultant working with the Health Policy Development and Planning Bureau (HPDPB) and PhilHealth as internal advisor and coordinator of HSPSP technical assistance. Both HPDPB and PhilHealth expressed much appreciation of the value of the technical assistance in health financing and tried to maximise opportunities for technology transfer and training of the staff through day-to-day work with the consultant.

According to the CSE Philippines EU-TA support which addressed the issue of rising out-of-pocket spendings has also been realised through, the preparation of a **PHIC Board resolution increasing premiums and benefits, the development of a pro-poor budgeting scheme for drugs for retained hospitals and the support to the preparation of the legislative agenda** that will accommodate the new policy frame. Improved financial protection through PHIC inpatient package should lead to decreased out-of-pocket as a source total hospital income in the 10 pilot hospitals. In terms of inpatient care, the policy involves a shift away from fee for service payment mechanisms to case payment schemes with no-balance billing for at least sponsored programme PhilHealth members. 23 medical and surgical cases have been identified for implementation and initially a pilot was foreseen in 10 hospitals. However, in the meantime it is being implemented nation-wide in government hospitals.

EC-TA's intervention in health finance was relevant and supported the DOH's stewardship of the Philippine Health Insurance Corporation or PhilHealth through the monitoring of PhilHealth performance against established indicators. Still, PhilHealth has inadequate staff and managerial absorption capacity to implement programme and policy recommendations generated by the technical assistance. At the time of the MTR and with the fee-for-service payment system in place, PhilHealth did not actively negotiate more reasonable prices with providers based on patient volumes. And PhilHealth still has not made the move to become a strategic purchaser of services and to come up with national fees for services. The design of EU support in this case is relevant, but problems of governance within PhilHealth and its particular place in the line of command challenge the health reform on a larger scale.¹¹⁸ This is a critical issue reflecting aid effectiveness. Success/failure depends in the end largely on government and is related to mutual accountability. In general the EC's TA on health care finance seems to have been ineffective.

I-212 The government's goal is to increase the share in expenses of social insurance. At present, the social insurance is the responsibility of the Philippine Health Insurance Corporation (PhilHealth). PhilHealth was created to assume the administration of the former Medicare program from the Government Service Insurance System (GSIS), the pension fund for government workers and the Social Security System (SSS), the pension fund for private employees. PhilHealth began to run only in 1998. The largest share of health expenditures, in 2009, is private expenditures.

According to the HSPSP MTR the Philippines has yet to achieve its targets for health financing reform set forth in 1999 when the first health sector reform agenda was formulated. At a little over 10% of

¹¹⁶ World Bank (2011): Philippine Health Sector Review, Transforming the Philippine Health Sector: Challenges and Future Directions

¹¹⁷ Stella Quimbo, Jhiedon Florentino, John W. Peabody, Riti Shimkhada, Carlo Panelo and Orville Solon. 2008. Underutilization of Social Insurance among the Poor: Evidence from the Philippines. PLoS ONE. 2008; 3(10): e3379, doi: 10.1371/journal.pone.0003379

¹¹⁸ Evaluation of the European Commission's Cooperation with the Philippines, Final Report, Volume 1, June 2011

health care expenditure, social health insurance did not provide adequate financial protection and with government also under-spending for essential public health services, it is little wonder that the greatest burden of payment for health care fell on household out of pocket).

The time trend for health expenditure ratios shown in the table below shows a mixed picture. For some indicators such as total health expenditure, the figures are improving, however it seems that government expenditure on health is decreasing from 2005 onwards.

Table 12: Health financing health expenditure ratios, Philippines 2002-2009

US\$/%	2002	2003	2004	2005	2006	2007	2008	2009
Health expenditure per capita (US\$)	28,11	33,09	36,83	42,12	48,40	57,23	68,03	66,88
Health expenditure private (% of GDP)	1,77	2,05	2,19	2,22	2,32	2,30	2,40	2,49
Health expenditure, private (% of total health expenditure)	59.99	59.77	61.47	60.77	64.64	65.23	64.94	64.71
Health expenditure, private (thousand- US\$)	136.2	162.9	190	218.8	272.5	331.2	401.6	401
Health expenditure, public (% of GDP)	1,18	1,38	1,37	1,43	1,27	1,23	1,27	1,33
Health expenditure, public (% of government expenditure)	5,04	5,94	6,28	6,80	6,16	6,15	6,13	6,09
Health expenditure, public (% of total health expenditure)	40,01	40,23	38,53	39,23	35,36	34,77	34,66	34,86
Health expenditure, total (% of GDP)	2,96	3,42	3,56	3,65	3,59	3,52	3,68	3,82
Private prepaid plans as a % of private expenditure on health	11,1	10,5	-	10,5	9,7	9,8	12,2	12,2
Social security expenditure on health (% of general government expenditure on health)	14,7	21,8	23,8	31,6	25,8	22,3	21,7	19,7
Out-of-pocket expenditure (% of private health expenditure)	77.97	78.43	80.23	80.92	80.87	83.32	82.49	82.81

Source: Worldbank¹¹⁹, WHO

Reforms in health care financing are of critical concern in the Philippines. According to the MTR HSPSP the HSPSP addresses the main issues in health care financing at the policy level through its technical assistance programme and has been quite effective in delivering the expected technical support to the DOH and PhilHealth. **The TA inputs has yielded the expected outputs in terms of policy papers, policy studies and corresponding recommendations and is on track in terms of work progress on the identified deliverables. However, the share of health care spending that is out of pocket has risen, indicating that, at best, EC support has laid the foundation for future improvement or prevented still further deterioration. The failure of TA to improve Philhealth's performance has been noted above.**

I-213 As of year 2002, the coverage of the National Health Insurance Program among the total population stood at 49%. The government aimed to reach 85% coverage by the end of year 2004.

¹¹⁹http://databank.worldbank.org/ddp/editReport?REQUEST_SOURCE=search&CNO=2&country=&series=SH.STA.BRTC.ZS&period=

According to the CSE Philippines, the Health Sector Reform Agenda (HSRA), which started in 1999, set targets for hospital reform, public health funding, local health system strengthening and capacity of regulatory agencies, but have largely remained unmet; however good progress has been made in advancing the National Health Insurance Programme (NHIP), which – according to the national health scheme administered by PhilHealth 83% of the population was covered in 2008, being generally in line with the statement of the HSPSP Final Report(2010), which stated that health insurance coverage had reached 85% of the general population, while the latest National Demographic and Health Survey (NDHS) speaks about only 38% coverage.¹²⁰ A discrepancy not explainable by the time difference of the two measurements- and out-of-pocket expenditure in health is still about 50% of the total health expenditure of the country (HSPSP Final Report, 2010).

The current President of the Philippines Benigno S. Aquino addressed this inconsistency of data regarding health insurance coverage in 2010:

“First, we will identify the correct number of Filipinos who sorely need PhilHealth coverage, as current data is conflicting on this matter. On one hand, PhilHealth says that eighty-seven percent (87%) of Filipinos are covered, then lowers the number to only fifty-three percent (53%). On the other hand, the National Statistics Office says that only thirty-eight percent (38%) of Filipinos are covered by PhilHealth.”¹²¹

A big problem is that the database of insurance coverage is poor in the Philippines.

According to the NDHS PhilHealth coverage is 38% nation-wide and in Mindanao depending on the region ranging from 17% up to 66%. Premiums are 1200 PhP per year and are being payed on a cost sharing basis by national and local government depending on the poverty classification of the LGU. The capitation fund goes to the general LGU funds. There are guidelines on how to use the funds but enforcement is often lacking. In order to increase enrolment of vulnerable people, there are several uncoordinated initiatives updating birth certificates for geographically isolated and depressed areas GIDA and IPs (challenged by cost-distance- bureaucracy.) Through its indigent program (SP), PHIC has greatly advanced the topic of universal coverage (UC) and access to health services within the political agenda at the national and LGU levels. This has helped secure more funding for health insurance coverage for poor families.

The Final Evaluation (2010) noted that the MHSPSP did not seem keen to take on the TA needed to increase the enrolment of indigents to the PhilHealth programme. The report further adds that this course of action is probably right, as national guidelines by the lead agency, DSWD, are being developed. However, under HSPSP the TA supported the F16 provinces focused in enrolling the real poor in PhilHealth’s Sponsored Program (SP) by promoting the use of households’ rankings in order to identify and include poor families excluded. Another TA input to the development of social health insurance has been the support to PhilHealth to move from the inefficient current fee-for-services to Care Based Groups (CBG) as provide payment system. Finally, the TA has contributed to the development of the Health Care Financing Strategy of the DOH, published in July 2010 and that is very influential in policy setting. Along the lifetime of the Program, enrolment under the Sponsored Program (fully subsidized by a mix of national and local government funding aiming to cover the poor), has had a marked U-shape trend, correlated to elections periods, where local politicians use enrolment as an electoral tool (see table below). Unfortunately, this apparent success story in terms of number of members has not been translated into „quality“ enrolment, since PhilHealth has been mainly using a manipulation-prone income based identification tool. This has resulted into a massive leakage of non-poor being enrolled. On average, 48% of SP members were non poor.¹²²

¹²⁰ Government hospital data also showed that less than 50% of admitted patients in 2007 to the first 3 quarters of 2008 were PhilHealth members, refuting claims of near-universal coverage of the poor in the provinces. insufficient coverage, delays of payment, poor advertising of rights on services and high out-of-pocket payments have led to widespread dissatisfaction with PhilHealth among provincial governments.

¹²¹ From the 1st SONA of President Benigno S. Aquino III, 26 July 2010

¹²² Final Report (2010): Technical Assistance to the Health Sector Policy Support Programme (EC-TA HSPSP) covering the period 1st February 2007 to 31st December 2010

Table 13: Health financing health expenditure ratios, Philippines 2002-2009

Provinces	Dec. 06	Dec. 07	Dec. 08	Dec. 09	Jun 10
Ifugao	27,440	14,846	21,489	11,547	22,330
Mountain Province	20,276	8,406	10,937	20,272	20,767
Ilocos Norte	70,024	74,458	31,028	100,386	96,448
Pangasinan	151,710	54,855	116,268	228,552	184,985
Nueva Vizcaya	18,146	11,330	12,047	12,697	13,292
Oriental Mindoro	66,426	50,553	51,739	74,072	81,578
Romblon	18,182	8,352	8,312	22,491	23,749
Capiz	38,015	40,246	43,418	70,507	85,819
Negros Oriental	77,174	49,899	48,182	53,116	60,162
Biliran	25,713	24,968	24,821	25,290	25,456
Eastern Samar	49,188	31,318	36,034	54,876	56,194
Southern Leyte	20,746	12,493	16,205	37,524	42,027
Missamis Occidental	88,528	63,929	71,859	64,533	92,885
North Cotabato	75,766	11,979	36,697	88,713	96,608
South Cotabato	84,151	22,496	31,441	60,163	76,031
Agusan del Sur	45,646	21,927	26,007	51,065	51,176
16 F1 sites	877,131	502,055	586,484	975,804	1,029,507

Source: HSPSP Final Report 2010

3.3.1.2 Resumé of the JC

Summarised, there are no improvements in the reduction of out of pocket payments for health care for Filipinos up to today, which are visible in the indicator trends. However EC provided support to a change of health spending out of pocket through HSPSP by strengthening the Philippine Health Insurance Cooperation under the Health Financing Pillar. The EC has contributed to improving access to facilities of PhilHealth members by supporting facility accreditation under HPSPe. This also reflects into I-214 and addresses the proportion of coverage by public health insurance schemes. Consequently there are small progresses in the proportion of population covered by health insurance (mainly PhilHealth). "Clearly, much still needs to be done to improve the PhilHealth benefit packages for both its regular members and the indigents. Other than the adequacy of benefits and its support value, there are issues with respect to efficiency and effectiveness of the current provider payment mechanisms and alternative modes of payment have been suggested, e.g. case-based reimbursement for specific cases, capitation for secondary level care, second peso payment scheme, etc. This has been the subject of donor-driven studies and technical assistance, but recommendations emanating from them still need to be translated into operational guidelines and new benefit packages."¹²³ EC TA to Philhealth in the area of health care finance has not translated into concrete improvements.

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

Indicators

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

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

3.3.2.1 Findings per indicators

I-221 No information has been found on trends for cost waiver and subsidies schemes in place. According to the EU Delegation HSPSP supported enrolment of the poor and developed segmentation schemes for the informal sector.

The HSPSP Final Report noted in this regard as part of the flexibility to make the program responsive to policy needs, during the workplan preparation, some short term inputs were generically defined, allowing allocating them aligned to update DOH and PhilHealth needs. In this context, DOH suggested

¹²³ Mid-Term Review Of The Health Sector Policy Support Programme (ASIE/2005/017638) In the Philippines, Final Report, January 2009

to use some TA to support the development and implementation of the segmentation of the Informal Paying Program (IPP) members, action consistent with the HCF strategy. This input aimed to, on the one hand, set the procedures to separate poor informal sector members from non-poor (most professionals) and, on the other hand, develop the partial subsidy potentialities of LGUs. This membership group will hand, represent the main challenge on the road towards universal coverage (enrolment), since their coverage against an estimated target of 10,4 million informal sector operators (2008 Informal Sector Survey from NSO) is around 50%, according to PhilHealth, although this figure is disputed by some partners working in that field, including GTZ. The results of the study are being used in the PHIC guidelines of the IPP segmentation, circulated in October 2010. Through a positive list approach, professionals will have higher premiums, while lower tier, which will have a list of documents allowing them to be waived of the high premium, will have the same premium level of the SP. The record of experience on partial subsidy, included in the report, is especially timely when considering that the full payment of SP premium will come from National Government, leaving spare enrolment capacity at LGUs.

I-222 No information has been found on household health care service consumption. According to PhilHealth out patient benefit (OPB) reform is supposed to lead to greater access to cost-effective primary care. The EU-TA has designed an OPB package, identified pilot sites and a route map for Case based payment in 2008 in partnership with GTZ health project with a plan for the introduction of diagnostic related groups (DRGs). According to DoH, the OPB is far from comprehensive. The patient needs more in the Universal Health Care Package. The pilots for OPB are not yet approved. In 2008, 63% of PHIC (PhilHealth) users reported claiming the already limited package of ill-known benefits and only 44.4% of PHIC members needing care actually availed of PhilHealth benefits. Weak benefit delivery is a major issue for PHIC to confront.

3.3.2.2 Resumé of the JC

This indicator has been assessed by two indicators (I). I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs, such as children, the elderly, persons living with HIV/AIDS and the disabled and (II) I-222 Health care financing schemes result in additional health care consumption by households. Based on the information available, the HSPSP supported enrolment of the poor and developed segmentation schemes for the informal sector. there was no information (I-221), for I-222 there seems to be only limited information available and it seemed that there is no improvement so far.

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

Indicators

- I-231 EC supported technical assistance, provides expertise on health care finances
- I-232 EC supports enhanced communication, cooperation between MoH and MoF/planning

3.3.3.1 Findings per indicators

I-231: Much information related to this Indicator has already been given above (see 3.2.1, 3.2.2 and 3.3.1). The European Commission (EC) (co-)financed several health related projects in the Philippines, e.g. HSPSP (Health Sector Policy Support Programme, 12/2006-12/2009) in cooperation with the Government of the Philippines and Technical Assistant Organisations. The EC extended this program in late 2010. The focus of the second phase of HSPSP is to try and ensure universal access to healthcare for all members of the population, especially disadvantaged members of society.¹²⁴

In the area of health the CSE Philippines stated, that it was recognised that EU support cannot cover all needs. The response was to align with the GoP's Formula1 reform initiative, covering financing, service delivery, regulatory matters and governance (1). This is a broad programme and captures well the fact that needs in health are synergistic, especially the need to simultaneously address service delivery and financing issues. In the area of financing, the project mid-term review found a need for more TA and capacity building at all levels (2). In the service delivery area, a broad reading of the MTR leaves the impression that insufficient anticipation was given to the need to strengthen primary health care facilities in order to relieve the strain on secondary and tertiary facilities (3). Project design

¹²⁴ <http://www.globalsurance.com/blog/eu-extends-support-for-philippine-healthcare-program-272220.html> and http://eeas.europa.eu/delegations/egypt/projects/list_of_projects/132325_en.htm

might have better assessed the challenges of strengthening maternal health and sexual and reproductive health services, the latter in particular for adolescents (4). In general, health-seeking behaviour was insufficiently addressed, leading in particular to difficulties in addressing the needs of indigenous populations (5).

Through EU-TA, the supported provinces annual operation plans (AOPs) have become more realistic working documents and contribute effectively to the province-wide investment plans (PIPH). More AOPs include implementation plans for health facility rationalisation. However, the report for Philippines Health Sector Reform Project noted that most AOPs in 2008 still focused on inputs rather than outcomes. The DoH responded by developing appropriate guidelines for the preparation of the 2009 AOPs that hopefully would enable the provinces to focus more on outcomes. Structural problems within the Department of Budget and Management (DBM) and DoH continue impeding smooth execution and the transfer of funds. In its context of limited absorptive capacity, the DoH prioritises spending its own budget, with as result delayed expenditure of the € 1 million grant to the DoH. However the HSPSP MTR mentioned as major accomplishment of the programme the assistance provided to the LGUs in the development of the province-wide investment plans (PIPH) amongst others.

Under the MHSPSP, the TA reviewed health funding mechanisms and fund disbursements to health facilities and services including the number and nature of indigent enrolments in devolved and non-devolved areas of CAA which led to a report review document including preliminary synthesis of current baseline situation. The results of the analysis indicate that the state of health financing in 2009 in Mindanao CM and ARMM was fragmented with a program-driven health financing framework facing significant challenges including high levels of Out-of-Pocket payments (OOP), a lack of regionally-adopted financing strategies and local health accounts and considerably weak implementation of PhilHealth¹²⁵.

I-232 The EUD Philippines reported that there have been major improvements in relations between MoH and MoF, not because of EC efforts, but because of a united front presented by all donors. Budget has increase for the MoH, but the crucial variable is budget available at local level, which is still lacking. Vertical coordination is still very weak. EC-supported-TA support to the provinces became essential to re-establish communication lines between DoH, DBM and the provinces in the context of the PFM reforms and assuring the commitment of local government structures (CSE Philippines), as communication between DOH and PhilHealth regarding quality of health care and accreditation of health facilities could be improved at all levels, but most critically at sub-national level. CHD and DOH Rep (Department of Health representative in the province) could play a role in facilitating communication and solving problems, particularly those related to quality of services, which remains deficient and limited access, as specialists tend to refer and shortcut patients to their private practice (CSE Philippines).

3.3.3.2 Resume of the JC

This JC has been assessed by two indicators (I) I-231 EC supported technical assistance, provides expertise on health care finances and (II) I-232 EC supports enhanced communication, cooperation between MoH and MoF/planning. Information was available for both indicators assessed, which indicate that the EC provided support to improvements in health finance policies to enhance affordability of services supported by the EC.

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

Indicators

- I-241 Evidence of EU supported dialogue between major stakeholders and pharmaceutical industry to encourage R&D targeted at diseases of poor countries
- I-242 North-South medical and public health research partnerships supported by EU to produce new medicines and treatments

3.3.4.1 Findings per indicators

I-241 No information available.

I-242 No information available.

¹²⁵ MHSPSP TA Progress report 2009

3.3.4.2 Resume of the JC

No information is available for assessment.

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

3.4.1 JC 31 Increase in availability of primary health care facilities

Indicators

- I-311 Change in number of primary care facilities per 10,000 population (towards >1 per 10,000 population) ; disaggregated by rural/urban and income level, where feasible
- I-312 Change in the proportion of rural population living in a radius of 1 hour of a primary health care facility.

3.4.1.1 Findings per indicators

I-311 The non-availability of disaggregated data of primary health facilities by rural and urban region and the travel distance to those is alarming. The Table below indicates that there is a stagnation in the improvement of health facilities availability in the Philippines. At the primary level, the number of Barangay Health Stations per 10,000 population has declined over the last decade.

Table 14: Health Facilities Philippines: 1999-2009¹²⁶

Government Health Manpower	2002	2003	2004	2005	2006	2007	2008	2009
Population (million)	80.6	82.3	83.9	85.5	87.1	88.6	90.2	91.7
Hospitals total	1,739	1,719	1,725	1,838	1,921	1,781	1,784	1,795
Per 10,000	0,216	0,201	0,206	0,215	0,221	0,201	0,198	0,196
Hospitals – Government total	662	662	657	702	719	701	711	721
Per 10,000	0,082	0,080	0,078	0,082	0,081	0,079	0,079	0,079
Hospitals – Private total	1,077	1,057	1,068	1,136	1,202	1,080	1,073	1,074
Per 10,000	0,134	0,128	0,127	0,133	0,138	0,122	0,119	0,117
Barangay Health Stations total	15,283	14,490	15,099	15,436	16,191	16,219	17,018	15,283
Per 10,000	1,895	1,176	1,799	1,804	1,859	1,830	1,887	1,667
Rural Health Units total	1,974	2,259	2,258	2,266	
Per 10,000	0,245	0,275	0,269	0,265				

Source: National Statistical Coordination Board,

http://www.nscb.gov.ph/secstat/d_vital.asp

The information available which is associated to these indicators also relates to I-141. Under MHSPSP the EC is supporting rural health units (RHU) by increasing the number of accredited RHU for out-patient benefits (PB), Emergency Obstetric and Neonatal Care (EmOC) and Tuberculosis – Direct Observed Treatment Strategy (TB DOTS). This has increase access for PhilHealth members. So far progress, as stated in CSE Philippines, was slow due to weak coordination with DoH and waiting for endorsement for short term expert (STE) ToR by technical assistance coordination team (TACT). In Compostella Valley, all 11 RHU are OPB and TB-DOTS accredited and the 4 hospitals and one RHU, BEmONC, have maternity care package (MCP) accreditation. In South Kotabato, all 11 RHU are OPB and TB DOTS accredited, 3 hospitals are MCP accredited, but 11 BEmONC and 1 CEmONC are not accredited. Fact is that the development of birthing centres has drastically increased facility based delivery. In Sultan Kudarat (SK), of 12 RHUs three are not TB DOTS accredited, 3 for MCP (4 in application stage) and 9 are OPB accredited (CSE Philippines).

¹²⁶ National Statistical Coordination Board, http://www.nscb.gov.ph/secstat/d_vital.asp

The NGO “Bringing Health into the People’s Hands: A Health Improvement Program for the Internally Displaced People of Mindanao” constructed 15 community clinics and simple laboratories in the 13 project provinces (see also I312).

In summary, the EC has provided direct support to increasing the number of primary health care facilities. It should be noted that under MHSPSP infrastructure is not being funded (although there was provision of equipment) and under HSPSP funds have been used mainly for upgrading of already existing facilities. However, loss of existing centres and population growth has prevented this from translating into an increased primary health care facilities per capita. That said, it is likely that EC assistance was focused on under-served parts, where the impact may have been significant (see I-312).

I-312 Concrete achievements are for instance mentioned in the CSE Philippines under STARCM. Accordingly the women of more than 10,000 households (STARCM) enjoyed easier access to health services, more frequent visits of doctors and nurses and the proximity of day care centres. More than 12,000 households enjoyed the services of 34 constructed or upgraded barangay health centres and 2,500 households are served by day care centres. Services provided by the health stations included pre-natal and childcare, birthing, vaccination, diagnosis and treatment of tuberculosis and treatment of minor injuries.

Furthermore, the NGO “Bringing Health into the People’s Hands: A Health Improvement Program for the Internally Displaced People of Mindanao” project’s accomplishments are the construction of 15 community clinics and simple laboratories in the 13 project provinces (see also I311).

Under HSPSP¹²⁷ support was mentioned in the form of a workshop designed to assist the provinces in identifying its health needs, health resources, options for rationalisation, **a map of health facilities** and other resources, an HR plan and an investment plan, both related to the selected rationalisation option. Over eight successive weeks from late May to mid-July, 2008, 15 provinces underwent this process of rationalising health facilities, thus enhancing their existing Province-wide Investment Plans for Health.

Additionally, in the working package 3.4. of the HSPSP a national map with botika ng barangay (BnB) density per province was created. The mapping of all the BnB shows they are situated in remote areas where there are few or no commercial pharmacies. In practice, BnB are the first point of contact to buy medicines for many communities. This exercise was taken as a model for potential mapping of all health facilities in the Philippines¹²⁸.

However, the problem is that it is not nearly so evident that, at the sub-provincial level, the EU has targeted the most disadvantaged areas. There a bias, in the sense that relatively well-to-areas may contain substantial numbers of poor people, e.g. IDPs. To complicate matters, it is not even clear that that concentrating on isolated areas would have been the best course to take, at least from the impact and sustainability points of view. Geographically disadvantaged areas are by definition challenging to work in; isolation and remoteness take a toll on capacity building and infrastructure development. The hard fact is that impact per Euro may be higher in accessible, moderately poor areas than in inaccessible, extremely poor ones.

3.4.1.2 Resume of the JC

Accessible primary healthcare is recognised as an important facilitator of overall population health. The non-availability of disaggregated data of primary health facilities by rural and urban region and the travel distance to those is alarming. Considering the fast population growth and the stagnation in the development of primary health care facilities, there seem to be a worsening of the health situation in the Philippines. Further investigation and research is of need. While EC assistance has not translated into an improvement in aggregate statistics, the concentration of EC support on disadvantaged areas may have improved access. However, the situation is complex and hard evidence is difficult to come by. The very worst areas may be prohibitively expensive to work in. Relatively well to do area may contain pockets of disadvantaged populations who were served by EC-financed infrastructure. It

¹²⁷ Report to the Delegation of the European Commission to the Philippines, Technical Assistance to the Health Sector Policy Support Programme (No. 17638) Contract N° 2006/132479, Interim Report 2 (v.2-final) (1st January – 31st July 2008), p.51

¹²⁸ Report to the Delegation of the European Commission to the Philippines, Contract No. 2006/32479, Technical Assistance to the Health Sector Policy Support Program (EC-TA HSPSP), Interim Report 5 v3 (1st August 2009 – 31st January 2010), pp. 44, 53

seems safe to conclude that EC projects (and policy advice under HSPSP) have improved access to primary health care facilities for a significant number of people, not least in Mindanao.

3.4.2 JC 32 Increase in availability of secondary health care facilities

Indicators

- I-321 Change in number of hospital beds per 10,000 population (to >10 per 10,000 population)
- I-322 Change in the proportion of population living in a radius of 2 hours of a secondary health care facility
- I-323 Increased number of Caesarean Sections

3.4.2.1 Findings per indicators

I-321 The number of hospital beds per 10,000 population is decreasing in the Philippines and is very small compared to developed countries. According to the WHO country profile (2010)¹²⁹ the bed-to-population ratio is roughly 10 per 10,000 inhabitants, lower than in other East Asian countries, such as China (26 beds per 10,000 inhabitants), Viet Nam (12 beds) or Thailand (22). Moreover many of these hospital beds are clustered in large city centres and better-off LGUs. This is particularly true for private hospital beds, which account for approximately half of all hospital beds in the country. As with primary health care, however, it is the geographically skewed distribution and geographical access that are the key issues, not the aggregate beds per capita statistic.

The EC has contributed to rationalisation of health infrastructure under HSPSP as discussed above. Furthermore, budget support as well as trust funds have been used to upgrade health infrastructure.

I-322 No information available.

I-323 According to a survey in 2003, 7% of births were delivered by C-section in total. C-section rate was higher in urban areas than in rural areas by approximately 2-fold.

The rate of caesarean sections is an indicator of access to essential obstetric care. The NDHS 2008 shows that one in ten live births (10%) in the five years preceding the survey was delivered by caesarean section, which is an increase from the proportion reported in the 2003 NDHS (7%).¹³⁰ By strengthening the catchment including BeMONC and CeMONC and patient flow analysis in support of health services rationalisation and meeting patients needs the EC could have contributed indirectly to an increased number of Caesarean sections.

3.4.2.2 Resume of the JC

The number of primary health care clinics and hospital beds per 10,000 population did not increase over the last decade and is low compared to the developed world. It is, however, geographical distribution and the crucial problem of geographical access that are key, not the aggregate statistics. The non-availability of data regarding the distance to health higher health facilities does not allow any assessment in this regard. The EC did contribute to infrastructure (at least at the PHC level) in disadvantaged areas, although the close analysis in the Philippines CSE gave rise only to qualified conclusions. It is safe, however, to conclude on the basis of the Indicators analysis that EC support, both in the form of direct infrastructure provision and support to rationalisation policies under the HSPSP, promoted access to health facilities among disadvantaged populations.

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

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

Indicators

- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving 4 or more ante-natal check-ups

¹²⁹ <http://www.wpro.who.int/NR/rdonlyres/86EB3F01-53A8-4B7F-A506-907B6568CCFA/0/30finalPHLpro2010.pdf>

¹³⁰ National Statistics Office (NSO) [Philippines] and ICF Macro. 2009. National Demographic and Health Survey 2008. Calverton, Maryland: National Statistics Office and ICF Macro, page 113f.

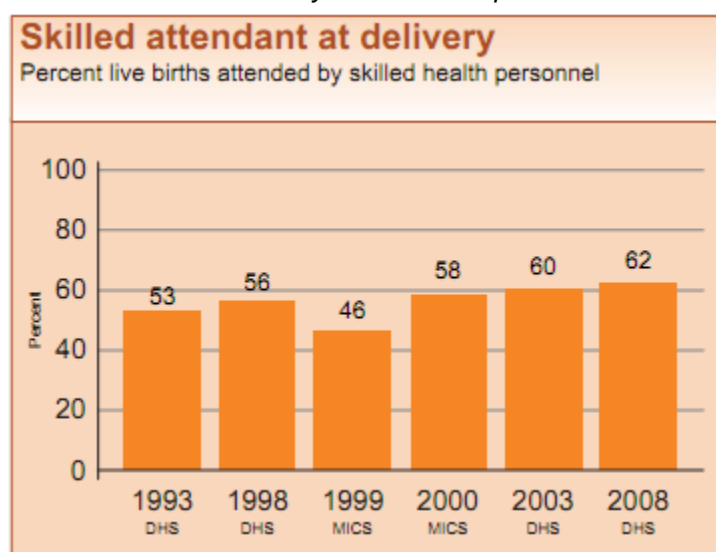
- I-413 Increased proportion of women using modern family planning

3.5.1.1 Findings per indicators

I-411 The first CSP criticised that access to social services, particularly primary health care, is still a problem in many areas in the country. While under-five mortality has declined slightly in recent years, infant mortality rates remain unchanged since 1998 at about 35 deaths per 1,000 births. Only 56% of these births are attended by skilled health personnel.

The skilled birth attendance in the Philippines is marked by a huge rural-urban gap. However, nationwide the proportion of deliveries supervised by a skilled attendant increased. The figure below (the figures from DHS - Demographic and Health Surveys¹³¹ and Multiple Indicator Cluster Survey - MICS are based on household survey conducted every five/two years) indicates that there is a slowly increasing trend from 1999 onwards regarding the percentage of births attended by skilled health personnel

Figure 30: Percent live births attended by skilled health personnel



Source: DHS, MICS¹³²

According to the 2008 and 2003 Philippine DHS surveys, there has been an increase in the proportion of births attended by a skilled provider (from 88% in 2003 to 91% in 2008) and a decline in the percentage of births assisted by a traditional birth attendant (from 7% in 2003 to 5% in 2008).

According to the MTR of the HSPSP¹³³ facility-based deliveries of pregnant women are increasing in many of the visited health facilities. An Administrative Order to develop the capacity of health centres and hospitals to deliver basic and comprehensive emergency obstetric care was issued by the DOH as part of its maternal and neonatal mortality reduction strategy. The manual of operations for its implementation has been carefully crafted but might be too vague. There is a need to incorporate the Maternity Care Package (MCP) of PHIC as an acceptable intervention in the provision of adequate obstetric care. Regarding NGO projects the EAMR 01/2011 Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health mentioned that the NSA LA portfolio contains 7 projects supporting actions that are directly supporting Indigenous People's strategic needs, such as securing land titles for their ancestral domains. 4 projects offer access to family planning services to the poor, while engaging their local governments to address reproductive rights.

The development of innovative Health Service Delivery (HSD) models and Behavioural Change Communication (BCC) strategies under MHSPSP¹³⁴ in support of the reduction of maternal and

¹³¹ <http://www.measuredhs.com/what-we-do/survey/survey-display-227.cfmshow>

¹³² <http://www.countdown2015mnch.org/documents/2010report/Profile-Philippines.pdf>

¹³³ Mid-Term Review Of The Health Sector Policy Support Programme (ASIE/2005/017638) In the Philippines, Final Report, January 2009, p.9

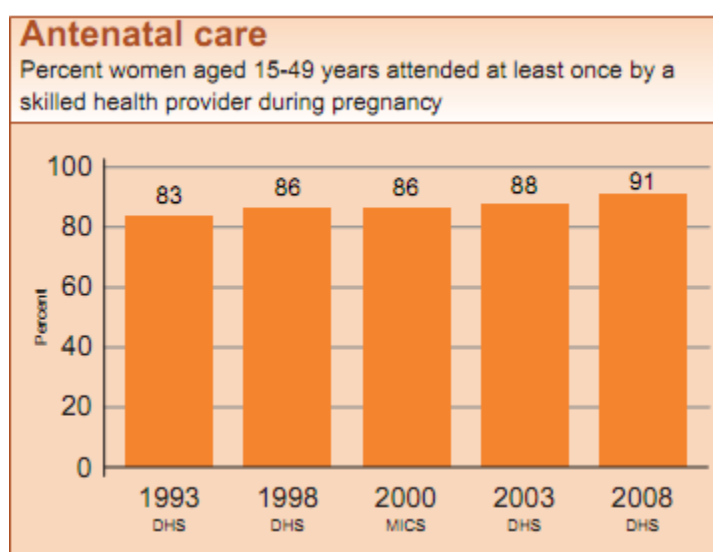
¹³⁴ Mindanao Health Sector Policy Support Programme (MHSPSP) Mid-Term Review EC ref n°: 2010/244731, Final Evaluation Report, Philippines, November 2010, pp.5,6,20.

neonatal mortality and morbidity in most-at risk and/or vulnerable population groups constitutes the third key result under the health service delivery pillar. A potential beneficiary of this initiative is the recently formulated EU-supported project on “Addressing Maternal, Neonatal and Nutrition Needs of Indigenous Cultural Communities/Indigenous People and Other Disadvantaged Groups in Mindanao”. Even though the project is expected to begin implementation late in 2011 and will thus not fall under this evaluation period, the MHSPSP provided support and could also lead to an improvement of the indicator.

In summary, at the aggregate level, improvement in the proportion of births supervised by skilled professionals has increased only modestly. However, through the implementation of EU supported projects in Mindanao to address “Maternal, Neonatal and Nutrition Needs of Indigenous People and Other Disadvantaged Groups”, improvement of the situation may be seen throughout the following years.

I-412 The percentage of women receiving four or more ante-natal check-ups increased from 70.4% in 2003 (see Figure below), to 91% in 2008. According to the 2008 Philippine DHS receiving of ante-natal care from a skilled worker is higher in urban areas (94%) than in rural areas (88%). It is also strongly related to the mother’s level of education, birth order and economic status. Women who have attended college are more than twice as likely to receive ante-natal care from a skilled professional (97%) as women with no education (44%). Women are more likely to consult a medical professional for antenatal care for the pregnancy for their first birth than for subsequent pregnancies (95%, compared with 93% or lower for subsequent pregnancies). While 98% of women in the highest wealth quintile consulted a health professional for antenatal care, the proportion for women in the lowest quintile is 77%. On the top there are wide variations in ante-natal care coverage and services across regions (also valid for I-411 and I-413).

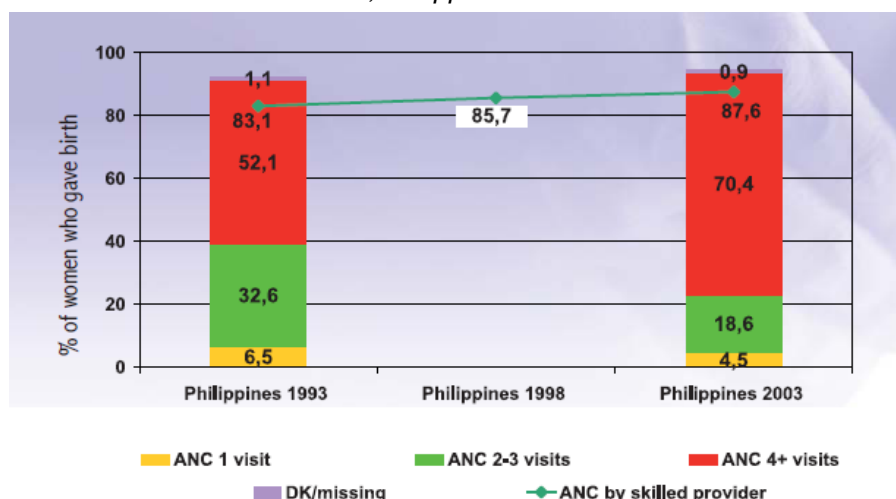
Figure 31: Percent women aged 15-49 years attended at least once by a skilled health provider during pregnancy



Source: DHS, MICS¹³⁵

¹³⁵ <http://www.countdown2015mnch.org/documents/2010report/Profile-Philippines.pdf>

Figure 32: Number of ante-natal care, Philippines 1993 and 2003¹³⁶



Source: WHO Philippines, Country Profile

However even though the EC contributed to maternal and child health, there is no indication that EC support led to an increased percentage of women receiving 4 or more ante-natal check ups.

I-413 In general, access to family planning is low in the Philippines, the opposition of the Catholic Church is vigorous and as a result, the Philippines have not experienced the sharp drop in fertility that has occurred in other Southeast Asian countries. At the macro-level, research, notably the World Bank's landmark 1993 study The Southeast Asian Economic Miracle suggests that fertility decline opens a "window of demographic opportunity" as families with few children are able to save and invest more, not least in the education of those children.

The contraceptive prevalence rate for married women in the Philippines has increased from 15% in 1968 to 51% in 2008. Generally the trend points towards a slow but positive development.

Table 15: Percentage distribution of currently married women by contraceptive method used, Philippines: 2003 and 2008

Method	2003	2008
Any method	49	51
Any modern method	33	34
Any traditional method	16	17
Not currently using	51	49
Total	100.0	100.0

Source: NSO Philippines¹³⁷

The CSE Philippines mentions that inadequate attention to maternal and child and sexual and reproductive health has been noted in a number of places. Increased attention would significantly improve the relevance of the EU programme, not only to women, but to promoting economic growth and reducing poverty in general. That said, the EU and other donors have repeatedly raised these issues in high-level policy dialogue. This investment may pay off under the new Government, which appears significantly more progressive in this area than its predecessor.

Besides raising the issues of maternal and child health in high-level policy dialogue, the EC contributed to an improvement of this indicator on project level under its NGO projects; Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH) The project aims to reduce poverty by

¹³⁶ WHO. Philippines: country profile, http://www.who.int/making_pregnancy_safer/countries/phl.pdf

¹³⁷ National Statistics Office (NSO) [Philippines] and ICF Macro. 2009. National Demographic and Health Survey 2008. Calverton, Maryland: National Statistics Office and ICF Macro.

addressing Reproductive Health (RH) issues and increasing the possibilities for income generation. The ROM report¹³⁸ states that work has been done to sensitise volunteers, Barangay and LGU on RH related topics, however this has not significantly led to increased attendance of the RH services made available by the project. A considerable amount of patients attend these services for general medical problems and not specifically for RH issues and the extent to which the project directly contributes to the uptake of birth control is questionable. Insufficient importance has been given so far to the need to address men's attitudes/beliefs to facilitate women's uptake of modern contraceptive methods.

Furthermore Several NGO projects which aimed at benefiting to vulnerable women included a SHR component. These include "Accelerating community-based responses to reproductive and sexual health, HIV/AIDS and Sexually Transmitted Infections (STI) concerns of Filipino youth," and "Capacity building programme for civil society organisations and local government units to prevent child and woman trafficking for commercial sex exploitation in the Visayas and Mindanao regions of the Philippines" (11). A small Asia-Urbs project, "Improving health services offered to marginalised mothers and young children," was active in 2002-2005.

3.5.1.2 Resume of the JC

Maternal health, as indexed by antenatal care and the proportion of deliveries attended by a skilled health worker, has improved over time in the Philippines, both in rural and urban areas. This is also found in the reduction of maternal and child mortality rates. Gaps between rural and urban areas remained, as well by educational and economic status and among administrative regions.

Despite the increase in the number of facility-based deliveries, the lack of access to a wide range of family planning services remains a major concern in the field. Opportunities are missed to provide family planning services in health centres in continuity with birthing facilities. Access to long-term and permanent methods of contraception is very poor and most health care providers are unaware vs. do not advocate the benefits offered by PhilHealth for sterilisation and IUD services. The maternal mortality induced by early pregnancy and malnutrition will hardly be influenced by concentrating merely on facility-based deliveries.¹³⁹

According to the CSE Philippines the EU provided major support to women in the Women' Health and Safe Motherhood Project during the first half of the evaluation period (2000-2004). Yet, the mid-term review of the Health Sector Policy Support Programme noted severe deficiencies in the availability of maternal and child health services and sexual and reproductive health services. The distribution of skilled human resources, specifically midwives and trained birth attendants is deeply influenced by local politics.

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

Indicators

- I-421 Percentage of children under 5 receiving regular growth monitoring
- I-422 Immunisation rate

3.5.2.1 Findings

I-421 Through Executive Order No. 128, signed in 1987, the Food and Nutrition Research Institute (FNRI) of the Department of Science and Technology (DOST) is mandated to undertake research to define the nutritional status of the population, particularly the malnutrition problem and its causes and effects and to identify alternative solutions to them.

While we do not have information on monitoring, we do have information on trends. The 7th National Nutrition Survey (NNS)¹⁴⁰ in the Philippines is the seventh in a row. The percentage distribution of children aged 0 to 5 by nutritional status (using the IRS-WHO) showed that 26.2% were underweight, 71.8% normal and 2.0% overweight. The growth monitoring showed that 27.9% are underheight, 70.9% normal and 1.1 tall. The Weight-for-Height measures are as following: 6.1% thin/wasted, 90.8

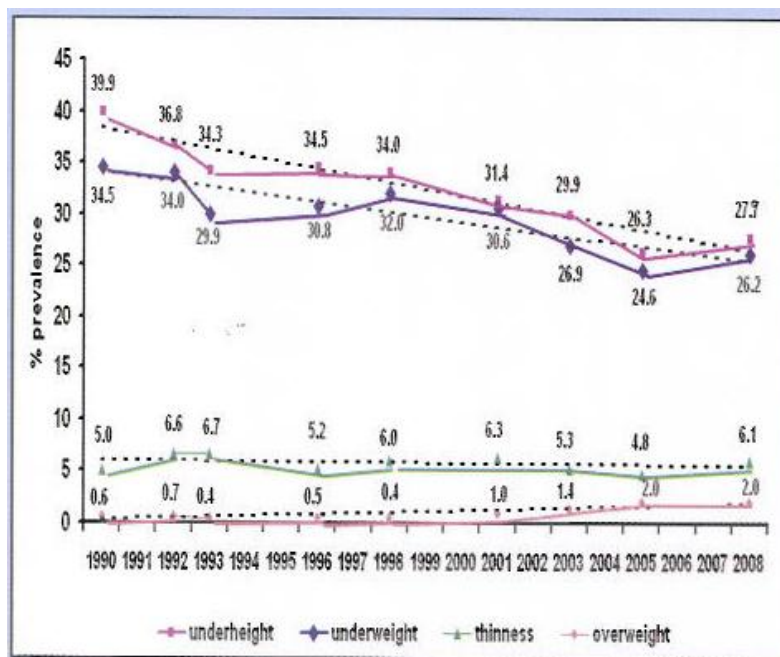
¹³⁸ Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH), Monitoring Report, MR-130925.02, 25/03/2011, p.

¹³⁹ Mid-Term Review Of The Health Sector Policy Support Programme (ASIE/2005/017638) In the Philippines, Final Report, January 2009, p.6

¹⁴⁰ 7th National Nutrition Survey. 2008, <http://www.sph.emory.edu/wheatflour/ttsgpublic/NNS.pdf>

normal, 2.8 overweight and 0.2% Necrotising enterocolitis (NEC)¹⁴¹ in 2008 (see Figure below). Accordingly from 2002- 2005 the figures were improving, whereas from 2005 to 2008, there was an increase in the proportion of children being underweight and underheight in the Philippines.

Figure 33: Trends in the prevalence of underweight, underheight, thin and overweight among 0-5 years old children: Philippines, 1989/90 to 2008



Source: National Nutrition Survey. 2008¹⁴²

There is no information available whether the EC contributed to an increased percentage of children under 5 receiving regular growth monitoring or not.

I-422 The Expanded Program on Immunisation (EPI) in the Philippines began in July 1979. Its objective is to reduce infant mortality and morbidity through decreasing the prevalence of six immunisable diseases (TB, diphtheria, pertussis, tetanus, polio and measles). According to the WHO Global Health Observatory Data Repository (see Table below), the immunisation coverage in 2009 was above 80% for all the major types of vaccines. The data suggest that in recent years the immunisation coverage increased with exception of BCG, which decreased slightly.

Table 16: Immunisation coverage among 1-year-olds, Philippines: 2000-2009

Type of immunization /	2000	2005	2009
Measles (MCV)	81	92	88
Diphtheria tetanus toxoid and pertussis (DTP3)	78	89	87
Hepatitis B (HepB3)	7	49	85
BCG	92	91	90
Polio (Pol3)	74	90	86

Source: WHO Global Health Observatory Data Repository¹⁴³

The trend presented in the table above clearly illustrates a positive development of the indicator. While the EC has supported a number of projects dealing with MCH it can just be assumed that these have

¹⁴¹ Necrotizing enterocolitis (NEC) is the most common gastrointestinal (GI) medical/surgical emergency occurring in neonates. An acute inflammatory disease with a multifactorial and controversial etiology; <http://emedicine.medscape.com/article/977956-overview>

¹⁴² 7th National Nutrition Survey. 2008, page 4, <http://www.sph.emory.edu/wheatflour/ttsgpublic/NNS.pdf>

¹⁴³ WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/>

somehow affected the trend but no precise information on EC support to immunisation coverage is available.

3.5.2.2 Resume of the JC

This JC has been assessed by two indicators. (I) I-411 Percentage of children under 5 receiving regular growth monitoring and (II) I-412 Immunisation rate. For one indicator there is a positive development of the trend visible. The Philippines can be considered as a good example in respect to immunisation coverage of new-borns, although there is some evidence that BCG coverage might be de-facto lower due to remaining tuberculosis health problem in the Philippine with, according to the WHO, a prevalence of 520 per 100,000 population in 2009. Alarming is the current increase of the already high proportion of children that are undernourished and/or underheighted. And according to the 2008 National Demographic and Health Survey, 19.6% of babies are of low birth weight.

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

Indicators

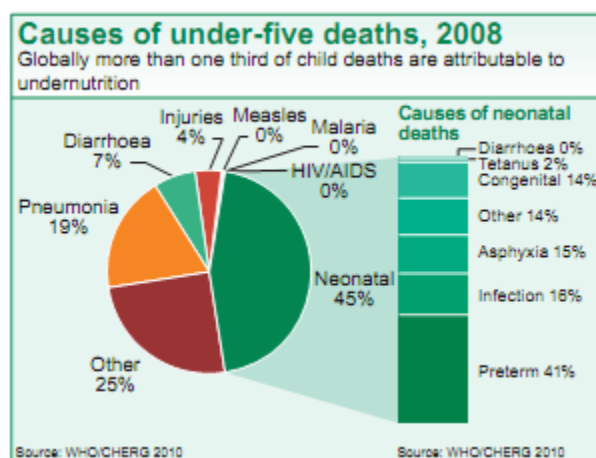
- I-431 Increased proportion of children sleeping under a bednets
- I-432 Reduction in rate of child deaths from diarrhoeal disease
- I-433 Improved household management of diarrhoea based on oral rehydration salts (ORS)

3.5.3.1 Findings per indicators

I-431 In the Philippines - a malaria country - the proportion of population (or children) sleeping under insecticide-treated nets is an indicator for the country's efforts reducing the malaria infection and prevalence rates. Unfortunately, there is no information available for the Philippines. Similarly, there is nor information available whether EC has supported an increased proportion of children sleeping under a bednet

I-432 Diarrhoea is the third most important cause of death in children aged under 5 years, with a rate of 7% in 2010.¹⁴⁴

Figure 34: Causes of under-five deaths, 2008



Sources: WHO, CHERG¹⁴⁵

According to the 2008 Philippine DHS, diarrhoea is more prevalent among children age 12-23 months, children whose mothers have elementary education and children in the poorer wealth quintiles. Prevalence of diarrhoea varies across regions from 5% in Bicol to 16% in SOCCSKSARGEN.¹⁴⁶

¹⁴⁴ Department of Health, Philippines, http://www.doh.gov.ph/kp/statistics/child_mortality.html

¹⁴⁵ <http://www.countdown2015mnch.org/documents/2010report/Profile-Philippines.pdf>

¹⁴⁶ National Statistics Office (NSO) [Philippines] and ICF Macro. 2009. National Demographic and Health Survey 2008. Calverton, Maryland: National Statistics Office and ICF Macro, p.127

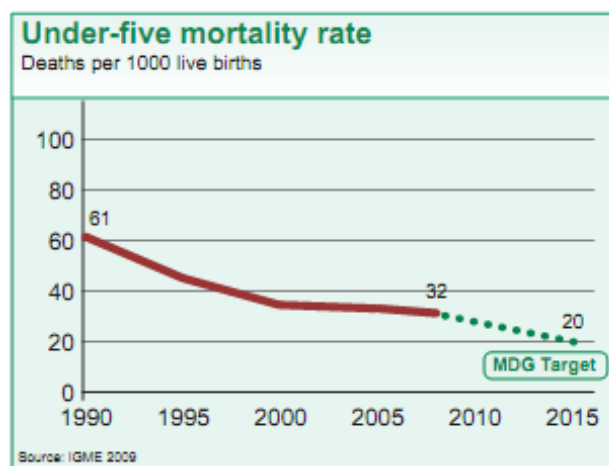
Table 17: Percentage of children under age five who had diarrhoea in the two weeks preceding the survey, by background characteristics, Philippines 2003 and 2008

Age in months	All diarrhoea 2003	All diarrhoea 2008	Number of children 2003	Number of children 2008
<6	7.0	5.3	603	575
6-11	19.2	14.6	733	640
12-23	16.3	16.0	1,348	1,286
24-35	11.5	10.0	1,326	1,225
36-47	6.3	5.5	1,434	1,238
48-59	5.4	3.1	1,267	1,221
Wealth quintile	All diarrhoea 2003	All diarrhoea 2008	Number of children 2003	Number of children 2008
Lowest	13.0	10.3	1,768	1,615
Second	11.1	11.1	1,527	1,419
Middle	9.3	8.1	1,312	1,188
Fourth	9.1	6.9	1,127	1,093
Highest	9.2	7.4	979	870
Total	10.6	9.0	6,712	6,185

Sources: National Demographic and Health Survey 2008¹⁴⁷ and 2003¹⁴⁸

There is no information available on rate of child deaths from diarrhoeal disease. The table above only provides data for 2003 and 2008 on percentage of children under age five who had diarrhoea in the two weeks preceding the survey. Accordingly the situation is improving to a small extent as there are 1.6% less children under age five in 2008 having diarrhoea in the two weeks preceding the survey. However the data available has to be taken with caution as it only provides a snapshot and does not give information whether there has been a reduction in rate of child deaths.

Figure 35: Under-five mortality rate, 2008



Sources: IGME¹⁴⁹

However from the figure above it can be assumed that the number of deaths from diarrhoeal disease has improved over the evaluation period as there was a slight decrease in the under-five mortality rate.

¹⁴⁷ Sources: WHO, CHERG

¹⁴⁸ http://aidsdatahub.org/dmdocuments/National_Demographic_and_Health_Survey_Philippine_2003.pdf

¹⁴⁹ <http://www.countdown2015mnch.org/documents/2010report/Profile-Philippines.pdf>

Even though, CSE Philippines mentioned that the EU has supported a number of projects dealing with MCH, such as a small Asia-Urbs project, “Improving health services offered to marginalised mothers and young children,” which was active in 2002-2005, there is no explicit information whether the EC has contributed to a reduction in rate of child deaths from diarrhoeal disease.

I-433 According to the 2008 NDHS, overall, 9% of children under five years had diarrhoea in the two weeks preceding the survey. This is a slight decrease from 2003, when the prevalence was 11%. 34% of children who were reported to have diarrhoea were taken to a health facility for treatment. This figure is slightly higher than that reported in the 2003 NDHS (32%). 59% of children with diarrhoea were treated with oral rehydration therapy (ORT), either oral rehydration salts (ORS) or recommended home fluids (RHF). 16% of children with diarrhoea did not receive any treatment; however, this figure is lower than that reported in the 2003 NDHS (22%). Diarrhoea is more prevalent among children age 12-23 months, children whose mothers have elementary education and children in the poorer wealth quintiles. Prevalence of diarrhoea varies across regions from 5% in Bicol to 16% in SOCCSKSARGEN.¹⁵⁰ Generally it can be said, that the trend points towards a positive direction.

Mother’s level of education is related to whether treatment was sought for the child’s diarrhoeal illness. Better-educated mothers were more likely than less educated mothers to seek advice or to administer ORS to their children with diarrhoea. Use of ORT (ORS or RHF) varies by background characteristics. Children in urban areas with diarrhoea were more likely than those in rural areas to be treated with either ORS or RHF (66 and 52%, respectively).¹⁵¹ Similarly to the two preceding indicators it is difficult to directly attribute EC contribution to an improvement of the indicator. For instance EC interventions listed in JC31 such as STARCM; or “Bringing Health into the People’s Hands: A Health Improvement Program for the Internally Displaced People of Mindanao” have probably indirectly contributed to an improvement as they increased the availability of health care facilities. Furthermore, increased number of health worker training and standards of and availability of training (JC13) could also have led to an improved household management as well as the interventions listed under I-112 which tackle the availability of selected essential medicines in public and private health facilities.

Table 18: Diarrhoea treatment in the Philippines¹⁵²

Background characteristics	% of children with diarrhoea for whom advice or treatment was sought from a health facility provider	ORS packets or pre-package liquid	Recommended home fluids RHF	Either ORS or RHF	Increased fluids	ORT or increased fluids	No treatment
DHS 2003							
Male	33.1	41.2	24.1	56.1		57.3	23.4
Female	31.6	43.3	22.8	59.2		60.8	21.3
Urban	36.2	51.7	22.9	66.9		67.6	18.1
Rural	28.6	32.6	24.2	48.2		50.2	26.8
Highest quintile	40.5	50.6	24.2	64.0		64.0	20.9
Lowest quintile	28.0	30.6	22.9	46.2		49.8	22.7
Total	32.4	42.2	23.5	57.6		58.9	22.4
DHS 2008							
Male	31.8	49.3	22.1	59.9	36.7	73.8	16.6
Female	37.2	43.1	20.5	57.0	34.9	71.1	14.8
Urban	37.4	57.7	17.6	66.2	40.3	79.5	11.8
Rural	31.3	36.3	24.9	51.7	31.8	66.3	19.4
Highest quintile	48.8	54.7	16.7	64.9	49.0	81.6	17.7

¹⁵⁰ Ibid, p.127

¹⁵¹ Ibid, p.128

¹⁵² Ibid, p.128; and National Statistics Office (NSO) [Philippines] and ORC Macro. 2004. National Demographic and Health Survey 2003. Calverton, Maryland: NSO and ORC Macro., p.144

Background characteristics	% of children with diarrhoea for whom advice or treatment was sought from a health facility provider	ORS packets or pre-package liquid	Recommended home fluids RHF	Either ORS or RHF	Increased fluids	ORT or increased fluids	No treatment
Lowest quintile	30.4	37.3	24.6	54.5	30.6	67.8	35.8
Total	34.2	46.6	21.4	58.6	35.9	72.6	15.8

Sources: DHS 2003 and 2008

3.5.3.2 Resume of the JC

Trends in the indicators identified have been generally positive in the Philippines: a reduction in under-five mortality and a rising proportion of children experiencing diarrhoea being treated with ORSs and a reduction of diarrhoea prevalence. Socio-economic and geographical differentials remain in the country and the situation is worse for remote and conflict regions, for children of less educated mothers and for lower income quintile groups.

Regarding children sleeping under insecticide-treated bednets, no information is available.

Generally it has to be noted that it is difficult to directly relate EC contribution to an improvement of the indicators. However according to the CSE Philippines the EU has supported a number of projects dealing with MCH. And even though they did not directly address the indicators of the JC it can be said that EC support at least indirectly influenced the indicators.

3.6 EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

3.6.1 JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support

- I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators)
- I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector
- I-513 EC contributed to decentralised capacity building to strengthen health policy capabilities at provincial, district and local levels.

3.6.1.1 Findings

I-511 The EC might have contributed to overall health strategy process and related documents in various ways. For instance the EU has an active role in the Health Sector coordination; government-donors' joint review of the health sector programme (JAPI); co-chairing of the Health Working Group of the Philippines Development Forum (PDF); membership in the Country Coordinating Mechanism of the Global Fund (GF). The TA contributed to the enhancement of the Philippines National Health Accounts (PNHA). It has provided inputs for the update, referring to 2006, but despite DOH and TA contributions, the PNHA 2006 have not yet been officially released at the end of September 2008.

According to the CSE Philippines and HSPSP Final Report (2010) the EU plays key role among donors in the policy dialogue and strategic orientation of the sector development approach to health (SDAH) under the overall leadership of DOH. The TA team supported DoH to steward health sector reform and exert sectoral leadership through the Sector Development Approach to Health (SDAH). The development partners have been active in the health sector in the Philippines. They have contributed with technical and financial inputs to the reform progress and aligned with national policy. In addition to the EU, a major partner has been the WHO, involved in all four pillars of the reform; the World Bank has been active in financing and maternal care, ADB in hospital reform and poverty alleviation, USAID in policy reform and particularly in service delivery, as well as other bilateral cooperation agencies. The HSPSP does not attempt to address the whole health sector reform agenda (HSRA) but to focus on key reform targets in the areas of good governance, health financing, health services delivery and regulation, specifically of drugs and medicines. EU funding, provided as a grant, explicitly targets pro-poor interventions. The program emphasizes systems development and capacity building, which are internationally recognized as major conditions of health development. The

EU aid also supports the government's efforts to improve public expenditure and public finance management, in line with the reforms initiated by the government oversight agencies and the requirements of the sectoral approach. In addition, at central level

The HSPSP Final Report (2010) further noted that the EC-TA assisted in drafting the Philippine Policy Framework for the Renewal to Primary Health Care, which is an input to the draft Administrative Order on the "Framework to Achieve Universal Health Care". In addition, the HSPSP Final Report (2010) noted that in Regulation and management at central level the EC-TA was heavily involved with the newly created FDA (Food and Drugs Administration) in the production of the Implementing Rules and Regulation (IRR) of „The Affordable and Quality Medicines Act (RA9502) and the IRR of the FDA Act, assisting in the internal re-organization needed for the transition from BFAD into FDA and in the cascading training for the FDA and CHDs on pharmacovigilance, thus also contributing to health policy strategy process.

Under MHSPSP the Progress Report (2009) noted that review and mapping of basic health indicators for populations in CAA with emphasis on immunization cover of children, maternal/peri-natal health, fertility/reproductive health and communicable/non-communicable diseases rates took place. A report has been produced including the preliminary synthesis of current baseline indicators, however, the report has been rejected for enhancement.

The view of the EUD Philippines was that PFM in the MoH improved as a result of EC-financed TA.

I-512 Regarding the CSE Philippines, the sector analysis undertaken by the EU concluded that significant progress was achieved in the areas of sectoral policy and strategy and donor coordination and that PFM systems were strengthened along the lines of an overall PFM reform encompassing the improvement of medium term financial planning, public finance management and procurement.

The EC incorporated PFM measures at national and local level.

At the national level, HSPSP through its TA supported the GoP's efforts to improve public expenditure and PFM reforms to promote fiscal sustainability, effective and efficient resource allocation and government operations to ensure fiscal consolidation for sustainable good governance. Those reforms include a number of (pre)conditions for a functional SBS: a) Medium Term Expenditure Framework (MTEF), b) Effectiveness and Efficiency Review, c) Organisational Performance Indicator Framework (OPIF), d) New Government Accounting System (NGAS) and New Procurement Law; and e) the requirements of SDAH. In addition to the DBM, participation of other national oversight agencies like the National Economic and Development Authority (NEDA) and Department of Interior and Local Government (DILG) were enjoined in the programme.

According to the HSPSP Final Report (2010) assistance to public finance management at the DOH had a focus on the production of Public Finance Management Reform Strategy drawn up with the objective of improving financial, procurement and logistics management systems as identified in the National Objectives for Health. It was followed by a Reform Strategy Implementation Plan specifying activities, timelines and responsible office for improvements in each of the PFM reform objectives in the DOH namely budget credibility, budget execution and internal controls. Additional to this was putting in place a Public Expenditure Tracking System (ETS) and Executive Information System (EIS); a Finance Management Tracking Information System (FMTIS); the design of the system integration of the DBM Philippine Government Electronic Procurement System (PhilGEPS) and budget system with the DOH integrated procurement logistics and financial information software; and a revised Health Sector Expenditure Framework (HSEF) for the period 2011-2016.

At the local level, PFM activities were determined in consideration of the PLGUs' different levels of development, resource availability, absorptive capacity and competence. Specific interventions are defined in line with the devolution concept and the SDAH and spelled out in a MOA and service level agreement (SLA) between the Department of Health and the concerned PLGU. To ensure that PFM improvements at the local level were in line with national/central level reforms, the DBM was expected to play a crucial role particularly in capacity building of PLGUs and their component LGUs in PFM. However operational problems were reported which led to delays in 2008. In 2010 the HSPSP Final Report concluded, that the production of a LGU PFM Road Map has been the most relevant output at the strategic level and it includes a strategy for capacitating LGUs in PFM. This will involve an expansion of the technical involvement of the Regional Offices (RO) of DBM from only monitoring the budgeting process as currently to active Monitoring and Evaluation and Internal Audit Services (IAS). Support to the F16 provinces was initiated with the development of LGU PFM improvement plans.

There was an observed general increase (from a low of 3% to a high of about 7%) in participating PLGUs' annual budgets for health from 2007 to 2008. These increases were on top of the HSPSP budget support to the provinces. Local Chief Executives (LCEs) appeared encouraged to step up local investments on health as a result of the programme. However, the LGU's need for focused assistance

in developing their capabilities for revenues generation to support increased investments was likewise apparent.

Eleven PFM work plans had been approved to date while the rest are still in various stages of review and approval. However, none of the approved work plans is in the process of implementation yet¹⁵³.

Under MHSPSP the 7th Progress Report (2011) noted that in order to strengthen financial management, procurement and functions, PFM improvement plans have been developed for all ARMM and non-ARMM provinces and PFM planning workshops have taken place.

Besides the successful PFM measure at national and local level, the CSE Philippines also expressed the reservation that appropriate management structures were neither present in PhilHealth nor the DoH. Weak partner capacities have led to a situation that projects need to provide appropriate – and often high - funding to strengthen implementing capacities. For example, in the case of STARCM (according to the 2005 monitoring report), “the situation. indicates that Organisation and Management accounts for 42% of costs incurred to date as against the budgeted amount of 38% over the life of the Project. Furthermore, the mid-term review of the Health Sector Policy Support Programme found serious deficiencies in the capacity of LGUs and PLGUs in the area of management and found that all along the chain, from local level to the central level, capacity was lacking to identify and target the poor and to put in place the procedures and processes needed to ensure universal coverage. To address this issue the EU-supported Philippine HSPSP contributed to strengthened financial management and procurement functions at least at provincial level (in target provinces).

I 513 In the health sector, the need for capacity building at the decentralised level was a major concern during project formulation of HSPSP. Yet, the mid-term review found serious deficiencies in the capacity of PLGUs and LGUs, as well as the Central Department of Health, to implement PFM reforms (5). The review called for increased attention to capacity building and, closely related, TA, at all levels and across a broad front. This included, in particular, the need to improve the capacity of the Department of Health and PhilHealth to implement reforms in health care financing in order to expand coverage and reduce out-of-pocket expenditures¹⁵⁴ Likewise, the HSPSP final report (2010) noted that tackling the fragmentation of the system through enhanced coordination was a key strategy of F1-for-health. Fragmented resources across different administrative levels called for coordination in order to clarify responsibilities and minimize funding gaps. While vertical programs still buy commodities, LGUs fund Rural Health Units services, both in a context of clear underfunding of activities at that level. The introduction of Provincial Investment Plans for Health (PIPH) and Service Level Agreements (SLA) contributed to give coherence to the system at provincial level. In addition, LGUs developed Province-wide Investment Plans for Health (PIPHs) and an LGU scorecard was put in place to assess their performance; this LGU scorecard produced by the DOH is also used by the Department of Interior and Local Government (DILG) as a component of the Local Governance Performance Management System (LGPMS). These valuable planning and monitoring systems still need time to show their results in terms of health systems improvement and translate into public health benefits.

However the CSE Philippines concludes that EU-TA under HSPSP and MHSPSP has invested huge capacity and succeeded in several provinces. The task has been taken up to different extent in each of the provinces and on different thematic of the four pillars of FOURmula One for Health. This ascertains the capacity of the Provincial Health Teams to reach quality with support of centres for health development (CHD), LRIC (Local Reform Implementation Coordinators are national TAs) but leaves the opportunity not always used to replication where it did not work that well.

Furthermore the TA prepared and delivered a training module for DOH personnel to strengthen DOH Internal Audit Service; workshops have been held in January 2009 with the objective of the DOH to be able to identify the key environmental, organisational, empowerment and financial risks. Attended by over 250 managers from the Central Office, CHDs and DOH hospitals, the DOH has become the first government agency to establish a comprehensive risk matrix in order to be able to identify and mitigate these risks.

The active participation/involvement of the Commission on Audit (COA) in the improvement of the audit functions within the DOH and the LGUs helps building internal audit capacities at the central and LGU levels. COA participated in this programme component.

¹⁵³ Extracted from the: Mid-Term Review Of The Health Sector Policy Support Programme (ASIE/2005/017638) In the Philippines, Final Report, January 2009, p.7

¹⁵⁴ 5.Mid-term review of the Health Sector Policy Support Programme, Final report, January, 2009, p. 7-9.

DBM has significantly moved to address the LGU PFM issues through developing capacity in regional DBM offices and to cover internal controls and audit, M&E monitoring and supporting the LGU PFM processes (see also I-522)¹⁵⁵.

Specifically under MHSPSP the TA has assisted municipalities and the ARMM in enhancing health service delivery at municipal level. Catchment and Case Flow Analysis (CCF) was considered a key element in identifying geographic demand for health services and patient flow in the volume of demand for services (MHSPSP, 2009). The Barangay Health Station (BHS) and the RHU are the “gateways” to the health services and starting point for the application of CCF tools. The skills training on CCF was conducted in all provinces in ARMM. The outcomes of analysis using CCF tool was an improved and organized health data which can be utilized for rationalization plans.

In addition, organizational strengthening at local level took place based on recommendation of the “Capacity Assessment of the Local Health Boards Survey” conducted by the MHSPSP in 2008-2009. Accordingly, the MHSPSP TA has supported the DOH- ARMM, but also in Non-ARMM provinces in Davao City, the Integrated Provincial Health Office (IPHOs) and the MLGUs address capacity limitations of LHB through the development and implementation training courses. The preliminary evaluation indicated that course objectives has been achieved and many aspects of the course were rated highly by the participants. The majority of the participants called for a replication of the course to cover other LHBs all over Mindanao¹⁵⁶. Delivery of structured training programmes for Local Health Boards (LHB) in target LGUs have continued to take place in 2011 and a fully costed LHB programme for Mindanao has been finalised.¹⁵⁷

3.6.1.2 Resume of the JC

The JC has been assessed by three indicators. (I) I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators); (II) I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector and (III) EC contributed to decentralised capacity building to strengthen health policy capabilities at provincial, district and local levels. Through the documents reviewed there has been evidence identified for all of the three indicators.

The Health Sector Support Programme carefully integrated decentralisation and governance into its design and recognised the need to address social safety net (in this case, health care finance) issues as well as service delivery. In the health sector, the need for capacity building at the decentralised level was a major concern during project formulation. Yet, the mid-term review found serious deficiencies in the capacity of PLGUs and LGUs, as well as the Central Department of Health, to implement PFM reforms. The review called for increased attention to capacity building and, closely related, TA, at all levels and across a broad front. This included, in particular, the need to improve the capacity of the Department of Health and PhilHealth to implement reforms in health care financing in order to expand coverage and reduce out-of-pocket expenditures.¹⁵⁸

3.6.2 JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

- I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc).
- I-522 EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing)
- I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

¹⁵⁵ CSE Philippines

¹⁵⁶ MHSPSP TA 6th six month report July 2010 – February 2011

¹⁵⁷ MHSPSP TA 7th six month report, February 2011 – July 2011

¹⁵⁸ Ibid., p.7-9 and 19-22

3.6.2.1 Findings

I-521 Following the CSE Philippines there is evidence of EC contribution, particularly in the context of internal audits. The EU-TA prepared and delivered a training module for internal audit personnel on the theory and practice of this approach and in liaison with the Internal Audit Service designed an orientation and awareness program for DOH managers in the DOH Central Office, CHDs and DOH hospitals, with developed tools and mechanisms to implement a risk-based approach to internal audit with a Risk-based Training module and a DOH Internal Audit Manual for risk-based audit developed (completed by TA June 2009, still not by DoH).

The active participation/involvement of the Commission on Audit (COA) in the improvement of the audit functions within the DOH and the LGUs helps building internal audit capacities at the central and LGU levels. COA participated in this programme component.

I-522 According to the CSE Philippines EU-TA facilitated the introduction of the Department of Budget and Management (DBM) tool to monitor the PFM plan implementation with as result a larger implication of central support level. There is yet no proof for increased health spending and effective rational use of resources in the published Health Accounts. We¹⁵⁹ can only confirm that on average in the provinces visited in Mindanao, the provinces' dedicated budget to Health for 2010 are on an increase, examples of 18 and 25% for 2010. Municipal budgets are on increase to 10 and 13% (target for LGU scorecard is 12-15%).

At national level the EU-TA is also supporting the Bureau of International Health Cooperation (BIHC) in developing the Sector Development Approach to Health (SDAH) architecture, including an Information System for Donor mapping, the Donor scorecard (with the addition of the Central office scorecard in the Transitional phase, which tool and results are to be presented by the Health Policy Development and Planning Bureau (HPDPB) in the Monitoring Evaluation for Equity and Effectiveness (ME3) conference on September alongside other scorecards).

At the national level, HSPSP also supports the GOP's efforts to improve public expenditure and PFM reforms which also include the Medium Term Expenditure Framework (MTEF) (see also I-512 for more information on this), However Strengthening of the DOH PFM is seemingly at a standstill for reasons which include the following: a) non-approval to date (finalisation of CSE report) of the DOH personnel rationalisation plan; b) delays in the approval of the DOH PFM work and procurement plans; c) DBM's positive role and participation had not been well defined and felt within the DOH CO and more so at the CHD level; and, d) TA's concentration on "assistance to transactions" at the DOH CO rather than on the improvement of PFM systems.

The EC also provided support to the development of annual operation plans (AOPs). Accordingly the EU-TA developed a tracker of progress in the preparation and approval of AOPs and supplementary plans, a tracker of performance relative to indicators of the different provinces in the Service Level Agreements and a tracker of progress in preparation and approval of provincial rationalisation plans. The report for Philippines Health Sector Reform Project noted that most AOPs in 2008 still focused on inputs rather than outcomes. The DoH responded by developing appropriate guidelines for the preparation of the 2009 AOPs that hopefully would enable the provinces to focus more on outcomes. In 2009, due to the tedious process endured by everyone in the previous JAC reviews of provincial investment and AOPs, the DoH developed guidelines to govern future reviews. Since the plans were already being reviewed at the technical level at both the CHDs and the Central Office, the JAC review became more focused on the following: conformity to existing guidelines, pro-poor thrusts, equity and results-orientation. This somehow facilitated the reviews but the sheer number of plans to be reviewed at times made the process daunting. Late or last minute submissions by the CHDs of their evaluations and of the finalized plans by the LGUs did not make the process any easier. Quality control of the submitted plans for review was at best erratic and inconsistent and became a persistent problem in all reviews. In 2010, The F16 provinces had their 2010 AOPs approved in December 2009 and they included implementation plans for health facilities rationalisation. They also benefited from additional DOH funding for health facility enhancement and basic emergency obstetric and neonatal care (BEmONC) improvements in rural health units (RHUs) and Barangay Health Stations (BHSs). In addition, the HSPSP TA included direct support to LGUs and CHDs through Local Reform Implementation Coordinators (LRICs) posted in each of the F16 provinces in the production and appraisal of PIPs (Province-wide Investment Plans for Health) and AOPs. The EC-TA produced a Program Operations Manual, an appraisal tool for AOPs and a „local reform implementation coordination reporting format“. An important volume of assistance went to the production of health

¹⁵⁹ The Evaluation team undertaking the CSE Philippines

facilities rationalization plans of the LGUs and then support to the procurement of equipment and civil works associated to them.

Under MHSPSP the TA aimed at establishing investment Plans for Health that begin to address the needs of the poor, minorities and women through civil society engagement. As a result in 2011 rationalisation plans have been developed for MHSPSP Provinces and enhanced AOP that includes health activities that addresses IP needs have been established¹⁶⁰.

I 523 Under the MHSPSP and HSPSP there have been significant EC contributions towards procurement improvements. According to the Philippine Institute for Development Studies (PIDS) review in 2009, there were inefficiencies in the procurement of important drugs and supplies at the LGU level. Procurement of drugs at the LGU level seems to be inefficient since none of the LGUs surveyed cooperate with their ILHZ for bulk drug purchases. Most would buy from pharmaceutical representatives which is more expensive (CSE Philippines).

The MHSPSP coordinates a project procurement management plan for goods and services needs of the provinces with the Bureau of local Health Development (BLHD) and gives TA in the development of the LGU annual procurement plan. The EU-TA delivered to the provinces management tools like the Inventory Management Assessment Tool, ABC¹⁶¹ analysis of annual procurement and forecasting needs tools.

The HSPSP TA has also stepped up assistance to the provinces in the preparation of the different plans (AOPs, Training plans, Procurement plans, Rationalisation plans) and advocating for closer communication between DOH – LGUs (CSE Philippines).

Besides providing support at national levels, further achievements have been identified in the CSE Philippines through EU-TA support at local level by helping local governments adopt Good Procurement Practices in Pharmaceuticals (GPPP) and by promoting the establishment of community-based pharmaceutical outlets. Drug Management Systems are enhanced at the local level to improve efficiency and performance of pharmaceutical supply management systems at LGU level starting from more focused selection of essential medicines through transparent and cost efficient procurement to effective, rational use through training in GPPP (see also I-112).

Besides these positive aspects, some issues regarding GPPP have been identified as well, which might mitigate EC contribution to the indicator, for instance where the TA package was introduced, the MTR Team observed inadequacies in design and implementation of the Good Procurement Practices in Pharmaceuticals (GPPP): i) over-reliance on the General Services Office (GSO) of the province to manage the procurement process; ii) minimal involvement of the provincial public finance team in the provision of oversight to the procurement process; iii) absence of a reliable local price monitoring system; and iv) no follow-through by the EU-TA Team or by the CHD after the GPPP training to provide continuing guidance to local staff, especially in critical stages of the procurement process.

Furthermore the EU-TA looked into the logistics and supply chain management to improve both central and local level procurement, logistics and warehousing to guarantee the availability and assured quality of essential health products along the supply chain (CSE Philippines).

However the HSPSP MTR states that progress regarding LGU warehousing and inventory systems are minimal and should be strengthened and that improvements in DOH procurement policies, procedures and practices had been limited to the DOH CO system.

3.6.2.2 Resume of the JC

This JC has been assessed by three indicators. (I) I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc). (II) I-522 EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing) and (III) I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement. Similarly to JC 51 documents reviewed indicate that there has been evidence identified for all of the three indicators. Consequently the EC has strengthened institutional and procedural systems related to transparency and accountability issues at national and sub-national level due to EC support even

¹⁶⁰ MHSPSP TA 7th six month report February2011-July2011

¹⁶¹ The ABC analysis is a business term used to define an inventory categorization technique often used in materials management http://en.wikipedia.org/wiki/ABC_analysis

though some issues such as cooperation and communication between national departments and national and local departments mitigate the achievements.

3.7 Annex

3.7.1 Key documentation used for the analysis

3.7.1.1 Project documentation of main interventions

Intervention	TAP	Evaluation	ROM	Progress (MTR)	Final reports/other
Philippine Health Sector Policy Support Programme (ASIE/2005/017-638)				MTR 2009	HSPSP Final Report, 2010
Mindanao Health Sector Policy Support Programme (MHSPSP) (ASIE/2006/018-016)			MR-118122.01 03/04/2009	MHSPSP MTR – Final Evaluation Report Philippines, November 2010 MHSPSP six month report January 2009 MHSPSP 6 th Six Month Report August 2010 – January 2011 MHSPSP 7 th six month progress report February 2011 – July 2011	
Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao" (REH/2005/017-108)					
Contract 172232, Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH) (DCI-NSAPVD/2007/019-404)					

3.7.1.2 EC documentation on the health sector in the country

Source	Explored
CSE	DONE
EAMR	DONE
Country note from old health evaluation	Not available
CSP	
Mid-Term Review Consultation of the Philippines Country Strategy Paper 2007-2013	DONE
First Phase of the Evaluation of the	DONE

Implementation of the Paris Declaration, Country Level Evaluation, Philippines	
Philippines Health Sector Reform Project Report 2007-2009	DONE

3.7.1.3 Bibliography

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Mid-term review of the Health Sector Policy Support Programme, Final report, January, 2009, p. 7-9.

7th National Nutrition Survey. 2008, <http://www.sph.emory.edu/wheatflour/ttsgpublic/NNS.pdf>

Acronym that stands for Mindanaos four provinces and one of its cities: South Cotabato, Cotabato, Sultan Kudarat, Sarangani and General Santos City

Council for Health and Development (2009) Bringin Health into the People's Hands – Aid to Uprooted People (Philippines), April 2006-March 2009

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European Commission(2011) Evaluation of the European Commission cooperation with the Philippines, Final Report, June 2011

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Evaluation of the European Commission's Cooperation with the Philippines, Final Report, Volume 1, June 2011

Extracted from the: Interim Report 5 v3 (1st August 2009 - 31st January 2010), Report to the Delegation of the European Commission of the Philippines. Contract No. 2006/132479, TA to the Health Sector Policy Support Program; and Interim Report 2 (1st January - 1st July 2008), Report to the Delegation of the European Commission of the Philippines. Contract No. 2006/32479, TA to the Health Sector Policy Support Program; and MID-TERM REVIEW OF THE HEALTH SECTOR POLICY SUPPORT PROGRAMME (ASIE/2005/017638) In the Philippines, FINAL REPORT, January 2009

Extracted from the: MID-TERM REVIEW OF THE HEALTH SECTOR POLICY SUPPORT PROGRAMME (ASIE/2005/017638) In the Philippines, FINAL REPORT, January 2009, p.7

Extracted from the: Mindanao Health Sector Policy Support Programme (MHSPSP) Mid-Term Review, EC ref n°: 2010/244731 FINAL EVALUATION REPORT. Philippines, November 2010.

Final Report (2010) Technical Assistance to the Health Sector Policy Support Programme (EC-TA HSPSP), covering the period 1st February 2007 to 31st December 2010 Contract No. 2006/32479,

From the 1st SONA of President Benigno S. Aquino III, 26 July 2010

Human Development Sector Unit East Asia and Pacific Region, WB Philippines' Health Sector Review, Draft May 2010

ILO Subregional Office for South East Asia. Philippines: Extension of Social Health Insurance Coverage to Workers in the Informal Economy Through Organized Groups, <http://www.ilo.org/public/english/region/asro/bangkok/events/sis/download/paper27.pdf>

MID-TERM REVIEW OF THE HEALTH SECTOR POLICY SUPPORT PROGRAMME (ASIE/2005/017638) In the Philippines, FINAL REPORT, January 2009

Mindanao Health Sector Policy Support Programme (MHSPSP) Mid-Term Review EC ref n°: 2010/244731, FINAL EVALUATION REPORT, Philippines, November 2010, pp.5,6,20.

MHSPSP TA six month report 2009

MHSPSP TA 6th six month report July 2010 – February 2011

MHSPSP TA 7th six month report February 2011 – July 2011

National Health Insurance Act of 1995, [Republic Act No. 7875] <http://www.doh.gov.ph/ra/ra7875.html>

National Statistical Coordination Board, http://www.nscb.gov.ph/secstat/d_vital.asp

National Statistical Coordination Board, Philippine National Health Accounts (PNHA), Health Care Financing Indicators, <http://www.nscb.gov.ph/stats/pnha/2007/targethealth.asp>

National Statistics Office (NSO) [Philippines] and ICF Macro. 2009. National Demographic and Health Government hospital data also showed that less than 50% of admitted patients in 2007 to the first 3 quarters of 2008 were PhilHealth members, refuting claims of near-universal coverage of the poor in the provinces. insufficient coverage, delays of payment, poor advertising of rights on services and high out-of-pocket payments have led to widespread dissatisfaction with PhilHealth among provincial governments.

Report to the Delegation of the European Commission to the Philippines, Technical Assistance to the Health Sector Policy Support Programme (No. 17638) Contract N° 2006/132479, Interim Report 2 (v.2-final) (1st January – 31st July 2008), p.51

Report to the Delegation of the European Commission to the Philippines, Contract No. 2006/32479, Technical Assistance to the Health Sector Policy Support Program (EC-TA HSPSP), Interim Report 5 v3 (1st August 2009 – 31st January 2010), pp. 44, 53

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Philippine statistical yearbook 2006. National Statistics Office, quoted in: Ronaldo D. Ico. 2007. Catastrophic Health Care, Poverty and Impoverishment in the Philippines, A paper submitted to the University of the Philippines School of Economics in partial fulfilment of the requirements for the degree of Master of Arts in Economics, p.21.

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Stella Quimbo, Jhiedon Florentino, John W. Peabody, Riti Shimkhada, Carlo Panelo and Orville Solon. 2008. Underutilization of Social Insurance among the Poor: Evidence from the Philippines. PLoS ONE. 2008; 3(10): e3379, doi: 10.1371/journal.pone.0003379

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3.7.1.4 Weblinks

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http://databank.worldbank.org/ddp/editReport?REQUEST_SOURCE=search&CNO=2&country=&series=SH.STA.BRTC.ZS&period=

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<http://www.countdown2015mnch.org/documents/2010report/Profile-Philippines.pdf>

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<http://www.measuredhs.com/what-we-do/survey/survey-display-227.cfmshow>

http://www.philhealth.gov.ph/about_us/statsncharts/snc2010.pdf

<http://www.scribd.com/doc/13885214/The-Fourmula-One-for-Health-DOH>

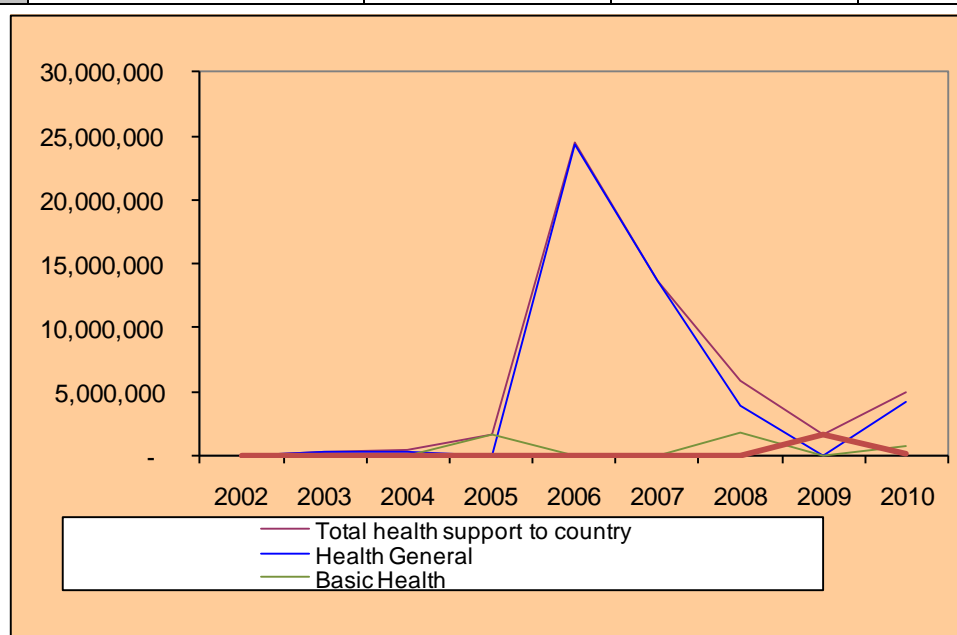
<http://www.who.int/whr/2004/annex/country/phl/en/> , accessed Sep.2011

<http://www.wpro.who.int/NR/rdonlyres/86EB3F01-53A8-4B7F-A506-907B6568CCFA/0/30finalPHLpro2010.pdf>

3.7.2 EU funds between 2002-2010 –detailed listing:

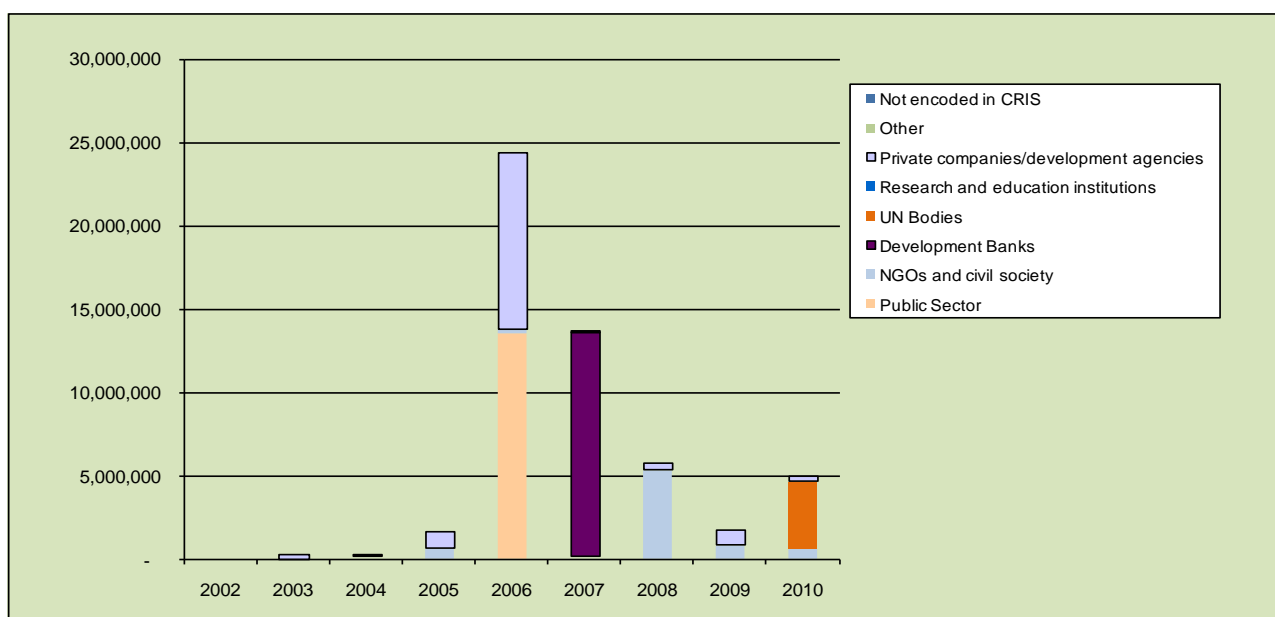
3.7.2.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to the country check
2002	-	-	-	-
2003	221,939	-	-	221,939
2004	305,708	-	-	305,708
2005	-	1,634,752	-	1,634,752
2006	24,398,371	4,900	-	24,403,271
2007	13,618,816	-	-	13,618,816
2008	3,952,639	1,837,274	-	5,789,913
2009	-	60,000	1,641,860	1,701,860
2010	4,166,700	684,746	71,384	4,922,830
Total	46,664,174	4,221,672	1,713,244	52,599,090



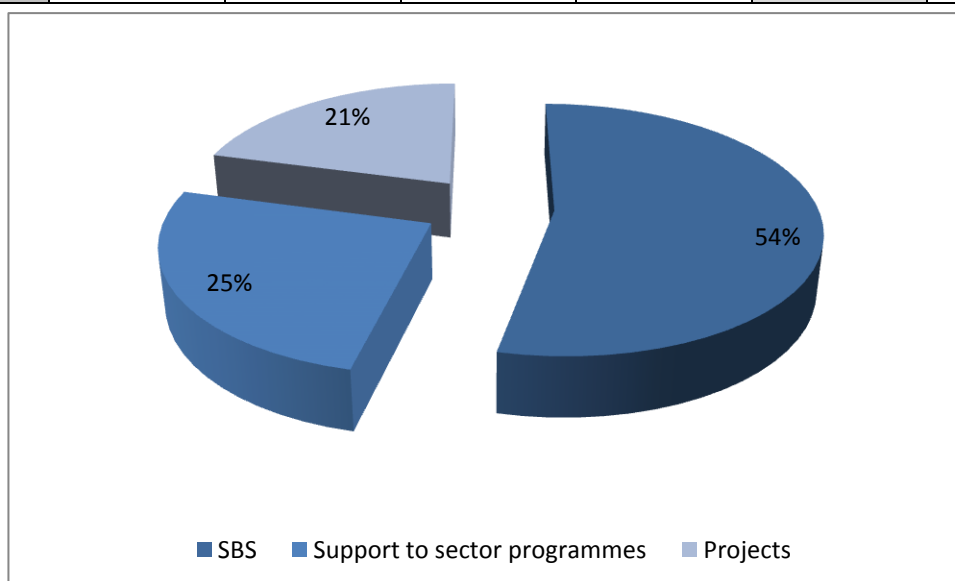
3.7.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	-	-	-	0
2003	-	-	-	-	-	221,939	-	-	221,939
2004	-	143,071	-	-	-	162,638	-	-	305,708
2005	-	638,494	-	-	-	996,258	-	-	1,634,752
2006	13,500,000	315,551	-	-	-	10,587,720	-	-	24,403,271
2007	-	126,438	13,450,000	-	-	42,378	-	-	13,618,816
2008	10,330	5,343,100	-	-	-	436,483	-	-	5,789,913
2009	60,000	791,860	-	-	-	850,000	-	-	1,701,860
2010	75,000	580,860	-	4,000,000	-	266,970	-	-	4,922,830
Total	13,645,330	7,939,375	13,450,000	4,000,000	0	13,564,385	0	0	52,599,090



3.7.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	-	-	-	-
2003	-	-	221,939	-	221,939	-
2004	-	-	305,708	-	305,708	-
2005	-	-	1,634,752	-	1,634,752	-
2006	24,068,496	-	334,775	-	24,403,271	-
2007	-	13,450,000	168,816	13,450,000	13,618,816	-
2008	3,810,704	-	1,979,209	-	5,789,913	-
2009	60,000	-	1,641,860	-	1,701,860	-
2010	241,700	-	4,681,130	-	4,922,830	-
Total	28,180,900	13,450,000	10,968,190	13,450,000	52,599,090	-



3.7.3 Overview of funds committed to the country's health sector

3.7.3.1 Main health programmes in the country

Database - Decisions 99-10.Title	Database - Contracts 99-10.Title	Database - Decisions 99-10.Decision No	Contract number	Contract year	Contracted amount
Philippine Health Sector Policy Support Programme	Budgetary Support to Selected LGUs	ASIE/2005/017-638	124524	2006	13.500.000€
	Financial Audit of the Philippine Health Sector Policy Support Programme	ASIE/2005/017-638	208150	2009	60.000€
			241080	2010	75.000€
	Health Sector Policy Support Programme (ASIE/2005/017638): Mid-Term Review	ASIE/2005/017-638	164064	2008	147.274€
	Interim Support Services to the Department of Health for the management of the EC health sector support	ASIE/2005/017-638	124779	2006	169.216€
	Technical Assistance to the Health Sector Policy Support Programme in the Philippines	ASIE/2005/017-638	132479	2006	10.399.280€
Mindanao Health Sector Policy Support Programme (MHSPSP)	Mindanao Health Sector Policy Support Programme (MHSPSP) Mid Term Review	ASIE/2006/018-016	244731	2010	166.700€
	National Human Resource for Health Forum - Manila, Philippines	ASIE/2006/018-016	169879	2008	10.330€
	Technical Assistance to Mindanao Health Sector Policy Support Programme of the Philippines	ASIE/2006/018-016	147653	2008	3.653.100€

Contracts that are related to both HSPSP and MSPSP

MULTI	Donor Trustfund for Health Sector Reform <i>From which: 6,75 million to HSPSP and 6,7 million to MSPSPS</i>	MULTI	132541	2007	13.450.000€
MULTI	EC Support to Health Sector Reform - Information, Communication and Visibility Plan (ICVP) - PR Agency <i>From which: 0,2 million to HSPSP and 0,1 million to MSPSPS</i>	MULTI	170528	2008	289.209€

3.7.3.2 Small health interventions

Database - Decisions 99-10.Title	Database - Contracts 99-10.Title	Database - Decisions 99-	Contract number	Contract year	Contracted amount
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		10.Decision No			
Framework Contracts Dev. Coop.in Asia	Health programme Philippines - pre-identification mission	ASIE/2000/002-965	59751	2003	159.857€
	Identification Mission Health Programme-Philippines	ASIE/2000/002-965	64056	2003	62.082€
NA	Health Sector Reform Programme - Public Finance Management start up TA	MULTI	97010	2004	162.638€
Framework Contract AMS/451 - Dev. Co-operation - Philippines	Philippines: Formulation Mission Health Sector	ASIE/2003/005-022	96849	2004	143.071€
pré-engagement dont dépendront les contrats PVD projets	Preventing HIV/AIDS among adolescents in the Philippines by building capacity of youth councils to engage in local decision-making processes on the rights of adolescents to sexual and reproductive health	ONG-PVD/2004/006-239	110816	2005	638.494€
Aid to Uprooted People in Asia- Call for Proposals- Philippines	"Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao"	REH/2005/017-108	111156	2005	996.258€
EU-Philippines Economic Co-operation Small Projects Facility	Developing a local monitoring system on the Millennium Development Goal 5, Target 8: Increase access to reproductive health services to 80% by 2010 and 100% by 2015	ASIE/2002/002-472	112064	2006	146.335€
OPERATIONAL SHORT TERM TECHNICAL ASSISTANCE RELATED TO THE FINANCIAL AND TECHNICAL COOPERATION WITH DEVELOPING COUNTRIES IN ASIA	Health sector support - Procurement and warehousing, phase 2	ASIE/2005/016-885	120455	2006	183.540€
	Support to the Formulation of the EC Supplemental HSPSP in the PH	ASIE/2005/016-885	123037	2006	4.900€
DCI-NSA Support measures 2007 not covered by strategy papers	Audit of ChristianAid's ONG/PVD Programme for Rehabilitation & Development in Mindanao	DCI-NSA/2007/019-144	141917	2007	42.378€
Operational short-term TA related to Financial and Technical Co-operation with Asian developing countries	Support to government's capacity development for the appraisal of Provincial Investment Plans for Health in reform roll-out provinces	ASIE/2006/018-300	145390	2007	126.438€
Global commitment for global multi-country calls for proposals - Objective 1 - PVD projects - Non State Actors -	South-Eastern Philippines Health and Economic Alternatives (HEAL) Project	DCI-NSAPVD/2007/019-406	172224	2008	700.000€

AAP 2007					
Global commitment for in-country and multi-country calls for proposals - Objective 1 - PVD projects - Non State Actors - AAP 2009	Enhancing maternal health services to selected underserved sectors in Eastern Visayas through the Cooperative Enterprise System	DCI-NSAPVD/2009/02 1-105	231290	2010	580.860€
	Strengthening Local Response for Improved Access to family Planning	DCI-NSAPVD/2009/02 1-105	226790	2009	791.860€
Global commitment for local calls for proposals Objective 1 - PVD Projects - Non State Actors - AAP 2007	Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH)	DCI-NSAPVD/2007/01 9-404	172232	2008	990.000€
NA	Integrating Population, Reproductive Health and Coastal Resources Management Actions in Tawi-Tawi, Mindanao, Philippines	(blank)	226549	2009	850.000€
Operational Short-Term Technical Assistance Related to the Political, Economic, Cultural, Financial and Technical Cooperation with Developing Countries in Asia	A FINANCIAL & SYSTEMS AUDIT CONCERNING ""SOUTH-EASTERN PHILIPPINES HEALTH AND ECONOMIC ALTERNATIVES (HEAL) PROJECT""	DCI-ASIE/2009/021-502	248167	2010	28.886€
NA	Early Recovery and Rehabilitation for Central Mindanao	(blank)	256456	2010	4.000.000€

3.7.4 Description of main EC intervention

3.7.4.1 Intervention no 1: THE HEALTH SECTOR POLICY SUPPORT PROGRAMME (HSPSP); (ASIE/2005/017638, Project period 2006-2010, SBS,

Budget: 49.6 million of which EC contribution 33.0 million (inc. 9,9 million TA, 13,5 million Budget Support and 6,75 million contribution to WB trust fund), Government¹⁶²: 8.3, WB: 8.3¹⁶³)

Start and end date: 2006-2010

Objectives and expected results

The Health Sector Policy Support Programme (HSPSP) is a 4-year programme. The HSPSP is implemented within the sector approach, pursued by the Philippine Government under its "Sector Development Approach for Health (SDAH)" strategy and is emphasising coordination and complementarity with donor partners as well as the harmonisation of aid which is in line with the Paris Declaration. The programme supported 16 provinces and the DOH.

The HSPSP is in accordance with the EU's commitment to the MDGs and is fully consistent with the poverty reduction of the EU development policy.

The overall **objective** of the HSPSP is "To contribute to the overall improvement of the health status of the population especially the poor, the women and other vulnerable groups to achieve health-related Millennium Development Goals (MDGs)."

The overall **purpose** was "increased utilisation of affordable and financially sustainable, quality essential health services and population programmes by the poor, based on progressive implementation of the government's sectoral reforms". #

In order to achieve the goals following indicators were selected for monitoring: e.g. increased drug availability; reduced drug prices; increased enrolment in the social health insurance (SHI) scheme; reduced share out-of-pocket expenditures in health; and improved health related MDGs. The HSPSP does not attempt to address the whole HSRA but to focus on key reform targets in the areas of good governance, health financing, health services delivery and regulation, specifically of drugs and medicines.

Expected results:

HSPSP formulated main **Results** are:

- improved financial sustainability of national health insurance and extended insurance cover of the poor; (
- improved governance, operational efficiency and service provision in public hospitals;
- increased utilisation of cost-effective public health programs and primary health care services;
- improved quality, accessibility and safety of health care related products, facilities and services; and
- improved governance in the health sector through: more efficient local health systems based on Inter-Local Health Zones and partnerships with the private sector;
 - increased public accountability;
 - improved health sector planning, monitoring and evaluation;
 - increased efficiency and effectiveness of public health spending; and
 - improved public finance management.

The major findings and recommendations of the Mid-Term Review of the year 2009 are: the validity and relevance of the HSPSP programme design; the preparation of the Provincial Investment Plans for Health (PIPH) at the local level; development of a plan to rationalise the network of health facilities

¹⁶² Government at central and local levels will also contribute to the programme through their regular budget.

¹⁶³ The World Bank budget support to the DoH is still under appraisal and negotiation and thus the amount might change. As of today up to USD 10 million of the total loan estimated at USD 60 million could be pooled with the EC grant in the multi donor trust fund. The Current exchange rate is € 1 = US\$ 1.205

in the province; highly centralised programme; and that due to this problem the provinces were not able to show much progress in terms of programme implementation.

Activities:

In line with the devolution concept and the thrust towards a sector approach, activities at LGU level are not prescribed; they will be funded based on plans to be submitted by LGUs and approved by the multi-donor Joint Appraisal Committee.

Social health insurance, drug management and drug regulation, the strengthening of health infrastructure in line with accreditation standards, systems development and capacity building will be the core activities which will be **made possible by the EC support**.

These activities will be supported **by long term technical assistance** posted at **central and local levels** and by **short term technical assistance** focussing on **capacity building and facilitating implementation**.

The first months of the programme, until December 2006, will be devoted to preparatory activities, like baseline data collection/updating in the participating provinces, rolling of provincial plans already being designed with support from the EC-funded Start Up TA and other donors, poverty mapping exercise, PFM priority actions, design of provincial training plans and stakeholder consultation for hospital rationalisation aiming at ensuring optimal coverage of referral services through the development of strategically located hospitals and partnerships with the private sector.

A Activities at local level

Adaptability is recognised as a key feature of a reforming system and the programme provides flexibility in order to ensure the autonomy of each of the participating provinces in their approaches to reform implementation. The provinces are at different levels of development, resource availability, absorption capacity and competence and it is important to acknowledge that they will take different approaches to the HSRA process and will progress at different paces. In line with the devolution concept and the thrust towards a sector approach, the interventions at the local level are not prescribed; they will be funded based on plans submitted by local government units and approved by a Joint Appraisal Committee, which will examine them based on adherence to HSRA principles and jointly defined reform and spending priorities. A policy dialogue with the respective provinces will be undertaken to ensure that pro-poor objectives will be pursued in its planning and investments activities to improve the provision of basic health services. Activities at the local level will be defined in the Memoranda of Agreement signed between the DOH and the concerned provinces, in consultation with the other donors involved in the programme.

B Activities at central level

1) At the Department of Health

- Development of guidelines and policy for allocation and use of grant funds by DOH to LGUs to achieve HSRA and wider health policy objectives.
- Consolidation of PhilHealth outpatient benefit package into a cohesive PHC package and implementation of the package in all provinces.
- Boosting enrolment into PhilHealth to broaden the risk base, specifically within the formal sector.
- Strengthen DOH capacity to lead the sector programme.
- Implementation of guidelines, prepared by the Philippines Academy of Family Physicians, for appropriate referral between primary and secondary care (two-way) and promotion of these to clinicians.
- Strengthen BFAD regulatory capacity for enforcement of cGMP accreditation for manufacturers, importers, distributors.
- Develop HR and management / financial reforms for BFAD.
- Support legal reforms at BFAD;
- Publish primary care level therapeutic formulary manual based on EDL.
- Regular publication of the National Drug Price Reference Index for drugs in PHC formulary.
- Support expansion of HealthPlus pharmaceutical distribution system.
- Develop generic performance indicators and monitoring framework for HSRA implementation.

- Strengthen financial management capacity of DOH, notably through the development of a comprehensive and integrated financial management information system.
- Strengthen procurement, logistics and warehousing capacity in DOH.
- Support the development of standard technical specifications for medical supplies, equipment and drug procurement.
- Provide training in financial management and procurement to operational staff as well as budget managers.
- Contribute to the development of a comprehensive Medium Term Health Sector Strategic Plan for 2007-2010.
- Contribute to the development of a sectoral MTEF for 3 years 2007-2009.
- Contribute to the development of a MOU and Code of Conduct between the DOH and donor partners and to the establishment of joint review and reporting mechanisms.

2) At the Department of Budget and Management

- Support the automation of the MTEF at the oversight level (DBM) complementary to the technical assistance provided by the WB.
- DBM's assistance to the formulation of DoH's sector MTEF and its linkage to the national MTEF mentioned above.
- Support the full development of Organisational Performance Indicator Frameworks (OPIF) at DOH and in other departments part of the initial submission to Congress. This would notably include the
 - a) Finalisation of OPIF' budget of DOH and other departments through a review of issues and concerns related to performance measurement, target setting, etc
 - b) Management of these departments overall adoption of OPIF, including regions, attached agencies and hospitals (for DOH) which include work on structural, procedural and operations requirements (cascading of MFOs to lower level units including Regional Offices)
 - c) Documentation of the OPIF work in the whole of DOH and other departments, to showcase an OPIF working model
- Incremental Operating Costs for project management. Related miscellaneous expenses for effective management by DBM PMO, GPS, ROCs and DBM concerned Regional offices, including communications services, travel, per diems for field monitoring costs at LGU level; additional technical staff if the magnitude of the work so requires it.

3.7.4.2 Intervention no 2: MINDANAO HEALTH SECTOR POLICY SUPPORT PROGRAMME (MHSPSP)

ASIE/2006/018-016

Budget: 12 million Euro, 4 million TA, 6,7 million : contribution to WB trust fund €

Start and end date: 2006-2012

Objectives and expected results

The MHSPSP follows the approach and purpose of the HSPSP programme summarised above. It is implemented in 14 regions in Mindanao including the Autonomous Region of Muslim Mindanao (ARMM). The target regions are specified being in terms of health and poverty indicators far below the national average. The MHSPSP follows a project-oriented approach aimed at preparing institutional beneficiaries for fully-fledged sector support at a later stage. As such, it was designed as a pre-SDAH accession programme. The project consists of two elements, a TA component and a grant contribution implemented through an Administration Agreement with the WB.

The MHSPSP also fully contributes to poverty reduction by assisting LGUs to identify indigent families and to enrol them in Philippine Health Insurance Cooperation (PhilHealth).

Overall objective: To contribute to the overall improvement of the health status of the population especially the poor, the women and other vulnerable groups and to the achievement of health-related Millennium Development Goals (MDGs) in the Mindanao's Conflict-Affected Areas (CAAs) and the ARMM.

Specific objective: Increased utilisation of improved priority primary health facilities, through a pre-SDAH accession programme implementing selected, doable elements of government's health sector reform.
Expected results:

5. Governance

Overall capacity of regional, provincial and municipal governments and other relevant institutions with respect to health governance strengthened, including:

6. Financing
 - Increased enrolment of indigents into PhilHealth, based on formal poverty mapping
 - Increased resources for RHUs from PhilHealth Capitation fund
 - Increased allocation to health sector by LGUs
7. Regulation
 - Improved access to enhanced sustainable drugs supply
8. Health Service Delivery
 - Increased number of RHUs accredited for the Outpatient Benefit Package, Emergency Obstetric Care and TB DOTs
 - Strategically located Barangay Health Stations developed
 - Innovative approaches to primary health care delivery tested, documented and advocated

3.7.4.3 Intervention no 3: Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao

(REH/2005/017-108, Contract 111156, project period 2006-2009)

Budget:

Start and end date: 2007-2009

Objectives and expected results:

This project is a three-year project started in 2006 and terminated in 2009. The project was designed to contribute in improving the health condition of the displaced communities and uplifting the health status of more than 12,753 Moro people, Christian, Lumads, Subanens, Manobos and other indigenous peoples in the conflict areas of Mindanao. Thus, the project aimed ultimately improving life conditions and well-being. It was implemented in 43 villages in 27 municipalities in 14 provinces in 5 regions of the Mindanao Island. The Bringing Health into the People's Hands project consisted of three integrated components (food production and livelihood improvement, health and nutrition improvement and capacity building) and various activities contributing towards an improved health condition for the beneficiary communities.

The major accomplishments of the project were: completion of 43 batches of Basic Health Sills Levels I, II and III Trainings were 893 community health workers acquired basic skills in higher level of health skills and anatomy and physiology, common diseases and pharmacology; formation of 43 community health committees and 143 health teams; conduct weight monitoring, feeding programmes and nutrition classes; construction of 15 community clinic and simple laboratories in the 13 project provinces; and construction of potable water systems.

The project's activities were successfully carried out but with problems that caused serious delays in particular in the first two years of the project (armed conflicts, natural disasters, economic difficulties in the region causing migration).

3.7.4.4 Intervention no 4: Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH)

(DCI-NSAPVD/2007/019-404, Contract 172232).

Budget:

Start and end date: 2007

Objectives and expected results:

Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH) project is a five-year project commencing in March 2009 and implemented by the Women's Health Care Foundation, Inc (WHCF). under a grant from the EC. Its overall objective is "to ensure access on sexual and reproductive health and rights information and services of women, men and young people in initially seven (7) communities in Metro Manila through the involvement of the community and local government."

According to the Monitoring Report of the year 2011 the project is still behind schedule. It has further organisational problems (high turn-over of staff and volunteers), the logframe has significantly to be revised and it is unlikely that the livelihood component will manage to properly cater for the planned 20,000 beneficiaries.

4 Annex 15: Country case study Lao PDR

***Thematic evaluation of
the European Commission support
to the health sector***

Country case study

LAO PEOPLE'S DEMOCRATIC REPUBLIC
(LAO - PDR)

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4.1 Introduction

4.1.1 Country context of EC support

The Lao People's Democratic Republic (Lao PDR) is a land-locked country situated in Southeast Asia bordering China, Myanmar, Thailand, Cambodia and Vietnam. The total population is of 6.1 million (2009) covering an area of 236,880 sq. km. Lao PDR is still one of the world's least developed countries. About 73% of the population is living on less than USD 2 a day and 25% live on less than USD 1 a day. Mountainous terrain, a highly diverse population with different ethnic groups and languages and extreme poverty all pose serious challenges for the government in its efforts to address the health needs of the people.

However, despite all constraints, Lao PDR has made great progress to promote health care services to the Lao people, nationwide. During 35 years after the revolution, there is evidence of increase in health awareness of the populations, resulting in improvement of the sanitation system, family planning coverage, HIV/AIDS and sexual transmitted diseases prevention, identification and treatment of tuberculosis cases and utilisation of treated mosquito bed net. The health care utilisation has also been continually increasing. The major achievements include 67% immunization coverage and 95% coverage of measles vaccination during mass campaign, 74% accessibility to safe water, 54% utilization of latrine and improvement of quality of health care services at all levels. Central hospital, regional hospital and provincial hospital has been gradually modernized providing advanced medical health care services e.g. laparoscopy surgery, orthopaedic surgery, brain surgery, cardiovascular surgery, haemodialysis (kidney failure), molecular laboratory, ultrasound, scanner, etc.

From 1995 to 2008, life expectancy of the Lao people has increased from 51.0 years to 65.2 years, infant mortality rate was reduced from 102 per 1,000 live births to 42; under five mortality was decreased from 128 to 73, maternal mortality was decreased from 650 per 100,000 live births to 339¹⁶⁴. MDGs for the health sector show a positive trend, but at a slower pace than projected. Still the progress as it is now will not be fast enough to achieve the relevant Millennium Development Goals by 2015 especially MDG 1 and MDG5¹⁶⁵.

In the Lao MDG Road Map, the target of reducing maternal mortality by three-quarters is assessed as "off track" and the target on universal access to reproductive health as "seriously off track."¹⁶⁶ There are remarkable disparities between urban and rural areas in access to basic health services. 51% of urban pregnant women gave birth at health facilities whereas 87% of women in rural with road and 96.5% women in rural without road gave birth at home. The contraceptive prevalence rate was 44.7% of married women in urban, 36% of women in rural with road and 25.6% of women in rural without road. Immunization has played an important role in Lao PDR in reducing the morbidity and mortality rate of women and children. Lao PDR was declared polio-free in 2000. However, the reported national immunization coverage rates for all antigens have not improved greatly within the last ten years. Although the routine coverage is low, the country has had better success with supplementary immunization activities (SIA) for polio and measles where very high coverage (96% for 2007 national measles campaign for children nine months-15 years and 91% for OPV SIA in 2009). Lao's National Immunization Program (NIP) faces several challenges in improving access and quality of immunization services due to the difficult geographical and, climatic conditions, scattered ethnically diverse population, inadequate financing and shortage of skilled human resources both at management and at service delivery level. One of the most important obstacles is absence of routine vaccination services at health centres and district hospitals (fixed sites) and the almost exclusive reliance on the delivery of immunization services through four annual rounds by outreach and mobile teams.

Important national health plans and programmes with chapters on health are: The Health Strategy to the Year 2020; The National Health Development Plan; The Sixth National Socio-Economic Development Plan (NSED 2006-2010); The Seventh National Socio-Economic Development Plan (2011-2015); the 2007 Primary Health-Care Policy of the Ministry of Health (MoH); The National Strategy for Malaria Control and Pre-Elimination 2011-2015; National Reproductive Health (RH) Policy

¹⁶⁴ IHME and The Lancet.

¹⁶⁵ The MDG targets for Lao PDR by the year 2015 are: Maternal Mortality Rate = 260 per 100,000 live births (MDG 5), Under-five mortality = 55 per 1,000 live births (MDG 4), IMR = 45 per 1,000 live births (MDG 4) and Reduce prevalence of malnourished under-five children by one quarter between 2005 and 2010 (MDG 1). (Source : MNCH Strategy).

¹⁶⁶ Millennium Development Goals Progress Report: Lao PDR, 2008.

2005; The 1999 National Population and Development Policy (NPDP), revised in 2006; The National Health Information System Strategic Plan 2009-2015; and The Strategic and Planning Framework for Integrated Maternal, Neonatal and Child Health Services 2009-2015. The National Health Financing Strategy and The National Strategy for Rural Water Supply and Environmental Health are under revision.

Health care issues cannot be dissociated from the pervasive public financial management issues that are now being addressed in the context of General Budget Support. The weaknesses in public financial management translate into inadequate health budgets in poor provinces and districts. The ratio of recurrent expenditure to capital spending, much of the latter financed by donors, is insufficient. The result is low salaries, poor equipment and inadequate maintenance. Health expenditure overall is very low and any growth that has occurred has been because of growth in private, out of pocket spending. Public health expenditure, because it tends to go to hospitals instead of clinics, is slanted towards the well to do, not the poor. Lack of household resources is as much a barrier to access to health care as is the lack of infrastructure. Overall, health care financing has been one of the most problematic areas in health, with no overall strategic vision or plan having emerged to date.

The Delegation is increasingly developing synergies between its activities conducted under the MIP and those implemented under thematic budget lines. Meetings, exchanges and workshops are regularly organised, or planned, with partners in Lao to optimise the EU assistance to Laos.

4.1.2 EU funds between 2002-2010

Overview of past and ongoing EC cooperation

EC assistance to Lao PDR started during the early 1990s when the main priorities were rural development, urban development and support for refugees returning from Thailand. The CSP 2002-2006 expanded the scope of cooperation to social sectors (education and health) and trade, while maintaining the focus on rural development as the main area of support. Governance was identified as a cross-cutting issue. For 2002–2004, the EC committed EUR 14 million, with EUR 5 million allocated for rural development, EUR 6 million for the education sector and the remainder for trade and governance respectively. In 2005–2006 a further EUR 4 million was allocated to strengthen the Lao small and medium-sized enterprise (SME) sector (EUR 3 million) and to promote good governance (EUR 1 million) in the field of legal reform, notably the adoption and enforcement of international legislation, support for the decentralisation process and freedom of expression. The overall amount of EC development aid to Lao PDR in 1993-2006 was approximately EUR 100 million.

Overall, the ongoing projects have a value of EUR 57 million, with rural development and food security projects making up some two thirds of the EC project portfolio. NGO implemented projects in food security and rural development, health, UXO clearance and basic education account for approximately 20% of past projects. In the same period, there were 14 Asia-wide projects with components affecting Lao PDR under implementation, as well as 10 projects under horizontal/thematic budget lines, bringing the volume of the existing portfolio for Lao PDR to **EUR 61 million**. Moreover, EUR 3 million has been allocated for Lao PDR and Cambodia for a direct aid regional food security programme and a further EUR 2 million for a call for proposals also divided between Lao PDR and Cambodia. ECHO and DIPECHO have funded 14 projects worth EUR 2.8 million in 2002-04 and six projects worth EUR 1.9 million in 2005. New ECHO funding in Lao PDR for 2006 amounts to EUR 2.1 million.

Programmes of EU Member States and other donors:

The key aspects of development assistance programmes in Lao PDR were anchored to the National Development Strategy and the Government's reform agenda. Reform of Public Finance Management (PFM) is one important area where several donors – most notably the WB, the ADB, the IMF, the JICA, the UNDP, SIDA and the EC – were/are involved. So far technical assistance in this area has been provided by the JICA (fiscal policy), SIDA (tax issues), France (customs and accounting), the WB (capacity building and fiscal policy), the UNDP (customs and PFM reforms at local government levels), the IMF (macro-economy) and the **EC (capacity building, budget process and fiscal policy)**. In November 2005, the Government launched a Public Expenditure Management Strengthening Programme (PEMSP) and set up a multi-donor trust fund to support its implementation. This is a fully government-owned programme and it is expected that the PEMSP will bring most of the donor-funded technical assistance under a single strategic reform framework in the PFM area. Another important instance of cooperation is the Public Expenditure Review (PER), which in 2005-06 has been a joint effort between the World Bank, the ADB, the IMF and the EC.

Among EU Member States, the top donors are France, Germany and Sweden. Belgium and Luxembourg also have bilateral development programmes. ECD and EU Member State fund accounts for some 25% of total assistance (loans and grants) to Lao PDR.

EC funds to the health sector

The EC support to the health sector has been limited. The **direct health component** of EC support to the Government of Lao PDR was discontinued in the NIP 2005-2006 due to “limitations in the budgetary envelope for the period of the NIP 2002-2004” (NIP 2005-2006). Only small NGO co-financing health projects and projects under the Global Fund umbrella were carried on in 2003 and afterwards. NGO projects targeted particularly vulnerable populations, basic health care remains inaccessible to a large proportion of the rural population, especially ethnic minorities and women (CSP 2007-2013).

According to the CSP 2007-2013 (p.19), EC cooperation in Lao PDR is phasing out specific support for “the health sector (high concentration of donors, little added value from our contribution). However, we will continue to support health projects through our contribution to the Global Fund.”¹⁶⁷

The EU Delegation of Lao PDR launched on 31st of September 2011 on its website that the EU will support health sector development in Laos. The EU provided a grant of EUR 3 million to fund a health project that will support capacity development in the provincial and district laboratories in Lao PDR to detect and control infectious disease outbreaks.

Table 19: EC contribution per sector, modality and channel - per Subsector in Euro

Year	Total health support to country	Health General	Basic Health	SRH
2002	49,426	49,426	-	-
2003	580,708	-	580,708	-
2004	869,745	119,745	-	750,000
2005	-	-	-	-
2006	-	-	-	-
2007	727,500	-	727,500	-
2008	503,112	36,300	466,812	-
2009	1,577,097	455,701	1,121,396	-
2010	-	-	-	-
Total	4,307,588	661,172	2,896,416	750,000

Source: CRIS database analysis, Particip GmbH

4.2 EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services?

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

Indicators

- I-111 National health policies guarantee access to drugs, officially recognised as essential
- I-112 Average availability of selected essential medicines in public and private health facilities, including pharmacies

4.2.1.1 Findings per indicator

I-111 All main health national policies guarantee access and utilisation of essential drugs in the country. The national health priorities are articulated in: (1) the 20-year Health Strategy to the Year 2020 (2000); (2) the Lao Health Master Planning Study (2002); and (3) the National Growth and Poverty Eradication Strategy (NGPES, 2001). The principles and visions of these documents, including access and use of essential drugs – as per WHO recommendation - have been included in the sixth five-year NSEDP (2006-10) and further improved with the current seventh NHSDP (2011-15) All of these have been developed by the Ministry of Health in consultation with development partners.

The 2000 revised national medicines policy in the Lao PDR aims to improve access to essential medicines through revolving funds. These funds exist at all levels of the health system: hospital, health centre and village. They are integrated with Ministry of Health directives and conform to the national

¹⁶⁷ EUR 40 million will be available in 2005-09, for Lao PDR among other countries. In 2003-05, the Global Fund made specific grants to Lao PDR of the order of EUR 23 million and a further EUR 15 million is expected to be committed in 2006, subject to positive performance in ongoing project implementation. The EC's share is around 6% of the total.

essential medicines list; follow the practices of rational medicine use; and assure medicine quality, prices and services. Revolving funds should not generate profit; the customer charge is 125% of cost and the funds are managed by local health staff. The Food and Medicine Directorate in the Ministry of Health has responsibility for revolving funds management. In August 2001, revolving funds were in place in 94% of hospitals, 83% of district hospitals, 86% of health centres and 11% of villages. The extent of revolving funds in remote areas needs to be determined (the aim is to reach 5000 villages). Financing is from users, the government and donors, but many funds find it difficult to replenish their resources.¹⁶⁸

There is no evidence of EC interventions supporting national government and ministries in formulating and implementing policies guaranteeing access to drugs to be found in relevant documents.

I-112 National data on the subject are not available. However a study of January 2011 on “Availability of essential drugs and sustainability of village revolving drug funds in remote areas of Lao- PDR”¹⁶⁹ explored the availability of essential drugs (EDs) in remote areas in two provinces in Laos and to explore the views on the performance and sustainability of village revolving drug funds (VRDFs) among the VRDF committees and community members. Four remote districts of Khammouane and Champasak provinces were purposely selected and five villages were randomly selected within each district. The study found that the average availability of 10 selected essential drugs at VRDFs was 37%. For three out of four villages the availability of EDs was higher in the village where a private pharmacy existed than in the village with only VRDF. The management system of VRDFs was weak and characterised by a lack of necessary guidelines and equipment for VHVs, no report and feedback system, no regular monitoring and not functioning supervision. The VHVs did not have enough knowledge and experience to manage the VRDF in a better way. When a family member was sick, care was sought in the VRDFs in 29% of cases, at private providers (pharmacies, clinics) in 34% and at public health facilities in 30%. The study concludes that the low availability of good quality ED in the VRDFs seems to be due to poor management. A comprehensive management mechanism system should be established to ensure availability of good quality drugs accessible for people in the remote areas.

The Lao Health Strategy to the Year 2020 has four basic components: full health care service coverage and health care service equity; development of early integrated health care services; demand-based health care services; and self-reliant health services. This then leads to six health-development policies: (i) strengthening the ability of providers; (ii) community-based health promotion and disease prevention; (iii) hospital improvement and expansion at all levels, including remote areas; **(iv) promotion of traditional medicine, integration of modern and traditional care, rational use of quality and safe food and drugs and national pharmaceutical product promotion;** (v) operational health research; and (vi) effective health administration and management, self-sufficient financial systems and health insurance One of the eight priorities of the Health Plan 2011-2015 is specifically related to Drug quality security and safety.¹⁷⁰

EC support to the health sector has indirectly contributed to enhancing the quality health services, mainly through EC-MS INGO projects¹⁷¹ in the past. Although nearly all countries published an essential medicines list, the availability of medicines at public health facilities is often poor.

4.2.1.2 Resume of the JC

Too little information is available to make a safe assessment. The 2000 revised national medicines policy in the Lao PDR aims to improve access to essential medicines through revolving funds, but predates the evaluation period. For I-122, the above mentioned study on drug availability concluded that the low availability of good quality ED in the VRDFs seems to be due to poor management.

¹⁶⁸ WHO. 2005. Regional strategy for improving access to essential medicines in the Western Pacific Region, 2005 -2010, p.4.

¹⁶⁹ Lamphone Syhakhang, Sivong Sengaloundeth, Chanthakhath Paphassarang, Solveig Freudenthal and Rolf Wahlström (2011), Availability of essential drugs and sustainability of village revolving drug funds in remote areas of Lao PDR. <http://www.povill.com/download/Availability%20of%20essential%20drugs%20and%20sustainability%20of%20village%20revolving%20drug%20funds%20in%20remote%20areas%20of%20Lao%20PDR.pdf>.

¹⁷⁰ MoH. 2010. National Strategy for Malaria Control and Pre-Elimination 2011-2015, <http://whothailand.healthrepositary.org/bitstream/123456789/1020/1/Lao%20PDR%20Malaria%20NSP%202011-2015%20FINAL.pdf>, pp.13-14.

¹⁷¹ For the overview of EC financed NGO project see Annex 4.7.3.

EC support to the health sector has directly contributed to increasing the availability of essential drugs, mainly through EC-MS INGO projects in the past.

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

Indicators

- I-121 Improvement in the mix of primary and secondary health facilities
- I-122 Increased proportion of health facilities with appropriate equipment

4.2.2.1 Findings per indicators

I-121 Constant improvements have been made in the mix of primary and secondary health facilities in the past decades in Laos. Support in this sector – mainly for infrastructures rehabilitation and basic equipment - has been provided mostly by the World Bank, the Asian Development Bank, JICA and Lux-DEV. Specific data are available in relation to those projects implementation (selected provinces and districts).

The strong infrastructure and equipment components strongly suggest an improvement in the Indicator. The quality (as well as quantity) of health services indicators in the 2002-2010 period in reports, reviews and evaluations are all showing improvements compared to the previous decade.¹⁷²

Yet, Annear et al wrote, in 2008, as follows: The public health care network has expanded significantly in the last 15 years with the construction or renovation of the majority of planned provincial and district hospitals and a network of more than 700 rural health centres now completed (as reported at the National Health Conference in August 2007).¹⁷³

There have been several NGO partners in EC health cooperation in the last decade: one (CARE) runs a food security project with only some primary health care (PHC) and nutrition components. Neither of the other two, Health Unlimited and Project Concern has an important component for physical health infrastructure, although they implement projects in underserved areas. Project documentation reports that the Handicap France/Action Nord-Sud project in Savannakhet built, equipped and staffed two new health centres (2).

Information gathered is very limited. The Health Unlimited project improved and equipped four health centres. As per the documents available, the Reproductive Health Initiative for Youth in Asia project renovated and equipped maternal and neonatal units (numbers not specified). The Handicap International / Action Nord-Sud project in Savannakhet built, equipped and staffed two new health centres

From the CSE Laos PDR, 2009 it is made clear that the EC never placed emphasis on infrastructure.¹⁷⁴

In the period covered, the EC supported a few small health sector projects through partner NGOs, as well as two large regional projects – the Reproductive Health Initiative for Youth in Asia (covering seven countries) and the EC Regional Malaria Control project (covering Lao PDR, Cambodia and Viet Nam). These projects, which ended around 2003, extending barely into the evaluation period, did not have significant physical infrastructure components. In addition, it financed Global Fund projects, but these, as well, had no significant infrastructure components.¹⁷⁵

However, three of six NGO projects whose representatives could be interviewed during the field mission of the CSE 2009 had engaged in at least some clinic construction or upgrading/equipping. Information available indicates that at least one EC-supported NGO project built two health centres and that the regional reproductive health project supplied neonatal health units (Indicator 2.1.2), but this does not add up to a consistent picture of the health infrastructure situation and whether the EC contributed substantially to improving it.

¹⁷² http://www.wpro.who.int/countries/lao/2010/national_health_priorities.htm.

¹⁷³ Peter Leslie Annear, Kongsap Akkhavong, Jean-Marc Thomé, Frank Haegeman, Frédéric Bonnet, Chansaly Phommavong and Soulivanh Pholsena. Moving towards greater equity in health: recent initiatives in the Lao PDR and their implications. *Studies in HSO&P*, 23, 2008, p.233.

¹⁷⁴ Laos CSE. 2009. Evaluation of EC co-operation with the LAO PDR, Final Report, Volume 1, p.24-25.

¹⁷⁵ Laos CSE. 2009. Evaluation of EC co-operation with the LAO PDR, Final Report, Volume 2, p.34.

I-122 The concept of “appropriate equipment” for each of the different level of health facilities is still vague. A list of a minimum package of equipment is available but it is impossible, based on sources reviewed, to estimate the proportion of health facilities with those implemented list.

4.2.2.2 Resume of the JC

The number and quality of health facilities has increased in the last 15-20 years. However, supply in impoverished and remote areas remains poor; in the latter case, largely because of the high cost of providing and servicing such facilities. While there has been a significant expansion of health facilities, all evidence indicates that access remains limited. From the available documentation EC support to Lao PDR never placed emphasis on infrastructure in the health sector, as emphasised in the CSE analysis for Laos, 2009.¹⁷⁶ Nonetheless, EC-financed regional projects, NGO projects and Global Fund projects.

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

Indicators

- I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population
- I-132 Improved availability and standards of health worker training
- I-133 High health worker attrition and absenteeism rate addressed

4.2.3.1 Findings per indicators

I-131 In 2009, there were 12,422 health workers (HWs), with 7,235 (58%) females and 2,021 (16%) from ethnic minority groups. Of the total health workforce, 2,986 (24%) were administrative officers and 9,436 (76%) were technical staffs (immunization-health promotion officers, curative-rehabilitation officers, teachers and researchers). 7,518 (61%) HWs provided health care services; of which 45% were high and middle level HWs, mostly in central and provincial level. The number of qualified HWs (medical doctors, nurses and midwives with middle and high level professional education) was 3,385, equal to 0.5 HWs per 1,000 populations significantly lower than the WHO recommend standard of 2.5 HWs per 1,000 populations.¹⁷⁷ No data have been found on the time trend.

The CSE Laos 2009 highlights that NGOs face the common difficulty which is the recruiting of staff to serve in the countryside. While salaries are higher in real terms because of the lower cost of living, payment delays are endemic in rural areas. Laos is a country in which more health workers could be enormously beneficial, but these would have to be health workers in the places that need them.

Figure 36: Average number of health staff by level and by category, Lao PDR, 2009-2010

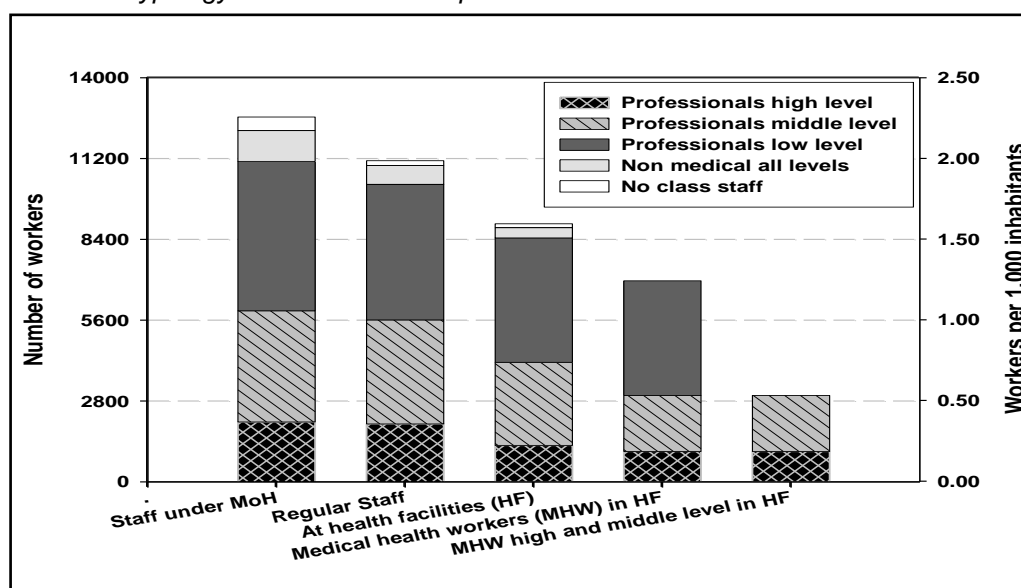
	Number	Average per 1000 population
Population (2010)	6 259 857	
High-level medical doctor	1 211	0.19
Mid-level medical assistant	1 449	0.23
High-level dentist	228	0.04
Mid-level dentist	96	0.02
High-level nurse	125	0.02
Mid-level nurse	1 008	0.16
Low-level nurse	3 835	0.61
High-level midwife	0	0
Mid-level midwife	80	0.01
Low-level midwife	274	0.04

Source: Ministry of Health, Lao PDR, 2011

¹⁷⁶ Laos CSE. 2009. Evaluation of EC co-operation with the LAO PDR, Final Report, Volume 1, p.24-25.

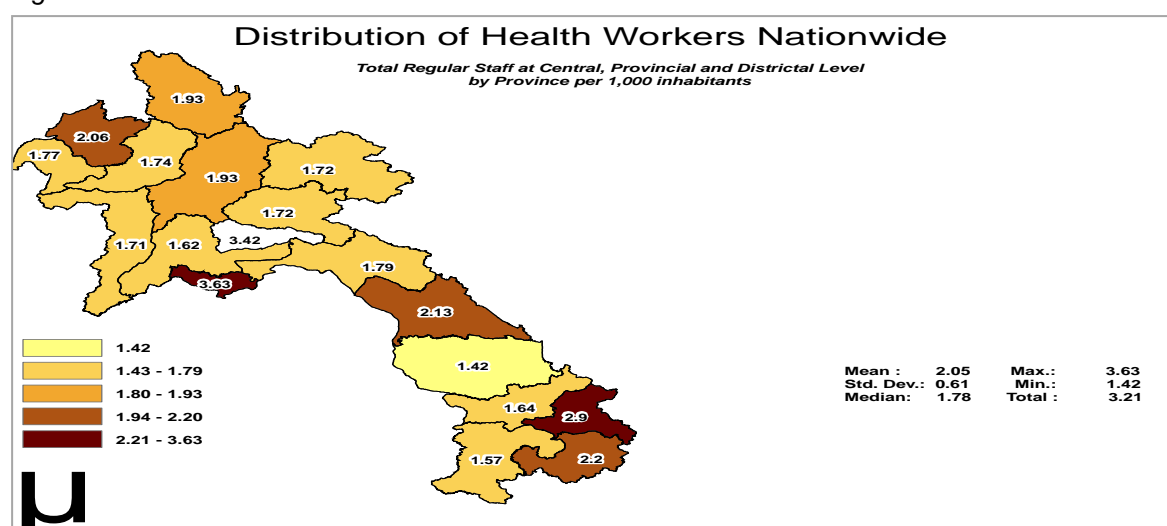
¹⁷⁷ WHO and MoH websites.

Figure: Typology of Health Workers per 1,000 inhabitants¹⁷⁸



Source: <http://www.wpro.who.int/countries/2008>

Figure 37: Distribution of Health Workers Nationwide¹⁷⁹



Source: <http://www.wpro.who.int/countries/2008>

The second EC General Budget Support programme “Government reform agenda under the national socio-economic plan”, commenced in 2008 with a period of 72 months, aimed to enhance progress in three areas of reform. One is related to health and is formulated as following: “Enhanced performance in the health and education sectors”, with the main expected result of “improved service delivery in the education and health sectors”. One indicator for evaluation is the number of health personnel in 47 priority districts to be increased.¹⁸⁰ According to the EUD Lao, in 2007, the number of health workers in these districts has increased from 1,644 to 2,106. Although there was no information on qualifications or professionals of new recruited health workers, the programme indirectly contributes to the increasing availability of human resources in disadvantaged areas.

Otherwise, the example of the Better Health project: Empowering Indigenous Women and Children, in the Three Districts of the Attapeu Province that included the training of traditional healers and traditional birth attendants, may be an good example that this project stimulated the interest in

¹⁷⁸ <http://www.wpro.who.int/countries/2008>.

¹⁷⁹ <http://www.wpro.who.int/countries/2008>.

¹⁸⁰ DCI-ASIE 2008/019-518, Government reform agenda under the national socio-economic plan.

receiving health education in remote areas of the country. But how this will be financed in future is not clear as government budgetary resources and their use are issues.”¹⁸¹

However, it is noteworthy that the EC Mid-Term External and Independent Review of PRSO conducted in May pointed out that the increase in number of health workers does not necessary contribute to improve the quality of health services.

As highlighted during the MoH interview, the Lao People’s Democratic Republic is facing a severe shortage of health staff. Globally, the country is included on the list of crisis countries in terms of health workforce. With the low number of recent graduates from universities and occupational training schools, this issue will not be solved soon. Hence, health system strengthening is now the top priority of the Ministry of Health. Overall, about 70% of the health workforce is working for the Ministry, of which 63% working at health facilities.

In this overall situation the EU supported capacity development of the HR for Health for an overall better management of the health sector. This upgrading/capacity building of health staff has been provided through two major strategies: (i) Short term training; with in service training; on job training and supportive training; (ii) Long term training/upgrading in other and associated countries. (University, affiliated/specialized training centres and). The EU supported HRH in the following sectors: Laboratory, emerging diseases, water & sanitation, rural development, nutrition, department of finance (PRSO) and Hygiene among others.

Despite EUD’s and other development partner’s support, the distribution of the health workforce at provincial and district levels is still not equitable and is dependent on the investment from the province. As such, trained health personnel are lacking in rural areas where they are most needed, while there are many trained doctors and nurses staying in big cities such as Vientiane. No data are available on how many trained person remain in their post and for how long. Lao has strongly benefitted from specific support from EUD (Regional Office and Country Office) and partners (e.g. Capacity Plus) to strengthen HRH, especially to address the mal-distribution of health workers between the rural and urban areas. In relation to coordination with other donors in the specific sector of HRH (but not only) in order to minimize brain drain great improvement have been achieved in this regards thanks to the Health Sector Working Coordination Mechanism of which the EUD is part.

Recognizing this, the first National Health Personnel Development Strategy 2009–2020 was endorsed in November 2010. This strategy addresses key issues and includes needs-based human resource planning, recruitment and retention through an incentive mechanism; review and development of curricula for training institutions for health personnel; and equity and equality.¹⁸²

I-132 The Ministry of Health has put emphasis on the development of three categories of health personnel: health leaders, managerial staff and technical staff. In 2009, there were 1,296 health managers – 486 females (37.5%) – Most of these officers received further education in Public Governance and Administration; of these, eight attained Master degrees , 13 graduated with Bachelor degrees , 41obtained high diplomas, 154 diplomas, 80 certificates and 812 completed the forty five-day curriculums; 1,224 were given English language training. Some additional technical staffs were given education opportunities in local and overseas institutions. In 2009, the health sector employed nine Professors, 31 Associate Professor, 31 PhDs, 12 Postgraduates, 410 Masters, 134 first level residents, 23 second level residents, 131 specialists, 2,145 bachelors, 262 high diplomas, 4,725 diplomas, 5,004 certificates and 109 HWs without profession.¹⁸³ No information on the time trend in health worker training availability and quality.

The CSE Laos PDR 2009 points out the importance of strengthening human resources on national level, through the capacity building at the Institute of Public Health as well as at central Ministry level, especially in the context of General Budget Support introduction. The EC has financed several activities: “The Institute for Public Health (IPH) participated in several EC-funded activities. Under a sub-contract, it has worked with the EC NGO co-financing Project Concern PHC project, providing training in basic health management skills for district and provincial health staff and in carrying out the baseline survey for the project. Until 2006, IPH participated in Asia-Link, the EC-funded exchange program, in this case with the Hanoi and Brussels Schools of Public Health. Together with nine institutions in China and Cambodia and with the UK Institute of Development Studies (IDS) IPH

¹⁸¹ Final Project Evaluation, 2010, p.20.

¹⁸² Source: Interview with EUD.

¹⁸³ WHO and MoH websites

participated in “Povill”, an EC-funded project (EUR 277,000) devoted to protecting the rural poor from the economic consequences of major illnesses. Povill carried out household surveys, participated in direct household assistance schemes, assessed the performance of health providers and has worked on encouraging pro-poor health policies. The EC has also recently become engaged in TA and capacity building at the central Ministry of Health. This is enabled by a set-aside of funds in the context of PRSO budget support for capacity building related to the eventual adoption of a sector approach to health in Lao PDR.”¹⁸⁴ In addition, in the context of the 2nd GBS, the EC has supported the Ministry of Health and the Institute of Public Health to attend short training courses on topics relating to health financing and economics in Thailand and Italy,

Regional projects contributed significantly to health care worker training availability and quality. Elsewhere in the CSE 2009, it can be read: “About 2,000 district workers and village volunteers were trained in managing impregnated mosquito nets under the EC-financed regional Malaria Control Programme. Health personnel of two districts and 30 village health volunteers were trained in Savannakhet and in 30 villages in Attapeu; moreover, the Reproductive Health Initiative for Youth in Asia project trained health personnel in pregnancy management, neonatal care, family planning and STD/HIV at provincial and district level. The significant scale of training made available under EC-supported programmes is confirmed by field-phase interviews. Nurses and health workers (including numerous volunteers) in NGO projects have been major beneficiaries of EC health cooperation. Doctors, nurses, as well as community health workers working on Global Fund projects have received extensive training. Thousands of cadres and community members in dozens of villages have acquired new knowledge and skills to address urgent health needs through EC-supported activities.

The EC funded “Better Health: Empowering Indigenous Women and Children, in Three Districts of Attapeu Province” project (2004-2009) trained trainers, village health volunteers, traditional healers and traditional birth attendants. Further, an organised health infrastructure was established in the project villages.¹⁸⁵ Though these interventions are not directly related to train medical staff at health care facilities and hospitals, or at universities, they certainly contributed to raising the capacity of grassroots-level. Health workers in remote and underserved areas in Lao PDR.

In summary, a number of EC interventions contributed to improving health worker training availability and quality and improving health worker capacity. No hard statistics of impact have been found, but it is to be safely inferred that EC support contributed to improved health worker training through these interventions.

I-133 The issue of health workers attrition in Lao PDR is less prominent than in others neighbouring countries; however, it does exist, as elsewhere. UN system and bilateral agencies, international NGOs and the private sector offer attractive salaries and bonuses which drain the public health workforce. However the Ministry of Health’s Health Personnel Development Strategy (not directly supported by the EC) is addressing this issue.

However, there is no question that attrition has limited the ultimate impact of the significant EC interventions identified in the previous Indicator.

The “Support to Third Poverty Reduction Support Operation” with an EC contribution of EUR 3.2 million (2007-2011) (GBS) with the general objective to reduce poverty with a view to achieving the Millennium Development Goals (MDGs) included one trigger, namely that “the government improves the timeliness of payment of salaries to teachers and health workers.”¹⁸⁶ Insofar as improvements were reached, these could not be assessed due to lack of information.

4.2.3.2 Resume of the JC¹⁸⁷

As discussed under I-3.1 and I-3.2, nurses and health workers (including numerous volunteers) in NGO projects, as well as EC-financed regional and Global Fund projects have been major beneficiaries of EC health cooperation. It can safely be concluded that the EC made a contribution to improvement in these Indicators, even though no hard time trend data are available. These projects especially helped to increase the availability of human resources in disadvantaged areas.

However, attrition continues to reduce the ultimate impact of the EC’s contribution to training. . A 2007 internal medium-term review of the EC-financed Health Unlimited project¹⁸⁸ found that high staff

¹⁸⁴ Laos CSE. 2009. Evaluation of EC co-operation with the LAO PDR, Final Report, Volume 2, p.36.

¹⁸⁵ Second Interim Report, 1 April to 31 March 2007; and Final Project Evaluation, 2010.

¹⁸⁶ DCI-ASIE/2007/19166, Support to Third Poverty Reduction Support Operation.

¹⁸⁷ Health Personnel Development Strategy by 2020, (HPDS) Ministry of Health November 2010.

turnover was a limiting factor. The Project Concern health project, implemented with Government staff, can expand by only fifteen villages per year because the MoH counterpart has problems in providing the human resources for expansion. Finally, improving emergency obstetric care has, so far, proven impossible due to the lack of doctors and it has proven difficult to recruit trained staff that is willing to relocate long-term to the province.

Summarised, the EC contributed to health personnel training primarily through NGO and Global Fund projects, mainly located in upland and underserved areas. No evidence could be found that EC addressed directly absenteeism and attrition problem in the country. EC GBS support “Government reform agenda under the national socio-economic plan”, commenced in 2008 and included a training factor of health personnel to be followed. How far the EC played a role in the formulation and implementation of the national Health Strategy to the Year 2020 and of the National Health Sector Development Plan (NHSDP) (2006-10) is not known to the authors of this report.

4.2.4 JC 14 Increased or maintained quality of service provision

Indicators

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)
- I-142 Clinical treatment guidelines available, disseminated and applied
- I-143 Percentage of people who are satisfied with the quality of the services (by facility and specific service provider: physician, dentist, nurse, etc.)?

4.2.4.1 Findings per indicators

I-141 Several quality assurance mechanisms are in place among the different layers of the Lao health system especially regarding vertical programmes related to the GFATM. In the past contracted EU-MS INGOs were responsible for quality assurance in the facilities where health related projects were implemented. These mechanisms were essentially based on international good practice standards set by WHO. EC-support played no role in placing quality assurance mechanisms in place, apart from the limited facility and equipment provision that embodied good practice monitoring by the implementing INGO.

I-142 In the health sector a vast range of treatment guidelines for health sectoral topics (e.g. PHC, EPI, MNCH, malaria, TB, HIV/AIDS, etc.) are available in Lao as well as in English. They are mainly derived and/or translated by WHO, UNICEF, UNFPA, UNAIDS, guidelines and/or from main multi/bilateral donors as JICA WB and ADB. In general those guidelines are disseminated at peripheral level; however it is not possible to quantify the rate of dissemination and real implementation of those treatment guidelines in the field. EC-support played no role in placing quality assurance mechanisms in place, apart from the limited facility and equipment provision that embodied good practice monitoring by the implementing INGO.

I-143 The quality (as well as quantity) of health services indicators in the 2002-2010 period in reports, reviews and evaluations are all showing improvements compared to the previous decade.¹⁸⁹ However a lack of evidenced based research on health services quality as well as client satisfaction is reported. Data on client satisfaction by facility and specific service provider is lacking. While no hard data have been found, it is safe to speculate (based, for example, on the experience of neighbouring Vietnam as spelled out in the 2009 Country Strategy Evaluation) that a significant proportion even of the poor seek care in the private health sector because there care is broadly perceived to be of higher quality than in the public sector.

4.2.4.2 Resume of the JC

This JC has proven rather jejune in the case of Lao PDR. Quality standards are set by international agencies, not by the EC. Infrastructure investment and provision of equipment were not major EC focal points, but as pointed out above, NGO implemented projects financed by the EC (sometimes via the GFATM) embodied such standards, implemented and monitored by the implementing NGO.

¹⁸⁸ Better Health: Empowering Indigenous Women and Children, Attapeu province, Lao PDR. ONG-PVD/2003/62-434, SECOND INTERIM REPORT, 1 April 2006 to 31 March 2007.

Embodied in these projects, then, was dissemination of international good practice health care, particularly in disadvantaged areas. Client satisfaction appears to have increased but the large role of the private sector is indicative of a widespread perceived lack of quality in public health facilities. The Indicators offer little reason for believing that EC support played a significant role in improving this JC.

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

4.3.1 JC 21 The cost of basic health care services is reduced for households due to EC support

Indicators

- I-211 Change in proportion of health spending out of pocket
- I-212 Change in share of health expenditure financed by social security schemes
- I-214 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

4.3.1.1 Findings per indicators

I-211 According to WHO 2011 data, out of pocket spending increased from 50.1% of total health spending in 2002 to 61.3% in 2009.

There is no evidence that EC projects and GBS support were directed towards the decrease in the out-of-pocket expenditures of population. Indirectly, however, the second GBS contains support helping the MoH in its efforts to increase insurance coverage (see I-214).

I-212 Private health insurance is exclusively available only to the highest income groups in Laos. Risk-pooling and pre-payment have been introduced through social security for the formal sector and health insurance for the public sector. See also I-211.

No further information is available, in particular on trends in this Indicator.

How far the EC contributed through its projects to increase the share of health expenditure financed by social security schemes, is unclear, however, as stated above the second GBS is assisting MoH in expanding insurance.

I-213 To understand how social security works in Lao PDR we explore briefly how it is set up in the country. Currently the social security system of Lao PDR consists of four schemes:

- Civil Servants Scheme (CSS) for the civil servants (SASS: State Authority for Social Security);
- Social Security Organisation (SSO) for the private sector employees since 2001 in response to the market economic growth;
- Community Based Health Insurance (CBHI) for the informal economy workers;
- Health Equity Funds (HEF) for the very poor;

Although CSS and SSO are already providing a relatively comprehensive set of social security benefits, the two others are focusing only on access to health care. The Table below shows that, close to the end of the evaluation period, numbers actually covered fell vastly short of target populations, although there was a dramatic increase in the number of informal and self-employed workers insured. However, a study reveals that there are many problems associated to the CBHI scheme. It concludes that the scheme increases utilization and decreases out-of-pocket expenditures for members, coverage for the scheme is extremely low and the positive impacts on a population level are therefore negligible. Furthermore, the results show that the scheme exacerbates inequities: the poor are not only less likely to enrol but among the poor who are enrolled, there has been no impact on utilization of outpatient services. Although the scheme offers protection against catastrophic expenditures for the top two income quintiles, the scheme actually increases catastrophic expenditures among the poorest quintile.¹⁹⁰ The Delegation disagrees with this statement and points to the information provided by MoH at the High Level Health Financing Leadership Seminar where the MoH reported that the utilisation of outpatient services increase from an extremely low 1.0 contacts/person/year to 1.2

¹⁹⁰ Presentation: The Impact of Community-Based Health Insurance in Lao PDR on Utilization and Financial Risk Protection for the Informal Sector, <http://ihea2011.abstractsubmit.org/presentations/324/>.

contacts. Mothers giving birth in facilities are increased in the insured population. The scheme has pulled back patients into the public health system, instead of the most prevalent self medication and buying drugs from un-licensed sellers. The revenue from insured members is significant representing an increased financial flow to the public hospitals.

Table 20: Insurance coverage

	CSS/SASS	SSO	CBHI	HEFs
Target	Civil servants and dependants	Private sector salaried workers and dependants	Self-employed and informal economy worker	Families identified as below poverty line
No of population (estimate)	399,672 + 590,000 policy military & dependants	386,988	3,000,000	1,600,000
Ministry in charge	MOLSW (Ministry of Labour and Social Welfare)	MOLSW	MOH (Ministry of Health)	MOH
Insured by December 2008	<i>To be updated</i>	86,690	33,121	26,772
Insured by October 2009			120,000 ¹	

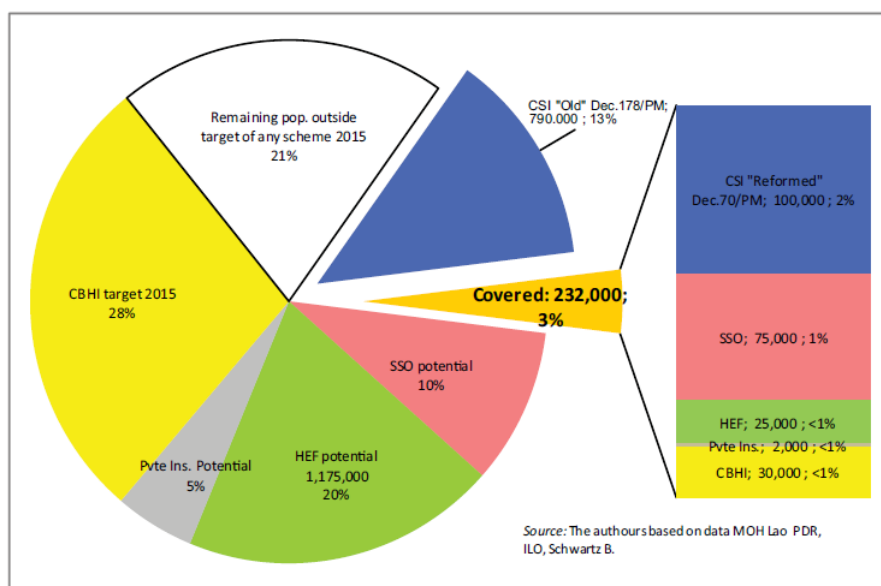
Source: Aviva, R. & Bart, J. 2009. Suggestions for a Roadmap towards merging social health protection schemes at Lao PDR.

Source: Aviva, R. & Bart, J (2009). Suggestions for a Roadmap towards merging social health protection schemes at Lao PDR.

More details on social security schemes in Lao PDR, how they work and what they services they cover, can be found in an ILO report.¹⁹¹

Figure 2 below shows that in 2007, 21%% of population remained ineligible for any of the available insurance schemes and that only 3% of population is covered by one of the four schemes.

Figure 38: Social protection coverage in Lao PDR: Estimates of 2007¹⁹²



¹⁹¹ <http://www.ilo.org/public/english/region/asro/bangkok/events/sis/download/paper30.pdf>

¹⁹² Jean-Marc Thome and Soulivanh Pholsena. Lao People's Democratic Republic: Health Financing Reform and Challenges in Expanding the Current Social Protection Schemes. Publication Year unknown, p.82.

Source: Jean-Marc Thome and Soulivanh Pholsena. Lao People's Democratic Republic: Health Financing Reform and Challenges in Expanding the Current Social Protection Schemes.

The second EC General Budget Support to Lao PDR "Support to the Government's reform agenda under the National socio-economic Plan" (p.27), commenced in 2008, includes the outcome "improved access to health care and financial protection". The associated indicator is: % of population enrolled in HEFs, CBHI, SSO, CSS and other payment and subsidised schemes (planned increases monitored regularly, starting from 9.2% in FY 2006/2007). The National Health Development Plan contains the target of covering 30% of total population by 2010. No report could be found that proves or rejects this target reached until today. There is probably some indirect contribution through the second GBS.

EC support prior to GBS was dispersed over many small projects, not necessarily focusing on health. No evidence could be elaborated that the small projects supported enhanced insurance coverage, except indirectly by the Better Health project. The establishment of the IEC Team, consisting of 18 members from Health Unlimited (HU) staff (IEC Officer and three IEC Assistants), Provincial Health Department (PHD), Provincial Lao Women's Union (PLWU), District Health Office (DHO) and District Lao Women's Union (DLWU)¹⁹³ This is, however, an isolated example and there is no real evidence that EC projects led to any significant increase in coverage.

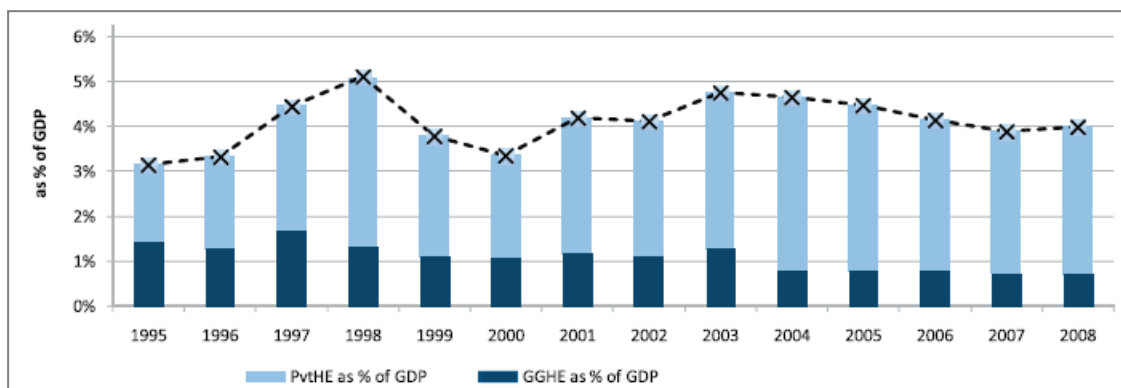
4.3.1.2 Resume of the JC

We approached this JC with one Indicator on trend in out-of-pocket payments as a proportion of total health spending. one on change in the share of health care spending covered by social insurance schemes and one on the proportion of the population enrolled in various available public health schemes (no information was found at all on contribution rates and this fourth Indicator is highly inappropriate to Lao PDR). There has been no significant change, at least in the second half of the evaluation period, in the very predominant share of health spending which is out of pocket. No information was found on the second and third and the third remains abysmally low although the raw numbers of informal sector and self-employed workers jumped towards the end of the evaluation period. GBS is helping the MoH to meet its ambitious commitment to expand the availability of appropriate public insurance schemes and social security coverage. One pre-GBS project made a contribution to improved coverage at the micro-level, but this was an isolated example. All in all, there is no evidence that EC support contributed to a significant improvement in the affordability of health care. This is hardly surprising in view of the high share of health care delivered by the private sector and the lack of fiscal space for expansion of social security and social security schemes (for which we do see some evidence for EC contribution, although the gains may be in the future).

According to the EUD, the expected supportive role played by GBS in encouraging the expansion of the public sector in health care financing is in way contradicted (or at least need further investigation) by the most recent available data. As well as there is no way to measure if the cost of basic health care services are reduced for households due to EC support. Data evidence show that in 2009, the average total health expenditure (THE) of the Lao People's Democratic Republic was 4.1% of GDP, equivalent to USD 36 per capita. That same year, the general government expenditure on health (GGHE) accounted for 19.4% of the total expenditure in health (Figure below) This means GGHE made up just 0.8% of GDP (see Figure below), a very low level of public expenditure on health. Moreover, public funding was mainly used to support recurrent costs such as salaries, administrative costs of the state health system and costs associated with disease control. 39 Social health protection schemes took up 12.1% of GGHE. 40 Funding for health from external donors made up 16% of THE in 2008.

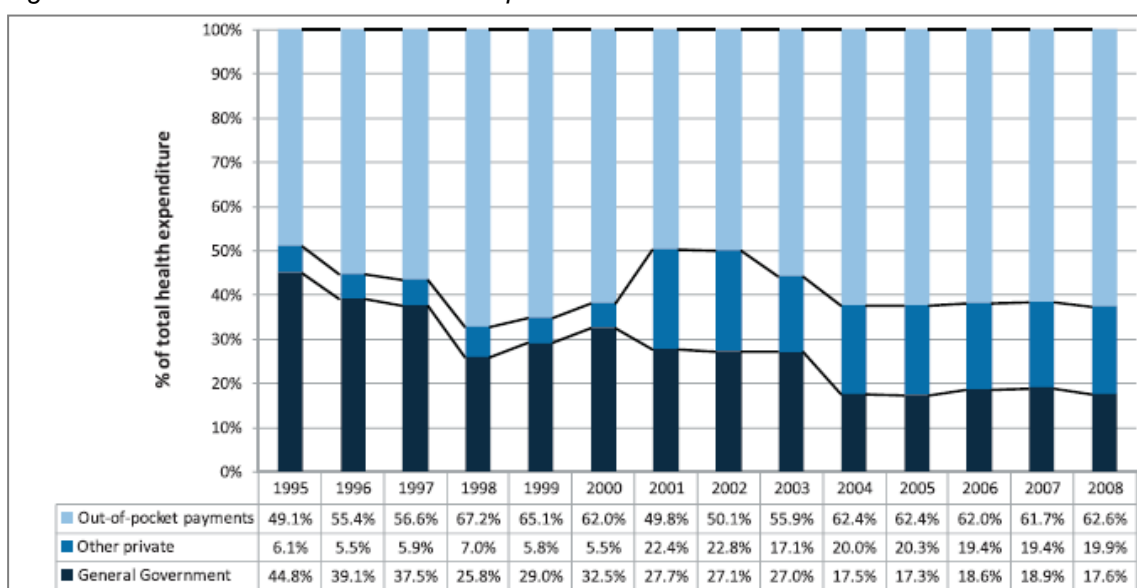
¹⁹³ Better Health: Empowering Indigenous Women and Children, Attapeu province, Lao PDR. ONG-PVD/2003/62-434, SECOND INTERIM REPORT, 1 April 2006 to 31 March 2007, p.5.

Figure 39: General trends in health expenditure (% GDP), 1995-2008



Source: Health Financing Country Profile 1995-2005, WHO

Figure 40: Structure of the health expenditure 1995-2005



Source: Health Financing Country Profile 1995-2005, WHO

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

Indicators

- I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs, such as children, the elderly, persons living with HIV/AIDS and the disabled
- I-222 Health care financing schemes result in additional health care consumption by households

4.3.2.1 Findings per indicators

I-221 Health Equity Funds (HEF) has been introduced in recent years into the public health system in the Lao PDR, following the experience in neighbouring Cambodia.

Those HEFs are being expanded and implemented on a small scale in Laos mainly through WB and ADB projects. Special safety nets schemes are in place for special and more disadvantaged groups of population as children, HIV/AIDS patients and disabled, however the eligible groups are still vaguely defined and vary from province to province. Decisions are mostly made at community level – by local leaders – on who will benefit of those advantages/support. However, the geographic, demographic and cultural characteristics of the Lao PDR present a series of challenges to the implementation of equity funds. The main population activities occur in the easily accessible Mekong River basin, while population in the surrounding highland areas is sparse and scattered.

There is not evidence to date that the EC has contributed to special schemes. A structural problem is one of health care finance: public budgeting for recurrent expenditure is low; making facilities highly dependent on user fees for this purpose. Except in the most general sense of supporting improved public financial management, etc., there is little that can be expected from EC support in this area.

I-222 No information obtained to date.

4.3.2.2 Resume of the JC

Based on the Indicators defined and sources consulted to date, there is no evidence that EC support contributed to improvement in this JC.

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

Indicators

- I-231 EC supported technical assistance, provides expertise on health care finances,
- I-232 EC supports enhanced communication, cooperation between MoH and MoF/planning

4.3.3.1 Findings per indicators

I-231 The EU is supporting the Ministry in the endeavour to improve health care finance. Encouraging steps are being taken in the health sector to prepare a health financing strategy, in a context of low government expenditures in the sector and low performance of the health-related MDGs.¹⁹⁴ These efforts were continued and the first Health Financing Strategy was submitted to the MoH Steering Committee in March 2010 and is expected to be approved by Prime Minister Decree in December 2010. A Technical Working Group which is a platform for dialogue between the GoL and many donors and agencies is actively supported by EU technical assistance (short term expert and long term team - two years).¹⁹⁵ The objectives of the health financing strategy are: improved service delivery; improved financial accessibility and equity; improved performance and efficiency; and financial and technical sustainability.

The EC is an active partner in the PRSO reform discussions with the government in the areas of public finance management, trade, private sector development, health, covered during the regular joint review missions. This is complemented by more specific cooperation and technical assistance provided under the PFM trade and private sector development programmes. The Delegation interacts closely with WB, Australia, Sweden, Switzerland and ADB on these issues.¹⁹⁶ This is a continuation of the process already mentioned in the EAMR 1/2009.

Further, the EC do provide indirect expertises on health care finances. The EC supports with a TA the Government's reform agenda under the National Development Strategy through the Poverty Reduction Support Operation. This is a reform programme of the Government supported by an IDA grant from the World Bank.

In the second GBS "Support to the GoL's reform agenda under the National Socio-Economic Plan" (p.10, 12) the Commission has identified and agreed with development partners and GoL a list of indicators for years 2009, 2010 and 2011. For the Health Sector the indicators are: (1) Health Financing Strategy; (2) Recurrent health budget as % of total recurrent budget (domestic allocation); and (3) Number of health personnel in 47 priority districts. The target by March 2011 should be the MoH initiates the implementation of the approved Health Financing Strategy (HFS). No evidence could be found that the HFS is implemented.

According to the interview with the EUD, a wide range of TA has been provided to the Ministry of Finance and related Department of Planning and Finance of the Ministry of Health. The EUD, TA in this specific sector appear to very much appreciate in term of its quality, relevance, timeliness, even if its specific impact is difficult to measure. Social health protection was introduced in 2002 and presently, there are four different schemes: a State Authority Social Security (SASS) scheme for civil servants; a Social Security Organisation (SSO) scheme for private sector employees; a voluntary community-based health insurance (CBHI) scheme; and a health equity fund supported by external donors focusing on the poorest population. The four schemes cover 12.5% of the total population. The Ministry of Labour and Social Welfare takes responsibility for two schemes: SASS and SSO. CBHI and

¹⁹⁴ EAMR Jan 2010 Final, p.15.

¹⁹⁵ EAMR July 2010 Final, p.20, see also EAMR 1/2010, EAMR 7/2009, EAMR 1/2009.

¹⁹⁶ EAMR Jan 2010 Final, p.18.

the health equity fund fall under the responsibility of the Ministry of Health. In 2009, the Ministry started working with WHO and DPs to develop a ministerial decree on national health insurance to combine the four social health protection schemes into one agency. This decree has been submitted for approval. Once approved, it will – together with the new regulation on user fee exemption for maternity and children-under-five services – bring the target of universal coverage closer.

I-232 According to the EUD, there is no doubt that the EC support has improved communication and interaction between MoF and MoH with regards to health finance mechanism. This was also accomplished thanks to the Health Sector Working Coordination Mechanism and its specific Sector Working Groups at policy and operation level of which the EUD is active part (PMFSP).

4.3.3.2 Resume of the JC

The EC is supporting recently the MoH in the preparation of the Health Financing Strategy with the overall outcome “improved access to health care and financial protection effective performance monitoring for health sector policy”.

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

Indicators

- I-241 Evidence of EU supported dialogue between major stakeholders and pharmaceutical industry to encourage R&D targeted at diseases of poor countries
- I-242 North-South medical and public health research partnerships supported by EU to produce new medicines and treatments

4.3.4.1 Findings per indicators

I-231 Not applicable to the country case.

I-232 Not applicable to the country case.

4.3.4.2 Resume of the JC

No evidence of EC support for this JC.

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

4.3.5 JC 31 Increase in availability of primary health care facilities

Indicators

- I-311 Change in number of primary care facilities per 10,000 population (towards >1 per 10,000 population); disaggregated by rural/urban and income level, where feasible
- I-312 Change in the proportion of rural population living in a radius of one hour of a primary health care facility.

4.3.5.1 Findings per indicators

I-311 No time trend data have been found in documents consulted. ILO data given in the tables below give a snapshot observation of 739 primary facilities, less than one per 10,000 population. Moreover, the state system remains underutilized, especially in the peripheral areas. Availability of facilities and trained personnel does not appear to be a major constraint at the national level, but facilities, equipment and staff are very unevenly distributed, resulting in continuing problems of access in rural and especially remote rural areas.

The EC co-contributed to the project “Appui au secteur de la santé” (PASS) by constructing two health centres in districts Phine and Nong, Savannakhet “(although one -location negotiated with the Lao authorities- is built “in the middle of nowhere”)”.¹⁹⁷ No further EC interventions are found.

¹⁹⁷ Support to government’s Capacity Development in the Health Sector, Lao PDR, contract number 219886.¹⁹⁷ Monitoring Report, MR-20248.01 – 03/12/04.

Table 1: Health facilities and personnel per 100,000 population, Lao PDR, ca. 2005

	Facilities per 100,000 population	Beds per 100,000 population
General hospitals	0.39	45.46
Specialised hospitals	0.05	2.85
District referral hospitals	2.26	42.10
District: General		0.93
Primary health care centres	13.37	29.50
Primary : District		0.71
Private hospitals	0.00	0.00
Private outpatient clinics	4.52	0.00

I-312 No information is available. However, rural and especially remote areas are underserved. For EC contribution see above.

4.3.5.2 Resume of the JC

This JC was assessed on the basis of two indicators: Change in number of primary care facilities per 10,000 population and the change in the proportion of rural population living in a radius of one hour of a primary health care facility. We have only been able to establish a snapshot of the situation in 2005; however, we found that the EC provided two primary health facilities. Remote and upland areas are underserved and the problem is exacerbated by remoteness, in particular during rainy seasons. The problem in Lao PDR seems to be not so much the number of facilities, but their underutilisation, worst at the hospital level, but affecting the primary level, as well. Furthermore, the underutilisation of health facilities, in particular in regional and district hospitals. No information could be gained for the proportion of population living in a five km (one hour) radius of a primary health care facility, but since most persons outside a five km range of a facility are in remote and highland regions and given the poor transport infrastructure, this Indicator is unlikely to have improved.

As indicated in the I-121 the EC were not health infrastructure-oriented. Anyhow, in the EC documentation available, the PASS project constructed two health facilities, equipped and staffed. Insofar other EC-MS-INGOs projects contributed to construction of health facilities/posts in remote areas could not be elaborated. No evidence could be found in the EC GBS documents.

4.3.6 JC 32 Increase in availability of secondary health care facilities

Indicators

- I-321 Change in number of hospital beds per 10,000 population (to >10 per 10,000 population)
- I-322 Change in the proportion of population living in a radius of two hours of a secondary health care facility
- I-323 Increased number of Caesarean Sections

4.3.6.1 Findings per indicators

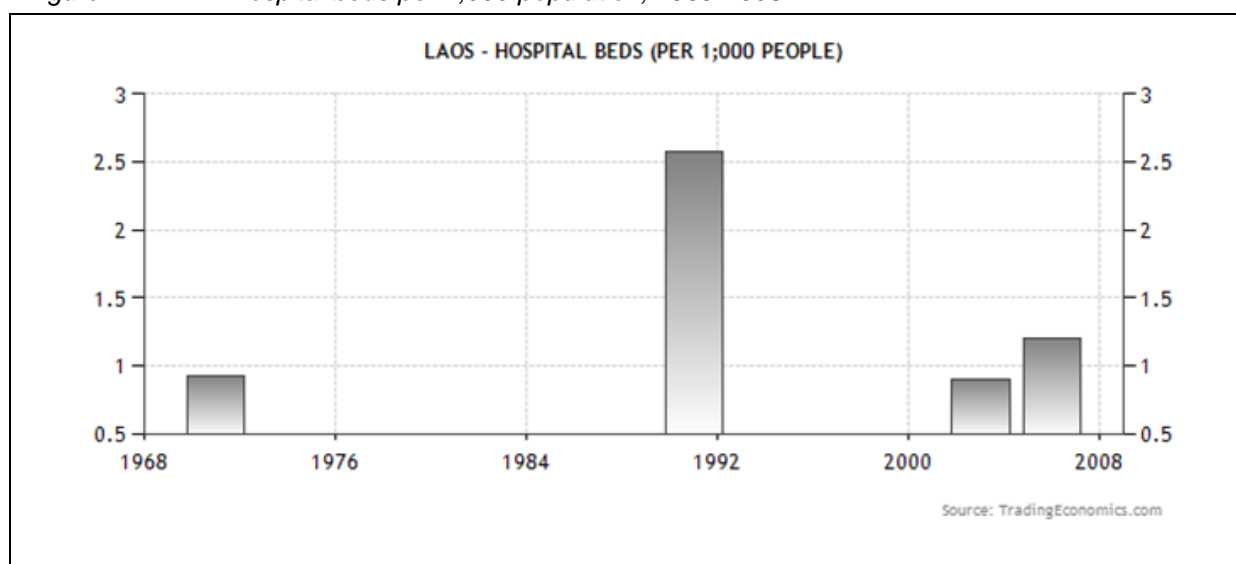
I-321 In 2005, its health facilities consisted of four central teaching and referral hospitals; five regional hospitals, including one teaching hospital; 13 provincial hospitals; 127 district hospitals; and about 746 health centres. District hospitals are further classified as category A or B, category A meaning that the facilities have surgical capacity, unlike category B. A total of 5081 hospital beds were available in 2005, giving a ratio of nine beds per 10,000 inhabitants. The WHO 2011 Statistical Report estimated to 12/10,000 population the hospital beds rate. This may be evidence of an increase; on the other hand, the difference is small enough that it may just be a statistical fluke.

Figure 41: Type of health facility and distributions of beds, ca. 2005

Type of facilities	N° of facilities	N° of bed	Bed occupancy	Average length of stay
Central hospital	4	835	77.9%	4.9
Specialist centre hospital	3	160		
Regional hospital	4	632	5.4%	3.27
Provincial hospital	13	985	43.5%	3.91
District hospital	127	2,366	33.4%	4.32
Health centre	739	0		
Total		4,978		

<http://www.tradingeconomics.com/laos/hospital-beds-per-1-000-people-wb-data.html>

Figure 42: Hospital beds per 1,000 population, 1969-2008



<http://www.tradingeconomics.com/laos/hospital-beds-per-1-000-people-wb-data.html>

The figure above shows roughly consistent data for the mid-2000s and 2008, again a slight increase is seen. No reason has been found for the spike in 1992.

The EC did not contribute to increasing the number of hospital beds as its infrastructure activities were at the primary level. For EC contribution in this area, see I-311.

I-322 Information not available.

I-323 Very little increase on number of Caesarean Section performed in the country. The WHO 2011 Statistical Report provides a 2% birth by caesarean section for the overall country deliveries. No DHS is available to gather more information.

4.3.6.2 Resume of the JC

Availability of hospital beds is not a major issue in Lao PDR; it is underutilisation due to lack of staff, lack of equipment, low client satisfaction, geographical remoteness and poverty that are the core concerns. Improving roads in the remote and highland regions would doubtless improve access more than that installing more facilities or more beds. The EC did not contribute to any of the Indicators under this JC.

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

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

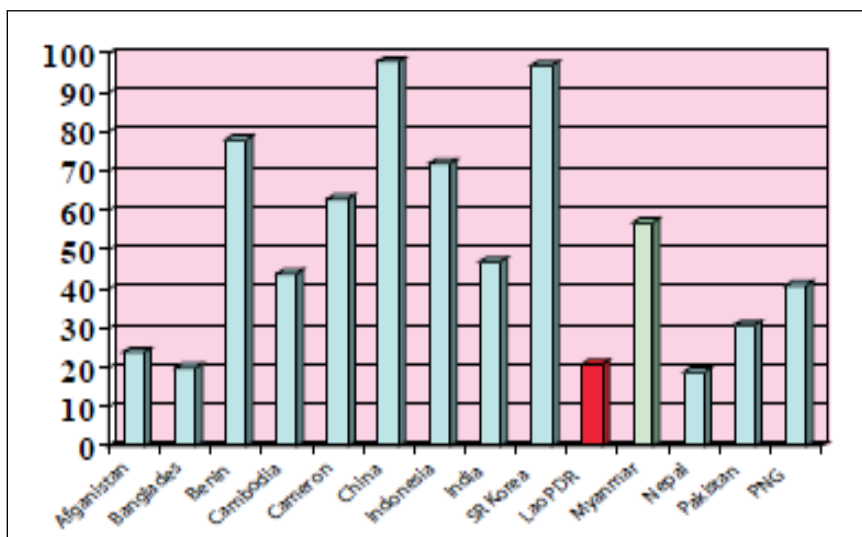
Indicators

- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving four or more ante-natal check-ups
- I-413 Increased proportion of women using modern family planning

4.4.1.1 Findings per indicators

I-411 Measuring MMR accurately is difficult therefore the proportion of births attended by skilled birth attendants (SBA) is used as a proxy measure to monitor the progress towards the MDG 5 target of reducing maternal mortality. The majority of Lao women (84.8%) give birth at home (LRHS 2005¹⁹⁸). Births assisted by health providers only marginally increased from 17.4% to 18.5% between 2000 and 2005 (LRHS 2005). The chart below puts this figure in regional perspective. The LRHS 2005 showed that 63.4% of births were assisted by family members or relatives, 12.1% by traditional birth attendants and 3.4% gave birth alone. Disparities between urban and rural settings are marked; 51% of the urban population delivered at health facilities, whereas most of the rural population delivered at home (87% of rural with road and 96.5% of rural without road) (LRHS2005). The LRHS 2005 found that the majority of women (75.7%) not giving birth in a hospital thought it was “not necessary”. Other reasons included cost of hospital delivery, low quality of the service provided at health facilities nearby (health centre and some districts), presence of a male health worker in health centre, cultural influences and geographical distance. The high percentage of women who give birth without skilled health personnel (doctor, nurse and midwife) is of concern as attendance at delivery by skilled health personnel and emergency obstetric care are key interventions that can substantially reduce maternal and perinatal mortality.

Figure 43: Skilled attendance at births



Source: Lancet 2005 and La MIC II

The Empowering Indigenous Women and Children Project in Three Districts of Attapeu Province funded by the EC, is an example of EC contribution. The project, implemented in thirty remote and poor villages of the three districts over a period of five years, aimed to reduce health risks and improve hygienic conditions in three districts of the province.

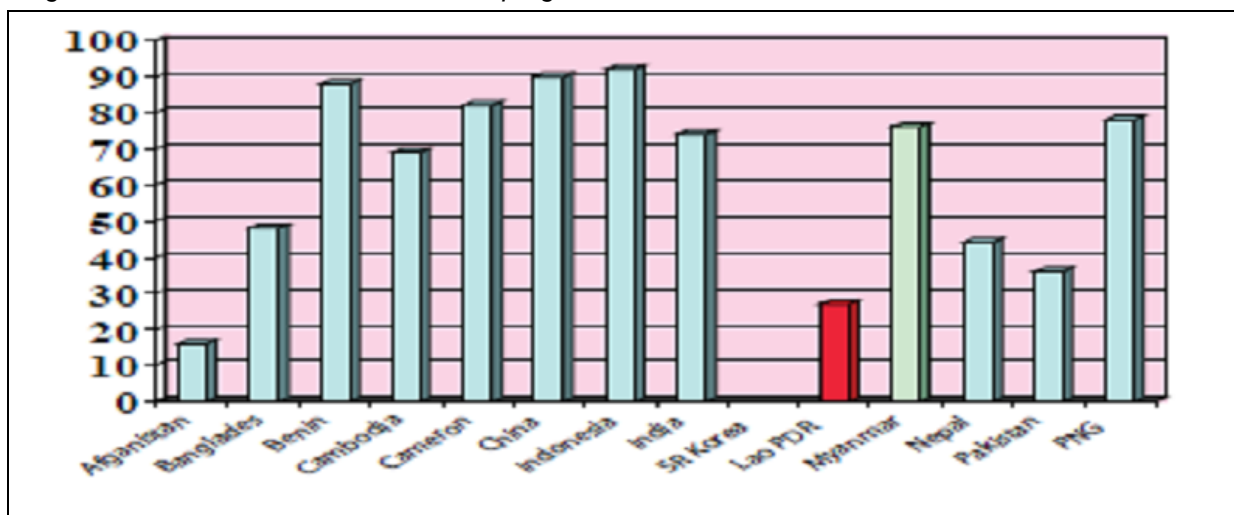
¹⁹⁸ UNFPA. Lao Reproductive Health Survey 2005, <http://countryoffice.unfpa.org/lao/drive/LAOREPRODUCTIVEHEALTHSURVEY.pdf>.

The project evaluation noted a significant improvement in women's awareness of key health issues over the course of the project. Women are increasingly responsible for managing their own health and addressing the health of their children. This could be evidenced by increased awareness of the importance of safe delivery conducted by trained Traditional Birth Attendants (TBA) in the villages. A baseline survey in July 2005, found delivery assisted by untrained TBAs to be 50% in Saysetha, 26.41% in Phouvong and 26.82% in Sansai. Others were assisted by relatives or self-delivery. In 2010, all deliveries were undertaken by trained TBAs.¹⁹⁹

I-412 In Lao PDR only 28.5% women received ante-natal care (ANC) and this proportion was lower among women with less education and rural, older and high-birth order women (LRHS 2005). Of those receiving ANC, 60.7% of women undertook four or more visits and only 10.9% of women obtained their first ANC during the first trimester of pregnancy. More than three quarters (76.4%) of women did not take iron tablets (93.7% of women in rural without road) and only 5.9% of mothers took 90 tablets or more (0.7% of women in rural without road).

The WHO Statistical Report 2011 provides data on the Antenatal Care Coverage (%) in relation to at least one visit: which is 35%, no data are available concerning the fully four recommended visits. 35% is significantly higher than the 28.5% figure given for 2005 by the LRHS. This is some evidence for improvement in the situation.

Figure 44: Antenatal care visits of pregnant²⁰⁰



Source: Lancet 2005 and La MIC II

For contribution see the discussion of the Attapeu Province project under I-411 and the PASS project under I-321.

I-413 The contraceptive prevalence rate (CPR) increased from 29% to 35% among married women between 2000 and 2005, but unmet need still remains high at 27% (LRHS 2005). The CPR is higher in urban than rural women in Laos and women living in rural areas with better access (urban 44.7%, rural with road 36% and rural without road 25.6%). No evidence of direct EC contraception was found. However, it is certain that the regional Asia Reproductive Health Initiative for Youth in Asia promoted condom utilisation in Lao PDR, as did projects implemented under the GFATM.

4.4.1.2 Resume of the JC

The EC was not directly involved in improving the Indicators on the basis of which this JC is assessed, except through the Better Health project in Attapeu Province and, to some extent, the ARHIYA regional project. Indirectly, the EC contributed through projects funded by GFATM. There has been an increase in contraceptive prevalence, the proportion of women receiving ante-natal care and, in areas covered by the Better Health project, the proportion of deliveries attended by a skilled health worker.

¹⁹⁹ Final Project Evaluation Better Health: Empowering Indigenous Women and Children, in three districts of Attapeu Province.

²⁰⁰ Source: Lancet 2005 and La MIC II.

Considering this Judgement Criteria, the picture that emerges is as follows: “Headline” health indicators such as infant mortality and under-five mortality have continued to improve.

According to the EUD interview, the EC did not play a direct role in policy dialogue related to increased use of appropriate ante-natal and maternal health care as well as sexual and reproductive right per se. It did it indirectly in supporting MDGs 4 and 5 through MoF and HRH.

According to data provided during the interview with the EUD, most recent available data shows that maternal, neonatal and child health (MNCH) is improving in the Lao People’s Democratic Republic. The coverage of antenatal care with at least one visit has increased from 35.1% in 2006 to 71.0% in 2009–2010. For the same period, the proportion of births assisted by skilled birth attendants has increased slightly from 20.3% to 37.0%. Despite progress made in the last decade, MMR remains very high in the country – estimated to be 405 per 100 000 live births (2005, National Census). Most of the maternal deaths happen in rural, hard-to-reach areas of the Lao People’s Democratic Republic. Nevertheless it is impossible to define and quantify the EUD specific contribution of SBS or/and GBS on MNCH, as highlighted by the EUD.

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

- I-421 Percentage of children under five receiving regular growth monitoring
- I-422 EPI immunisation rate

4.4.2.1 Findings

I-421 No data are available in relation to the percentage of children under five receiving regular growth monitoring. However, in Lao PDR postnatal care is provided only around six weeks after birth and coverage is estimated to be low.

According to the WHO Global Health Observatory Data Repository, 2.7 % of children <5 years in 2001 and 1.3 % in 2006 were overweight; 36.4 % and 31.6 % underweighted; 48.2 % and 47.6 % stunted and 17.5 % in 2000 and 7.3 % in 2006 wasted respectively. The data generally point to significant improvement in child nutrition over the first half of the evaluation period.

As usual, there is no evidence of a major, nationwide contribution of EC-supported projects. However, to quote the evaluation of the EC funded project Better Health: Empowering indigenous women and children, Attrepeu province. “The quarterly Health Days, where beneficiaries can benefit of check-ups and medicine free of charge are a real success. Records show that although approximately the same number of women comes to consultation with their children, the number and seriousness of diseases has dropped since the beginning of the project.”²⁰¹

I-422 In 2000, according to UNICEF/WHO official estimates only 42% of children received immunization against measles and this coverage has declined even further to 40% in 2007, then increasing to 59% in 2009. DPT3 coverage stagnated in the early part of the evaluation period, and then increased to 57% in 2009; still low but a significant improvement nonetheless. Polio3 and Hepatitis B coverage also ended the evaluation period significant higher than midway through. However, the situation remains unsatisfactory. The percentage of children who have received all eight recommended vaccinations by their first birthday is 27%. In Lao PDR, 55.5% of women are protected against neonatal tetanus (MICS 2006) but the protection at birth figure has declined in 2007 to only 52%. While some uncertainty exists on the number of births used as denominator, these declines have been attributed to financial shortfalls in operational costs both for outreach and supervision and vaccine stock-outs.

²⁰¹ ROM MR-111542.02 – 2009.

Table 21 Immunisation coverage among 1-year-olds, Lao PDR: 1981-2009²⁰²

	2009	2008	2007	2006	2005	2000
Measles (MCV)	59	52	40	48	41	42
Diphtheria tetanus toxoid and pertussis (DTP3)	57	57	57	57	49	51
Hepatitis B (HepB3)	67	61	50	57	49	
BCG	67	68	56	61	65	69
Polio (Pol3)	67	60	46	56	50	57

Source: Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

Due to the extremely low routine immunization coverage it has been necessary to conduct supplementary immunization activities (SIA) in 2007 and 2008. First there was a highly successful national measles SIA that vaccinated more than 2,000,000 children aged nine months to 15 years achieving 96% coverage. This should give an effective coverage of 81.6% when sero-conversion failures are accounted for and keep the country free from outbreaks for the next 2-3 years. Sub-national immunization days for polio protection were conducted in December 2008 and continued in February/March 2009. There also is a plan to conduct large scale tetanus toxoid SIA targeting 1,000,000 child bearing age women for maternal and neonatal tetanus elimination in 2009 and 2010.

No EC interventions that directly contributed to improved immunisation have been found, however, there are likely to be indirect impacts, e.g. the training of health workers through NGO-implemented projects.

4.4.2.2 Resume of the JC

This JC was assessed by using two indicators: Percentage of children under five receiving regular growth monitoring and EPI immunisation rate. For the first indicator the authors could not collect any information on the proportion of children receiving growth monitoring. Postnatal care is provided only around six weeks after birth and coverage is estimated to be low. Hence we can assume that growth monitoring is very low, too. However, two studies collected by the WHO (see above) show improvements if underweight, stunted, wasted and overweight children aged <5 years. There is evidence that the Better Health project led to improved child health in Attapeu Province. The improvement in check-ups would have given health workers to spot nutritional problems at an early stage.

The figures of the second indicator show that immunization coverage in Lao PDR is relatively low, but improved, especially in the second half of the evaluation period. The training of health personnel through NGO projects may have contributed to the improvements concerning immunization. EC support to the Global Alliance for Vaccines and Immunisation also contributed.

4.4.3 JC 53 Children better protected from key health threats as a result of EC support

Indicators

- I-431 Increased proportion of children sleeping under a bednets
- I-432 Reduction in rate of child deaths from diarrhoeal disease
- I-433 Improved household management of diarrhoea based on oral rehydration salts (ORS)

4.4.3.1 Findings per indicators

I-431 The WHO Statistical 2011 Report provides the following data: (i) Children aged <5 years (%) sleeping under insecticide treated nets are 18% of the overall under five population. (ii) Children aged <5 years (%) with fever who received treatment with any anti-malarial is 9%.

This National Strategy for Malaria Control and Pre-Elimination 2011-2015 of the GoL and the MoH have a long list of targets to be reached and includes one target for children under 5: "Increase the proportion of children under five sleeping under a treated bed net (ITN or LLN) last night to 80% by 2012."²⁰³

There is no evidence that the EC contributed in the formulation process of this programme and that it will contribute financially and/or with know-how.

²⁰² Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>.

²⁰³ Ibid, p.39

The EC funded regional malaria control programme, covering Lao PDR, Cambodia and Vietnam, predated the evaluation period, but deserves mention because the GFATM projects picked up where the MCP left off (many the staff trained were taken over). In addition to awareness creation and providing microscopes and training to health centres, the project (Lao PDR Country Strategy Evaluation 2008), The WHO representative in Vientiane was of the view that the EC had made a highly significant contribution to the fight against malaria with the distribution of impregnated bed nets.

I-432 According to National Census 2005, the Infant Mortality Rate is 70 per 1000 live births and the under-5 mortality rate is 98 per 1000 live births. Cause specific mortality data are not available for Lao PDR, but clearly a large proportion of infant and child deaths are due to diarrhoeal disease

The EU co-funded project “Education to health and improvement of the sanitary arrangements in Laos” (06/2003-12/2006) in the provinces of Vientiane and Sayaboury set targets to improve the sanitary and safe drinking water situation and to educate population on health issues. How far this project decreased the diarrhoea incidence rate was not measured, but one can conclude that overall situation improved.²⁰⁴ Another sanitation and water project is the « *Amélioration des conditions sanitaires des populations rurales vulnérables (Province de Vientiane et de Sayabouri) par l'appropriation communautaire et le renforcement des capacités de la Croix Rouge Lao* », evaluated in the mid-term review as successful, but with some delays.²⁰⁵ Apart from this, there is no evidence for direct EC interventions on reductions of deaths due to diarrhoea.

I-433 Only limited information available. The MICS survey 2006 showed that in cases of diarrhoea 50.5% of children were given oral rehydration (ORT) therapy and 49.2% received ORT or increased fluids and continued feeding.²⁰⁶ The WHO Statistical 2011 Report estimates that 50.5% of children under five with diarrhoea received ORT. This suggests no improvement during the second half of the evaluation period.

There is no evidence of direct EC contribution to improving the prevalence of ORT. However, it is safe to assume that projects such as Better Health promoted awareness of proper disease management.

4.4.3.2 Resume of the JC

This JC was assessed by using three indicators: proportion of children under five sleeping under bed nets; reduction in rate of child deaths from diarrhoeal disease; and improved household management of diarrhoea based on oral rehydration salts (ORS). The EC contributed to improvement in the number of children sleeping under insecticide treated bed nets through its regional malaria project, which ended at the beginning of the evaluation period, but provided a foundation for GFATM projects implemented during the evaluation period. No data could be obtained for the death rates from diarrhoeal diseases; however, at least two EC-supported projects can safely be assumed to have contributed to improvements in this Indicator. About half of the children with diarrhoea receive ORT treatment, a number that appears unchanged if 2006 MICS data are compared with data in the statistical annex of the WHO 2011 World Health Report.

4.5 EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

4.5.1 JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support

- I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators)
- I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector
- I 513 EC contributed to decentralised capacity building to strengthen health policy capabilities at provincial, district and local levels

²⁰⁴ RAPPORT INTERMEDIAIRE 2BIS. Education to health and improvement of the sanitary arrangements in Laos. ONG-PVD/2002/019-950

²⁰⁵ Monitoring Report, MR-123062.01, 30/07/2009

²⁰⁶ MICS survey 2006.

4.5.1.1 Findings

I-511 The EC has been involved in General Budget Support policy dialogue since late 2004. Under PRSO-I one of the sectors was health. Under PRSO-II, as described above at I-231, the Commission has identified and agreed with development partners and GoL a list of indicators for the years 2009, 2010 and 2011. For the Health Sector the indicators are: (1) Health Financing Strategy; (2) Recurrent health budget as percentage of total recurrent budget (domestic allocation); and (3) Number of health personnel in 47 priority districts. The target by March 2011 should be the MoH initiates the implementation of the approved Health Financing Strategy (HFS). No evidence could be found that the HFS is implemented. As also elaborated in I-231, the EC contributed with other donors in drafting the Health Financing Strategy over the last two years. The EC also participated in the Public Expenditure Management Strengthening Programme (PEMSP), which took place early in 2007. EC involvement in the preparation of the PRSO-2 programme has taken place through the Public Expenditure Review (PER) and through various preparatory studies. The PER provides an assessment of the Government's reform performance, serving as a basis for yearly PRSO negotiations and the 2005-06 version was a joint exercise between the EC, the WB, the IMF, the ADB and the Government. As a result of policy dialogue with the Government and the World Bank on PRSO and the PER as well as the National Development Plan, the current policy reform agenda in Lao PDR largely reflects EC priorities.

According to the EU Delegation, under PRSO 4-7, through the variable Tranche indicator (1) Health Financing Strategy: the EU Delegation has been active in supporting the capacity development for financial management of the health sector, understanding of health financing, routine monitoring of coverage and financial flows in the health sector, support to policy and strategy dialogue and legislation/guidelines related to more equitable health financing and support to health information systems for improved evidence-based management. Most of these policy changes and actions were promoted and implemented by dialogue and technical assistance under the second general budget support programme (PRSO 4-7).

Specifically in the area of health, the EU submitted a newly piloted curriculum on the use of a Health Management Information (HMIS) for improved evidence-based management at all levels in the health sector. The MoH accepted the curriculum (March 2010), after it was much involved in the development and piloting the training at provincial and district level. The MoH is now rolling out the management training and has shared the EC-developed curriculum with World Bank and Luxembourg Development for use in their health projects in eight provinces in Laos.²⁰⁷

I-512 PFM has traditionally been nearly opaque in Lao PDR and been a key focal point in both PRSO-I and PRSO-II. The Public Finance Management Strengthening Programme (PFMSP) (multi donor trust fund with EUR 3 million EC contribution), the weaknesses in the institutional setup in the Lao Ministry of Finance to manage the Multi-Donor Trust Fund supporting the implementation of the PFMSP emerged in 2009 and continued in 2010. The management of the Trust Fund remains a major concern for the partners. The governance structure needs to be further strengthened and adapted to increase efficiency and effectiveness of the overall programme. One quarterly progress (Q1) report was received from the MoF, Q2, Q3 and Q4 are still pending.²⁰⁸

I-513 No information could be found on this indicator.

4.5.1.2 Resume of the JC

This JC is assessed by three indicators: (1) EC contributed to overall health policy strategy process and related documents (2) EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector; and (3) EC contributed to decentralised capacity building to strengthen health policy capabilities at provincial, district and local levels. No information could be found on the latter.

We found that the EC assisted the GoL and the MoH in the preparation of health related strategies and in particular in the Health Financing Strategy. Much of the EC's contribution may reside in policy dialogue related to the health care finance EC triggers in PRSO-II.

According to the EU Delegation, although HFS have not yet been approved (officially) by the government, as scheduled by a ministerial decree in 2011, several actions have been taken as part of HFS implementation; the draft Decree on National Health Insurance (NHI) was drafted and is waiting

²⁰⁷ EAMR July 2010 Final, p.20

²⁰⁸ EAMR Jan 2011 Final, p.17 and 53

for approval. The new institution for NHI is mentioned in the draft NHI Decree but the detail on administration and system set up are in the process of preparing under the direction of the new committee assigned by Prime Minister with the taskforce from line Ministries (MoH, MoLSW, MOF) as secretariat team. However, this represents a limited impact and the achievement of broad-based sustainable health care finance in Lao PDR remains a significant challenge.

4.5.2 JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

- I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc).
- I-522 EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing)
- I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

4.5.2.1 Findings

I-521 The PRSO I to PRSO-III policy matrix sets down the expected results in the social, trade, financial, infrastructure, natural resources, PFM and PSD sectors. These include i) contributing to good governance by increasing the transparency and accountability of the budgetary process, ii) strengthening public expenditure management capacity, including in the health and education sectors, iii) improving public service delivery, for instance, upgrading health centres and increasing access to primary education, iv) promoting a competitive environment for private sector development and v) achieving greater liberalisation in the trade regime. The budget execution and financial reporting policy areas foresaw that the MoF submitted in 2007 (PRSO III) to the National Assembly an appropriately revised Budget Law, adopted a decree on organisation and operation of MoF and drafted a ministerial instruction on organisational structure of the National Treasury. The expected outcome was progress towards centralised treasury with consolidated functions. A further outcome was that there will be a streamlined budget preparation process and timely publication of the budget. Additionally, the plan was to have an increased coherence between provincial expenditure allocation and NGPES priorities. The MoF, in collaboration with the MoH and provinces has set up a sub-committee to develop a framework for a set of Budget Norms under the leadership of the Budget department of MoF.²⁰⁹ The EC can be said to have contributed substantially to the process by which this stage was reached.

I-522 No information

I 523 The EC supported through the PRSOs I to PRSO-III procurement regulations of the MoF. The plan was to approve the Charter of the Procurement Management Office (PrMO) by 2005. The PrMO should develop the Procurement Manual including Standard Bidding Documents, which should be further circulated by the PsMO. The next step, by 2007, should ensure standardised application of procurement rules, including the systematic collection of procurement information and monitoring of performance and outcomes.²¹⁰ No information was obtained on whether these goals have been reached, so we have no real basis on which to assess this Indicator.

4.5.2.2 Resume of the JC

There was some contribution of the EC to consolidate the drawing up and control for MoF annual budgets in the PRSOs I to III (period 2005-2007). Concerning the budgeting procedures improvements of the MoH no evidence of support could be found. However, a sub-committee led by the MoF and including MoH has been set up to improve budgetary procedures in the provinces. The EC further supported the implementation of an efficient and transparent procurement system of the MoF. These interventions were not extended in the follow up PRSOs. However, overall, the EC has been deeply implicated in improving PFM, including in health. The PRSO I-III policy matrix included health finance triggers.

²⁰⁹ DCI-ASIEI2007/19166, Support to Third Poverty Reduction Support Operation, pp.2-3 and 10-11.

²¹⁰ Ibid.

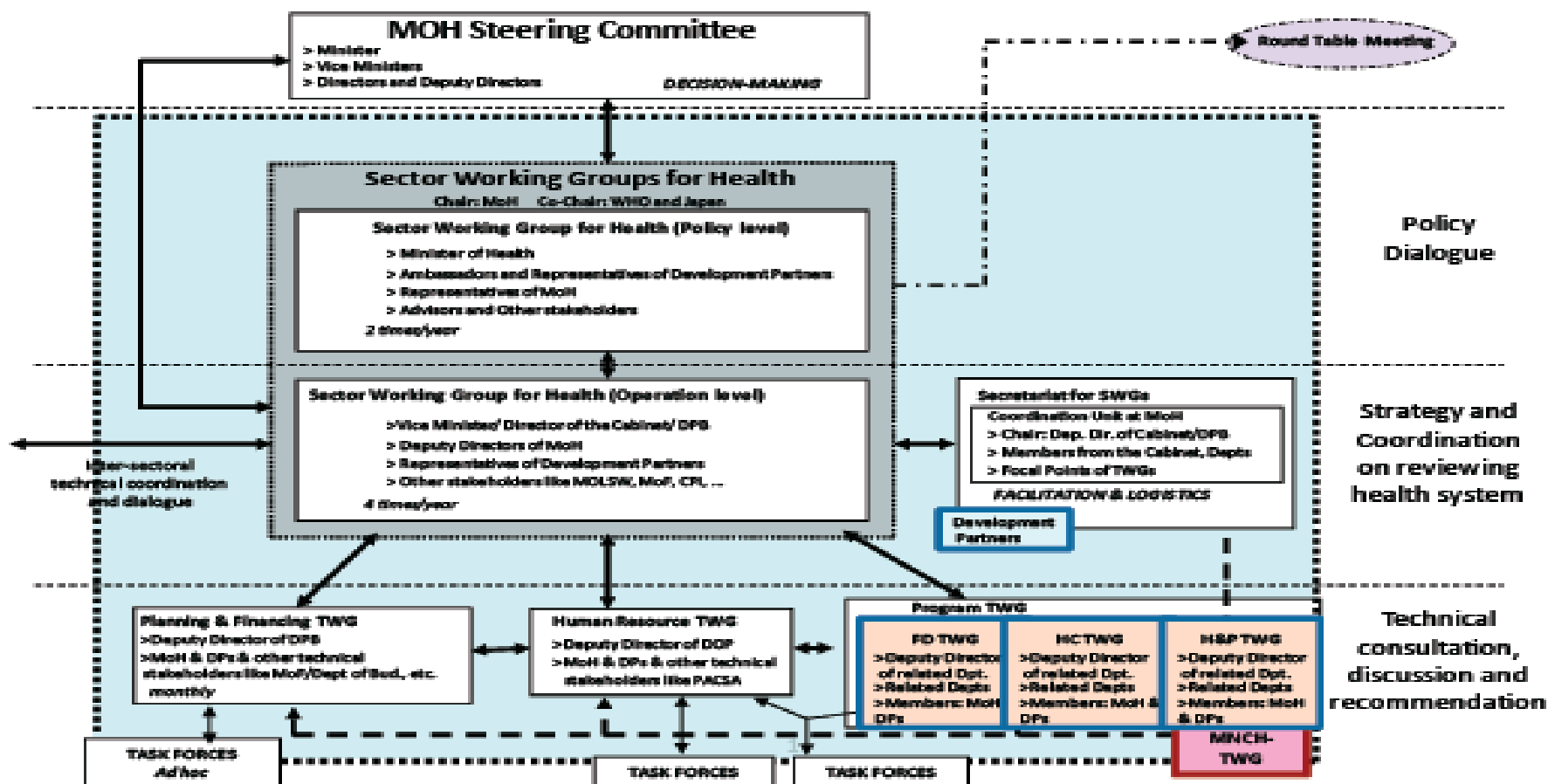
4.6 EQ6 donor coordination

According to the interview with the EUD, the health SWG coordination mechanism is an important government–donor forum for cooperation on health issues in the Lao People’s Democratic Republic. It comprises members of the Government, United Nations agencies, bilateral and multilateral donors and international NGOs. Under the leadership of the Ministry of Health, WHO and Japan co-chair and act as Secretariat for the health SWG coordination mechanism. Under this SWG coordination mechanism, a number of TWGs have been set up to coordinate and support the Ministry of Health in key health sector development areas. Other coordinating mechanisms in the Lao People’s Democratic Republic are the GFATM Country Coordinating Mechanism (CCM); the Immunization Coordination Committee (ICC) for immunization and the GAVI Alliance operations. The next figure shows the organigramme of the sector coordination group.

Figure 45: Health sector working group coordination mechanisms in the Lao People's Democratic Republic

Figure 7: Health sector working group coordination mechanism in the Lao People's Democratic Republic

Structure of Sector Coordination Mechanism for Health



Source: Health SWG Secretariat, 2011

4.7 Annex

4.7.1 Key documentation used for the analysis

4.7.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluations</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
DCI-ASIEI2007/19166, Support to Third Poverty Reduction Support Operation	Available			Mid term independent review of the PRSO, 2009	
DCI-ASIEI2008/19518 Support to the Government reform agenda under the National socio-economic Plan - Second General Budget Support Lao PDR"	Available				Government reform agenda under the national socio-economic plan. Final Project Evaluation, 2010
ONG-PVD/2003/004-562) Contract 62434 Better health: empowering indigenous women and children, Attrapeu province, lao pdrhealth	Not relevant	-	ROM available done	2 interim reports available MTR 2007 Mission report available	Available
Contract 19950 Education a la sante et amelioration des conditions sanitaires, laos	Not relevant	-	Monitoring Report, MR-123062.01, 30/07/2009	Mission report available	
((DCI-NSAPVD/2008/020-081) 226050 Rural community empowerment through health promotion, dialogue and capacity building of local Red Cross and local authorities (2009)	Not relevant	-	No ROM	No doc available	No doc available
(DCI-ASIE/2008/019-518) 219886 Support to government's Capacity Development in the Health Sector, Lao PDR (2009)	Not relevant	-	No ROM	No doc available	No doc available

4.7.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSPs'/NIPs/MIPs	available
CSE	Laos CSE. 2009. Evaluation of EC co-operation with the LAO PDR, Final Report.
EAMR	available
Country note from old health evaluation	Not available
Other Evaluations	Paris Declaration – Thematic case study Lao, untied aid

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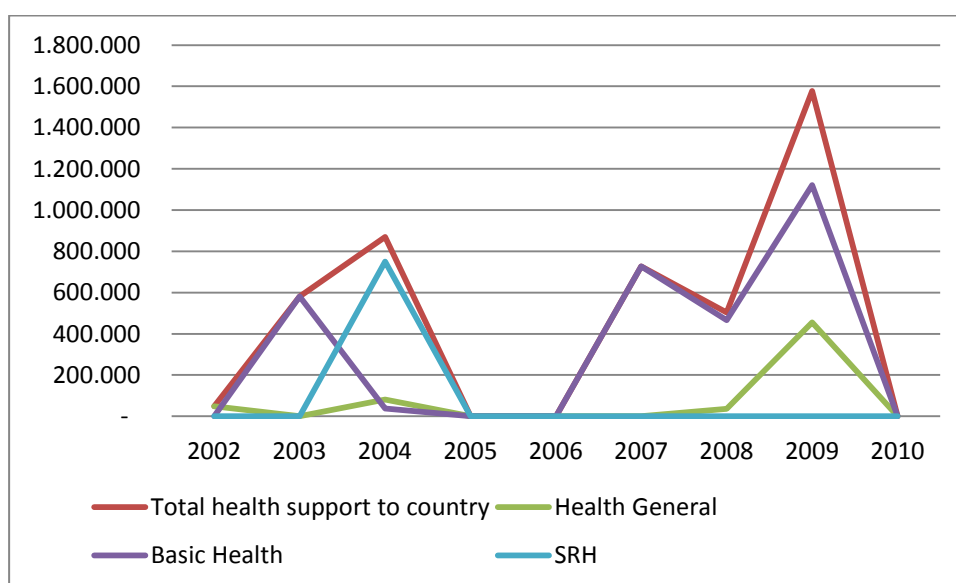
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National Strategy for Malaria Control and Pre-Elimination 2011-2015,
http://www.wpro.who.int/countries/lao/2010/national_health_priorities.htm

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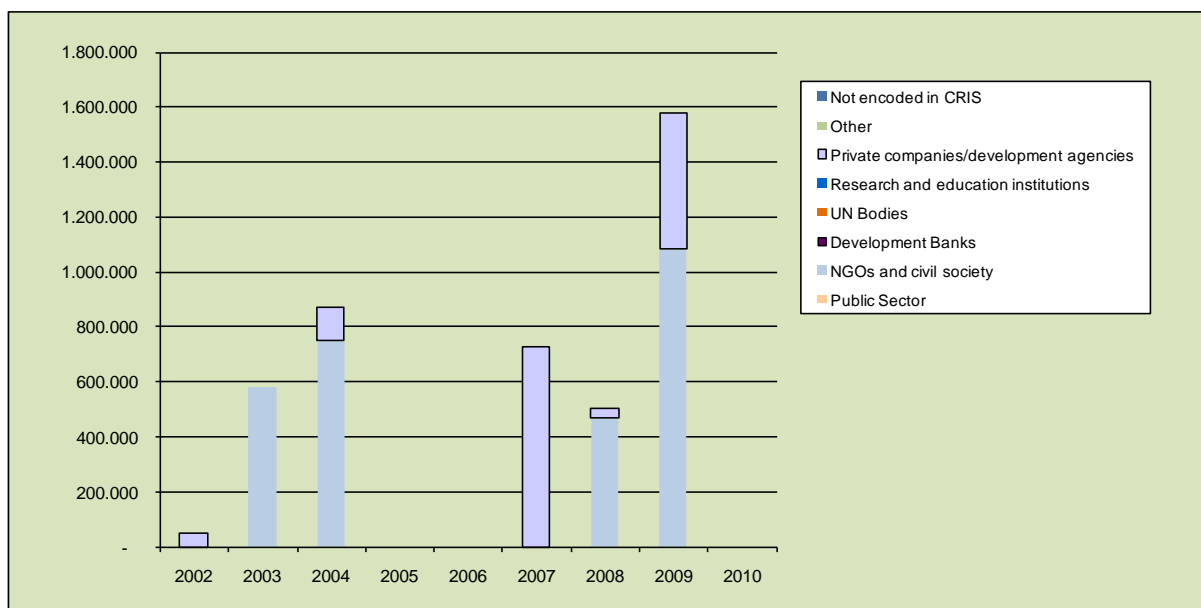
4.7.2.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to country
2002	49,426	-	-	49,426
2003	-	580,708	-	580,708
2004	81,698	38,047	750,000	869,745
2005	-	-	-	-
2006	-	-	-	-
2007	-	727,500	-	727,500
2008	36,300	466,812	-	503,112
2009	455,701	1,121,396	-	1,577,097
2010	-	-	-	-
Total	623,125	2,934,463	750,000	4,307,588



4.7.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	49,426	-	-	49,426
2003	-	580,708	-	-	-	-	-	-	580,708
2004	-	750,000	-	-	-	119,745	-	-	869,745
2005	-	-	-	-	-	-	-	-	0
2006	-	-	-	-	-	-	-	-	0
2007	-	-	-	-	-	727,500	-	-	727,500
2008	-	466,812	-	-	-	36,300	-	-	503,112
2009	-	1,081,411	-	-	-	495,686	-	-	1,577,097
2010	-	-	-	-	-	-	-	-	0
Total	0	2,878,931	0	0	0	1,428,657	0	0	4,307,588



4.7.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	49,426	-	49,426	-
2003	-	-	580,708	-	580,708	-
2004	-	-	869,745	-	869,745	-
2005	-	-	-	-	-	-
2006	-	-	-	-	-	-
2007	-	-	727,500	-	727,500	-
2008	-	-	503,112	-	503,112	3,198,902
2009	-	-	1,577,097	-	1,577,097	12,886,058
2010	-	-	-	-	-	-
Total	-	-	4,307,588	-	4,307,588	-

4.7.3 Overview of funds committed to the country's health sector

Decision number	Contract title	Contract number	Contract year	Total per contract
ASIE/2000/002-965	Programming Mission - Health Sector	31841	2002	EUR 49,426
(blank)	EDUCATION A LA SANTE ET AMELIORATION DES CONDITIONS SANITAIRES, LAOS	19950	2003	EUR 580,708
ONG-PVD/2003/004-562	BETTER HEALTH: EMPOWERING INDIGENOUS WOMEN AND CHILDREN, ATTRAPEU PROVINCE, LAO PDR	62434	2004	EUR 750,000
ASIE/2003/005-025	Capacity Building for the Communicable Diseases Control Task Force of the Ministry of Health	83198	2004	EUR 81,698
	Public Expenditure Policy in Primary Education and Primary Health in Lao PDR	95041	2004	EUR 38,047
	Healthy Huameuang Project	133800	2007	EUR 727,500
DCI-NSAPVD/2007/019-404	Community-based Health Development for remote, vulnerable communities.	166159	2008	EUR 466,812
DCI-ASIE/2007/018-889	Identification mission: Capacity development needs of the Ministry of Health, Lao PDR	159385	2008	EUR 36,300
DCI-NSAPVD/2008/020-081	Promoting mental health and development in Borikhamxay Province	217686	2009	EUR 332,044
	Rural community empowerment through health promotion, dialogue and capacity building of local Red Cross and local authorities in Lao PDR	226050	2009	EUR 749,367
DCI-ASIE/2008/019-770	Support Lao Ministry of Health to draft Health Financing Strategy	215346	2009	EUR 56,180
DCI-ASIE/2008/019-518	Support to government's Capacity Development in the Health Sector, Lao PDR	219886	2009	EUR 399,521
	Healthy Wetlands for Healthy Women, Children and Men, Attapeu, Lao PDR	209934	2009	EUR 39,985
				EUR 4,307,588

5 Annex 16: Country case study Ecuador

***Thematic evaluation of
the European Commission support
to the health sector***

Country case study
ECUADOR

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5.1 Introduction

5.1.1 Country context of EC support

Ecuador is a constitutional State organized as a republic and with a decentralized government. In 2007, the country had a total population of 13.4 million. With 30% of the total population represented by children under the age of 15, the demographic structure of the population is primarily young. It is a multiethnic, multicultural country made up of indigenous, Afro-Ecuadorian, mulatto, mestizo and white populations. Like many developing countries, Ecuador is battling an increasing tide of non-communicable diseases associated with population ageing and prosperity while communicable diseases and diseases of poverty remain at a high level. Deficiency diseases and communicable diseases coexist with chronic degenerative conditions.

In the past 15 years, the political context of the country has been characterized by significant institutional instability and a high level of social conflict. Between 1992 and 2007, there were eight different national governments. This led to a significant governance crisis and social violence, as well as an increase in corruption, administrative instability and lack of continuity in public administration. These problems have affected the dynamic of the health sector and its reforms. The recently approved Constitution of 2008 establishes a legal framework for the creation of the National System for Social Equity and Inclusion, of which health is a component. The Constitution states that health is a right. The document outlines the characteristics of the national health system, which will operate according to the principles of universality and equity, with an integrated public health network under the steering of the national health authority. In this regard, the articles of the new Constitution favour reform of the health sector, which is referred to as Sectoral Transformation of Health in Ecuador (TSSE).

The health service delivery system is marked by fragmentation and segmentation, since there is a lack of coordination between actors and no separation of functions between the sub-systems. Each sub-system has a subscriber or beneficiary population with access to differentiated services. Each institution in the health sector has its own organizational scheme, management and financing. The public sub-sector includes the Ministry of Public Health (MPH), Ecuadorian Social Security Institute (IESS-SSC), Armed Forces Social Security Institute (ISSFA) and National Police Social Security Institute (ISSPOL) services and the health services in some municipalities. The Guayaquil Welfare Board (JBG), the Guayaquil Children's Protection Society, the Cancer Society (SOLCA) and the Ecuadorian Red Cross are private entities with activities in the public sector.

The budget for the health sector increased from USD 115.5 million in 2000 to USD 561.7 million in 2006. During the same period, the budget as a percentage of the central government budget (PGC) and GDP increased from 2.7% to 6.6% of PGC and from 0.7% to 1.4% of GDP. The population covered by public or private health insurance was slightly under 23% in 2004. In 2007, there were 55,578 people working in health care facilities, primarily physicians (19,299), nursing assistants (13,923) and nurses (7,499). The number of physicians per 100,000 inhabitants in 2006 was 14.4. There were 5.6 nurses and 10.4 nursing assistants per 100,000 inhabitants. The highest percentage of physicians (63%) work in general hospitals and clinics. Only 24.9% of the total physicians in health care facilities work at outpatient and primary care services.

As a result of the 2008 Constitution, which declares health as right and priority of President Correa's Government, the national health budget saw a major increase from USD 620 million in 2007; USD 728 million in 2008; USD 1057 million in 2009 and USD 1245 million in 2010.

Ecuador has not had any real health sector reform in terms of sustained, in-depth changes in the structure of the sector. From 1995 to 2005 this process was characterized by development and discussion of several initiatives with different approaches to insurance, the legal framework and partial or targeted application of health service deconcentration and decentralization; programmes for the extension of coverage, new primary health care-based family and community health care models and the universal insurance program (AUS). The political and administrative instability experienced by Ecuador during this period prevented the development of specific and sustained implementation plans as a result of the contradictory policies adopted in different periods by each new government, the resistance of progressive social organizations and the lack of consensus among stakeholders.

5.1.2 EU funds between 2002-2010

With the adoption in May 2002 of the EC's Country Strategy Paper for 2002-2006, the first priority sector accounting for the greatest amount of money (EUR 28 million) was Support for health care reform - The *Programa de apoyo al sector salud en Ecuador* (PASSE). This programme worked to implement an integrated intercultural model of care based on primary health care, health promotion and disease prevention with a focus on the highland provinces of Cotopaxi, Chimborazo and Bolívar which have significant indigenous populations.

Programmes of EU Member States and other donors: Seven of the EU Member States have in-country cooperation offices and bilateral aid programmes with Ecuador, the most important in terms of financing and strategic location being those of Spain, Germany and Belgium. The EU Member States are mainly involved in **health**, the environment, education and regional and local development while the key priorities of the three leading Member States are natural resources management, support to civil society and decentralisation. The EC started with the provision of sector budget support in education (PAPDE) and local economy (PASES: supporting the solidary and sustainable economy) in 2008. No SBS modality has been used yet for the health sector. While Member State interventions have not been explicitly coordinated with EC interventions, there is no major inconsistency between them.

Table 22: Overview of EC funds per sector in Ecuador between 2002 and 2010²¹¹

<i>Decisions Title</i>	<i>Contracts Title</i>	<i>Decision Number</i>	<i>Contract number</i>	<i>Contracted amount until 2010 (contract level)</i>
Contrat-cadre - coopération au développement	MISION DE IDENTIFICACION Y FORMULACION PARA UN PROGRAMA DE APOYO AL SECTOR DE LA SALUD EN ECUADOR	ALA/2000/004-333	80296	EUR 129,476
Pré-engagement P1 dont dépendront 190 contrats en faveur de pays en développement	Promoting a holistic health response to HIV/AIDS and human rights through education, advocacy and training in Ecuador.	ONG-PVD/2002/001-092	20583	EUR 732,013
Annual Work programme 2006 PRD	Unidos para combatir el VIH / SIDA en Ecuador - UNIVIDA	SANTE/2006/017-998	104297	EUR 2,727,527²¹²
Allocation de crédits pour des prestations d'audit externe	"Audit du projet ECU/1997/0044 "Proyecto integral de salud en Esmeraldas" ²¹³	ALA/2003/004-696	74502	EUR 32,402
Programa de apoyo al sector salud en Ecuador (PASSE)	Asistencia Tecnica Internacional para el PASSE	ALA/2004/016-916	105617	EUR 3,375,534
	Evaluacion de Termino Medio, Programa de Apoyo al Sector Salud en Ecuador, PASSE	ALA/2004/016-916	154586	EUR 39,740
	GASTOS LOCALES DEL PASSE	ALA/2004/016-916	153845	EUR 1,601,745
	Gastos Locales Programa PASSE	ALA/2004/016-916	105122	EUR 22,387,603
	Mission de Evaluación Final del Programa de Apoyo al Sector Salud en Ecuador, PASSE	ALA/2004/016-916	222678	EUR 79,355
	Programa de apoyo al Sector Salud PASSE - mission de apoyo a la elaboración POG y POA1 ALA 2004 16916	ALA/2004/016-916	102380	EUR 184,929
Global commitment for local calls for proposals Objective 1 - PVD Projects - Non State Actors - AAP 2007	Fortalecimiento de unidades productivas familiares que prestan servicios en dos ejes turisticos del Distrito Metropolitano de Quito	DCI-NSAPVD/2007/019-404	164143	EUR 238,684
Allocation de crédits pour prestations d'audit externe	Programa de apoyo al sector salud en Ecuador (PASSE)	DCI-ALA/2008/019-840	160826	EUR 30,938
Grand Total				EUR 31,559,945

²¹¹ Only contracts committed between 2002 and 2010 are listed in this table. E.g the programme PISIE (ALA/1997/004-615) is not counted in the total.

²¹² Initially geographical zone is labeled as "TPS", as part of a worldwide programme. The funds (2,7 million Euro) are therefore not included in the detailed listing of funds in Annex 5.6.2

²¹³ Contracts of PSIE, committed before 2002 have not been taken into account in this overview.

Source: inventory, Particip GmbH

5.2 EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services?

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

Indicators

- I-111 National health policies guarantee access to drugs, officially recognised as essential
- I-112 Average availability of selected essential medicines in public and private health facilities, including pharmacies

5.2.1.1 Findings per indicators

I-111 A major goal of the 1999 national drug policy was to guarantee the availability, access to, quality and rational use of drugs, as well as the lowest price. The 2000 Law on the Production, Importation, Marketing and Sale of Drugs for Human Consumption established regulations that fostered expansion of the generic drug market, as well as a list of essential drugs and provided incentives for national production and facilitated registration through the equivalency procedure for imported products. The National Committee for Drugs and Supplies of CONASA updates, publishes and disseminates the national list of essential medicines on a biannual basis. In 2006, the sixth revision was approved. Use of the drugs on this list is required in all public health facilities and reference institutions in the private sector. In short, access to essential drugs was guaranteed prior to the evaluation period and EC interventions over the evaluation period did not affect policy in this area.

I-112 No information available.

5.2.1.2 Resume of the JC

EC support was not directly related to this JC.

According to the interview with the EUD, the EC projects, especially the SPSP had not any impact on the Ecuadorian pharmaceutical policy. The SPSP during the period 2000/2010 purchased minimal quantity of drugs for the two regions where the SPSP was implemented.

This has been confirmed by the MoH. He stretched however, that in two region in which the SPSP.

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

Indicators

- I-121 Improvement in the mix of primary and secondary health facilities
- I-122 Increased proportion of health facilities with appropriate equipment

5.2.2.1 Findings per indicators

I-121 There has been no significant change in public infrastructure at the primary and secondary care levels in the past 15 years, with the exception of an increase in non-institutional primary care. Clinics were, however provided with EC support as described under Indicator I-122. Private infrastructure has grown from 61.3% to 74.4% of the total, which represents an increase from 277 to 514 establishments between 1994 and 2004²¹⁴. Documents consulted to date have not identified what are the most pressing infrastructure needs in Ecuador. If we speculate that the need is for more primary facilities, then the EC contributed as described under Indicator I-122.

I-122 The reorientation of services towards the implementation of a comprehensive health care model based on the renewed PHC strategy has begun with extramural care in family, community and work environments. The increased number of health facilities received updated and appropriate equipment, however the proportion with appropriate equipment is not available.

²¹⁴ PAHO/WHO. Health Situation in Ecuador, 2006. Pan American Health Organization, Washington DC. 2006. MSP – INEC. Indicadores Básicos de Salud, 2006.

The EC programme PSIE – *Proyecto Integral de Salud en la Provincia de Esmeraldas* – implemented in 2002-2007 in five areas (cantons) of the province Esmeraldas carried out construction or rehabilitation of 29 operative health care units. In addition, total of 55 units were provided with equipment based on their functions. The programme also achieved a significant improvement of medical transport systems through the provision of four ambulances, a boat, six vehicles and 32 radio stations for intercommunication for medical transportation and coordination of activities.²¹⁵ The programme also included training in the field of equipment maintenance, electricity, vehicles etc. to increase sustainability of all purchased equipment (17 participants for five days).

The subsequent EC programme PASSE – *Programa de apoyo al sector salud en Ecuador* – operating in three provinces of Ecuador (Chimborazo, Bolívar and Cotopaxi – total population of over 920 thousand persons) with high proportions of indigenous populations aimed at increasing the quality and coverage of health services. The final evaluation report²¹⁶ concludes that there is no documentary evidence that the programme has resulted in increased health care coverage. However, the availability of ambulances, equipment, supplies and medication is believed to have had a positive impact on improving the quality of health care in the three provinces.

PASSE directly carried out 94 works of improvement of health units and 27 new constructions. While the coverage data for these units are not available, in relation to the total of the three provinces it can be considered a big step forward, as since according to the data of the programme the initial number of units was 191 across the network. In addition, all the units in the network were equipped according to the MPH standard. In conclusion, there has been an extensive effect of increasing the supply of services. It was also noted that one infrastructure, more precisely the health centre located in the province of Cotopaxi, is still not in use despite being completed for one year because of the lack of equipment or construction problems. In this specific case the agreement was that the EC built the first floor, the second floor was under the responsibility of the MoH. During the lifetime of PASSE the MoH did not proceed to the construction.

5.2.2.2 Resume of the JC

The EC contribution has been operating solely in four provinces of the country. The impact therefore related to above indicators can be gauged only through the analysis of the provincial data of the health information system and comparative data.

The PSIE programme achieved improvements in the availability of physical health infrastructure, including equipment and transportation and communication systems in the province of Esmeraldas.

The PASSE programme also improved the availability of quality infrastructure in the highland provinces of Cotopaxi, Chimborazo and Bolívar which have significant indigenous populations. Therefore the EC contribution improved availability of quality health infrastructures.

The health and political authorities interviewed during previous field mission, in the targeted provinces of PASSE, indicated that one of the most remarkable and positive things of the program was the improved availability of quality health infrastructure such as: Laboratory capabilities, constructions and rehabilitation of health infrastructure in rural areas (sub-centres and health centres) and provision of a good number of means of transport (ambulances, trucks and motorcycles).

According to the EUD, there has been slight improvement on the data availability on equipments in primary and secondary facilities since 2007 when the new president increased emphasis on PHC approach. This results in better access and better quality of care in 2nd and 3rd levels health facilities and therefore in equipments availability. The 2010 constitution increased budget and investments for the health sector; special emphasis has been given in strengthening 2/3 health services specifically on the preventive and promotive aspects of health more than on the curative one. This was done – among other – to reduce the overload at health facilities level.

According to the MoH, the EC supported infrastructure in two regions through the SPSP.

²¹⁵ Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007.

²¹⁶ Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.

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

Indicators

- I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population
- I-132 Improved availability and standards of health worker training
- I-133 High health worker attrition and absenteeism addressed

5.2.3.1 Findings per indicators

I-131 The EC programme PSIE – *Proyecto Integral de Salud en la Provincia de Esmeraldas* – was implemented in 2002-2007 in five areas (cantons) of one province (Esmeraldas) with the EC contribution of EUR 6 million. The capacity building of health care workers was its central focus, both in the areas of health management and care. According to its mid-term review,²¹⁷ the project managed to provide training to 83% of all staff of the areas (and the provincial directorate) of implementation (surpassing its goal of 70% staff trained). This meant over 400 persons trained, including doctors, nurses and auxiliary medical staff, at the time of the review. In addition, 716 people (auxiliary medical staff) were trained in the use of medicinal plants and a guide to medicinal plants was provided. Further 124 health workers received training in management and rational use of drugs.

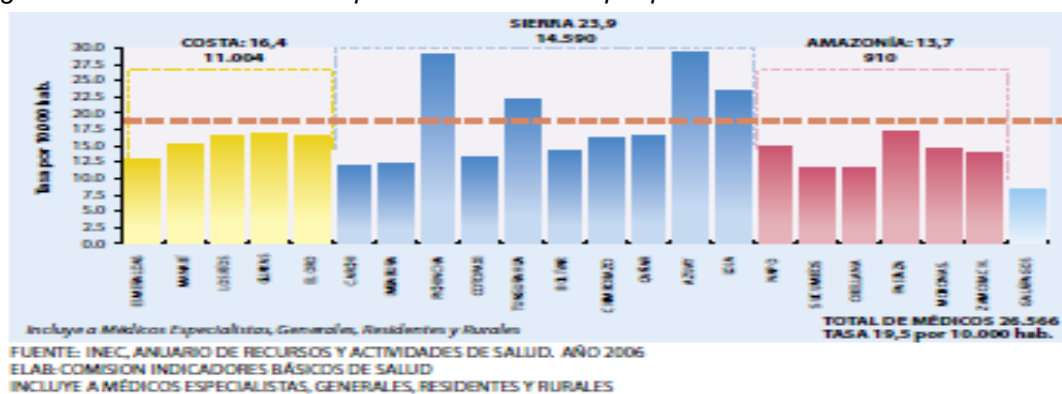
The subsequent EC programme PASSE – *Programa de apoyo al sector salud en Ecuador* – was operating in three provinces of Ecuador (Chimborazo, Bolívar and Cotopaxi). Within its framework 133 professionals were trained in a graduate programme Specialist in Primary Health Care (Atención Primaria de Salud); 91 professionals graduated in health policies from which 37 specialised in Health Economy. 369 persons were trained in the process of reform and transformation of the Health Sector; and 235 employees from the Ministry of Education received training in Healthy School. Furthermore, 300 auxiliary nurses, 200 midwives and 2500 health promoters were trained.

The programme also implemented training of 967 professionals from the Provincial Health Directorates (DPSs) in Information, Education and Communication techniques within the socialized model of care and primary health care strategy. It is concluded that the three provinces are now in a better position to absorb the changes that the deepening of the transformation of the sectors involved. More time and human resources would have ensured a better quality of processes and products of the programme and these effects might have been greater and more sustainable. According to the EUD, PASSE can be seen as a programme which had extensively trained and formed health professional and through which the EC has contributed to the health sector.

The EC programme – *Unidos en la lucha contra el VIH/SIDA en Ecuador* – UNIVIDA – implemented by CARE between 2006-2010 with EC contribution EUR 2.7 million, was focussed on prevention of transmission of HIV. Within the framework of the programme the number of health centres that offer HIV-AIDS related services increased by 46, within which a total of 131 healthcare professionals in care for patients with HIV-AIDS were trained. Over the duration of the project, the services were used by over 70,000 people for pre-test counselling and over 60,000 people for post-test counselling in the participating health care centres. Number of persons living with HIV-AIDS that acquired access to basic and specialised care was over 900. The centres contributed to the identification of new cases of HIV-AIDS through voluntary testing reaching over 47,000 of first tests. Project activities are contained in six of the 10 strategic sectors of the Multisectoral Strategic Plan of National Response to HIV AIDS of the Ministry of Public Health, therefore it is foreseen that MPH will continue to support the network of services developed by UNIVIDA.

²¹⁷ Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007.

Figure 46: Doctors ration per 10.000 habitants per province



Source: Minister of Public Health – 2007

I-132 Human resources training²¹⁸ is under the responsibility of the National Council for Higher Education (CONESUP), which serves as the regulator; the National Council for Educational Accreditation (CONEA) which is responsible for accreditation; the National Health Council (CONASA), which formulates policies; the MPH, IESS, Armed Forces, Police, JBG, SOLCA and the municipalities, which are practice scenarios; the Association of Ecuadorian Schools of Medicine and Health Sciences (AFEME) which serves as the academic coordinator; and public and private universities that provide education and training. In 2008, there were 25 schools of medicine and health sciences, 13 of which were public and 12 private. In order to ensure the application of legal and constitutional principles in regards to the coordination between the Ministry of Health and educational institutions, agreements are signed regularly by MPH and AFEME for the development of undergraduate, graduate, continuing education, research and community programs.

I-133 According to the EUD, government policies have changed in 2010 and force health personnel to work eight hours a day. Until then and as a result of low salaries, health professionals worked less (in public facilities) in order to earn money through other means. There is no information that the EC was involved in this change.

5.2.3.2 Resume of the JC

The EC was not directly involved in this JC with the exception of the provinces where the “*Programa de apoyo al sector salud en Ecuador (PASSE)*” implemented its activities. In these provinces a number of health care professionals were trained as well as professionals of the Provincial Health Directorates. This has contributed to improving the capacities of human resources and the availability of primary care as well as health care management.

The EC also supported the increase in capacity of health care workers to provide services related to HIV-AIDS nationwide.

5.2.4 JC 14 Increased or maintained quality of service provision

Indicators

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)
- I-142 Clinical treatment guidelines available, disseminated and applied
- I-143 Percentage of people who are satisfied with the quality of the services (by facility and specific service provider: physician, dentist, nurse, etc.)

²¹⁸ Merino C; Observatory of Human Resources in Health in Ecuador; National Committee of Human Resources. Empleo de los recursos humanos en salud en instituciones del sector público. Quito; 2006. CONARHUS-CONASA, MPH-MODERSA Project, PAHO/WHO, Merino, Cristina, Empleo de los recursos humanos en salud en instituciones del sector público. Quito; 2006, Observatory of Human Resources in Health in Ecuador, National Committee on Human Resources, Quito, Ecuador, 2006.

5.2.4.1 Findings per indicators

I-141 A quality assurance mechanism for health facilities was set by MoH in 2004. The Coverage Extension Programme developed and implemented a licensing system for Level I and Level II health units in the 200 poorest parishes identified according to unmet basic needs. This program was based on the primary health care and comprehensive care model. The data from the licensing process shows that 11.3%, or 150, of the operative Level I units have complete licensing, 51.7%, or 690, have conditional licensing and 37%, or 489, are unlicensed.²⁹ The certification instrument used by the IESS (Ecuadorian Social Security Institute) for its operative units is based on higher standards than those of the MPH. This instrument can determine the amount of resources required to maintain intermediate operating standards.

The EC-funded project *Unidos en la lucha contra el VIH/SIDA en Ecuador – UNIVIDA* was implemented 2006-2010 with EC contribution of EUR 2.7 million. According to its final report, the project has brought 20% of HIV-AIDS counselling centres nationwide to the standards established by the Ministry of Public Health.

I-142 A vast range of treatment guidelines for health sectorial topics (e.g. PHC, EPI, MNCH, Malaria, TB, HIV/AIDS, etc.) are available in Spanish and Indio dialects for the rural areas. They are mainly derived and/or translated by WHO, UNICEF, UNFPA, UNAIDS, guidelines and/or from main multi/bilateral donors as USAID, WB and ADB. In general those guidelines are disseminated at peripheral level; however it is not possible to quantify the rate of dissemination and real implementation of those treatment guidelines in the field.

The EC programme PSIE – *Proyecto Integral de Salud en la Provincia de Esmeraldas* – implemented in 2002-2007 in five areas (cantons) of the province Esmeraldas **contributed to the control and treatment of major vector-borne diseases and TB and HIV**. According to its mid-term review,²¹⁹ the programme trained 52 persons in high-risk areas in outbreak control and surveillance and updated analysis training for laboratory technicians. Further training was provided in the application of strategy for treatment of new TB cases (*Esquema de Tratamiento Directamente Observado*). In addition, the programme conducted staff awareness and training in the protocol for prevention and management of HIV.

I-143 Improvements have been constant in the last decade in the health sector; however a lack of evidenced based research on health services quality as well as client satisfaction is reported.

The final evaluation of PASSE programme carried out survey of users in the intervention sites, who considered the quality of care 'good' on average. In addition, overwhelming majority of users reported a positive effect of improved infrastructure and equipment in terms of comfort and range of services and improved quality of care. However, the evaluation report acknowledges the survey being conducted with only very small number of users and lacking representativeness in respondent selection. Therefore the results cannot be considered as robust evidence.

5.2.4.2 Resume of the JC

The quality of service provision has been mainly maintained with little changes in the last decade.

The PSIE programme contributed to treatment of some major diseases, although only on a small scale of five areas of one province.

The EC contribution in the targeted provinces of PASSE, indicated that one of the most remarkable and positive things of the program was the increased and maintained of services provision.

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

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

Indicators

- I-211 Change in proportion of health spending out of pocket
- I-212 Change in share of health expenditure financed by social security schemes

²¹⁹ Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007.

- I-214 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

5.3.1.1 Findings per indicators

I-211 According to the World Bank indicators, private health expenditure²²⁰ as a % of GDP rose slightly during the 2002-2009 period, with irregular trend. Out of total private health expenditure, out-of-pocket payments constituted increasing share, representing 87.3% in 2009, while the percentage of private prepaid plans was also increasing, up to 5.4% in 2008. However, the share of public health expenditure as a percentage of total health expenditure increased substantially in the same period.

Table 23: Health expenditure, 2002-2009²²¹

	2002	2003	2004	2005	2006	2007	2008	2009
Private health expenditure (% of GDP)	3.08	2.99	3.02	3.09	2.97	3.11	3.07	3.14
Out-of-pocket health expenditure (% of private expenditure on health)	85.68	84.18	85.23	85.25	85.53	85.93	87.29	87.29
Private prepaid plans (% of private expenditure on health)	4.80	2.20		5.60	5.70	5.20	5.40	
Public health expenditure (% of total health expenditure)	37.66	38.92	41.25	40.10	43.60	42.30	42.26	48.41

Source: World Bank

The EC supported the transformation of health care system towards the provision of universal care through technical assistance in policy development, as discussed in EQ5.

I-212 In 2006, the Ecuadorian Government implemented the universal health insurance program, PRO-AUS. The objective of this program was to provide an insurance system that offers comprehensive benefits characterized by quality, efficiency and equity; includes social protection and public insurance; and gives priority to the population living in poverty and extreme poverty (most vulnerable groups). However, in 2007, implementation of this strategy was limited to the city of Quito and the cantons of Guayaquil and Cuenca. Financial data are not available

The social security expenditure on health as a percentage of general government expenditure on health increased substantially during the 2002-2008 period, from 28% to 43%, according to WHO Health Statistics 2010.

Table 24: Social security expenditure on health as a percentage of general government expenditure on health, 2002-2008

	2002	2003	2004	2005	2006	2007	2008	2009
Social security expenditure on health (% government expenditure on health)	28.0	31.9	39.2	37.5	41.4	40.1	42.8	

Source: WHO Health Statistics 2010.

The EC supported the reform process through its PASSE programme with the provision of technical assistance to the MPH. See Ind. 5.1.1 for more details.

I-213 The Ecuadorian population covered by either public or private health insurance was slightly under 23% in 2004. There were significant differences between the quintiles: in the poorest quintile (Q1), as little as 12% had health insurance, whereas in the wealthiest quintile (Q5), 36% of the

²²⁰ Includes direct household (out-of-pocket) spending, private insurance, charitable donations and direct service payments by private corporations

²²¹ World Bank

population had insurance coverage. No time trend data have been found, nor has it been possible to separate public from private insurance. No information is available on whether the EC contributed.

5.3.1.2 Resume of the JC

The EC contributed to the reform of health care financing from health care insurance into universal health care provision financed through the government budget by providing technical assistance to the MPH in developing public policies and strengthening the institutional capacities (see EQ5). It is likely that the implementation of the reform would lead to increasing the affordability of care for the poor.

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

Indicators

- I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs, such as children, the elderly, persons living with HIV/AIDS and the disabled
- I-222 Health care financing schemes result in additional health care consumption by households

5.3.2.1 Findings per indicators

I-221 Cost waiver and subsidies schemes in place for the poor and persons with special health care needs are confined to local initiatives with the exception of HIV/AIDS patients care. The Ministry of Health has promoted ongoing actions to empower the community in decision-making in the health councils (83 cantonal health councils and eight provincial health councils). The cantonal and provincial health councils (CCS and CPS) are venues for consensus-building, coordination and dialogue that promote participation in decision-making in health by citizens and institutional representatives from the public and private sector. Users' committees have also been created to monitor enforcement of the Free Maternity and Family Violence Prevention Law. Citizen participation has become one of the key elements of the sectoral transformation of health, creating opportunities for the community to provide input for decision-making and social control.

The EC programme PASSE, PSIE and UNIVIDA had component dealing with the promotion and prevention and dissemination on the rights access health care to communities, local government, schools, rural and urban health care centers. The UNIVIDA project concentrated on the rights to access to free diagnostic and medication for HIV/AIDS. The PSIE and PASSE promoted and disseminated knowledge on the existence of the law on Free Maternity and Child care, not only among health care providers but also among the beneficiaries.²²²

I-221 See JC 21.

5.3.2.2 Résumé of the JC

No evidence of EC involvement.

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

Indicators

- I-231 EC supported technical assistance provides expertise on health care finances
- I-232 EC supports enhanced communication, cooperation between MoH and MoF/planning

5.3.3.1 Findings per indicators

I-231 The sector of Health care finances was not supported by the EC.

I-232 The EC did not support and enhance communication and coordination between MoH and MoF

²²² Source: EUD Ecuador

5.3.3.2 Resume of the JC

EC not involved in this JC. The health finance policies as well as other health reforms as still to come. Ecuador has not had any real health sector reform in terms of sustained, in-depth changes in the structure of the sector. The political and administrative instability experienced by Ecuador during this period under evaluation prevented the development of specific and sustained implementation plans as a result of the contradictory policies adopted in different periods by each new government, the resistance of progressive social organizations and the lack of consensus among stakeholders.

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

5.4.1 JC 31 Increase in availability of primary health care facilities

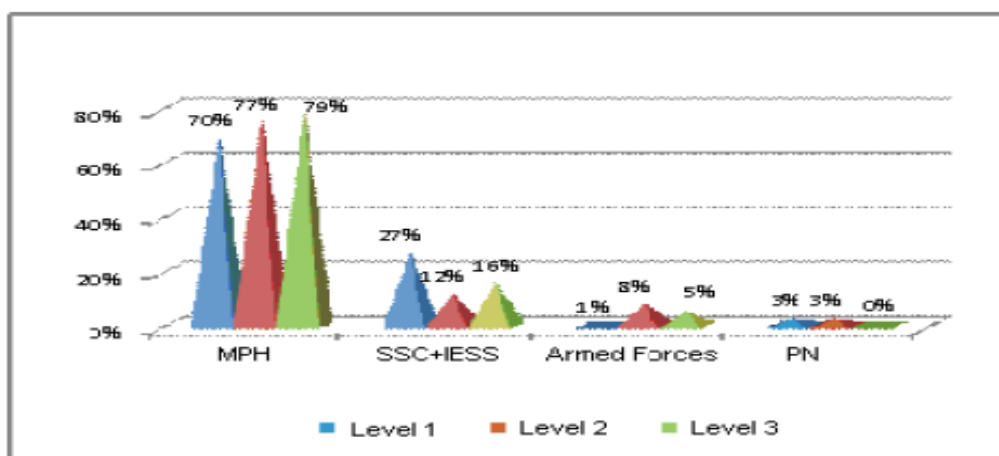
Indicators

- I-311 Change in number of primary care facilities per 10,000 population (towards >1 per 10,000 population); disaggregated by rural/urban and income level, where feasible
- I-312 Change in the proportion of rural population living in a radius of one hour of a primary health care facility

5.4.1.1 Findings per indicators

I-311 It is very difficult to meaningfully estimate this Indicator due to the great fragmentation of the health system. However in 2006, there were 3,681 health facilities, 2,999 public and 682 private, in Ecuador. A total of 683, or 18.6%, of these facilities offered hospital inpatient care and 2,998, or 81.4% did not. In 2009 these numbers increased to 728 hospital inpatient care in total, of which 186 were public and 542 private. The health facilities without inpatient hospitalisation amounted to 3.166, 2.973 public and 193 private²²³. A comparison of the data from 1997 and 2009 indicates the number of facilities with hospital inpatient care increased. However, no information has been found that would allow us to hazard a guess as to the increase in the number of primary facilities.

Figure 47: Percentage share of public health services in 2008



Source: MPH, 2008

As discussed in I-1.2.2. and I-1.3.2 the EC programmes PSIE – *Proyecto Integral de Salud en la Provincia de Esmeraldas* – and PASSE – *Programa de apoyo al sector salud en Ecuador* – operating in four provinces of Ecuador (Esmeraldas, Chimborazo, Bolívar and Cotopaxi) provided physical infrastructure and equipment for primary health care facilities as well as health workers training. It has resulted in increased the supply of health care services and had a positive impact on improving the quality of health care in the provinces. Yet, as the final evaluation of PASSE noted, “It is still early for the weak health information system to adequately capture these changes in either process indicators

²²³ Instituto Nacional de Estadística y Censos, statistical data 2010.

(increased consultation or care) or result or impact (improved health) and it is not possible to demonstrate and adequately support the finding".²²⁴

It is concluded that the three provinces are now in a better position to absorb the changes that the deepening of the transformation of the sectors involved. More time and human resources would have ensured a better quality of processes and products of the program and these effects might have been greater and more sustainable.

I-312 No information available.

5.4.1.2 Resume of the JC

The PSIE and PASSE programmes implemented contributed to the increased availability of primary health care facilities in the four provinces where they were implemented by building and improvement of physical infrastructure, provision of drugs, equipment and health workers training, as also discussed in EQ1.

5.4.2 JC 32 Increase in availability of secondary health care facilities

Indicators

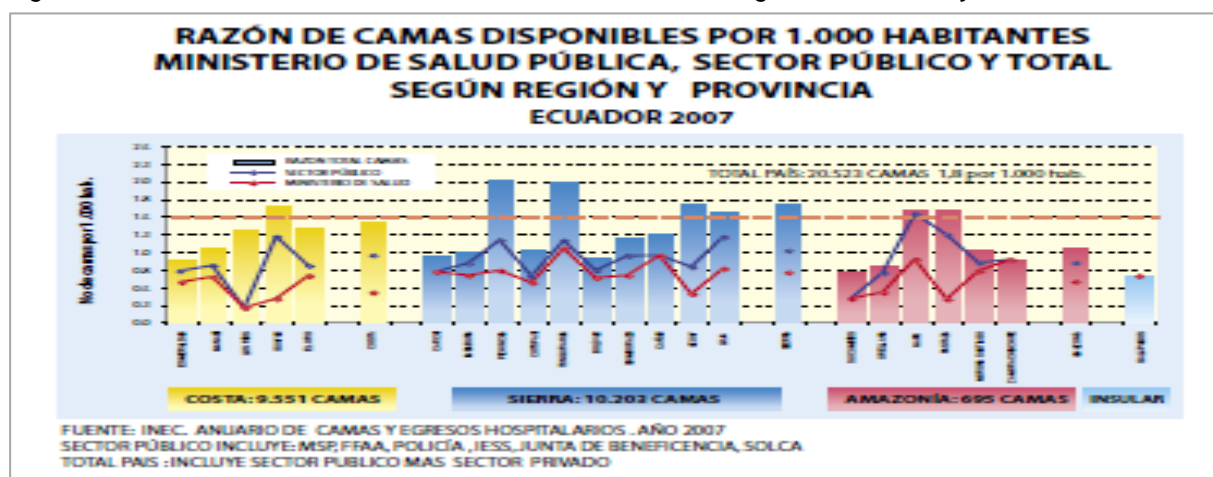
- I-321 Change in number of hospital beds per 10,000 population (to >10 per 10,000 population)
- I-322 Change in the proportion of population living in a radius of two hours of a secondary health care facility
- I-323 Increased number of Caesarean Sections

5.4.2.1 Findings per indicators

I-321 Central hospital, regional hospital and provincial hospitals has been gradually modernized providing relatively advanced medical health care services. Latest available information reports: 121 hospitals (25 general, 85 cantonal and 14 specialized hospitals). The WHO 2011 Statistical Report estimated the ratio of hospital beds to population to be to 15 per 10.000. A comparison of the data from 1997 and 2006 indicates the number of facilities with hospital inpatient care increased from 494 to 683, but we have not calculated the impact on beds per capita.

The network and availability of public and cantonal hospitals has shown little improvement in the last decade.

Figure 48: Bed Ration for 1.000 inhabitants in different region of the country



Source: Ministry of Public H

I-322 Not available

²²⁴ Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010 [translation by Particip].

I-323 The WHO 2011 Statistical Report states that 26% of births occur by caesarean section. This is in line with international clinical good practice. No information on time trend has been found.

5.4.2.2 Resume of the JC

As discussed in JC12, the EC funded programme PASSE contributed to increasing availability of health infrastructure by implementing new constructions and works of improvement of health units in three provinces. It is not clear however, what part of the works was aimed at secondary health care facilities and thus no conclusion can be made with regards to this JC.

According to the EUD, there has been slight improvement on the data availability on equipments in primary and secondary facilities since 2007 when the new president increased emphasis on PHC approach. This results in better access and better quality of care in 2nd and 3rd levels health facilities and therefore in equipments availability. The 2010 constitution increased budget and investments for the health sector; special emphasis has been given in strengthening 2/3 health services specifically on the preventive and promotive aspects of health more than on the curative one. This was done – among other – to reduce the overload at health facilities level.

According to the MoH, the EC supported infrastructure in two regions through the SPSP. He further highlights that improvements in the infrastructure can be seen. First Access to primary facilities between 2002 and 2010 has constantly increases especially in the two regions were the EC concentrated its support, secondly the gap between urban and rural has been reduced, but is still wide. Nevertheless it is as usual difficult to quantify and measure the specific EC impact in the overall health system. The interview underlined the great appreciation of the GoE of the EC support which positive input allowed an amelioration of those indicators.

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

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

Indicators

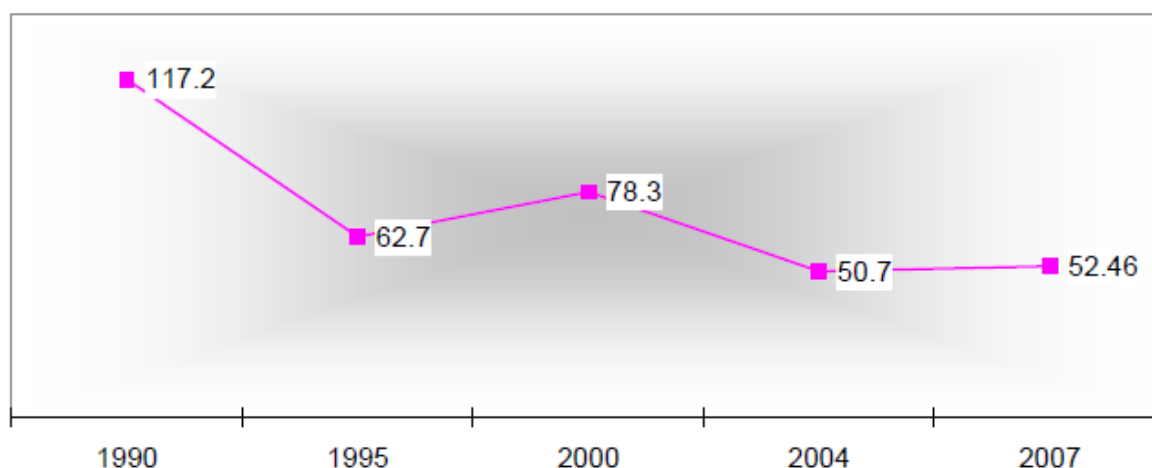
- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving four or more ante-natal check-ups
- I-413 Increased proportion of women using modern family planning

5.5.1.1 Findings per indicators

I-411 According to the WHO 2011 Statistical Report 99% of deliveries are attended by skilled health personnel.

The trend in the maternal mortality rate has been irregular: in 1990, the rate was 117.2 per 100,000 live births, whereas in 2007, a rate of 52.46 per 100,000 live births was recorded. Most maternal deaths are due to obstetric bleeding (43.3%), postpartum bleeding accounts for 31.8% of these cases. The second leading cause is eclampsia (32.7%) and sepsis (1.7%). The factors most often associated with maternal mortality include the location where the birth is attended, the staff providing the care, the timeliness of care and the location and staff providing the care for complications and postpartum examinations. Some 75.9% of deliveries from 1999 to 2004 occurred in health care institutions and 24.1% in households. In 15% of the deliveries that occurred in households, care was provided by an unqualified midwife, a family member, or the mother herself. According to the demographic and maternal-child health survey (2005), postpartum monitoring is the least common health service provided in Ecuador. Only 36.2% (44.4% in urban areas and 26.4% in rural areas) of women received at least one postpartum examination.

Figure 49: Trend in maternal mortality rate Ecuador. Selected years. (Rate per 100.000 live births, includes live births in the year of birth and those recorded 1 year later)



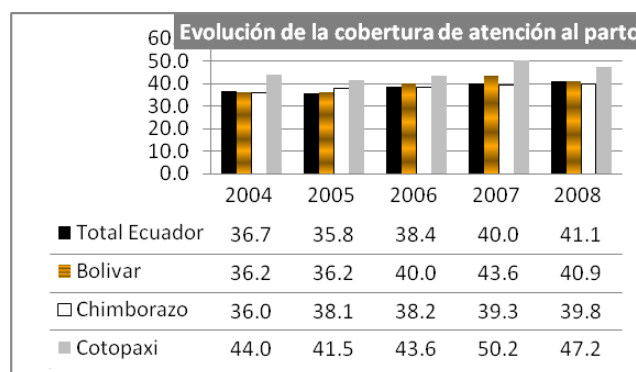
Source: INEC: Yearbook of Vital Statistics, Births and Deaths.

With regard to MDG five, “Improve maternal health,” although significant progress has been made in reducing maternal mortality, the figure is still very high. Indigenous women and women living in rural areas are most affected. The maternal mortality rate decreased significantly from 117.2 deaths per 1,000 live births in 1990 to 50.7 deaths per 1,000 live births in 2004. However, in order to reach the goal of 29.3 deaths, efforts must be scaled up through the sustained expansion of the Free Maternity and Child Care Program and their partners.

A referral system for complicated obstetric cases has also been developed through training and transport for free. Transportation to the obstetric emergency health centres is provided for free. In some cases the city hall has been responsible for the costs of driver, maintenance and gasoline.

The figures of the Ministry of Public Health, presented in the PASSE evaluation report, show different statistics however:

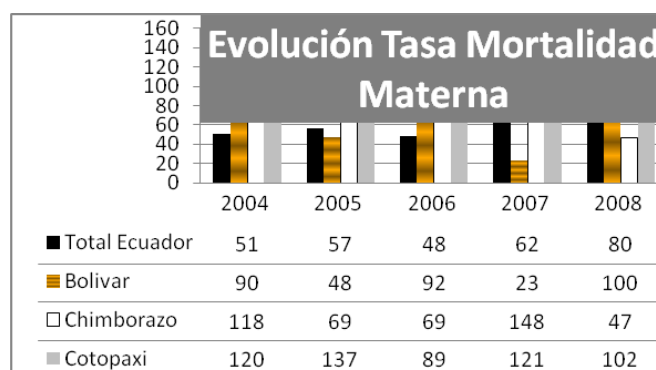
Figure 50: Delivery care coverage - Comparison between the national average and the three provinces of PASSE implementation in the period 2004 - 2008



Source: Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.

The delivery care coverage levels remain relatively stable for the entire period for both the national average and the three provinces (albeit with an improving trend in all three), with slight variations in Cotopaxi. No distinct trend can be observed.

Figure 51: Maternal Mortality Rate - Comparison between the national average and the three provinces of PASSE implementation in the period 2004 - 2008



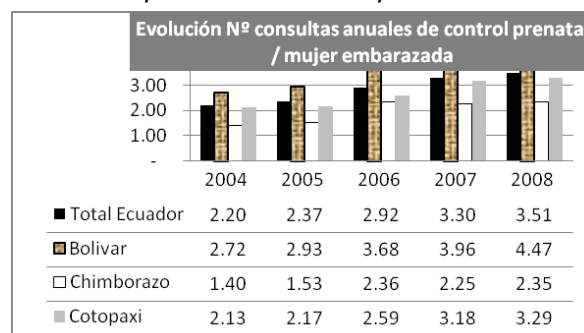
Source: *Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.*

The three provinces have large variations in maternal mortality rate, significant reductions in two of the areas between 2004 and 2008, with significant increase in the remaining one. The national rate was an increase. In the framework of PASSE 200 midwives were trained in traditional medicine, intercultural approaches and medicinal plants. It has been shown elsewhere that PASSE did have positive effect on primary health care coverage in the three provinces, both in physical facilities and equipment and trained health workers. This coverage is likely to also have benefitted to maternal health.

I-412 According to the WHO 2011 Statistical report in Ecuador the data related to antenatal care are: (1) 84% of women received at list one antenatal visit and (2) 58% the recommended four antenatal visits.

The figures of the Ministry of Public Health, presented in the PASSE evaluation report, present the following time-trend statistics:

Figure 52: Prenatal visits per pregnant woman - Comparison between the national average and the three provinces of PASSE implementation in the period 2004 – 2008²²⁵



Source: *Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.*

Nationally, the number of consultations for pregnant women is increasing. Bolívar follows a similar trend, while maintaining best coverage. Chimborazo has the lowest coverage but it is also rising. Cotopaxi has similar coverage to the national. It is likely that PASSE contributed, by expanding primary health care availability, to the increase in the number of antenatal care visits per woman.

I-413 According to the UNFPA State of World Population indicators, the proportion of women using modern family planning in Ecuador rose from 50% in 2002 to 58% in 2010. More people in rural Ecuador are moving to urban areas and rates of literacy, family planning use and the proportion of women in the workforce are increasing. WHO reports a contraceptive prevalence of 73% however a contraceptive practices survey in 1982 found that 65 % of the women not using contraceptives

²²⁵ Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.

nevertheless wanted to participate in some form of family planning and would have participated in family planning if a program were available. Given continued high birth rates, many demographers doubted government estimates that 40% of women of childbearing age were using contraceptives in the mid-1980s. The WHO 2011 Statistical report provides the following data: (1) Unmet need for family planning 7.5%; (2) Contraceptive prevalence 72.7%.

5.5.1.2 Resume of the JC

Training of midwives was a part of the PASSE programme of the EC, implemented in three provinces. The statistics for the ante-natal check-ups and supervised deliveries do not show a significant difference in the indicator trends in these provinces compared to national average. Despite the fact that recent data are not available and the health information system is generally weak, it is likely that PASSE contributed overall to an improvement in maternal health in its target provinces.

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

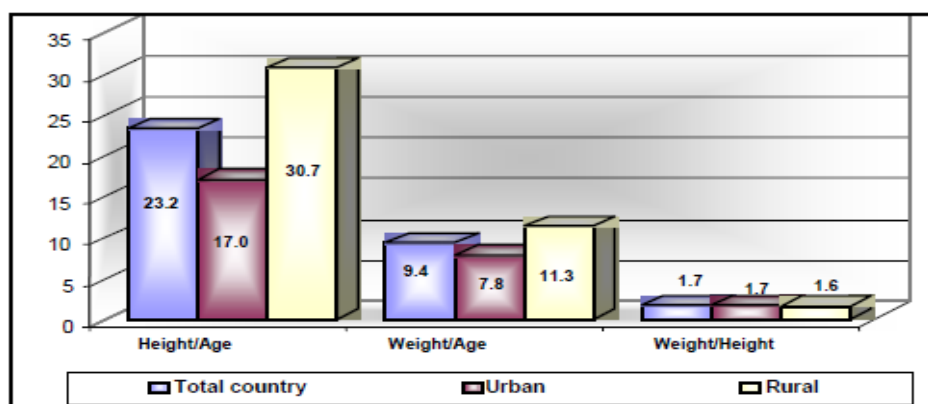
Indicators

- I-421 Percentage of children under five receiving regular growth monitoring
- I-422 EPI immunisation rate

5.5.2.1 Findings

I-421 With regard to nutritional status²²⁶, according to the most recent demographic and maternal child health survey (2005), 23% of children under five suffer from chronic malnutrition. This figure is significantly higher in children of indigenous women (47%), in mothers with lower educational levels (38% in children of mothers with no education) and among the population living in the Sierra (32%) and rural areas (31%). In addition, 9.1% of children in Ecuador under the age of five suffer from acute malnutrition.

Figure 53: *Percentage of chronic, acute and general malnutrition in children under 5. Total country, urban and rural sector, Ecuador 2004*

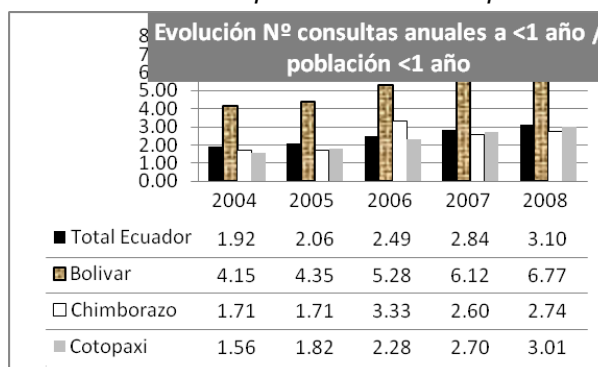


Source: *Minister of Public Health - 2007*

The figures from the evaluation report of PASSE provide the following statistics on annual check-ups for children as a national average and for the three provinces where PASSE was implemented.

²²⁶ PAHO. Health Situation in the Americas: Basic Indicators 2005. Washington, DC: PAHO; 2005. Ministry of Public Health (MPH), National Zoonosis Program, Ecuador, 2001–2005.

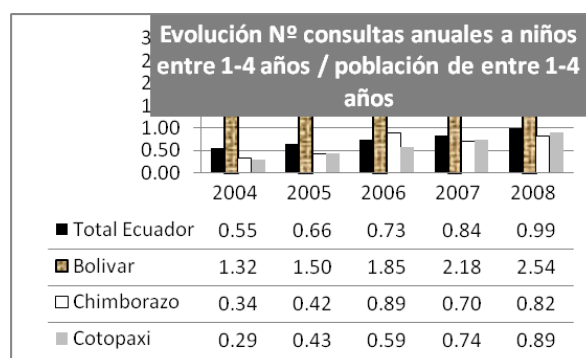
Figure 54: Annual check-ups for children under one year - Comparison between the national average and the three provinces of PASSE implementation in the period 2004 to 2008



Source: *Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.*

The number of annual check-ups for children under one year exhibits a growing pattern similar to the entire country and the three provinces, even though Chimborazo suffers a decline in the last two years in the given period. Notably, coverage in the province of Bolivar remains nearly double the national average and the other two provinces. Despite the trend in Chimborazo, these data tend to suggest that the EC supported project had a positive impact on this indicator, at least during the mid-to-late years of the evaluation period.

Figure 55: Annual check-ups for children under between one and four years - Comparison between the national average and the three provinces of PASSE implementation in the period 2004 to 2008



Source: *Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.*

The number of annual check-ups for children between one and four years show growing pattern similar to the entire country and the three provinces. Notably, coverage in the province of Bolivar remains nearly four times that of the national average and the other two provinces. Again, the project is likely to have contributed to the improving trend.

I-422 The World Bank reports BCG immunisation rate at stable 99%²²⁷ throughout the period 2002-2009, the DPT immunisation²²⁸ rate at 75%, measles immunisation²²⁹ at 66% and polio immunisation²³⁰ at 72%. Immunisation rate for HepB3²³¹ fell from 85% in 2002 to stable 75% since 2004. The demographic and maternal-child health survey (2005) also highlights the pronounced and sustained reduction in morbidity and mortality associated with vaccine-preventable diseases (VPD)

²²⁷ Immunization, BCG (% of one-year-old children).

²²⁸ Immunization, DPT (% of children ages 12-23 months).

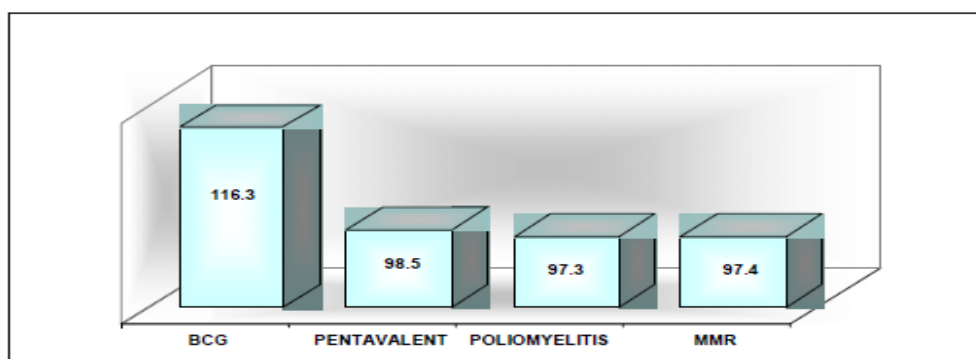
²²⁹ Immunization, measles (% of children ages 12-23 months).

²³⁰ Immunization, Pol3 (% of one-year-old children).

²³¹ Immunization, HepB3 (% of one-year-old children).

included in the Expanded Program on Immunization (EPI) implemented by the MPH since 1985. The impact to date has been the elimination of some diseases from the national territory. For example, measles was eliminated nine years ago; poliomyelitis was eliminated sixteen years ago; yellow fever six years ago; diphtheria, rubella and congenital rubella syndrome two years ago; whooping cough has been reduced; neonatal tetanus has been eliminated as a national and provincial public health problem; and pneumonia and meningitis due to *Haemophilus influenzae* type B has decreased.

Figure 56: Vaccination coverage Ecuador, 2006



BCG, pentavalent, and poliomyelitis vaccine coverage are in children under 1 year. MMR vaccine coverage is in children from 12 to 23 months of age. Of the total persons vaccinated, the number of children from other countries is not known.

Source: MPH. Expanded Program on Immunization

Source: MPH Expanded Programme on immunization

5.5.2.2 Resume of the JC

The EC support was not directly aimed at improvements in children's health, by increasing growth monitoring or immunisation rates. However, as discussed elsewhere, by increasing the access to health care in the three provinces of PASSE implementation, the EC has likely contributed to increased use of services and facilities to support health care for children as well.

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

Indicators

- I-431 Increased proportion of children sleeping under a bednets
- I-432 Reduction in rate of child deaths from diarrhoeal disease
- I-433 Improved household management of diarrhoea based on oral rehydration salts (ORS)

5.5.3.1 Findings per indicators

I-431 The WHO Statistical 2011 Report does not provide data.

I-432 According to the Survey of Living Conditions 2005 – 2006, the prevalence of diarrheal disease in children under five is still 25% and respiratory infections 56%. The high rate of morbidity due to gastrointestinal conditions reveals a lack of basic sanitation still present in the country.

According to the World Bank indicators, the proportion of population with access to improved sanitation facilities rose from 90% in 2005 to 92% in 2008 (81% to 84% in rural areas).

One component of the EC programme PSIE – *Proyecto Integral de Salud en la Provincia de Esmeraldas* – implemented water and sanitation works in two areas (cantons) of the Esmeraldas province (Esmeraldas Rur and Quinindé). According to its mid-term review,²³² 20 water works have been completed or rehabilitated. In addition, 36 rural schools received new or reconstructed sanitation facilities. Corresponding water management boards at local level were established for maintenance and 73 people were trained in water quality control. Similarly, one component of the EC programme PASSE – *Programa de apoyo al sector salud en Ecuador* – operating in three provinces of Ecuador (Chimborazo, Bolívar and Cotopaxi) was aiming at improving health by building better infrastructure and sanitation through the construction of water systems, basic sanitation and solid waste disposal.

²³² Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007.

The evaluation report provides the following numbers for the increased coverage of water systems through the PASSE programme:

Figure 57: Increased water coverage (approximate data)²³³

Number of people benefiting from better coverage	Cotopaxi	Bolivar	Chimborazo	TOTAL
New system (increased coverage)	2.130	3.970	17.145	23.245
System improvement (improvement of coverage)	1.460	1.270	3.780	6.510

Source: *Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007.*

The field visits have shown: (a) Amount of water: in six of eight communities surveyed (75%), users of water services reported that the amount of water at the level of household connections increased after installation of the system, (b) Water Quality: In four out of eight projects visited (50%), water is not chlorinated.

However, the findings of the evaluation show serious problems in the quality of implementation of this component of the programme. The selection of interventions was not based on a prior study of needs for health and demand from communities, municipalities or MIDUVI (Ministry of urban development and housing). The programme did not have sufficient quality control, to the point that on occasion the work had to be suspended. The coverage of Water and Sanitation increased by approximately 4.7% in Bolivar, 5.8% in Chimborazo and 5.5% in Cotopaxi (average of 5.3%, rising to 8.4% if the calculation is not on total population of the provinces but on population with inadequate services), but the objective of increasing coverage by 40,000 was only achieved in approximately 75%. The vast majority of works were carried out separately for Water works and Sanitation works, i.e. the communities that benefited from an improvement in their water system were not the same where sewage works undertaken or basic sanitation units were introduced. This way a high number of beneficiaries was achieved but coherence in the intervention was lost and the effectiveness decreased, which probably explains why the beneficiaries of the interventions have not seen an improvement in the health of their children. The quality of all the works is considered low.

I-433 Information not available.

5.5.3.2 Resume of the JC

Apart from increasing the availability of primary health care as discussed elsewhere, the PSIE and PASSE programmes also aimed at decreasing the prevalence of diarrheal disease in population, through improved access to water and sanitation. PSIE mid-term review noted some improved access to safe drinking water, albeit on a very small scale. While some progress was made in the three provinces where PASSE was implemented general quality of the works is considered low and no improvement in the health of children was noted as a direct impact when PASSE was evaluated.

1.1 EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

5.5.4 JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support

- I-511 EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators)
- I-512 EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector
- I 513 EC contributed to decentralized capacity building to strengthen health policy capabilities at provincial, district and local levels

²³³ Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.

5.5.4.1 Findings

I-511 One of the objectives of the *Programa de apoyo al sector salud en Ecuador* (PASSE) – EC contribution: EUR 28 million – was to support the Ministry of Public Health (MPH) in developing an integrated intercultural model of care (MAIS). According to the final evaluation of PASSE²³⁴ the programme showed flexibility in adaptation to changing priorities for the model stemming from profound political changes in the country. The initial focus on increasing public health care insurance coverage was transformed into an approach aimed at developing universal health care provision financed through the government budget. The programme supported this new approach with the provision of technical assistance to the MPH – which was for that purpose removed from support to provincial infrastructure by a contract amendment. As a result of the PASSE a technical team for reform was established at the MPH as a Coordinating Office for Health Policy. The technical assistance was one of the key inputs to PASSE processes and subsequent discussions on the construction of the MAIS and proposals for the new Constitution. A MAIS proposal document prepared with funding from PASSE is considered valuable by the MPH, though only as the first step of a long process. **Contribution of PASSE to the process of reform by supporting establishment of public policies and strengthening the institutional capacities of MPH for the process is considered high.** However, the evaluation also concludes that the priority that was given to this component of the programme negatively influenced the results under the other objectives of PASSE.

I-512 No information available.

I-513 The programme PSIE – *Proyecto Integral de Salud en la Provincia de Esmeraldas* – implemented in 2002-2007 in five areas (cantons) of the Esmeraldas province provided **support to the strengthening of the health service management at the local level.** According to its mid-term review,²³⁵ the programme achieved **good results in capacity building** of the personnel in health service management in the five areas and in the Provincial Health Directorate (Dirección Provincial de Salud - DPS), which would likely have positive impact on the improvement of health service provision and the quality of the information systems. Specifically, a year long training (four days a month) was given to management staff of the five areas (total of 30 area managers, statisticians, financial and HR managers) in different aspects of health care management. Two microprojects per each area were delivered, aiming at improving the information systems, through training and technical support for three months at the Operational Units in information management (medical records, diagnostics, archiving etc.). Some progress was also made in establishing the system of references of cases to the provincial hospital, even though it was not utilised at the time of the review. The PSIE programme also developed Local Health Plans (*Planes Cantonales de Salud*) in four out of the five areas for the years 2006-07 and they were found by the mid-term review as being implemented in three areas.

Regarding general **training and capacity building of institutional personnel**, it is considered by the PASSE programme evaluation to have positive results. It facilitated the change of attitude of the staff through workshops discussing the health sector reform and the new management model. The use of participatory methods in the delivery of courses was assessed positively. 42% of respondents in operational units reported having participated in any training of the PASSE, mostly in the MAIS, in intercultural health and some postgraduate courses. Of these, 35% indicated that they apply directly in their work either in home visits or in better patient care. At the level of community actors (midwives, traditional healers, volunteers, members of the water administration boards, beneficiaries of the local initiatives), the evaluation team collected very good opinions of the workshops. Those interviewed indicated that the content of the workshops they were very useful for the implementation of their projects. In conclusion, the PASSE programme is viewed as **delivering high value for the capacity building at the technical level of support to the health care reform and medium high at the community level.**

The PASSE programme supported the strengthening of the provincial and cantonal health systems, specifically **supporting the shift from a highly decentralised health care system based on insurance to a universal coverage system with a lower degree of decentralisation.** This transformation resulted in the need to establish management bodies of the provincial and local (cantonal) levels. Total of 23 Local Health Boards (Consejos Cantonales de Salud) were established

²³⁴ Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010.

²³⁵ Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007.

(one less than planned) and two Provincial Health Boards (Consejos Provinciales de Salud), also one less than planned. The PASSE programme reinforced the work of the Health Councils on the two levels with success and supported the inclusion of community participation in the development of Local Health Action Plans (PASL), although it has been found that few of them are actually being implemented. It has been found that the **programme was instrumental in creating the conditions for the institutionalization of the Health Boards** at provincial and local level.

It has been found, however, that the ownership of the process by the Provincial Health Directorates (Dirección Provincial de Salud - DPSs) is generally weak, linked to difficulties in relations between the provincial structures of the programme and those DPSs. It seems that staffs of the Provincial Offices and the provincial technical assistance have failed to find cooperative ways. The DPSs appear weak and face frequent political changes and most likely had different expectations from the programme. The MPH appears not to have played a proactive role in mediating between the two parties.

As a result of the above, the programme had smaller effects at the provincial level than at the central level. The interviews at DPSs showed almost universal discontent with the way the programme was managed. The reasons for this discontent seem to be various, such as the knowledge of real achievements of the programme and the perceived low quality of many of the activities. Furthermore the programme had a clear line of action to be followed after it has been approved by the central level, resulting in a lesser marge de manoeuvre for newly appointed DPs. But also issues like the differences of salaries and a high turnover might be explanatory factors for the discontent, according to the EUD.

Technical assistance was provided by the PASSE to conduct a situation analysis of existing information systems. Design of a **geo-referenced system for provincial use** was tendered and it was implemented for the three provinces of PASSE intervention. It is used for the situation analysis at local level but is not being used for management by the DPS (Provincial health directorates). It follows that the effect has been limited at the operational level, although it has served as human resource training (50 officials of the three DPS were trained) to be aware of useful tools for management. The **overall effect was limited**.

5.5.4.2 JC Resume

EC contributed significantly through its PASSE programme to building the capacities at the central level (MPH) in relation to process of reform by supporting establishment of public policies and strengthening the institutional capacities of MPH for the process. EC also contributed to the decentralised capacity building by strengthening the management and administrative capacities at local level, first in the PSIE programme in five areas (cantons) of one province and subsequently in the framework of the PASSE programme implemented in three provinces. The programmes were responding to the needs created by the shifting of political priorities to create a universal system of health care and EC support was instrumental in creating Local and Provincial Health Boards and community participation in the development of Local Health Action Plans.

According to the EUD, the EC contribution to health sector governance can be consider positive although difficult to quantify. The EC played an important role in redefining the approach and the model of the present health services towards a more consistent and efficient PHC approach. This was particularly evident in the two provinces where the SPSP was implemented; the EC played a consistent role in redefining health policy at local level. Since 2007 a greater stability of the MoH staff personnel resulted in a more efficient training of staff, less turnover and an increased stability. The EC contribution was particularly appreciated in the field of staff training which automatically strengthen accountability and capacity building of the health sector.

The MoH stretched, that the relation between the ECD and MoH have been positive and with constant dialogue and interaction in between the two parties. The MoH staff interviewed was not in the position to express any opinion concerning the role that policy dialogue has played concerning PFM, accountability and capacity building.

5.5.5 JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

- I-521 EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc)
- I-522 EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing)

- I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

5.5.5.1 Findings

I-521 The PASSE's objective was also to strengthen the budgetary and financial management at the central level of MPH. Two local consultants conducted the identification of the situation in terms of budgetary and financial management and established guidelines for the management of the Ministry in this area. Based on the situational analysis conducted on the Budget and Financial Management, TORs for a study of cost accounting instead of GRD'S (diagnosis related groups) were prepared and tender process launched. There were no bidders however and this activity was not further completed. The initial objective of 25% of operational units in the system of health care, which apply System for Budget and Financial Management (SGPF) was still at 0% at the end of the programme and thus this component of the programme has not been seen as successfully implemented and having any positive effect.

I-522 No information available.

I-523 No information available.

5.5.5.2 JC Resume

The EC did not significantly contribute to strengthened and operational systems related to transparency and accountability issues in the health sector.

5.6 Annex

5.6.1 Key documentation used for the analysis

5.6.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
<i>Programa de apoyo al sector salud en Ecuador (PASSE)</i>	-	Final report, September 2010	MR 2007	-	-
<i>Unidos en la lucha contra el VIH/SIDA en Ecuador - UNIVIDA</i>	-	-	MR 2007, 2008, 2009	-	-
<i>Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE)</i>	ok			MTR 2007	

5.6.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	Not existing
EAMR	ok
Country note from old health evaluation	ok

5.6.1.3 Other sources

Ecuador, Ministry of Economy and Finance. Consolidated financial statements in December 2005. Available at: www.minfinanzas.ec-gov.net. Accessed 14 April and 15 May 2006. INEC, National Health Accounts

Evaluación final del programa de apoyo al sector salud en Ecuador, PASSE, final report, September 2010 [translation by Particip]

Evaluación de medio término del Proyecto de Salud Integral en la provincia de Esmeraldas (PSIE), Final report, February 2007

Merino C; Observatory of Human Resources in Health in Ecuador; National Committee of Human Resources. Empleo de los recursos humanos en salud en instituciones del sector público. Quito; 2006.

Ministry of Public Health (MPH), National Zoonosis Program, Ecuador, 2001–2005.

MSP – INEC. Indicadores Básicos de Salud, 2006.

PAHO. Health Situation in the Americas: Basic Indicators 2005 .Washington, DC: PAHO; 2005.

PAHO/WHO. Health Situation in Ecuador, 2006. Pan American Health Organization, Washington DC. 2006. MPH, Proceso de Normatización, 2005.

Paredes P, Romo H, Quevedo M. Estudio del Mercado Farmacéutico en el Ecuador. Quito; July 2004.

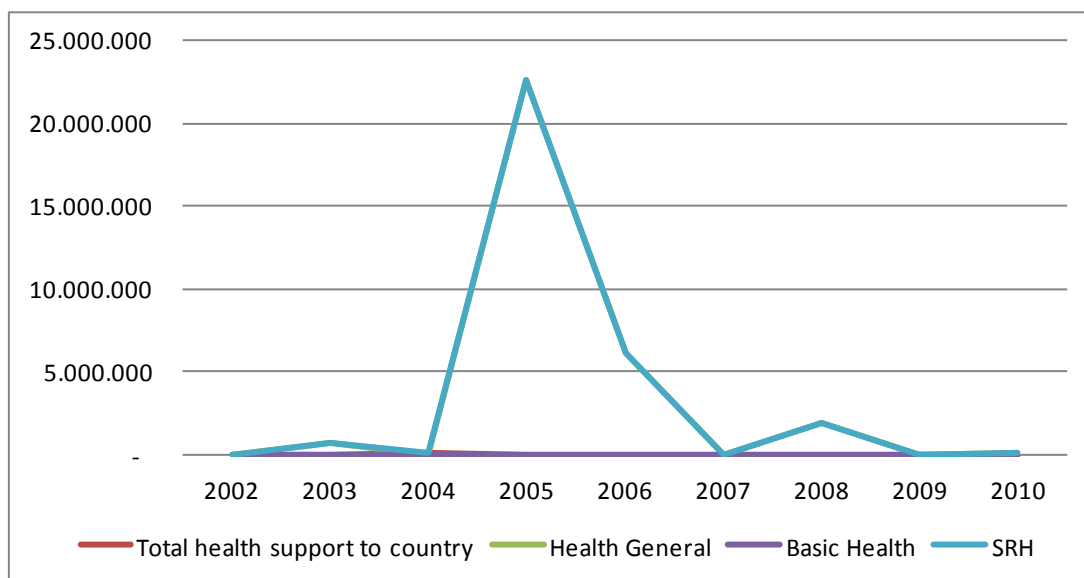
5.6.2 EU funds between 2002-2010 –detailed listing

5.6.2.1 Per Subsector (excl. GBS)

Year	Health General	Basic Health	SRH	Total health support to the country
2002	-	-	-	-
2003	-	764,414	-	764,414
2004	129,476	-	-	129,476
2005	-	22,572,532	-	22,572,532

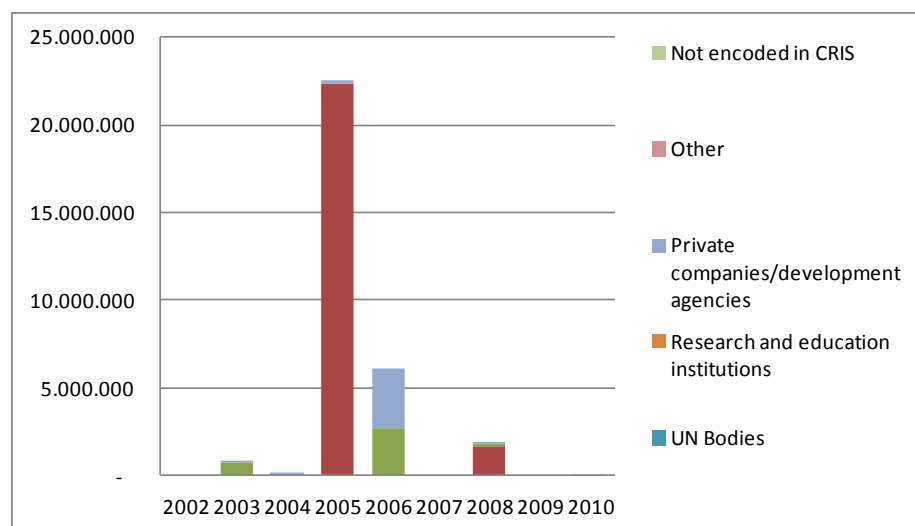
Thematic evaluation of the European Commission support to the health sector

2006	-	6,103,061	-	6,103,061
2007	-	-	-	-
2008	-	1,911,107	-	1,911,107
2009	-	-	-	-
2010	-	79,355	-	79,355
Total	129,476	28,702,942	-	8,832,418



5.6.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	-	-	-	0
2003	-	732,013	-	-	-	32,402	-	-	764,414
2004	-	-	-	-	-	129,476	-	-	129,476
2005	22,387,603	-	-	-	-	184,929	-	-	22,572,532
2006	-	2,727,527	-	-	-	3,375,534	-	-	6,103,061
2007	-	-	-	-	-	-	-	-	0
2008	1,601,745	238,684	-	-	-	70,678	-	-	1,911,107
2009	-	-	-	-	-	-	-	-	0
2010	-	-	-	-	-	79,355	-	-	79,355
Total	23,989,348	3,698,224	0	0	0	3,872,373	0	0	31,559,945



5.6.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	-	-	-	-
2003	-	-	764,414	-	764,414	-
2004	-	-	129,476	-	129,476	-
2005	-	22,572,532	-	-	22,572,532	-
2006	-	3,375,534	2,727,527	-	6,103,061	-
2007	-	-	-	-	-	-
2008	-	1,641,485	269,622	-	1,911,107	-
2009	-	-	-	-	-	-
2010	-	79,355	-	-	79,355	-
Total	-	27,668,906	3,891,039	-	31,559,945	-

5.6.3 Overview of funds committed to the country's health sector

Decisions Title	Contracts Title	Decision Number	Contract number	Contract year	Decision year	Total
Contrat-cadre - coopération au développement	MISION DE IDENTIFICACION Y FORMULACION PARA UN PROGRAMA DE APOYO AL SECTOR DE LA SALUD EN ECUADOR	ALA/2000/004-333	80296	2004	2000	€ 129,476
pré-engagement P1 dont dépendront 190 contrats en faveur de pays en développement	Promoting a holistic health response to HIV/AIDS and human rights through education, advocacy and training in Ecuador.	ONG-PVD/2002/001-092	20583	2003	2002	€ 732,013
Annual Work programme 2006 PRD	Unidos para combatir el VIH / SIDA en Ecuador - UNIVIDA	SANTE/2006/017-998	104297	2006	2006	€ 2,727,527 ²³⁶
Allocation de crédits pour des prestations d'audit externe	"Audit du projet ECU/1997/0044 "" Proyecto integral de salud en Esmeraldas" ²³⁷	ALA/2003/004-696	74502	2003	2003	€ 32,402
Programa de apoyo al sector salud en Ecuador (PASSE)	Asistencia Técnica Internacional para el PASSE	ALA/2004/016-916	105617	2006	2004	€ 3,375,534
	Evaluación de Término Medio, Programa de Apoyo al Sector Salud en Ecuador, PASSE	ALA/2004/016-916	154586	2008	2004	€ 39,740
	GASTOS LOCALES DEL PASSE	ALA/2004/016-916	153845	2008	2004	€ 1,601,745
	Gastos Locales Programa PASSE	ALA/2004/016-916	105122	2005	2004	€ 22,387,603
	Misión de Evaluación Final del Programa de Apoyo al Sector Salud en Ecuador, PASSE	ALA/2004/016-916	222678	2010	2004	€ 79,355
	Programa de apoyo al Sector Salud PASSE - misión de apoyo a la elaboración POG y POA1 ALA 2004 16916	ALA/2004/016-916	102380	2005	2004	€ 184,929
Global commitment for local calls for proposals Objective 1 - PVD Projects - Non State Actors - AAP 2007	Fortalecimiento de unidades productivas familiares que prestan servicios en dos ejes turísticos del Distrito Metropolitano de Quito	DCI-NSAPVD/2007/019-404	164143	2008	2007	€ 238,684
Allocation de crédits pour prestations d'audit externe	Programa de apoyo al sector salud en Ecuador (PASSE)	DCI-ALA/2008/019-840	160826	2008	2008	€ 30,938
Grand Total						€ 31,559,946

5.6.4 Description of main EC interventions

5.6.4.1 Intervention no 1

Title: EC- Programa de apoyo al sector salud en Ecuador (PASSE)

Budget: EUR 50,247,832

Start and end date: 2004

²³⁶ Initially geographical zone is labeled as "TPS", as part of a worldwide programme. The funds (2,7 million Euro) are therefore not included in the detailed listing of funds in Annex 5.6.2.

²³⁷ Contracts of PSIE, committed before 2002 have not been taken into account in this overview.

Objectives and expected results:**Overall objective:**

Apoyar el proceso de Reforma del Sector Salud y el Modelo de Atención Integral e Intercultural basado en la Promoción de la Salud la Prevención de la Enfermedad y Atención Primaria de Salud.

Specific objective:

Contribuir a mejorar la equidad, la cobertura, la calidad y la eficiencia de los servicios de salud y saneamiento básico en tres provincias de la sierra central, y la descentralización del sistema de salud

Expected results:

- R0: Realizada la Gestión operativa del Programa
- R1: El proceso de reforma de salud a nivel central ha sido apoyado y fortalecido, mejorada la función rectora del Ministerio de Salud Pública.
- R2: Las instituciones de salud que forman parte del Sistema Cantonal y Provincial de Salud, han fortalecido su gestión y la capacidad de asumir las transferencias de las competencias sanitarias.
- R3: El funcionamiento de la red de servicios de salud a nivel local ha mejorado en cobertura, en utilización, en calidad y en capacidad de resolución.
- R4: El número de comunidades que disponen de sistemas de abastecimiento de agua / de eliminación de excretas adecuados se ha incrementado.
- 40.000 habitantes se han beneficiado en lo que se refiere a abastecimiento de agua segura.
- R5: La organización y la participación comunitaria en el sector salud se ha fortalecido; se dispone de estructuras comunitarias eficientes para la ejecución y gerencia de los sistemas de agua y saneamiento básico; y se han fomentado hábitos saludables de vida e higiene personal y familiar

Activities:**Actividades por resultado R0:**

- Creación y funcionamiento de la Entidad de Gestión (EG) y Unidad Financiero Contable (UFC)
- Creación y funcionamiento de oficinas provinciales
- Arranque y ejecución del Programa
- Elaboración - aprobación de planes operativos

Actividades por resultado R1:

- Fortalecimiento Institucional del MSP en el proceso de reforma
- Apoyo a la Gestión Presupuestaria y Financiera del MSP
- Capacitación al personal de MSP, DPS, UCAs y Red de Servicios
- Fortalecimiento de los Sistemas de información

Actividades por resultado R2:

- Identificación, promoción e integración de capacidades locales
- Creación de Consejos Cantonales (CCS) y Consejos Provinciales de Salud (CPS)
- Apoyo a programas de salud prioritarios y costo – efectivos
- Capacitación al personal de la red de servicios en gestión sanitaria e interinstitucional

Actividades por resultado R3:

- Capacitación de los profesionales, promotores y parteras
- Integración de las medicinas tradicionales y alternativa en el sistema formal de APS
- Apoyo para mejorar la calidad y coordinación entre APS y atención especializada, niveles de referencia, contra-referencia y emergencias
- Mejora de las infraestructuras de las unidades operativas y administrativas de la red de servicios de salud
- Mejora del equipamiento de las unidades administrativas y operativas de la red de servicios de salud
- Mejora de la eficacia y sostenibilidad del Sistema de Abastecimiento de Insumos Médicos (SAIM)

- Mejora de los servicios de asistencia socio – sanitaria: ancianos, discapacitados, etc.

Actividades por resultado R4:

- Identificación, priorización y ejecución de los proyectos de agua y saneamiento
- Identificación, priorización y ejecución de proyectos de eliminación y manejo de basuras
- Apoyo a la operación y mantenimiento de sistemas de agua, saneamiento y basuras

Actividades por resultado R5:

- Desarrollo organizacional comunitario en salud
- Desarrollo organizacional comunitario para manejo de sistemas de agua y saneamiento
- Apoyo a la Implementación de programas de Información, Educación y Comunicación (IEC) para la promoción de la salud y prevención de enfermedades
- Apoyo a la investigación operativa aplicada a la promoción de la salud
- Fomento de iniciativas locales (IL) aplicadas al sector de la salud.

6 Annex 17: Thematic case study – The European Commission and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

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6.1 Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, Global Fund) is a multi-billion dollar international financing mechanism that aims to increase the availability of funding by directing money towards areas of greatest need. The organisation works as a partnership between governments, civil society, the private sector (including businesses and foundations) and affected communities by combining resources towards fighting HIV and AIDS, Tuberculosis and Malaria through grant programmes.

GFATM was born in response to a series of global realities that had coalesced by the end of the 20th century²³⁸. New knowledge about the scale of epidemics - especially malaria and tuberculosis - and a deeper understanding of the complex causal links between poverty, development, and disease pushed international issues of public health to the centre of the world's development agenda. At its first meeting, the GFATM Board adopted its framework document, which outlines the guiding principles for the organisation and clearly established its purpose in relation to the global development agenda: ***“To attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and malaria in countries in need and contributing to poverty reduction as part of the Millennium Development Goals.”***

The day-to-day running of the Global Fund is carried out by the Secretariat, which consists of five departments, including the Corporate Service, Finance, Country Programmes, External Relations and Partnerships, and Strategy, Performance and Evaluation. Day-to-day operations include mobilising resources from the public and private sectors, managing grants, providing financial, legal and administrative support and reporting information on the Global Funds activities to the Board and general public. The Secretariat consists of approximately 470 employees representing more than 89 nationalities and makes up 5% of the total annual expenditures. In addition, there are six advisory committees.

The Technical Review Panel (TRP), which exists to review grant applications made by recipient countries, also assists the Board²³⁹. The TRP is made up of an independent panel of health experts who thoroughly examine the technical merits of every application. They can then propose to the Board that a grant application is approved without any conditions, or it is approved with conditions, that it is to be re-written and resubmitted, or that it is rejected altogether.

Box 1: *The Global Fund in a Nutshell*

- Operates as a financial instrument, not an implementing entity.
- Makes available and leverages additional financial resources.
- Supports programs that reflect national ownership and respect country-led formulation and implementation.
- Operates in a balanced manner in terms of different regions, diseases and interventions.
- Pursues an integrated, balanced approach to prevention, treatment and care.
- Evaluates proposals through independent review processes.
- Established a simplified, rapid and innovative grant-making process and operates transparently, with accountability. The fund should make use of existing international mechanisms and health plans.
- Focus is on performance by linking resources to the achievement of clear, measurable and sustainable results.

²³⁸ In January 2000 at the G8 conference in Okinawa, Japan, it was recognised that there was a need for greater resources to fight AIDS, tuberculosis and Malaria. This recognition was further supported by the United Nations (UN) former Secretary-General, Kofi Annan in 2001 and contributed to the Global Fund's foundation in January 2002 in Geneva, Switzerland. Just three months later, the grant board approved the first round of grants for 36 countries.

²³⁹ The current chairperson of the Global Fund's Board is Dr. Tedros Adhanom Ghebreyesus, Health Minister of Ethiopia, who replaced Mr. Rajat Gupta in July 2009. The vice-chair - Dr. Ernest Loevinsohn, replaced Mrs Elizabeth Mataka in July 2009. Dr Loevinsohn is also Director General of the Global Initiatives Directorate of the Canadian International Development Agency. The Chairperson alternates between an expert from a donor country and one from a recipient country every two years. The Board is dedicated to operate by consensus and in the spirit of partnership. However, when this is not achievable, a two-thirds majority can pass motions.

6.2 Contribution and Interaction of the EC with the GFATM

The EC contribution and interaction with the GFATM is mainly in relation to the following aspects:

9. Political and Strategic contribution
10. Financial contribution
11. Indirect contribution through the EC-MS INGOs and different organisations in the implementation of the grants provided for HIV/AIDS, Malaria and Tuberculosis
12. A special case: The Three Diseases Fund in Myanmar

6.2.1 EC political and strategic contribution to the GFATM

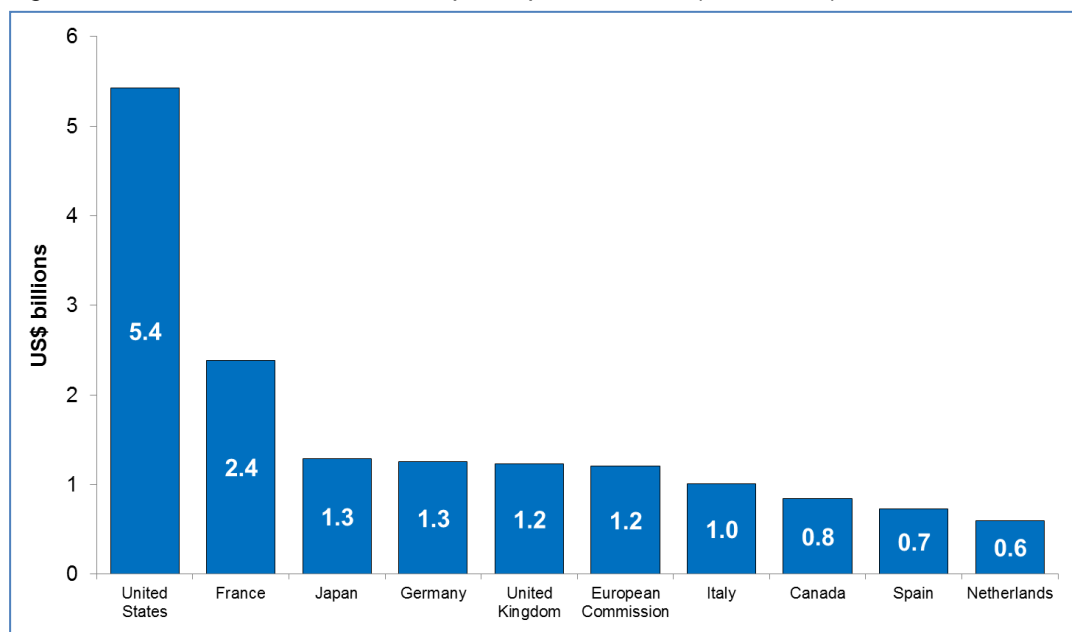
The effects of these three diseases are particularly devastating and they represent a substantial obstacle to development. From the beginning, the EC has played an active role in the establishment of the Fund and the implementation of its policies, including the drafting of the associated rules.

In 2000, the Commission redefined its role and accelerated its response to fight HIV/AIDS, malaria and tuberculosis in a coherent and comprehensive framework. Based on this framework, in 2001 the Commission adopted a Programme for Action to improve the effectiveness of existing initiatives targeting the major communicable diseases and poverty reduction, to make pharmaceuticals more affordable and to support research and development on global public goods to confront these diseases. The Commission policy on HIV/AIDS, malaria and tuberculosis is further spelt out in the Commission communication adopted in October 2004 “**A coherent European policy framework for external action to confront HIV/AIDS, malaria and tuberculosis**”. In April 2005, the Commission adopted a new Programme for Action, “**A European programme for action to confront HIV/AIDS, malaria and tuberculosis through external action 2007-2011**”, which proposes a series of actions at both country and global levels. The actions at country level include capacity building, enhancing human resources capacity to mitigate brain drain, broad cooperation between stakeholders, investing in social services and surveillance, monitoring health outcomes, and strengthening local production capacity for pharmaceutical products. Proposed actions at global level cover five areas: affordable pharmaceutical products, strengthening regulatory capacity in developing countries; developing new tools and interventions, strengthening partnerships with multilateral agencies and other institutions, and maintaining a strong European voice at G8 and EU summits. A major objective of the programme is to increase efforts to scale up interventions that have shown results.

6.2.2 EC financial contribution to the GFATM

Around fifty countries have pledged money so far to the Global Fund. Many of these are wealthy western or middle-eastern nations, although pledges have also been received from countries directly affected by AIDS, TB and Malaria. Uganda for example has pledged USD 2 million to the Fund, while Burkina Faso has given USD 75,000. The biggest single donor country is the US, whose donations make up around 33% of the funds pledged every year.

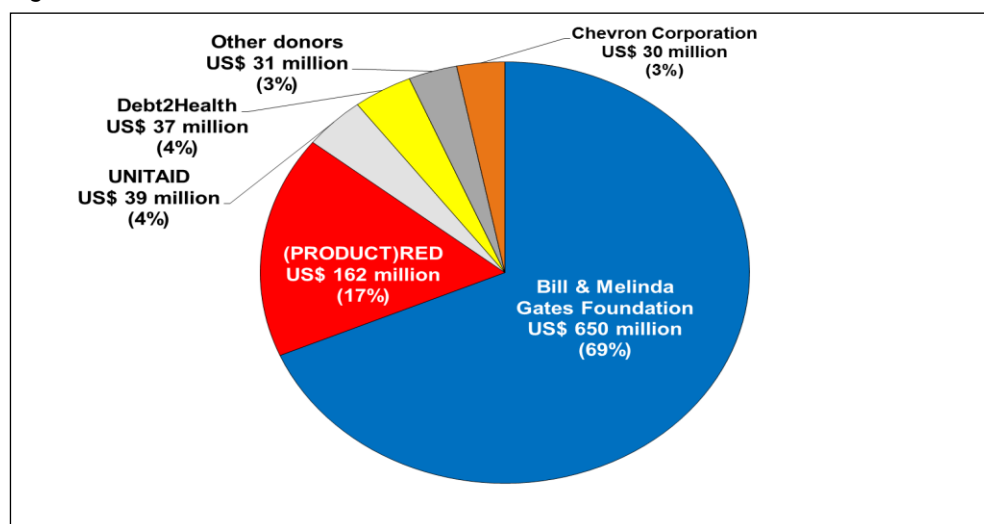
Figure 58: Contribution from Top Ten public donors (2002-2010)



Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

As well as national governments, contributions to the Global Fund also come from large organisations, (see Figure 59) below such as the International Olympic Committee and the Bill and Melinda Gates Foundation), from individuals (Kofi Annan has personally donated USD 100,000), from private sector partnerships such as (PRODUCT) RED, and from fundraising events - a Real Madrid Soccer Match held in 2002 raised a total of USD 112,487.

Figure 59: Contributions from NON-Traditional Donors to the Global Fund



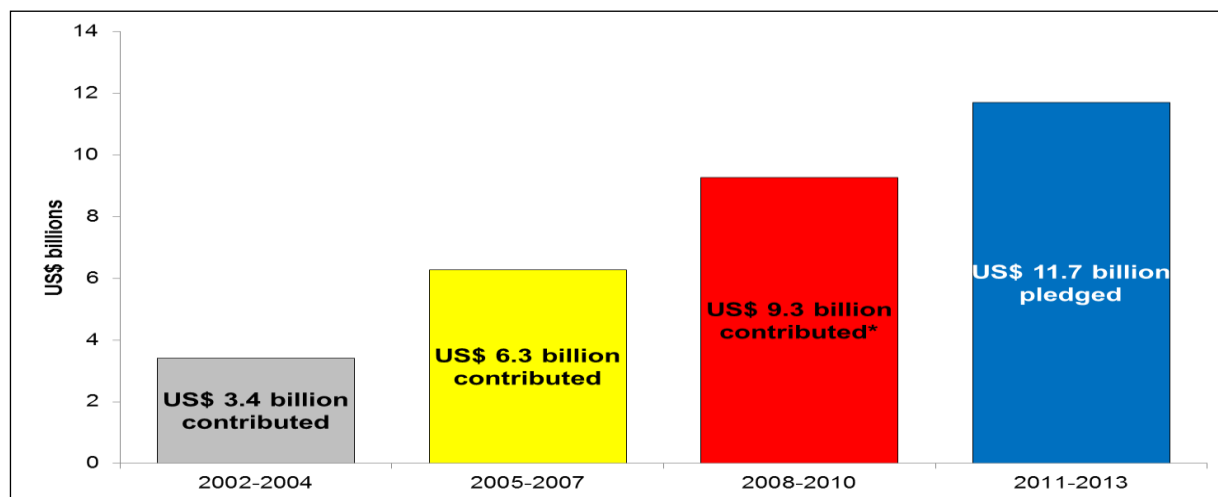
Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

The board of the Global Fund does not dictate who should donate money nor how much should be donated, but it does issue guidelines on how much will be needed to maintain funding and approve new grants. Since 2007 the Global Fund also has a system based on regular **periodic replenishments**²⁴⁰, which enables more accurate forecasting of available resources over the coming

²⁴⁰ In the early years of the Fund's operation, pledges were not made to any set schedule. In the first year of the Fund's operation, most countries pledged a large amount sufficient for several years of funding. Any extra resources that were necessary were then negotiated on an ad-hoc basis. However, this method eventually led to

years. This replaces a more 'ad hoc' and flexible system of replenishment that was used in the early years to attract new donors who may otherwise have been wary about committing large sums to an untested scheme. To implement the new system, special 'replenishment conferences' are now held on a regular basis, facilitating debate about the Global Fund's needs and encouraging potential new donors to enter into discussion and offer pledges. The regular replenishment mechanism works by establishing regular meetings that allow donors to discuss and negotiate current funding needs for a set period, both with the Global Fund board, and with their fellow donor nations.

Figure 60: Evolution of Funding of the Global Fund



Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

Table 25: GFATM funding, approved and disbursed

Type	Amount
Funding to the Global Fund	Total pledges available = USD 29.8 billion
	Total amount paid = USD 18.8 billion
Total Proposals Approved	Total approved grant amount = USD 21.7 billion
	Total lifetime budget of grants = USD 35.5 billion
Grant Agreements Signed	Phase 1 agreements (two-year) = USD 10.2 billion
	Grant renewals (Phase 2, RCC) = USD 7.3 billion
Total Amount Disbursed:	USD 13 billion

Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

In this framework the EC is the sixth major financial contributor to the GFATM with USD 1.2 billion and if we do consider the overall EC plus EC-MS contribution, the EC is by far the major contributor of the GFATM.

1st Replenishment

The first GFATM replenishment was made by Decision 2002/36/EC of the European Parliament and of the Council of 19 December 2001 concerning the Community contribution to the Global Fund to fight HIV/AIDS, tuberculosis and malaria. The Community contributed EUR 120 million from the EC budget to the Global Fund for 2001/2002. For the period 2003-2006, the Community contribution increased to EUR 340 million (EUR 170 million each from the budget and from the European Development Fund).

the appearance of funding gaps (where the amount of money held by the Fund was less than the total needed to fully finance grants), so in 2005, a new system was implemented. The first three "Voluntary Replenishment Conferences" were held in Stockholm, Rome and London. These conferences enabled donors to see the extent to which the Fund would need to be replenished in 2006 and 2007, and pitch their pledges accordingly. Donations for 2008 and beyond were negotiated in three similar meetings in 2007. A review meeting is to be held in March 2009, to review the performance of the Global Fund, and to consider the funding situation.

A further EUR 62 million was allocated in 2006 from the 9th EDF. As of 2007 the European Union (Commission and Member States combined) contributed almost 55% of the total fund.

Last Replenishment

The GFATM Conference took place in New York on the 4th and the 5th of October 2010, with the aim to generate debate on resource mobilisation activities and comprehensive funding policy review. The pledging session of the Conference was chaired by Ban Ki Moon, the UN Secretary General, where donors committed to increase funding to fight the three diseases – which constitute a major challenge for many developing countries in the effort to achieve health-related Millennium Development Goals (MDGs) by 2015.

Donors made a USD 11.7 billion financial commitment GFATM for the years 2011-2013. This new funding compares with USD 9.7 billion committed to the Global Fund in Berlin in September 2007 for the period 2008-2010. EU Commission increased its contribution, which alone contributes EUR 100 million per year. In addition, every year, the European Commission invests more than EUR 300 million to the programs aimed at reducing child mortality and improving maternal health. For the period 2011-2013 the European Commission has proposed to the budgetary authorities of the European Union and to the ACP group to scale up its contribution to reach EUR 330 million over the next three years. This would represent a 10% increase as compared to the current period.

Table 26 below provides data about the EU contributions to GFATM in the last decade.

Table 26: The EU contributions to the Global Fund to fight AIDS, Tuberculosis and Malaria (total pledged to date)

DONORS	Currency	PERIOD OF PLEDGE	AMOUNT PLEDGED	EQUIVALENT IN USD	Total (USD)
Australia	AUD	210,000,000	171,027,145	2004-2010	171,027,145
Belgium	EUR	93,333,222	118,775,977	2001-2010	118,961,280
Denmark	DKK	1,236,600,000	209,357,495	2002-2010	209,357,495
European Commission	EUR	1,072,500,000²⁴¹	1,399,874,546	2001-2013	1,204,218,118
Finland	EUR	15,000,000	20,176,700	2006-2009	20,176,700
France	EUR	1,825,000,000	2,425,121,928	2002-2010	2,196,856,097
Germany	EUR	923,500,000	1,247,695,504	2002-2010	1,186,389,823
Greece	EUR	1,600,000	2,150,085	2005, 2007, 2008	2,150,085
Hungary	USD	55,000	55,000	2004-06, 2008	55,000
Ireland	EUR	170,000,000	220,471,439	2002-2010	160,535,353
Italy	EUR	850,000,000	1,132,238,407	2004-2010	793,100,600
Italy	USD	200,000,000	200,000,000	2002-2003	215,160,273
Latvia	USD	10,000	10,000	2008	10,000
Luxembourg	EUR	18,550,000	24,037,270	2002-2010	24,037,270
Netherlands	EUR	485,000,000	636,613,874	2002-2010	519,220,017
Poland	USD	150,000	150,000	2003-06, 2008	150,000
Portugal	USD	15,500,000	15,500,000	2003-2010	13,000,000
Romania	EUR	475,000	675,017	2007-2010	609,798
Slovenia	SIT	5,400,000	28,080	2004-2006	28,080
Slovenia	EUR	110,000	157,229	2007-2008	157,229
Spain	USD	764,547,085	764,547,085	2003-05, 2007-10	518,751,614
Spain	EUR	50,000,000	63,900,000	2006	63,900,000
Spain	EUR	5,500,000	7,898,369	2005-2008	7,898,369
Sweden	SEK	3,856,000,000	537,226,451	2002-2010	468,040,397
United Kingdom ⁸	GBP	1,359,000,000	2,227,376,561	2001-2015	1,179,417,200
TOTAL EU			11,425,064,163		9,073,207,945
Total public support			21,000,660,740		16,232,481,898
Total private support			839,846,099		934,062,801
Grand Total			21,840,506,839		17,166,544,699

Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

²⁴¹ Between 2002 and 2010, the EC contracted approximately EUR 803 million to the Global Fund (source: inventory of the health evaluation).

As a founding member of the Global Fund, the European Commission has been providing strong political and financial support since 2002. From 2002 to 2010, the European Commission contributed a total of EUR 803 million (source: inventory), which makes it the fifth largest donor to the fund (after the USA, France, Italy and Japan). Over the same period, the European Union together with its member states has contributed more than USD 9 billion or 52% of the GFATM resources. The table on the next page, shows the estimated results (in terms of outputs covering 144 countries) attributable to the EC and EU contribution to the GFATM.

Table 27: Results attributable to the EU contribution to the GFATM (2002-2009)

	GFATM	EU (50.32%)	EC (7.4%)
Nr of people with advanced HIV infection receiving antiretroviral combination therapy	2.500.000 people 1.900.000 people (76%) in Sub-Saharan Africa.	1.258.000 people 956.000 people (76%) in Sub-Saharan Africa	185.000 people 140.600 people (76%) in Sub-Saharan Africa
Nr of people smear positive tuberculosis under DOTS (the internationally agreed strategy for Tuberculosis control ant treatment)	6.000.000 people 1.400.000 people (23%) in Sub-Saharan Africa people	3.019.200 people 694.400 people (23%) in Sub-Saharan Africa	444.000 people 102.120 people (23%) in Sub-Saharan Africa
Nr of insecticide treated nets distributed	104.000.000 nets 72.000.000 nets (69%) in Sub-Saharan Africa	52.332.800 people 36.109.632 nets (69%) in Sub-Saharan Africa	7.696.000 people 5.310.240 nets (69%) in Sub-Saharan Africa
Nr of HIV-positive pregnant women with treatment to prevent mother to child transmission of HIV	790.000 women 674.100 women (85%) in Sub-Saharan Africa	397.528 women 337.898 women (85%) in Sub-Saharan Africa	58.460 women 49.844 women (85%) in Sub-Saharan Africa
Nr of lives saved	4.900.000 lives	2.465.680 lives	362.000 lives

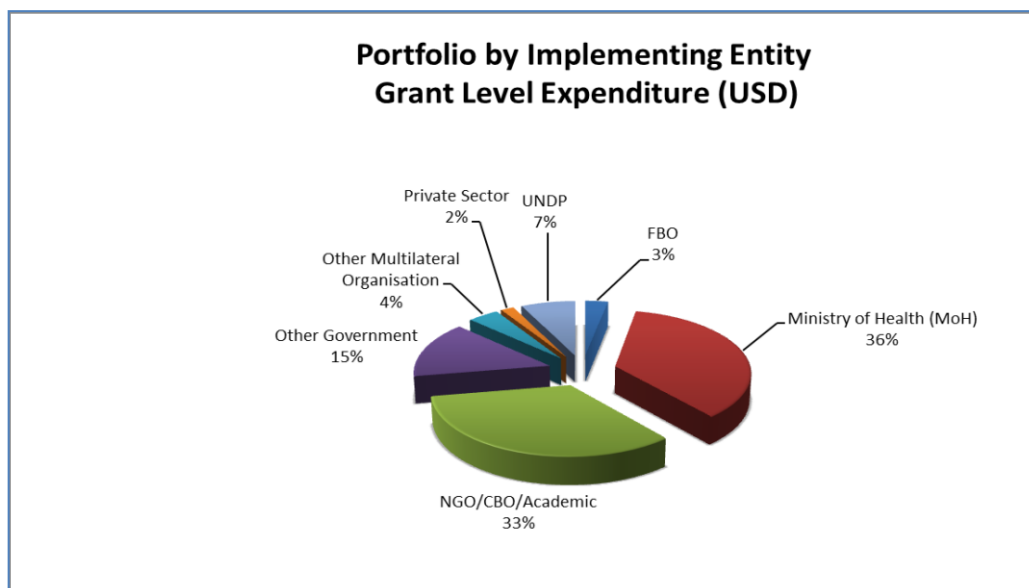
Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

6.2.3 Indirect contribution through the EC- MS INGOs and different organisations in the implementation of the grants provided for HIV/AIDS, Malaria and Tuberculosis

In this brief assessment, one must also consider the indirect contribution of the EC provided to the GFATM through its INGOs and organisations in the implementation of the different grants. This contribution has mainly been in applying knowledge and local know-how. As the following figure shows, 33% of the GFATM grants are implemented by NGO/CBO/Academics which does not include the 4% of Multilateral Organisations and 4% of Faith Based Organisations (FBO). Many European INGOs and academic organisations fall within these categories.²⁴²

²⁴² For more information please refer to the GFTAM website: The Global Fund website (<http://www.theglobalfund.org>)

Figure 61: Global Fund: Principal Recipient and Sub-Recipient Expenditures by Sector



Source: The Global Fund website (<http://www.theglobalfund.org/en/pledges/>)

6.2.4 A special case: The Three Diseases Fund in Myanmar (where the EC and EC MS, plus other donors, substitute the GFATM in Myanmar)

In August 2005, upon a pure political decision made by the USA Bush administration claiming difficult access to GFATM's projects areas in the country by Principal Recipients (PR) and Sub Recipients (SR), the GFATM withdrew its support to Myanmar²⁴³. The reason given was the Myanmar government's restriction over the GFATM performance. The suspension of GFATM aid weakened the country's international resources for fighting the three diseases.

The Three-Diseases Fund (3DF) was created to provide a 'stop gap' until the anticipated return of the GFATM, and started its operation in Myanmar in July 2006. 3DF is a multi donor consortium, which raised an initial USD 100 million to assist Myanmar in the control of three diseases over a five year period 2006-2011/12. It was set up with the donations of six countries and organizations - the European Commission, the UK's Department for International Development, Australia's AusAID, Sweden's SIDA, the Netherlands and Norway. The United Nations Office for Project Services (UNOPS) is the Fund Manager on behalf of the Donor Consortium. In 2009, Denmark also joined the consortium.

The core aim is to provide a simple and transparent instrument to finance a nationwide programme of activities to reduce the transmission of HIV and AIDS, TB and malaria and enhance care and treatment through access to essential drugs and related services. The target beneficiaries are the most vulnerable and under-served populations, especially those living in remote and inaccessible areas, and those most at risk.

Through three funding rounds, 3DF has signed grant agreements worth over USD 100 million with 34 implementing partners for 53 projects, making it the biggest single contributor to the fight against the three diseases in Myanmar. The Fund achieved broad geographic coverage, reaching remote communities through diverse independent organisations, including international and local non-governmental organisations and community-based organisations, as well as five United Nations entities. All current funding rounds will end by 30th June 2012, including a USD 10.8 million Myanmar Artemisinin Resistance Containment (MARC) malaria programme. After a decision of the Board of November 2011 on the basis of sufficient assurances, many donors, including the European Commission have unfrozen and paid their contributions for 2011.

By the end of 2010, 3DF had effectively supported 28 HIV projects, nine TB projects, 10 malaria projects, and four integrated projects. In addition, as part of its identified priorities, the 3DF has provided gap-filling support to the GFATM PRs until their programmes are fully-functioning.

²⁴³ In 2010, with no apparent change in the operating context, the GFATM restarted its contribution in Myanmar

The 3DF portfolio grew in 2009. DFID pledged an additional GBP 10 million (approximately USD 15.5 million), the Netherlands increased its contribution by EUR 1.0 million (approximately USD 1.48 million) and Sweden by SEK 10 million (or approximately USD 1,280,000). In late 2009, Denmark committed DKK 30 million (approximately USD 5.87 million) bringing the total pledges for the 3DF until 2012 to approximately USD 125 million, before additional MARC funds. In terms of contributions received between 2006 and 2009, the breakdown is as follows:

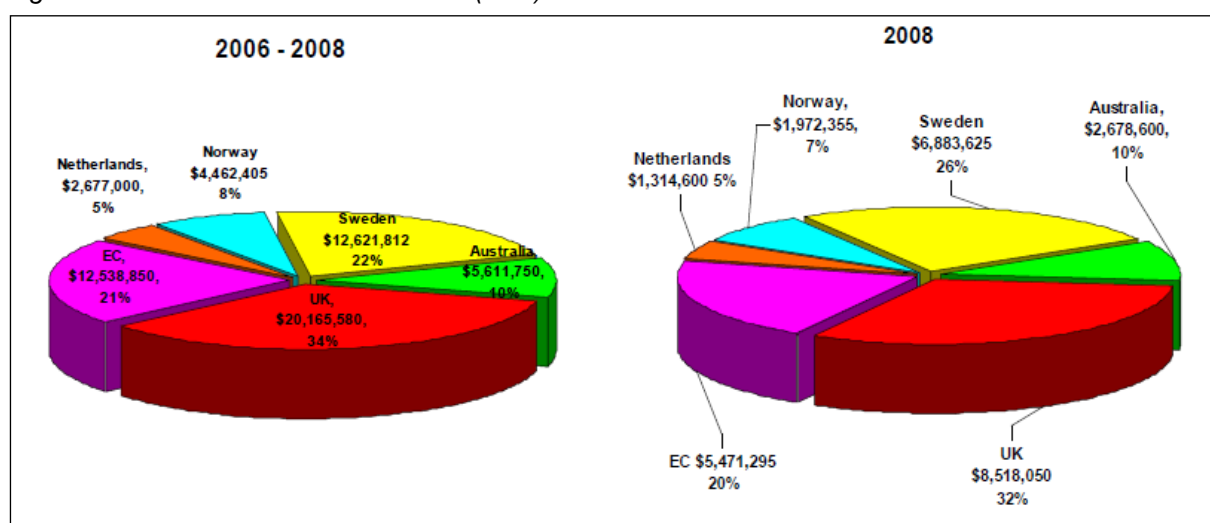
Table 28: Three-Diseases Fund (3DF): Donor contributions 2006-2009 (in USD)

	2006	2007	2008	2009	Total
AusAid	786,600	2,146,550	2,678,600	1,707,317	7,319,067
DFID	2,661,540	8,985,990	8,518,050	15,029,375	35,194,955
EC		7,067,555	5,471,295	6,344,625	18,883,475
The Netherlands		1,362,400	1,314,600	2,993,000	5,670,000
Norway	754,152	1,735,898	1,972,355	1,545,563	6,007,968
SIDA		5,738,187	6,883,625	3,699,790	16,321,602
Danida				1,950,116	1,950,116
Total USD	4,202,292	27,036,580	26,838,525	33,269,786	91,347,183

Source: Three Disease Fund Annual Report 2008

The overall EC financial contribution to the 3DF can be estimated at 21% of the overall envelope over the five years period. If EU member states are considered the financial contribution to the fund exceed 80% of the total budget.

Figure 62: Three-Diseases Fund (3DF): Sources of funds



Source: Three Disease Fund Annual Report 2008

6.2.5 Present Situation: The Funding environment for the Global Fund has changed dramatically

The change in the funding environment of the Global Fund is due to:

13. Pre-existing 'AIDS fatigue' among some donors;
14. Funding for AIDS has far outpaced maternal, newborn, and child health, malaria, tuberculosis, non-communicable diseases;
15. ODA at risk due to record public debt among most OECD DAC donors;
16. The Euro crisis;
17. Media reports on corruption have created reputation damage;
18. Signs that US pledges are under severe pressure.

The new situation is as follows:

19. The USD 11.7 billion replenishment outcome is in danger of not being achieved;
20. Round 10 is in danger of not being fully funded;
21. Round 11 is in danger of being squeezed (including NSA and joint HSFP proposals).

The Global Fund remains millions of dollars short of what it needs to operate as governments continue to withhold donations over in-country corruption allegations. **Several donors to the Global Fund to Fight AIDS, Tuberculosis and Malaria continue to hold back their contributions for 2011.** Some have yet to make pledges; others have frozen disbursements pending the outcomes of two ongoing reviews of corruption. The result is that resources available to the Global Fund for 2011 remain USD 5 billion short of what the Fund was expecting for this year. While the GAVI Alliance celebrates the results of a recent pledging conference that exceeded expectations, the Global Fund is operating with a budget that is well below that for 2010 (see Appendices 1 and 2).

6.2.6 Incidences of 2011²⁴⁴

Between 2008 and 2010, resources available to the Global Fund grew by about 8% a year, reaching almost USD 3.6 billion in 2010. But at the tenth pledging round of the fund for 2011-13, donors promised to give substantially less than what the Fund had hoped for; the Global Fund received USD 11.7 billion for the three years. Although this was 20% more than for 2008-10, it fell well short of what the Fund said it needed to maintain progress.

In January 2011, the Global Fund was already preparing to scale back on its planned new activities when a spate of negative articles, triggered by a story by the Associated Press (AP) about misuse of Global Fund money, caused three major donors to get cold feet.

The coverage was based on a report from the Office of the Inspector General to the Global Fund Board, dated December, 2010, and made public in January 2011. According to the report, a total of USD 34 million in Global Fund grants were not accounted for and are to be refunded by recipient countries. Although substantial, most of these figures had been in the public domain since autumn 2010. Indeed, the Inspector General's findings had caused **Sweden** to withhold its pledge for Round Ten in November, 2010. But following the media coverage in January 2011, three other donors reacted swiftly. **Germany**, the Global Fund's fourth largest donor after the USA, France, and the UK, immediately froze its disbursement of USD 285 million that had been allocated for 2011. Publicly, the German move was linked to concerns about corruption, though the German Development Minister has been sceptical of collective international efforts like the Global Fund, preferring bilateral projects.

According to the Lancet, the press secretary at the German Development Ministry (BMZ) said the AP story showed that the dimensions of the corruption in the Global Fund were much bigger than what the Fund had reported earlier. *"Once there are allegations in the air we have to follow them"*, he said. **Denmark** followed suit. *"It was a good occasion to take a deep hard look at what is going on, since we had also heard of some problems within the Global Fund"*, said Danish Development Minister Søren Pind. *"We will not pay more money as long as it is unclear what has been going on."* In January 2011, **the European EC** also froze its disbursement for 2011 following the widespread publicity about misuse of funds Catherine Ray, the then spokesperson at the European Union's (EU) Development Directorate-General underlined that the problems identified have not been committed by the Global Fund itself, but in individual countries by people contracted to implement the programmes. The fact that the Global Fund's Inspector General identified the misuses and corruption is a good example of aid transparency both for the countries and the organisations, she said. **In addition to Germany, Denmark and the EC, by September 2011 two other key donors Sweden and Spain had still not announced their pledges for 2011.** Taken together, missing Swedish and Spanish funds probably represent around USD 200 million in resources that the Global Fund had expected to have on the books for 2011.

Under pressure from Germany, an independent international panel was set up to assess the risk of fraud and misappropriation in the Global Fund portfolio, and the robustness of the Global Fund's existing systems of control. The panel is being headed by former President of Botswana Festus Mogae and former US Secretary for Health and Human Services Michael Leavitt. Its remit was to deliver an interim report in summer 2011 and a final report in September 2011.

The interim report was released June 30, and Germany announced the following day that it was releasing half of its funds for 2011 EUR 100 million (USD 142 million). According to a press release from the German Development Ministry BMZ, the independent commission of experts states that there

²⁴⁴ Source: *The Lancet*, Volume 378, Issue 9790, Pages 471 - 472, 6 August 2011

is a great and urgent need for reforms at the Global Fund. The German Development Minister emphasised: *“There is a need for better accountability, as well as potential for an increase in the effectiveness of the Fund's work.”* The release of this first portion of funding is subject to the condition that German funds can only be used in those countries where the Global Fund mainly relies on implementing agencies such as the UNDP or the GIZ (Deutsche Gesellschaft für internationale Zusammenarbeit), aiming at reducing the likelihood for corruption.

Germany will consider releasing the other half of this year's allocation to the Global Fund after the commission's final report is completed. Denmark has also indicated that the release of its funds will depend on the outcomes in the final report. All in all, unannounced pledges and frozen disbursements from these five donors add up to more than USD 500 million that the Global Fund had been counting on for this year out of a total budget of about USD 3 billion. In a parallel process, the EC launched an institutional audit of the Global Fund in January 2011 to look more deeply into the situation in the four countries that were highlighted by the Inspector General where fraud and irregularities were identified. A draft audit report has been completed and, in August 2011, was being discussed by the EC and the Global Fund. While the independent commission's final report will be made public, the EC audit will remain a confidential document.

Meanwhile Sweden wants to be sure that the Global Fund Secretariat is implementing the reform agenda according to the instructions of the Board. According to the Lancet, positive outcomes in the two reviews will probably lead the Swedes to release their funds as well. Regarding the questions whether the donors sudden decisions to withhold hundreds of millions of dollars from the Global Fund carries the risk of endangering the lives of patients, the Global Fund Secretariat insists that, despite the shortage of funds, no planned activities under ongoing programmes, including distribution of drugs, have been affected so far. The Global Fund can say this with certainty because it only enters into legally binding contracts to fund activities such as the supply drugs when sufficient donor contributions have been received.

The signing of such contracts usually occurs 8-10 months after the Board has approved project proposals from countries. New contracts based on programme proposals approved by the Global Fund's Board in December, 2010, will be ready for signing in autumn 2011. At that point, if the Global Fund is still short of resources, head of resource mobilisation at the Global Fund indicated to the Lancet that *“we may have to look at the sequencing of signings and whether to delay the implementation of life-saving activities or hold off on some of them until the funds are unfrozen”*.

It must be noted, that, following a decision of the Board of November 2011, many donors, including the European Commission have unfrozen and paid their 2011 contribution. This meant that all round 10 grants on which negotiations have been concluded could be signed.

6.3 EC & the GFATM in Africa: Conclusions of an audit²⁴⁵

Here follow concluding excerpts from the European Court Report from 2008 entitled “Special Report 10: “The EC Development Assistance to Health Services in Sub Saharan Africa”.

6.3.1 The Global Fund has disbursed a large volume of funds but the rate of disbursement has been slower than the EDF

One of the objectives of setting up the Global Fund was to establish a faster delivery mechanism. While the EC's contributions to the Global Fund, which began under the ninth EDF, have accelerated the speed with which the EC disburses overall EDF health commitments, disbursement, by the EC, to the Global Fund is only the first step in channelling this assistance to the final beneficiary.

In terms of increasing the overall volume of disbursements for combating HIV/AIDS, malaria and tuberculosis, the Global Fund has been effective. Its disbursements in sub-Saharan Africa amounted to USD 2.931 million from 2002 to 2007. However, the rate at which the Global Fund disburses in sub-Saharan African countries does not compare favourably with EDF health interventions. For the first round of grants launched in 2002, at the end of their five-year implementation period only 73% of the budget had been disbursed. The ECA's analysis did not indicate an improvement in the disbursement rate of Global Fund grants approved in subsequent years.

Besides the Global Fund's legitimate emphasis on performance-based funding, which means it reduces disbursements to less effective grants, according to ECA, two further factors affecting the rate

²⁴⁵ European Court of Auditors (2008): EC Development Assistance to health services in Sub-Saharan Africa. Special Report No 10 -2008.

of disbursement have been: (a) difficulties of some recipients of Global Fund support in establishing financial, procurement and monitoring systems of the standard required by the Global Fund and difficulties in quickly disbursing the funding; (b) new funding sources such as PEPFAR enter in countries during Global Fund grant implementation, which has reduced their absorption capacity.

Unlike the EDF, Global Fund grants are approved on the basis of annual funding rounds. Countries do not know if their applications for funding will be approved and for what amount. Thus, over the first six years of the Global Fund only 39% of grant applications submitted for financing were actually approved.

6.3.2 The Commission played an important role in the setting up of the Global Fund but has done little to support or monitor it at country level

In the framework of its 'accelerated action' policy, the Commission has made a significant contribution to the establishment of the Global Fund. It is represented on the Board and is consequently in a position to influence the overall principles according to which it operates. The Global Fund has quickly become a major player in tackling HIV/AIDS, tuberculosis and malaria and by 2007 it had approved grants of USD 8.947 billion for 136 countries, of which almost 60% has been for Sub-Saharan Africa.

Over the period 2002–10, the EC disbursed 100% of the contracted amounts, namely EUR 803,140,722. EUR 420 million to the Global Fund came from the EDF intra-ACP funds and the health general budget lines accounted for EUR 383,140,722.

According to ECA, the significant role played by the EC headquarters in the setting up of the Global Fund, as well as the considerable resources it has allocated to it, are in contrast to the limited role played in relation to the Global Fund by most EUDs. Guidance notes issued by EC headquarters did not instruct but only 'encouraged' EUDs to support Global Fund operations. In none of the three main areas earmarked by EC headquarters for delegations' involvement have they played an active role:

- *Actively participating in Global Fund country coordinating mechanisms (CCM) and help strengthen them:* according to the ECA's survey, only 35% of EUDs participate in the CCMs. The most common reasons given for not attending were insufficient staff in the delegations and the fact that the health sector was not a focal sector for the EC;
- *Reporting on aspects of the Global Fund functioning in country:* according to the ECA's survey, just 8% of EUDs reported regularly to EC headquarters, 59% reported occasionally while one third had never reported. While the EC is on the Global Fund board, its lack of feedback on Global Fund operations from EUDs has reduced its capacity to act at this level to improve the effectiveness of operations;
- *Providing technical assistance for developing grant proposals and assisting implementation:* in the face of the lack of capacity of national bodies to draw up grant proposals and then implement them²⁴⁶, the Global Fund has particularly stressed the need for the international community to provide technical assistance in Sub-Saharan Africa to address this problem, but the EC has not responded to this need.

6.3.3 The Global Fund has made a significant contribution to tackling HIV/AIDS, malaria and tuberculosis but it depends on complementary long-term health system support from donors to become more effective

One key measure of the effectiveness of the Global Fund is the output indicators used to cover what is termed 'Global Fund supported-programs'. These indicators include outputs not only from programmes financed solely by the Global Fund but also from programmes which the Global Fund co-finances along with national governments and other external assistance. This makes it difficult to determine what outputs can be specifically attributed to the Global Fund. Nevertheless, according to ECA, the Global Fund, until 2007, had made a major contribution to the outputs set out in the following table. In the five countries visited, the ECA auditors noted in particular the Global Fund's contribution to scaling up anti-retroviral (ARV) therapy and HIV/counselling and testing, while prevention of mother to child transmission (PMTCT) was proving difficult because of staffing shortages and cultural issues. Also, some malaria grants had experienced procurement delays for ITNs and ACTs.

²⁴⁶ European Court of Auditors (2008): EC Development Assistance to health services in Sub-Saharan Africa. Special Report No 10 -2008; paragraph 57.

Table 29: Global Fund Performance Indicators for its three Sub-Saharan African Regions (at 31st December 2007)

HIV/AIDS	Percentage of target	Activities
Anti-retroviral therapy	93%	1 100 000 people on ARV therapy
HIV counselling and testing	101%	16 million people reached
Prevention of mother to child transmission (PMTCT)	64%	100 000 HIV positive pregnant received a full course of prevention of mother-to-child transmission
Support to orphans	116%	2 million orphans provided with care and support
Tuberculosis		
DOTS treatment	86%	800 000 people on treatment
Malaria		
Insecticide treated nets (ITN)	63%	35 million nets distributed
Anti-malarial treatment (ACT)	43%	37 million malaria treatments delivered
Other indicators		
Care and support	107%	1,7 million people received care and support
People trained	105%	1,8 million people trained to deliver services

The Global Fund has been faced with the issue of whether it should follow a narrow interpretation of its mandate and focus exclusively on the three diseases or take a broader view and also provide funding for health systems support.

The Global Fund has, however, emphasised that the main support for health system strengthening should come from other donors: 'There is an urgent need for their strategies to prioritise substantial long-term health system and infrastructure strengthening with additional finance'²⁴⁷. Such finance is important both to achieve a better balance between health systems and disease-specific interventions and to make Global Fund support more effective since weaker health systems can be a bottleneck which reduces countries' absorption capacity for Global Fund grants.

The fact that the Global Fund's mandate is to tackle the three diseases means that the amount of support it provides to specific countries reflects more the disease burden in these areas than the overall income poverty levels in the country. That said, the Global Fund has had a poverty focus within countries. Particularly through its extensive use of community-based organisations, it has sought to intervene in the poorer regions of countries which are less well-covered by government health services.

According to ECA, the role of the Global Fund in health system strengthening and poverty reduction are issues which have not received adequate attention from the EC, at either board or country level. This reflects the limited overall involvement of EUDs in Global Fund operations and the insufficient priority EC headquarters has given to ensuring EUDs' involvement.

²⁴⁷ See Global Fund (2008): Partners in impact – Results report 2007.

7 Annex 18: Thematic case study –EC Support to the health sector in Fragile States

7.1 Defining Fragile States

While the term ‘Fragile States’ is widely used, there is no real consensus definition. The term emerged around 2005, when agencies like World Bank, DFID and OECD had started to realise that poorly governed countries, including most (post)conflict countries, would have great difficulty to achieve the MDGs. Conventional aid practice favoured spending money in ‘good governance’ countries with a higher rate of return on investments, which led to underfunding of less well governed countries. However, the emphasis on the MDGs from the year 2000 onwards, in combination with increased security concerns following the 9/11 event, led to work within these and other agencies to better understand the issues and options for support to what became known as ‘fragile states’. Initially agencies used different terms, like the World Bank’s LICUS (Low income countries under stress), but around 2005 the term fragile states became widely adopted, although not necessarily a favourite term with the countries concerned.

An often quoted definition defines Fragile States as ‘**countries affected by conflict, emerging from conflict, or otherwise lacking the will or capacity to implement pro-poor policies**’²⁴⁸. Within the fragile states group usually most attention goes to the post-conflict countries, where there might be an increased willingness to implement more inclusive, pro-poor policies and where the international community is willing to provide substantial support, among others in an attempt to prevent the country slipping back into conflict. But, while most of the countries on the various fragile states lists are in conflict or have been in conflict in the recent past, there are quite a few others that are not in open conflict but are otherwise considered fragile. Because various agencies use slightly different definitions, those lists, of usually around 40 fragile countries, also show variation. There is also variation over time, when countries slip into or out of fragility. More recent there is a tendency to talk about ‘fragile and conflict-affected countries’ or even ‘situations’ instead of countries to indicate that some countries may not be fragile as a whole, but may have areas that are.

The EC does not have its own definition on fragile states, with accompanying list. The EC endorses the Principles of Good International Engagement in Fragile States and Situations, elaborated by the OECD Development Aid Committee (DAC). For the purpose of this paper, we will therefore adopt the OECD definition and list of fragile countries, which it uses as the base for an annual report on resource flows to Fragile States²⁴⁹.

OECD/DAC defines fragile states on the criteria that fragile states lack capacity within two criteria:

22. legitimacy of the government and
23. effectiveness of state mechanisms to carry out governmental functions.

A fragile state is “unable to perform basic functions [like] maintaining security, enabling economic development and ensuring the essential needs of the population are met” (OECD 2008). By this definition, these states are not just poor or corrupt; they are essentially incapable of accomplishing their basic objectives.

²⁴⁸ DFID, 2005 *Why we need to work more effectively in fragile states*

²⁴⁹ OECD-DAC Conflict and Fragility dossier at www.oecd.org/dac/incaf

Table 30: List as used in OECD-DAC reports on fragile states

Afghanistan	Equatorial Guinea	Liberia	Sierra Leone
Angola	Eritrea	Myanmar	Solomon Islands
Burundi	Ethiopia	Nepal	Sudan
Cameroon	Gambia	Niger	Tajikistan
CAR	Guinea	Nigeria	Timor-Leste
Chad	Guinea-Bissau	Pakistan	Togo
Comoros	Haiti	Papua New Guinea	Tonga
Côte d'Ivoire	Iraq	Republic of Congo	Uganda
DRC	Kenya	Rwanda	Yemen
Djibouti	Kiribati	São Tomé & Príncipe	Zimbabwe

Source: <http://bit.ly/vNZGMi>

7.2 The case for support to the health sector in Fragile States

In its 2004 report²⁵⁰, DFID calculated that while they are home to only 14% of the world's population, fragile states contain a third of the world's poor, a third of the world's maternal and under-5 mortality cases and a third of those living with HIV/AIDS in developing countries.

A recent conference paper (USIP, Washington 2011)²⁵¹ provided the following table on the link between fragility and a range of health indicators:

Table 31: Health Indicators in Fragile States Summary

	Countries	% of births attended by a skilled health personnel	Measles immunization coverage among 1 year olds, 2009	Children under 5 years that are underweight, 2000-2009,	Total fertility rate (per woman) 2009,	Life Expectancy at Birth (years) 2009	Neonatal Mortality Rate per 2000 live births 2009	Maternal Mortality Ratio per 100,000 live births 2008
Fragile States	43	50%	73%	23% (42)	4.5	58.1	33.7	558.0
GLOBAL WHO Data	All countries	NA	82%	NA	2.5	66.0	24.0	260.0

Source: United States Institute of Peace, *Health in Fragile and Post-Conflict States: Challenges for the Next Decade*, Conference Working Paper, June 2011, Washington DC USA

MDG reports showed that the MDGs could never be met, even if all other countries were doing well, if the lack of progress on MDGs in fragile states would not be addressed. And, as presented during the European Union Development Days in December 2010, one of the key messages from the World Bank's World Development Report 2011 was: "No low income fragile or conflict-affected country has yet achieved a single Millennium Development Goal".

Based on these statistics there have been calls to step up aid in fragile states and increase service delivery to accelerate MDG achievement. However, the very fragility of countries hampers scaling up of sustainable service delivery. On the other hand, improved health service delivery may have a role in strengthening the compact between a (new) government and its citizens and may therefore contribute to stabilisation efforts after periods of conflict. It has also been postulated that improved health systems and health service delivery, resulting in better health, may contribute to wider state building objectives. There is some, but still insufficient evidence to support this hypothesis²⁵². Only recently has some research been commissioned to shed more light on these relationships.

²⁵⁰ How important are difficult environments to achieving the MDGs. A. Branchflower et al, DFID, UK, 2004.

²⁵¹ United States Institute of Peace, *Health in Fragile and Post-Conflict States: Challenges for the Next Decade*, Conference Working Paper, June 2011, Washington DC USA.

²⁵² Health System Reconstruction: Can it Contribute to State-building? Jack Eldon et.al. Health & Fragile States Network, October 2008.

7.3 EC policy on Fragile States

Unlike most other major donors, there seems limited documentation available in the public domain where the EC addresses fragile states issues and none could be identified specific about health and fragile states. Key documents are an October 2007 Communication from the Commission 'Towards an EU response to situations of fragility – engaging in difficult environments for sustainable development, stability and peace work'²⁵³ and its ensuing 'Conclusions of the Council'²⁵⁴. The documents contain a range of recommendations to ensure improved EC policy and implementation in case of fragility, as can be seen from the following summary of the Communication:

Box 2: Summary of the EC Communication "Towards an EU response to situation of fragility"

Fragile situations are a major obstacle to sustainable development, regional stability and international security. They are triggered by several factors, such as structural fragility of the economy, a number of democratic governance shortcomings, environmental degradation or access to natural resources. In these situations, the State is unwilling or incapable of meeting its obligations regarding service delivery, management of resources, rule of law, security and safety of the populace and protection and promotion of citizens' rights and freedoms. By virtue of its position as main donor of humanitarian aid and development aid and as an important actor in international security and policy matters, the EU has special responsibilities in addressing situations of fragility. Early warning, analytical, monitoring and assessment tools have been developed in the area of fragility **prevention**. Development cooperation and political instruments play an important role in the implementation of preventive measures. Development cooperation addresses the root causes of insecurity. Within this context, **country strategy papers (CSPs)** present a potential that needs to be enhanced. And political dialogue, an essential element of any cooperation agreement between the EU and third countries, can help to build national strategies aiming at a durable exit from fragility.

First of all, the **response** to fragility is ensured by long-term development cooperation, through the CSPs in particular. In cases where this is not possible due to deterioration of the situation, the EU applies political and diplomatic instruments. Finally, when situations of fragility slide into crises with humanitarian implications, humanitarian aid is provided.

Response to fragility must be adapted to the country concerned, by focusing long-term strategic response and initial response on addressing the immediate needs of the population, vulnerable groups in particular. Moreover, it is important to avoid creating "aid orphans", by striving for complementarity in interventions through the EU Code of Conduct and, within the humanitarian aid framework, through its Forgotten Crisis Assessment methodology. Further coordination within the EU is also necessary.

Management of the **post-crisis** phase is ensured by the "Linking Relief, Rehabilitation and Development" (LRRD) strategic framework, which aims at the creation of synergies between the withdrawal of humanitarian aid and the transition to development activities. The Commission underlines the need to improve the framework, through better integration of governance, institutional development and security in particular.

In addressing fragility, **the EU must improve the use of its resources**, i.e. Community instruments, the common foreign and security policy (CFSP) and the European Security and Defence Policy (ESDP) instruments, but also Member States' bilateral aid. Specifically, it should encourage increased synergy between existing financial instruments, i.e.:

- The European Development Fund (EDF), which finances flexible mechanisms for post-emergency action and transition to the development phase.
- The Development Cooperation Instrument (DCI) and European Neighbourhood and Partnership Instrument (ENPI), which provide for a special emergency procedure allowing transition to development and specific measures to be implemented when stability and humanitarian aid measures cannot intervene.
- The Instrument for Stability, which provides for support in situations of crisis or emerging crisis, initial post-crisis political stabilisation and early recovery from natural disasters.
- The humanitarian aid instrument, used when situations of crisis have humanitarian implications, whatever the level of fragility and the causes of the crisis.
- The thematic programme Non State Actors and Local Authorities in Development and the European Instrument for Democracy and Human Rights (EIDHR), which provide for procedures applicable to situations that are not favourable to participatory development or to respect for human rights. Specifically, the EIDHR can fund activities without approval from the governments of partner countries, which is fundamental in certain situations of fragility.
- Budget support, which has often been used by the Commission in post-conflict cases to address urgent

²⁵³ Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions of 25 October 2007 – Towards an EU response to situations of fragility – engaging in difficult environments for sustainable development, stability and peace.

²⁵⁴ Conclusions of the Council and the Representatives of the Governments of the Member States meeting within the council on 'An EU response to situations of fragility'.

financial needs, consolidates key state functions and maintains social stability.

Finally, the Commission proposes a series of actions, namely:

- Endorsement and implementation of Principles of Good International Engagement in Fragile States and Situations, elaborated by the OECD Development Aid Committee (DAC).
- More systematic inclusion of issues concerning fragility in the political dialogue with fragile partner States.
- Regular exchanges of risk analyses and relevant EU responses, at the field level and also at headquarters.
- Mapping of bilateral and EU aid modalities with particular focus on the complementarity of CFSP/ESDP joint actions, the Instrument for Stability, the African Peace Facility and long-term cooperation instruments.
- Review of assessment and analytical tools on governance, conflicts and disaster monitoring.
- Improvement of the budget support mechanism, including through better coordination with international financial institutions.
- Strengthening of the partnership with the United Nations and other multilateral organisations.

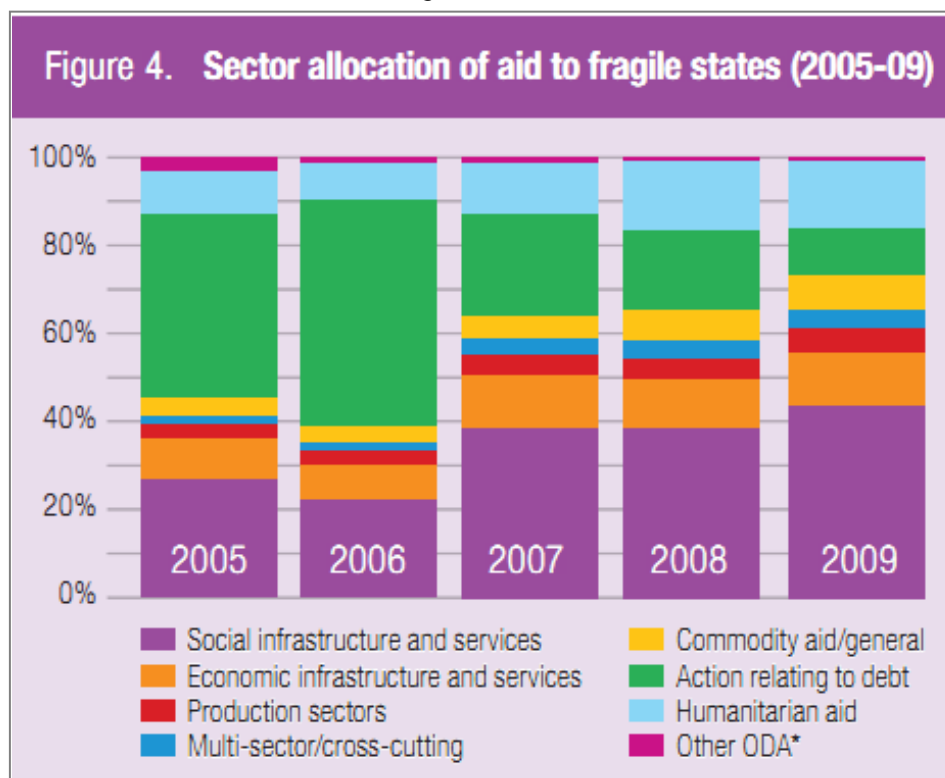
This 'whole of EU' approach has obviously many facets, and will need to be operationalised. In its Conclusions, the Council called on the Commission to present an implementation plan by 2009. The evaluation team is not aware whether and how these plans have materialised yet.

7.4 Some general trends regarding aid to Fragile States

Before discussing EC support to health sectors in Fragile States over the past decade in the next paragraph, the following summary of some recent key findings by OECD regarding aid to Fragile States may provide a useful context.

While overall ODA, including the share for fragile states, has increased over the decade (OECD report 2010), ODA to fragile states remains highly concentrated, with 51% of 2008 ODA for the 43 fragile states benefiting just six countries²⁵⁵, which account for only 23% of the population of the total fragile states group. The figure below shows the sector allocation of aid to fragile states between 2005 and 2009. A relative increase in 'social infrastructure and services', which will include health.

Figure 63: Sector allocation of aid to fragile states 2005-2009



Source: OECD/DAC 2011 Factsheet on Resource Flows in Fragile States

²⁵⁵ Afghanistan, Ethiopia, Iraq, West Bank and Gaza, Sudan, and Uganda.

According to 2011 OECD reports²⁵⁶, a new monitoring survey of the Paris Declaration on Aid Effectiveness shows that the quality of aid to fragile states is markedly poorer than in other developing countries. There are three main issues of concern in fragile states: (1) Aid volumes are very concentrated, with a great share going to only a handful of countries (typically those of geopolitical interest); (2) There are too many donors in a handful of fragile states, and there are too few in others; (3) Aid volatility continues to be a problem in fragile states

7.5 Data analysis of EC support to health sectors

Three of the 12 case countries studies in the evaluation report are considered to be fragile states: Afghanistan, DRC and Burkina Faso.

Our analysis of the CRIS database showed that the EC provides aid to 35 fragile countries. Table 32 shows the total amounts per country. As for OECD at large, but for different countries, 50% of the total goes to only a few countries: Afghanistan, Nigeria, DRC, Zimbabwe and Angola, with by far the largest share going to Afghanistan.

Table 32: Contracted amounts per fragile state (2002 – 2010)

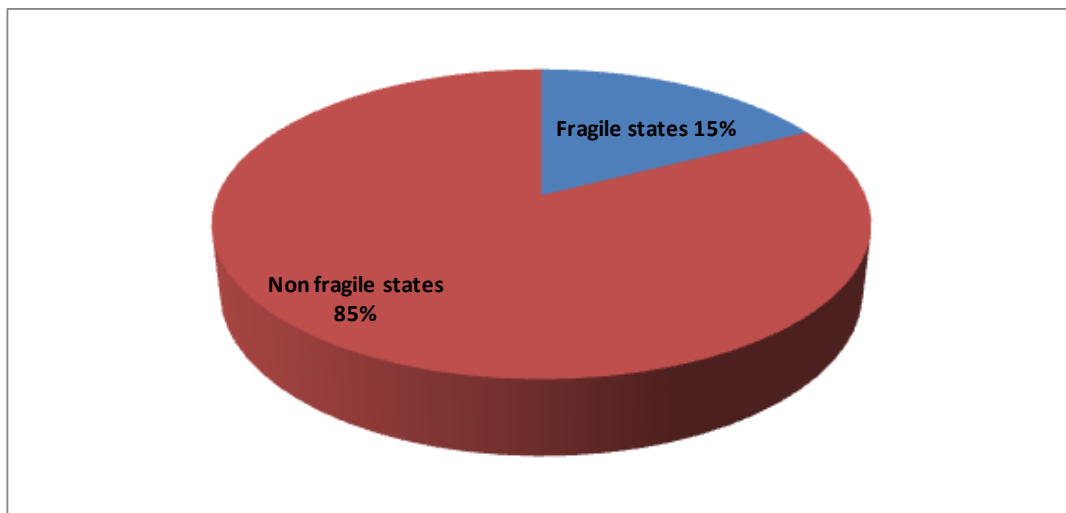
Country	Contracted amounts to 1/2011 (EUR)	Country	Contracted amounts to 1/2011 (EUR)
AFGHANISTAN	149,373,043	CÔTE D'IVOIRE	14,203,061
NIGERIA	94,747,375	IRAQ	13,000,000
CONGO, THE DEMOCRATIC REPUBLIC OF THE	92,482,220	CAMEROON	10,044,561
ZIMBABWE	81,286,205	KIRIBATI	8,580,000
ANGOLA	47,287,992	NEPAL	6,562,547
MYANMAR	42,866,111	PAKISTAN	6,532,021
SIERRA LEONE	38,389,689	LIBERIA	6,104,460
YEMEN	29,911,038	RWANDA	5,698,658
CHAD	29,563,853	PAPUA NEW GUINEA	5,537,358
UGANDA	25,089,450	TAJIKISTAN	2,782,627
KENYA	24,451,261	SUDAN	2,741,501
ETHIOPIA	21,392,551	HAITI	2,071,790
BURUNDI	19,364,333	TOGO	2,057,902
GUINEA	19,336,497	SAO TOME AND PRINCIPE	1,897,217
CENTRAL AFRICAN REPUBLIC	17,036,901	ERITREA	949,868
TIMOR-LESTE	16,689,978	GUINEA-BISSAU	735,462
CONGO	15,497,089	COMOROS	548,875
NIGER	15,255,005		
Grand Total		870,068,497	

Source: CRIS database, Particip analysis

²⁵⁶ OECD (2011) International Engagement in Fragile States. Can't we do better? And OECD (2011) Ensuring Fragile States are not left behind. 2011 Factsheet on Resource Flows in Fragile States.

The total amount allocated for the health sector to fragile states represents 15% of the total amount allocated to the health sector Table 31. OECD reports overall ODA to fragile states to be around 30% of all ODA.

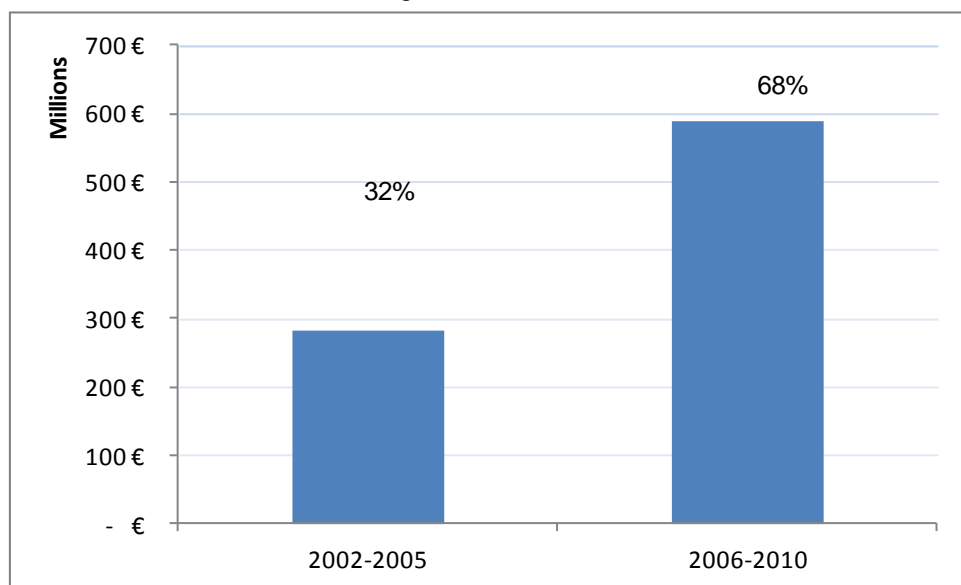
Figure 64: Percentage of total funds in the health sector allocated to fragile states



Source: CRIS database, Particip analysis

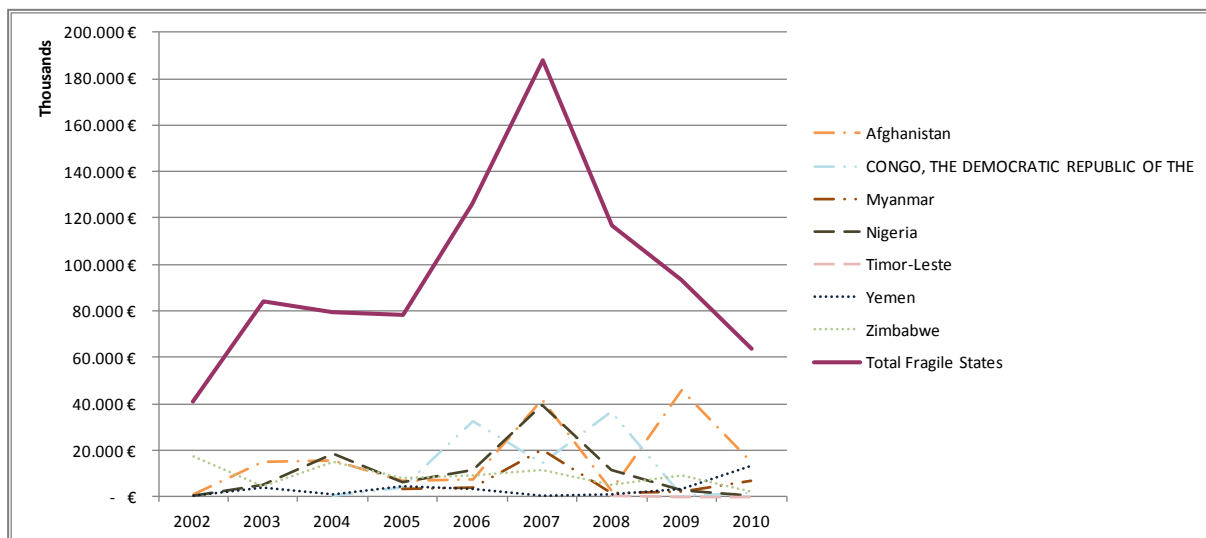
Since the fragile states agenda only really emerged around the year 2005, further analysis was done on the trend in EC funding to fragile states. The two figures below do point in the direction of an increased flow of funds in the period after 2005. Some caution is needed in the interpretation of the figures. The peak in 2007 may be partly caused by multi-year allocations. Another factor is that fragility in countries changes over time and some countries may therefore receive aid in a specific period. For instance the higher percentage of aid to fragile states after 2005 may not be so much the result of a change in underlying policy to allocate more funds to fragile states, but due to the bulk of funding to Afghanistan being allocated in that period and the deteriorating situation in Zimbabwe during that period. Both countries have been relatively main recipients among the fragile states group.

Figure 65: Contracted amounts to fragile states



Source: CRIS database, Particip analysis

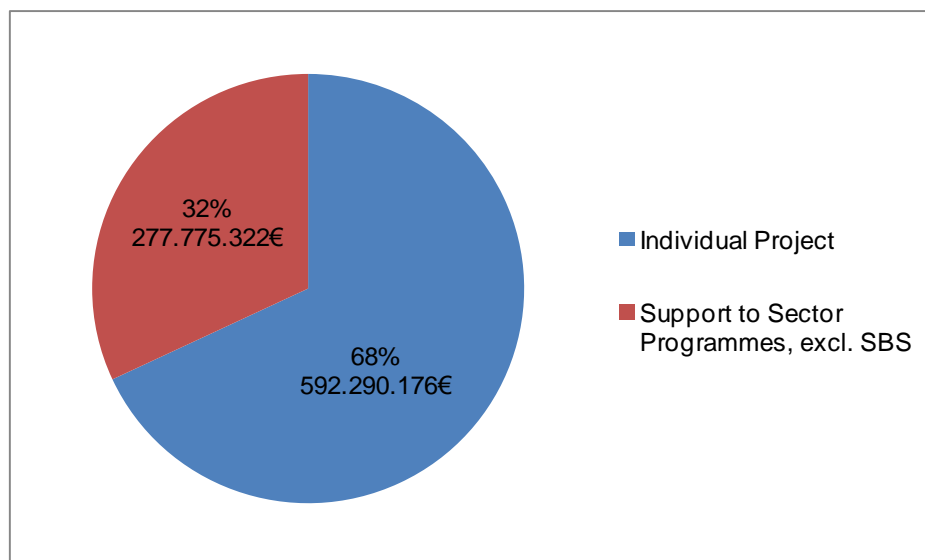
Figure 66: Contracted total amount of EC support to fragile states and amount to selected fragile states (desk study countries) between 2002-2010



Source: CRIS database, Particip analysis

Of the EUR 870 million allocated to Fragile States, EUR 592 million (68%) has been spent through individual projects, with the remaining being allocated to 'support to sector programmes, excl SBS. However, several countries receive over 50% for forms of sector support, i.e. Afghanistan, Angola, Cameroon, Chad, Sierra Leone, Timor-Leste and Zimbabwe.

Figure 67: Direct EC support to the health sector: % financing modalities used in fragile states, 2002-2010



Source: CRIS database, Particip analysis

The next table provides insight in the support by channel, showing overall heavy reliance on the use of NGOs. However, a number of countries do get relatively large sums through the public sector, like Zimbabwe, Angola, DRC, Nigeria, and Chad.

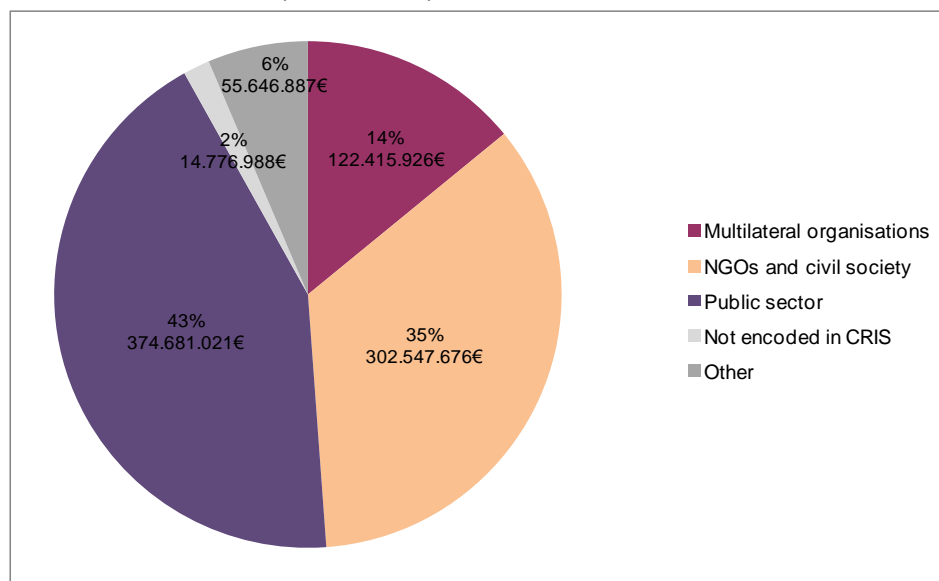
Table 33: Direct EC support to the health sector: Amounts contracted (EUR) by channel in fragile states, contracts (EUR million), health sector, 2002-2010

Country	Multilateral organisations	NGOs and civil society	Public sector	Other	Not encoded in CRIS	Grand Total
Afghanistan		EUR 136,036,689	EUR 524,129	EUR 12,812,225		EUR 149,373,043
Angola	EUR 1,397,252	EUR 5,609,208	EUR 39,499,640	EUR 703,284	EUR 78,607	EUR 47,287,992
Burundi		EUR 6,512,397	EUR 10,870,752	EUR 1,517,331	EUR 463,854	EUR 19,364,333
Cameroon		EUR 1,484,827	EUR 4,857,761	EUR 294,749	EUR 3,407,224	EUR 10,044,561
CAR		EUR 8,845,843	EUR 6,065,793		EUR 2,125,264	EUR 17,036,901
Chad		EUR 3,732,576	EUR 21,554,585		EUR 4,276,692	EUR 29,563,853
Comoros		EUR 548,875				EUR 548,875
Congo		EUR 3,426,962	EUR 12,070,127			EUR 15,497,089
DRC		EUR 40,380,857	EUR 49,750,742	EUR 2,350,621		EUR 92,482,220
Côte d'Ivoire	EUR 4,019,163	EUR 9,247,124	EUR 486,774	EUR 450,000		EUR 14,203,061
Eritrea		EUR 949,868				EUR 949,868
Ethiopia	EUR 13,100,000	EUR 3,695,238		EUR 4,488,177	EUR 109,136	EUR 21,392,551
Guinea	EUR 2,699,788	EUR 1,546,545	EUR 14,916,616		EUR 173,548	EUR 19,336,497
Guinea-Bissau		EUR 561,985	EUR 173,477			EUR 735,462
Haiti		EUR 2,000,000	EUR 43,293	EUR 28,497		EUR 2,071,790
Iraq	EUR 13,000,000					EUR 13,000,000
Kenya	EUR 2,260,000	EUR 5,988,801	EUR 12,869,904	EUR 3,312,076	EUR 20,480	EUR 24,451,261
Kiribati		EUR 752,000	EUR 7,828,000			EUR 8,580,000
Liberia		EUR 2,024,069	EUR 3,762,713		EUR 317,678	EUR 6,104,460
Myanmar	EUR 22,166,618	EUR 15,461,698		EUR 5,237,795		EUR 42,866,111
Nepal		EUR 4,126,714		EUR 2,435,834		EUR 6,562,547
Niger	EUR 7,000,000	EUR 4,634,193	EUR 1,706,707	EUR 1,500,000	EUR 414,105	EUR 15,255,005
Nigeria	EUR 32,900,000	EUR 1,663,299	EUR 58,068,062	EUR 2,093,849	EUR 22,164	EUR 94,747,375
Pakistan		EUR 3,656,222		EUR 2,875,799		EUR 6,532,021
Papua New Guinea		EUR 1,937,343	EUR 2,218,316	EUR 1,111,238	EUR 270,461	EUR 5,537,358
Rwanda		EUR 2,507,902	EUR 2,941,655	EUR 62,853	EUR 186,248	EUR 5,698,658
Sao Tome and Principe			EUR 1,897,217			EUR 1,897,217
Sierra Leone	EUR 2,478,105	EUR 13,061,375	EUR 18,479,529	EUR 3,793,824	EUR 576,857	EUR 38,389,689
Sudan		EUR 2,741,501				EUR 2,741,501
Tajikistan		EUR 1,391,760		EUR 1,390,867		EUR 2,782,627
Timor-Leste	EUR 16,500,000			EUR 189,978		EUR 16,689,978
Togo		EUR 1,499,648		EUR 558,254		EUR 2,057,902
Uganda		EUR 2,737,252	EUR 18,808,231	EUR 2,833,174	EUR 710,794	EUR 25,089,450
Yemen	EUR 4,800,000	EUR 2,644,727	EUR 17,973,261	EUR 4,493,050		EUR 29,911,038
Zimbabwe	EUR 95,000	EUR 11,140,180	EUR 67,313,737	EUR 1,113,413	EUR 1,623,876	EUR 81,286,205
Grand Total	EUR 122,415,926	EUR 302,547,676	EUR 374,681,021	EUR 55,646,887	EUR 14,776,988	EUR 870,068,497

In brown: countries included in the sample of 25 desk study countries

Source: CRIS database, Particip analysis

Figure 68: Direct EC support to the health sector: Breakdown of support by channel in fragile states, contracts (EUR million), health sector, 2002-2010



Source: CRIS database, Particip analysis

7.6 Conclusion

The database does not really allow in-depth analysis of any possible increase in allocation to fragile states during the second half of the decade when Fragile States started to appear higher on the agenda.

However, overall allocation to the health sector in fragile states by the EC, 15% of total, seems rather modest. However, to better appreciate the appropriateness of the allocations more in-depth analysis would be needed, like per capita allocations, complementarity to other donors, and, more fundamental, the expected role of the health sector in relation to a country's fragility. Future research into this topic will be needed, but it may very well be the case that the health sector in different contexts plays a different role in addressing underlying fragility.

OECD, in its latest report²⁵⁷, hints to an overall lack of progress in paying more and better attention to fragile states. Policy development in this area is still in its infancy. According to the report, future policy of donors will have to take the following issues into account:

- Lessons learned and sound analysis often do not translate into programming because operational procedures remain too 'pre-packaged' and unsuitable for fragile settings.
- Traditional approaches such as the MDGs and PRSPs are not always suited either: Fragile settings require a sharp focus on a few priorities — at least in the immediate post-crisis — and these should include peace building and state building objectives to make any progress towards poverty reduction.

The same is likely to apply to the EC, for all aid to fragile states as well as more specifically for health sector support in these countries. This may require having a better understanding of the link between state building and health sector support, translated into programmable action.

²⁵⁷ OECD (2011) International Engagement in Fragile States. Can't we do better?

8 Annex 19: The European Commission and Global Public Goods (GPG) for Health

8.1 Definition of Global Public Goods

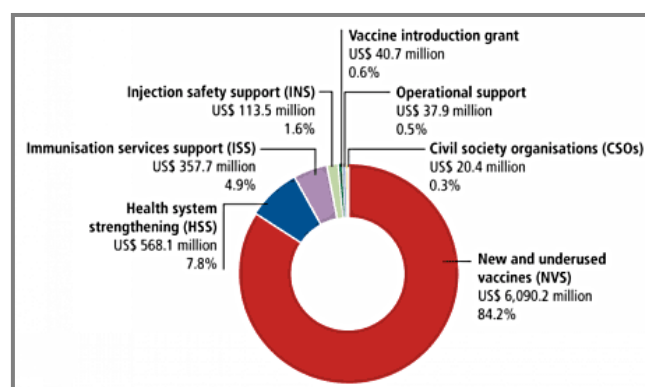
Public goods can be distinguished from private goods in two characteristics: *non-rivalry* (i.e., consumption of the good by one individual does not lessen the amount of the good available to another individual) and *non-excludability* (i.e., once produced, the consumption of the good cannot be restricted to certain individuals). A number of aspects of global health – development of new drugs and technologies via research and development, epidemiological surveillance and infectious disease control, and immunisation are classic examples – are public.²⁵⁸ It is universally accepted that public goods require public, i.e. collective, action if they are to be adequately supplied. If not, one group of individuals will have an incentive to free-ride off the production of another, with resulting global undersupply. As a supranational organisation, the EC is uniquely suited to encourage the production of global public goods for health.

8.2 Example 1: Global Alliance for Vaccines and Immunisation (GAVI).

Immunisation is not only a public good, but moreover the development of new vaccines, as well as the production and sale of existing one, are not attractive lines of business for the international pharmaceutical industry. The EC has been one of the major donors to the Global Alliance for Vaccines and Immunization (GAVI) since 2003, supporting GAVI through direct contributions. From a cumulative USD 5.8 billion of funding received from 2003-2010, the EC accounted for USD 57 million (EUR 39.4 million, 1.2% of direct funding). EC member states contributed another USD 1.2 billion in the same period.²⁵⁹ The EC contribution comes in part from the Development Co-operation Instrument and in part from the intra-ACP envelope of the European Development Fund. In October 2010, the EC pledged EUR 20 million to GAVI. At the most recent pledging conference in June 2011, the EC committed an additional EUR 10 million to GAVI.²⁶⁰

The figure below outlines the use by GAVI's investment lines of the total contributions and pledges of 2011. 84% are directed to vaccinations programs, and the second largest tranche goes to health systems strengthening. By the end of 2010, GAVI had supported the immunisation of 326 million additional children, who might not otherwise have had access to vaccines, and prevented over five million future deaths.²⁶¹

Figure 69: Distribution of GAVI funds by sector (USD 7.2 billion committed to countries incl. pledges)



Source: GAVI Alliance data as at 30 September 2011

²⁵⁸ Smith and MacKellar (2007). "Global public goods and the global health agenda: problems, priorities and potential" <http://www.globalizationandhealth.com/content/3/1/9>

²⁵⁹ <http://www.gavialliance.org/funding/donor-contributions-pledges/>, Particip inventory.

²⁶⁰ <http://www.gavialliance.org/funding/donor-profiles/ec/>

²⁶¹ <http://www.gavialliance.org/about/mission/impact/>

Anyhow, the two major health GPGs are health research and development (R&D), and communicable disease control. The next sections discuss the situation, R&D, and EC contributions of three major diseases relevant to GPGs for health: polio, malaria, and highly pathogenic avian influenza.

8.3 Example 2: The EC and polio

One of the signal triumphs of international public health was the eradication of smallpox in 1975. Polio has proved to be a more stubborn foe. Remains endemic in four countries – Afghanistan, India, Nigeria and Pakistan – with a further four countries known to have (Angola, Chad and Democratic Republic of the Congo, and Sudan) re-established transmission of poliovirus. Eleven countries had on-going outbreaks in 2010 due to cross-border spread of the polio virus (China, Congo, Côte d'Ivoire, Gabon, Guinea, Kenya, Liberia, Mali, Mauritania, Nepal, and Niger).²⁶² Reasons include funding shortages, resistance to immunisation from traditional religious leaders, and the difficulty of working in remote and conflict zones.

The Global Polio Eradication Initiative (GPEI), the major player in the field of polio eradication and immunisation programmes, consists of five major partners (Rotary International, the U.S. Centres for Disease Control and Prevention, WHO, UNICEF, and the Bill and Melinda Gates Foundation). The EC is the sixth largest public-sector donor to the GPEI, with contributions totalling USD 193.73 million, plus the contributions from EU member states.²⁶³ Between 1988 and 2012, donors will have invested over USD 9 billion in polio eradication.

Beside the contributions to GPEI, the following EC funded initiatives against polio have been:

- The EC committed EUR 13.2 million Euros in support of the polio eradication campaign in *Ethiopia* in 2007. Ethiopia used to be a polio-free country. But since 2004, outbreaks crossing the border from neighbouring countries have led to increasing infections within the country.²⁶⁴
- The EC supported polio eradication in 14 *ACP Countries* projects with EUR 25.38 million for the period 2004-2006.²⁶⁵
- The EC has approved a EUR 20 million grant for the intensification of *Nigeria's* polio eradication effort for the period of 2011-2013.²⁶⁶
- The Humanitarian Aid and Civil Protection (ECHO) department of the EC has agreed to a EUR 782,110 grant for implementation of supplementary immunization activities (SIAs) in *Côte d'Ivoire*.²⁶⁷

8.4 Example 3: Malaria research

Malaria occurs in 109 countries around the world. The global burden of malaria is severe, and according to WHO there were estimated 247 million malaria cases in 2008 among more than 3 billion people at risk, causing nearly 1 million deaths. Studies show that there is a strong correlation between malaria and socio-economic factors, i.e., with the respective GDP, and with lower rates of economic growth in malaria endemic countries.²⁶⁸

Global malaria efforts have been spearheaded by the Bill and Melinda Gates Foundation together with WHO's Global Malaria Action Plan (GMAP)²⁶⁹, aiming at eradicating totally malaria as the ultimate goal. The GMAP consists of three components that will ensure that these ambitious goals can be achieved: 1) controlling malaria, 2) eliminating malaria, and 3) research into new tools and approaches.

Malaria research has received sustained funding under the EU's research framework programmes. In the 5th Framework Programme (FP5, 1998-2002), under the "International Co-operation (INCO)" and the "Control of Infectious Diseases" sections, around EUR 35 million were spent on a total of

²⁶² <http://www.polioeradication.org/Infectedcountries.aspx>

²⁶³ gpei | Annual report 2010, p.62

²⁶⁴ http://www.capitalethiopia.com/index.php?option=com_content&view=article&id=2500:ec-commits-132-euro-in-support-of-polio-eradication-campaign-in-ethiopia-&catid=11:news-in-brief&Itemid=3

²⁶⁵ http://www.delnga.ec.europa.eu/projects/development_cooperation_projects_final.htm

²⁶⁶ <http://www.polioeradication.org/Portals/0/Document/PolioSitRep/Sitrep2011AugENG.pdf>

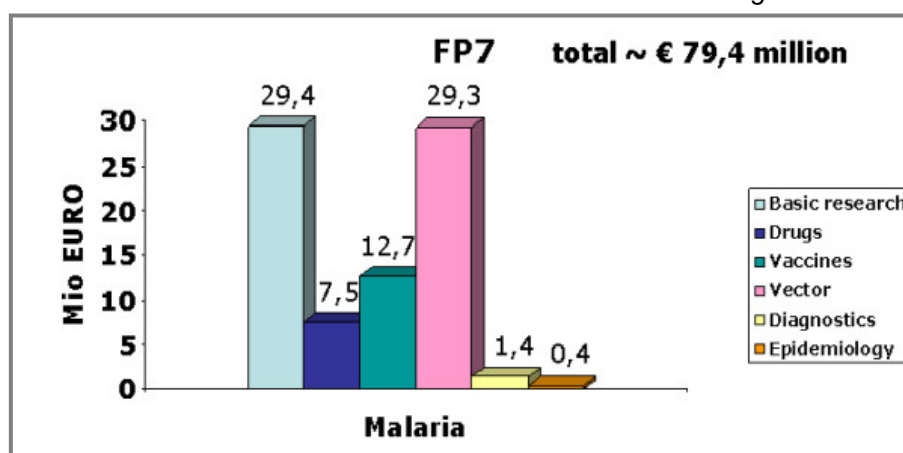
²⁶⁷ Ibid.

²⁶⁸ Sachs J, and Malaney P. 2002. The economic and social burden of malaria. *Nature* 2002, 415:680-685

²⁶⁹ <http://www.rbm.who.int/gmap/index.html>

approximately 30 separate malaria co-operative research projects.²⁷⁰ The 6th Framework Programme (FP6, 2002-2006) placed malaria research in the context of a rationally structured, open and sustained "European Research Area" (ERA)²⁷¹. The currently on-going FP7 programme builds in research designed to develop approaches to better target the mosquito vector (figure below).

Figure 70: EU-funded malaria research under the 7th Framework Programme



Source: A. Holtel, et al. EU-funded malaria research under the 6th and 7th Framework Programmes for research and technological development. *Malaria Journal* 2011, 10:11

The European Vaccine Initiative (EVI) is leading European efforts to develop effective, accessible, and affordable vaccines against diseases of poverty. Increased funding by private and governmental organisations has resulted in accelerated clinical development of malaria vaccines targeting various stages of the malaria parasite life cycle. The EC, EVI and European and Developing Countries' Clinical Trials Partnership (EDCTP), beside others, belong to the Malaria Vaccine Funders' Group (MVFG), which was established in response to the increasing need to coordinate efforts and share information regarding the funding of various malaria vaccine projects in order to avoid overlapping and double funding.²⁷² For over 10 years, the EVI has contributed to the development of 24 malaria candidate vaccine antigens with 13 vaccine candidates being advanced into Phase I clinical trials, two of which have been transitioned for further clinical development in Sub-Saharan Africa. In the future, the EVI will remain instrumental in the pharmaceutical and clinical development of vaccines against 'diseases of poverty' with a continued focus on malaria.²⁷³

8.5 Example 4: Tuberculosis

The EC has been a major funder of tuberculosis research and development, including TB vaccine development and drug supply.²⁷⁴ In 2010, for example, the EC's contribution of about USD 25 million placed it fifth in the list of global supporters of TB research and development. 42% supported vaccine research (USD 10.6 million). The EC's TB research priorities include research to develop new diagnostics, therapies, and preventive tools ranging from basic molecular research to preclinical tests. The EC is particularly interested in TB research that addresses MDR-TB.

²⁷⁰ A. Holtel, M. Troye-Blomberg, and I. Penas-Jimenez. EU-funded malaria research under the 6th and 7th Framework Programmes for research and technological development. *Malaria Journal* 2011, 10:11

²⁷¹ Towards a European Research Area (ERA), http://europa.eu/legislation_summaries/other/i23010_en.htm

²⁷² <http://www.euvaccine.eu/>

²⁷³ M.J. Geels, E.B. Imoukhuede, N. Imbault, H. van Schooten, T. McWade, M. Troye-Blomberg, R. Dobbelaer, A.G. Craig, and O. Leroy. European Vaccine Initiative: lessons from developing malaria vaccines. *Expert Review of Vaccines*, December 2011, Vol. 10, No. 12, Pages 1697-1708

²⁷⁴ <http://www.stoptb.org/assets/documents/resources/publications/acsm/TAG%20TB%20R&D%202011%20Report.pdf>

8.6 Example 5: Avian and Human Pandemic Influenza

The EC played a leading role in responding to the highly pathogenic avian influenza (HPAI) crisis and policy preparations to combat a potential pandemic influenza outbreak. The European Union, together with key partners like the USA, Japan, Canada, Australia, the United Nations Influenza Coordination, UN agencies, the World Organization for Animal Health (OIE) and the World Bank, has been a leader of various initiatives, and of the international coordination process generated. This includes five International Ministerial Conferences on Avian and Pandemic Influenza in Beijing in 2006²⁷⁵, Bamako in 2006, New Delhi in 2007, Sharm-El-Sheikh in 2008 and Hanoi in 2010. The EU committed more than EUR 400 million to the A(H5N1) response. Additional contributions were made by EU member states during the A(H1N1) pandemic in 2009.²⁷⁶ At the Beijing conference in 2006, the EC pledged EUR 100 million to combat the avian influenza and to prepare for a possible outbreak. EUR 20 million was spent on scientific research projects via the FP6, and the remaining EUR 80 million to assist projects outside the EU.²⁷⁷ At the Beijing meeting the 'One Health' approach was agreed on, which addresses health hazards at the interface between humans, animals and the environment — including neglected or forgotten diseases. At the Bamako conference, the EC signed an agreement to provide USD 10.5 million additional funding to the ALive Partnership.²⁷⁸ At the International Ministerial Conference on Animal and Pandemic Influenza in Hanoi, the political commitment to One Health was reiterated through the adoption of the Hanoi Declaration. In total, in the period 2006 to 2009, USD 2.7 billion had been disbursed (52% in cash and the remainder in kind). The largest contributor was the United States, which committed USD 1.6 billion and disbursed USD 1.4 billion. The European Union (Community and Member States) was the second largest global donor with a contribution of EUR 413 million. The EC alone pledged and committed EUR 245 million, accounting also for 76% of the Avian and Human Influenza Facility (AHIF), a WB-administered multi-donor trust fund pulling together resources from 10 donors.²⁷⁹

For more than 10 years the EC has been supporting research on influenza in both humans and animals. Already under the 5th Framework Programme for Research (1998-2002, FP5) about EUR 6 million was spent in 22 institutions and national reference laboratories across eight European countries. In FP6 (2002-2006) activities were extended and reinforced with a set of new projects launched with an almost tenfold increase in funding (more than EUR 50 million plus share in several larger projects dedicated to influenza as well as to other viral infections). In the FP7 (2007-2013) the pandemic influenza is addressed in the 'Cooperation Programme', Theme 1 'Health' under the sub-heading 'Emerging (Infectious) Epidemics' and avian influenza in animals is dealt within the Theme 2 'Food, Agriculture and Biotechnology Research'.²⁸⁰

The Avian and Human Influenza Facility (AHIF) is a multi-donor financing mechanism administered by the World Bank that helps developing countries to minimize the risk and socio-economic impact of avian influenza (H5N1) and other zoonoses and of possible human pandemic influenza, created

²⁷⁵

<http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,contentMDK:20765526~menuPK:2077305~pagePK:41367~piPK:51533~theSitePK:40941,00.html>

²⁷⁶ http://eeas.europa.eu/health/index_en.htm

²⁷⁷ http://ec.europa.eu/world/avian_influenza/

²⁷⁸

<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21173754~pagePK:34370~piPK:34424~theSitePK:4607,00.html>.

The World Bank, together with the World Organization for Animal Health (OIE), the FAO, and the African Union, has created the ALive platform, www.ALIVE-online.org. ALive is a multi-institutional and interdisciplinary partnership created as a coordinating mechanism not only for the fight against avian influenza, but also for the prevention of future emerging and re-emerging animal diseases.

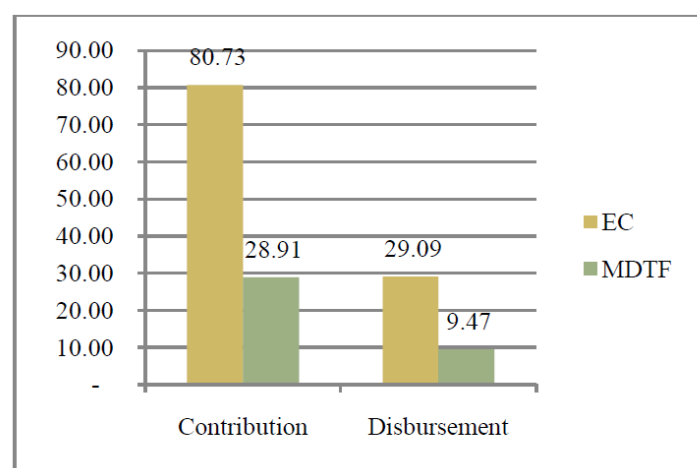
²⁷⁹ A. Wilsmore, A. Ancía, E. Dieleman, and N. Faiz. 2010. Outcome and Impact Assessment of the Global Response to the Avian Influenza Crisis 2005 – 2010. Study commissioned by the European Commission

²⁸⁰ http://ec.europa.eu/world/avian_influenza/. A catalog of funded projects on avian influenza of the period 2001-2007 is at: http://ec.europa.eu/research/health/poverty-diseases/doc/influenza-research_en.pdf; FP7 projects are at http://ec.europa.eu/research/health/infectious-diseases/emerging-epidemics/fp7projects_en.html

following the Beijing conference.²⁸¹ AHIF complements the World Bank supported Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI) which has as its objective “to minimize the threat posed to humans by highly pathogenic avian influenza (HPAI) infection and other zoonoses to prepare for, control and respond to influenza pandemics and other infectious disease emergencies in humans”.²⁸²

The AHIF is currently supported by ten donor agencies, led by the EC, which have collectively pledged more than USD 127 million. The EC is the largest donor to AHIF with total contribution of USD 80.73 million since inception to 2010 (figure below). EC funds are earmarked for East and South Asia, the Mediterranean, Central Asia and Eastern Europe. The other nine donors - Australia, China, Estonia, Iceland, India, Korea, the Russian Federation, Slovenia, and the United Kingdom – contributed to AHIF which is not geographically restricted and can be used, notably, to assist countries in Africa and Latin America and the Caribbean regions.²⁸³

Figure 71: Contribution and disbursement to AHIF (cumulative in USD million)



Source: AHI Facility, *Avian & Human Influenza: A Partnership for Results*.

8.7 Conclusion

We have cited five areas – GAVI, polio eradication, malaria-related research, TB-related research, and the fight against avian influenza / preparation. Many other examples could be cited, and we have not discussed the EC’s support for the Global Fund.

Support in the area of global public goods for health is uniquely suited to the EC. As a supranational organisation, it is able to rise above the temptation to free-ride that is found at the national level. As a major player in health sector support, it is well placed to integrate public good actions into its country-level cooperation programmes. Given the non-excludability aspect of global public goods for health, the EC can convincingly demonstrate that its support in the area is bringing immediate, tangible benefits to the European taxpayer.

²⁸¹

<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTAVIANFLU/0,,contentMDK:21355695~menuPK:3124611~pagePK:210058~piPK:210062~theSitePK:3124441~isCURL:Y,00.html>

²⁸² AHI Facility, *Avian & Human Influenza: A Partnership for Results*.
http://ec.europa.eu/europeaid/where/asia/regional-cooperation/animal-human-health/documents/ahif_results_report.pdf

²⁸³ Ibid.