Thematic evaluation of the European Commission support to the health sector

Final Report
Volume IIe

August 2012

Evaluation for the European Commission

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Germany

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Framework contract for

Multi-country thematic and regional/country-level strategy evaluation studies and synthesis in the area of external co-operation

LOT 2:
Multi-country evaluation studies on social/human development issues of EC external co-operation

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This evaluation is carried out by

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

The author accepts sole responsibility for this report, drawn up on behalf of the Commission of the European Union. The report does not necessarily reflect the views of the Commission.

Thematic evaluation of the European Commission support to the health sector

Final Report

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

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3. Approach and methodological tools used in the evaluation
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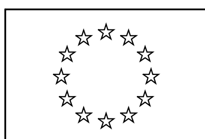

EUROPEAN COMMISSION
EuropeAid Co-operation Office
Evaluation

Thematic evaluation of the European Commission support to the health sector

TERMS OF REFERENCE

December 2010

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1. Mandate

Systematic and timely evaluation of its expenditure programmes is an established priority for the European Commission (further referred to as 'Commission'), as a mean of accounting for the management of allocated funds and as a way of promoting a lesson-learning culture throughout the organisation.

The Commission Services have requested the Evaluation Unit of the EuropeAid Co-operation Office to undertake an evaluation of the health sector policy development.

This evaluation was included in the 2007-2013 work programme of the Evaluation Unit, as approved by External Relations and Development Commissioners.

2. Background

The following chapter gives a general background to the Commission support to health sector policy development. Nevertheless, in order to ensure its usefulness, the evaluation shall be focused to the extent specified further, mainly in chapter 3 'Purpose and scope of the evaluation'.

I. Strategy documents

- The health of individuals and populations is considered one of the major determinants of economic growth and development, while ill health is both a cause and effect of poverty. Of the eight Millennium Development Goals, three are specifically health related: reduction of child mortality, improvement of maternal health and combat HIV/AIDS, malaria and other diseases.

- Investment in health as one of the priority elements in any strategy of poverty eradication was highlighted in the Cotonou Agreement (2000), the most comprehensive partnership agreement between developing countries and the EU, of which the second revision was signed in March 2010.

- In 2002 the Commission issued a Communication on Health and Poverty Reduction in Developing Countries, constituting a single Community policy framework to detail the relationship between health and poverty and to outline critical elements of a coherent approach in this area.

  The Communication defined four objectives of the Commission health and poverty policy: (1) improving results in this area at country level, especially among the poorest (2) maximising health benefits and minimising any potential negative health effects of other Community activities, (3) protecting the most vulnerable from poverty through support for equitable and fair health financing mechanisms, (4) investing in the development of specific global public goods such as research and development.

- Subsequently, in May 2002, a Council Resolution on Health and Poverty was adopted.

- In 2004 the Commission adopted a Communication providing a coherent policy framework for Commission's external action to confront the three diseases (HIV/AIDS, malaria and TB) in the poorest countries, in middle-income countries, including neighbouring countries, and in areas of difficult partnerships.

- In order to make the Policy Framework operational, in April 2005 the Commission adopted a 'European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action'. The document provides a coherent Programme for EU actions, both at country and global level. The Council Conclusions on Progress the European Programme for Action were adopted in November 2009.

- With regard to increasing affordability of medicines, the Commission supported the provisions of the 2001 Doha Declaration on Trade-Related Aspects of Intellectual Property Rights (TRIPS), including the WTO Decision (August 2003) on compulsory licensing. In May 2003 the Council adopted a Regulation to avoid trade diversion into the EU market of certain key medicines sold at reduced prices in developing countries. Furthermore in 2006 the EU adopted a Regulation on compulsory licensing. The Commission was also playing an active role in the 2006-2008 WHO Inter Governmental Working Group on Public Health, Innovation and Intellectual Property Rights which lead to the Resolution on The Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA).

- In 2004 the European Neighbourhood Policy (ENP) was developed. The ENP covers a broad range of sectors including health. ENP Action Plan refers to public health issues including increased dialogue, health sector reform, progressive involvement of partners in EU related health activities/networks, health information, communicable diseases, health security. The European Neighbourhood and Partnership Instrument (ENPI) supports, as from 2007, activities in the ENP geography. Health is among the eligible sectors1.

- In December 2005 the Presidents of the Commission, Parliament and the Council signed the new statement on EU development policy, the **European Consensus**, which defines the framework of common principles within which the EU and its Member States will each implement their development policies in a spirit of complementarity.

  The first part of the document - *the European Union Vision of Development* - sets out common objectives and principles for development cooperation: poverty eradication, ownership, partnership, delivering more and better aid and promoting policy coherence for development. The second part of the document - *the European Community Development Policy* - defines how the Community will implement the European vision on development and indicates nine main areas of activity, among which human development policy for health, education, culture and gender equality.

- In 2005 the EU adopted a **Strategy for Africa** which constitutes a common and coherent European response to the challenges faced by Africa. It focuses on priority areas which all together contribute to the achievement of the MDGs, increased financing and improved effectiveness.

- In December 2005 the Commission adopted a Communication EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries which draws the attention to the problem of health worker crisis and need for a coherent EU response. As a result the **Programme for Action to tackle the critical shortage of health workers in developing countries (2007 – 2013)** was developed and adopted in 2006. In 2008 Progress report on implementation was issued.

- In December 2006, the **Regulation (EC) No 1905/2006 of the European Parliament and the Council was adopted establishing a financing instrument for development cooperation (DCI)** which replaces the range of geographic and thematic instruments created over time.

- Having for its legal bases the Regulation No 1905/2006 mentioned above, the **Strategy Paper for the Thematic Programme 2007-2013 'Investing in People'** had been developed. The programme consolidates previously disparate regulations, budget lines and other Commission action in the area of social and human development with the goal of strengthening the impact of Commission action and helping the Commission's partner countries to achieve the relevant MDGs. Under this instrument, there are four key issues to be addressed through external action in the area of health: (1) the crisis in human resources in health care, (2) the main poverty related diseases such as HIV/AIDS, malaria and tuberculosis, (3) sexual and reproductive health and rights (SRHR), (4) balanced approach between prevention, treatment and care. Recently (2010), the mid term review was approved.

- In 2010 the Commission adopted **the Global Health Communication**. The objective is to make Europe's contribution more effective so as to better accompany developing countries in getting back on track towards achieving health-related Millennium Development Goals (MDGs). The Commission presents four approaches to improving global health: (1) establish a more democratic and coordinated global governance; (2) push for a collective effort to promote universal coverage and access to health services to all; (3) ensure better coherence between EU policies relating to health; (4) improve coordination of EU research on global health and boost access in developing countries to new knowledge and treatments. Furthermore, the Communication is accompanied by three Staff Working Documents dealing respectively with "Contribution to Universal Coverage of Health Services through Development Policy"; "Global health: responding to the challenges of globalization" and "European Research and Knowledge for global health". The Council Conclusions on The EU role in Global Health were adopted in May 2010.

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[1] Cf. article 2.2 of the ENPI: supporting policies to promote health, education and training, including not only measures to combat the major communicable diseases and non-communicable diseases and disorders, but also access to services and education for good health, including reproductive and infant health for girls and women; supporting policies aimed at poverty reduction, to help achieve the UN Millennium Development Goals.

II. IMPLEMENTATION MODALITIES

- Regarding the implementation modalities, the Commission is one of the forerunners in promoting sector approaches in development aid (in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action). It also calls for the use of partner country systems and procedures to the maximum extent possible. This entails an enhanced health sector policy dialogue at country level and moving away from projects, as the most favoured Commission financing modality, towards the use of sector/general budget support.

- In the years 2002 – 2006 the average annual Commission programmed support to health reached, according to the estimations, approx. 700 M€. This support was channelled through the following financial tools: country-programmed support; regional and global initiatives; thematic budget lines on poverty diseases and sexual and reproductive health and rights; NGO co-financing budget line; humanitarian aid interventions; health research in partnership with developing countries; General Budget Support.

- For the period 2007-2013, the EU's actions in the field of health in developing countries are mainly financed through two types of instruments:

  Geographical instruments: They are implemented at national and regional level. Some of them are the European Development Fund (in the ACP countries), the Development Co-operation Instrument (in Latin America, Asia and South Africa), and the European Neighbourhood & Partnership Instrument (in the neighbouring regions). The geographical instruments constitute the major share of EU's support for health in developing countries.

  The thematic strategy paper 'Investing in people' (mentioned above): 55% of the budget of 'Investing in People' goes to the pillar Good health for all, which focuses on improving access to health related public goods. The distribution of funds for the period 2007-2010 is further specified in the Multi-Annual Indicative Programme for 2007-2010.
- The Commission plays also an important role, through partnerships / financing channels, in the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria; GAVI Alliance; etc.

III. INTERNATIONAL AGREEMENTS

Among others:

- The Paris Declaration and Accra Agenda for Action.
- Monterrey Consensus on Financing for Development.
- Economic and Social Council on Global Public Health.
- Relevant World Health Assembly resolutions: especially on MDGs and on Primary health Care / Strengthening of Health Systems.
- Outcome document (in drafting) of the coming High-level Plenary Meeting of the UN General Assembly (referred to as HLPM) on the MDGs (section Global Public Health and sections on health MDGs).
- International health Partnership.

3. Purpose and Scope of the Evaluation

3.1 The purpose and scope

The purpose of the evaluation is to assess to what extent the Commission assistance has been **relevant**, **effective**, **efficient** and **sustainable** in providing the expected **impacts** in the health sector.

It should also assess the coordination and complementarity with other donors and actors, the coherence with the relevant Commission policies and the partner governments' priorities and activities as well as with international legal commitments in health.

The evaluation will also relate to the overall EU support to health and the Commission's and EU **added value** in supporting countries towards improved health services and status.

The evaluation should come to a general overall judgement of the extent to which Commission policies, strategies, sectoral programmes have contributed to the achievement of the objectives and intended impacts, based on the answers to the agreed evaluation questions **(see chapter 5)**.

The evaluation shall lead to conclusions based on objective, credible, reliable and valid findings and provide the Commission with a set of operational and useful **recommendations**.

Given the multiplicity of objectives in development cooperation in general and in health sector support in particular, an assessment of these objectives, their interrelations and possible conflicts of objectives should be made. The evaluation will then need to **focus on a more limited set of objectives**.

In particular, the evaluation shall be used as a **baseline** for future Commission support to the health sector and as an **indication of bottlenecks / challenges** that should be addressed. The findings of this retrospective evaluation will mainly inform the implementation of the current health policy presented in the 2010 Global Health Communication.

In this respect, the evaluation **shall assess** how, in the time frame considered, the Commission support to the health sector has affected:

- the design and implementation of national policies, strategies and programmes to make faster progress towards achieving of health MDGs and other priority health goals;
- the strengthening of health systems in a comprehensive fashion to ensure that their main components – health workforce, access to medicines, infrastructure and logistics, decentralised management and stewardship[2] – are effective enough to deliver basic equitable and quality health care for all without discrimination on any grounds;
- the effectiveness of aid in terms of predictability, the implementation of national health strategies through country systems, the use of countries' procurement and public financial management systems, fair financing and policy dialogue.

Considering the above mentioned, the evaluation shall cover **all bilateral health specific cooperation**, **Sector Budget Support** as well as **General Budget Support**.

The evaluation shall cover aid implementation over the period **2002-2010**.

In principle, the geographical scope includes **all the countries where identified activities are undertaken, countries other than those which have been recognised as candidates[3] for EU membership as defined by COM(2001)252**, but might be narrowed down for the more detailed analyses of this evaluation.

The evaluation shall be **forward looking** taking into account the most recent policy and programming decisions, providing lessons and recommendations for the continued support to the health sector within the present context and relevant political commitments (such as the European Consensus, the Paris Declaration, all regional instruments and 'Investing in People') as well as taking into account the current processes within the Commission (including the consequences of the creation of the European External Action Service – EEAS) and the EU (Lisbon Treaty).

3.2 The evaluation users

[2] A term used by the WHO since 2000 to describe leadership and sector governance by the Ministry of Health.
[3] The activities in this domain in candidate countries are evaluated within their proper agenda.

The evaluation should serve policy decision-making and project management purposes. The main users of the evaluation will be DG DEV, DG Relex, the EuropeAid Co-operation Office, the EU Delegations and the EEAS.

Other Commission services like DG ECHO, DG RTD and DG SANCO may also benefit from the results of this evaluation.

However, the evaluation should also generate results of interest to a broader audience, including governments of partner countries, Member States, civil society and others.

4. Methodology and Approach

The overall methodology guidance is available on the web page of the Evaluation Unit under the following address:

http://ec.europa.eu/europeaid/how/evaluation/introduction/introduction_en.htm

In addition, during their work the consultants shall also refer to and test the evaluation techniques and tools previously elaborated for the evaluation of the health sector[4].

The evaluation basic approach consists of **4 phases**[5], subdivided in **subsequent methodological stages** (phases for which consultant contribution is requested are marked in grey).

Five Main Phases of Development:	*Methodological Stages:*
1. Preparation Phase	▪ Reference group constitution ▪ ToR drafting
	▪ Launch Note
2. Desk Phase 3. Synthesis phase	▪ Structuring of the evaluation ▪ Data Collection, verification of hypotheses ▪ Analysis ▪ Judgements on findings
4. Feedback and Dissemination	▪ Dissemination Seminar in Brussels
	▪ Quality Grid ▪ Summaries ▪ Evinfo (summary for OECD and Commission databases) ▪ Fiche contradictoire (a statement of key recommendations followed by the Commission’s response)

[4] EuropeAid / Contract B-7 6510/2002/003; Evaluation techniques and tools. Sectors and Themes – Health.
[5] The field phase is not foreseen under this evaluation as the data collected during the field phase of the refused Health evaluation should be used to the maximum extent possible. However, if additional field missions are necessary, there will be an amendment added to the ToR.

4.1 Preparation Phase

The evaluation manager, within the Evaluation Unit, identifies the Commission services to be invited to the Reference Group (RG), which will ensure that the Commission expertise is fully utilised and all the relevant information is provided.

The evaluation manager prepares the *Terms of References* (ToR) for the evaluation and sends them to the Contractor.

The contractor will then present a *Launch Note* that shall contain: (i) the contractor understanding of the ToR, (ii) the proposed composition of the core evaluation team with individuals' Curriculum Vitae and (iii) the proposed work plan and budget for the evaluation.

4.2 Desk phase

4.2.1 Inception report

Following the approval of the *Launch Note* by the Evaluation Unit, the work will proceed to the structuring stage which shall lead to the production of an *Inception Report*.

The *Inception report* will be divided into two parts. The first part (inventory) will contain the complete overview of the Commission financial contribution (commitments and disbursement) and their typology. At this stage the consultants are requested to use, to the extent possible, the work already done by AIDCO F3 - EU health and education expenditure study. The complete overview will also include all relevant Budget Support operations (both General Budget Support and Sector Budget Support). The related database will form integral part of the inventory.

The second part of the *Inception report* will consist of the analysis of all relevant key documents, including the relevant policy, programming documents and agreements.

If already clearly identifiable, the need of any complementary ways of data collection should be already suggested at this stage. The Evaluation Unit will decide on the further procedure regarding such proposal.

On the basis of the information collected, the evaluators will:

(1) **Reconstruct the intervention logic** of the Commission aid to partner countries within the health sector, by producing policy impact diagrams relevant for the evaluated period, geographic and thematic sub-areas.

(2) Present a **preliminary set of maximum 10 evaluation questions** (EQ) together with judgement criteria for each EQ and provisional indicators for each of the proposed judgement criteria.

(3) Specify the methodological tools for data and information collection and validation that will be used. Take into account all information from the refused Health evaluation as well as other evaluations and present how these data will be further examined and elaborated. As concerns the Budget Support, define the specific approach.

(4) Present the approach to ensure quality assurance throughout the different phases of the evaluation.

(5) Present a detailed work plan, specifying the organisation and time schedule for the evaluation process.

The Contractor will present the *Inception Report* which shall be formally approved by the Evaluation Unit. The Reference group will comment on the *Inception Report* and validate the Evaluation Questions.

4.2.2 Desk phase report

Upon approval of the *Inception Report*, the team of consultants will proceed to the Desk Phase of the evaluation.

The *Desk Report* takes up the points dealt with in the *Inception Report* and goes in as much detail as necessary. In this stage, the consultants are asked to:

(1) Present a final set of **identified evaluation questions** along with appropriate **judgement criteria** and the relevant quantitative and qualitative **indicators**.

(2) Present the methodology for **data and information collection and validation**[6].

(3) Present the **methods of analysis** of the information and data collected in order to draw findings that would enable to draw general conclusions; due to the difficulty of this exercise any limitation should be made explicit.

(4) Present the way to come to **judgements** that directly relate to the Judgement criteria.

(5) Analyse **all relevant evaluations (see Annex 1 Key documentation – Related evaluations and assessments)** upon which the consultants must build.

(6) Analyse the hypothesis and present the **findings responding to the evaluation questions**.

(7) In this particular case, the field phase is not foreseen as an integral part of this evaluation. It is expected that the data of the refused Health evaluation (collected during its field missions) will be used and further elaborated (relevant country case study notes will be annexed to the evaluation report, both desk phase and final). Moreover, as alternative to the field missions, other ways of data collection as e.g. video-conferences with relevant EU Delegations are possible.

However, if the need to undertake additional field missions arises, an amendment to these ToR will be added. In such case, the consultants have to justify the reasoning why to undertake additional case studies[7] and criteria which have been applied for their selection.

At the completion of this work, the evaluation team will present a *Desk Phase Report* setting out the results of this phase of the evaluation including all the above listed tasks[8] (the core part of the *Inception Report* will be annexed to the *Desk Phase Report*). Furthermore, the PowerPoint presentation which is being referred to in the Annex 3 should be already integrated to the *Desk Phase Report* and further up-dated in the Final Report.

The RG will comment on the *Desk Phase Report.* Based on their comments the necessary amendments will be specified. Formal approval of this report is to be made by the Evaluation Unit.

4.3 Final report-writing phase

Following the formal approval of *Desk Phase Report* the evaluators will elaborate and submit the *Draft Final Report.*

The *Draft Final Report* will follow the structure set out in Annex 3, taking in due account comments received from the RG. The *Draft Final Report* shall include the answers to the evaluation questions and a synthesis of main conclusions of the evaluation.

The evaluation manager will verify the quality of the submitted draft report, on the basis of the grid in Annex 4. A sufficient quality report will be circulated among RG for comments. It will then be discussed in the last RG meeting with the Evaluation Team.

On the basis of the comments expressed by the Commission services (RG members and Delegations) the Evaluation Team shall make appropriate amendments and submit the *Final Report*.

The *Final Report* quality will be judged according to the quality assessment grid in Annex 4. The Final Report should clearly account for the observations and evidences on which findings are made so as to support the reliability and validity of the evaluation. The report should reflect a rigorous, methodical and thoughtful approach. Conclusions and recommendations shall build upon findings.

Recommendations must be:

- Linked to the conclusions;
- Clustered, prioritised and targeted at specific addressees;

[6] Further assess if it is possible to reply the identified evaluation questions with the existing data (i.e. data collected for the refused Health evaluation during its field missions). In case of missing information, present the methods to be applied for their collection (if not already done in the previous inception phase).
[7] Information which are still missing and methods to be used to gather such information have to be well presented.
[8] All the databases produced for this aim will be integral part of the document.

- Useful and operational;
- If possible, presented as options associated with benefits and risks.

The final version of the *Final Report* shall be presented in a way that enables publication without any further editing. The *Final Report* shall be written in English and submitted to the Evaluation Unit in 110 copies with additional 10 reports with all printed annexes. A CD-Rom with the Final Main Report and annexes has to be added to each printed copy.

4.4 Dissemination and follow-up

Following the approval of the final report, the evaluation manager will proceed to dissemination of the results (conclusions and recommendations) of the evaluation: (i) make a formal judgement on the evaluation using a standard quality assessment grid (see Annex 4); (ii) prepare an Evaluation Summary following the standard DAC format (EvInfo); (iii) prepare and circulate a three-column *Fiche Contradictoire* (FC). The FC is prepared by the Evaluation Unit in order to ensure feedback from the evaluation and an active response from the Commission services. All three documents will be published on the Web alongside with the *Final Report*.

The Evaluators will be required to assist in dissemination and follow-up activities. In co-ordination with the Evaluation Unit, they shall present the conclusions and recommendations during a seminar in Brussels. Limited number of other brief presentations might also be required.

4.5 The seminar

The final report will be presented at a seminar in Brussels. The purpose of the seminar is to present the results, the conclusions and the recommendations of the evaluation to all main stakeholders concerned (including EC services, Member States, international organizations, representatives of civil society organisations and other donors).

The Consultants shall prepare a presentation (PowerPoint) for the seminar. This presentation shall be considered as a product of the evaluation in the same way as the reports and the databases. For the seminar 60 copies of the report and 10 reports with full printed annexes have to be produced.

The Final **presentation** will include slides for:

- Context of the evaluation;
- Intervention logic and focus of questions;
- Answers to the evaluation questions (1);
- Conclusions and;
- Recommendations.

(1) For every question 4-5 slides will present:

- The theory of action (part of the intervention logic concerned) with the localisation of the EQ;
- One table with Judgement Criteria and Indicators;
- Findings (related to JC and Indicators) and their limitations;
- Conclusions and recommendations.

5. Identification of the Evaluation Questions/Issues

The evaluation will be based on a limited number of evaluation questions (up to a maximum of ten), covering seven evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability (5 DAC criteria), coherence and the Commission's value added (2 EC criteria).

Besides the evaluation criteria, evaluation questions will also address: cross-cutting issues, the 3Cs and other key issues.

The evaluation criteria and key issues will be given different emphasis based on the priority given to them within the evaluation questions.

More information on the evaluation criteria, key issues and on the main principles for drafting evaluation questions can be found in annexes 5, 6 and 7.

6. Management and supervision of the evaluation

The responsibility for the management and supervision of the evaluation will rest with the Evaluation Unit of the EuropeAid Co-operation Office. The progress of the evaluation will be followed closely by the Reference group (RG) consisting of members of different Commission services concerned.

The RG will act as the main interface between the Evaluation Team and the Commission Services. The principal function of the RG is to follow the evaluation process and more specifically:

- To advise on the scope and focus of the evaluation;
- To act as the interface between the consultants and the Commission services;
- To advise on the quality of the work of the consultants;
- To facilitate access to information and documentation;
- To facilitate and assist in feedback of the findings and recommendations from the evaluation.

Several RG meetings will take place during the process of the evaluation, as indicated below in a time schedule.

7. Evaluation team

This evaluation is to be carried out by a team with advanced knowledge and experience in development co-operation in general terms and in various aid implementation modalities (including the SBS and GBS) and special expertise will be required concerning the health sector. Previous experience of conducting big evaluations for international organisations will be considered as an asset. Experience in evaluating Budget support operations with link to health/social sector indicators will be also considered an advantage.

The team leader must have a proven experience in Commission evaluation methodology.

Furthermore the team-leader shall have considerable experience in managing evaluations of a similar size and character. The team leader shall also be aware of the different approaches and international debates on these issues.

Consultants should possess an appropriate training and documented experience in the management of evaluations as well as evaluation methods. The team should cover the key areas of development cooperation in the health sector as described in the Global health staff working document on the development policy (section 1.1.3.). The consultants should be familiar with the different regions. The team must be prepared to work in English, and possess excellent drafting skills. Knowledge of French and Spanish is as well required.

The Evaluation Unit recommends that consultants from beneficiary countries will be employed.

The team should be composed of health experts with the following profile (“long term” - min. of two years):

- academic degree (in medicine, social sciences or related);
- postgraduate degree: Master of Public Health or equivalent;
- at least one long term work experience within service delivery institution of the health sector plus at least one long term experience in the implementation of a development cooperation programme in the health sector;
- long term involvement in at least 2 health care reform programmes (at least one of which in a low income country);
- proven evaluation experience (at least 3 health sector specific evaluations);
- regular academic exposure or involvement (through teaching, research, publications or other forms of peer review).

The agreed Team composition may be subsequently adjusted if necessary in the light of the final Evaluation Questions once they have been validated by the Reference Group.

A declaration of absence of conflict of interest should be signed by each consultant and annexed to the launch note.

8. Timing and Deliverables

The evaluation will start in December 2010 with completion of the *Final Report* scheduled for December 2011 and the *Dissemination seminar* taking place in January 2012. The following is the *indicative* schedule[9]:

Evaluation Phases and Stages	***Key Deliverables***	***Dates***	***Meetings***
Desk Phase			
Structuring Stage	Inception Report	March 2011	RG meeting
Desk Study	Draft Desk Report	June 2011	RG meeting
	Final Desk Report	July 2011	
Final Report-Writing Phase			
	Draft Final Report	September/October 2011	RG meeting
	Final Report	November/December 2011	
Dissemination Seminar		January 2012	

NB: For all reports, the Consultants may either accept or reject the comments made by the Joint Evaluation Unit and/or the Reference Group, but in case of rejection they must justify (in writing) the reasons for rejection (the comments and the Consultants' responses are annexed to the report/deliverable). When the comment is accepted, the reference to the text of the report (where the relevant change has been made) has to be included in the response sheet.

9. Cost of the Evaluation and payment modalities

The overall cost of the evaluation should not exceed **240.000,00 €.**

This amount includes a provision for the international feedback seminar in Brussels. The seminar is organised by the Evaluation Unit to present the results of the Evaluation. The budget for the seminar (fees, per diems and travel) will be presented separately in the launch note.

According to the service contract payments modalities shall be as follow: 30% on acceptance of the Inception Report, plus 2.5% of the agreed budget to be used for quality control; 50% on acceptance of the Draft Final Report; and the balance on reception of: hard copies of the accepted final report; the methodological note on the quality control system; the list of all the documents red; and data collected and any databases built. The invoices shall be sent to the Commission only after the Evaluation Unit confirms in writing the acceptance of the reports.

[9] The dates mentioned in the above table may be changed in view of possible field missions – the adjusted work plan will be part of an amendment concerning the field phase.

Annex 1. Key Documentation

(Not an exhaustive list)

The evaluation shall use, to the greatest extent possible, the data collected for the 'Health evaluation' launched in 2007 but refused at the later stage.

EU policy documents

- Council Regulation (EC) No 1484/97 of 22 July 1997 on aid for population policies and programmes in the developing countries - NO LONGER IN FORCE (1997-2003)
- Council Regulation (EC) No 550/97 of 24 March 1997 on HIV/AIDS-related operations in developing countries - NO LONGER IN FORCE (1997-2003)
- COM (2000) 212(01), The European Community's Development Policy
- COM (2000) 585(02), Accelerated action targeted at major communicable diseases within the context of poverty reduction
- Resolution - Programme for action: accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, 2346th Council meeting - General Affairs, 14/15 May 2000
- COM (2001) 0612 final Proposal for a Decision of the European Parliament and of the Council Concerning the European Community contribution to the "Global Fund to fight HIV/AIDS, Tuberculosis and Malaria"
- Report of the Commission on Macroeconomics and Health; 2001
- COM (2001) 96(01), Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction
- Communication from the Commission on Health and Poverty Reduction in Developing Countries; COM (2002) 129 final
- Council Resolution on Health and Poverty; 2002
- Decision No 36/2002/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
- Council Regulation 953/2003 of 26 May 2003 to avoid trade diversion into the EU of certain medicines
- Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on reproductive and sexual health and rights in developing countries
- Regulation 1568/2003 of the European Parliament and of the Council of 15 July 2003 on aid to fight poverty diseases (HIV/AIDS, tuberculosis and malaria) in developing countries
- Decision No 1209/2003/EC of the European Parliament and of the Council of 16 June 2003 on Community participation in a research and development programme aimed at developing new clinical interventions to combat HIV/AIDS, malaria and tuberculosis through a long-term partnership between Europe and developing countries, undertaken by several Member States
- COM/2003/0093 final - Update on the EC Programme for Action - Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction - Outstanding policy issues and future challenges
- COM (2004) 629/2 "Proposal for a Regulation of the European parliament and the Council establishing a financing instrument for development co-operation and economic co-operation"
- Communication (2004) 487 "Financial perspectives 2007-2013"
- European Neighbourhood Policy: strategy papers, action plans, progress reports (see http://ec.europa.eu/world/enp/documents_en.htm)

- Communication from the Commission to the Council and the European Parliament – A European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007 – 2011); COM (2005) 179 final
- Communication (2005) 324 "External actions through thematic programmes under the future financial perspectives 2007-2013"
- Regulation 1638/2006 laying down general provisions establishing a European Neighbourhood and Partnership Instrument (ENPI)
- Regulation 1905/2006 establishing a financing instrument for development cooperation
- The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and malaria and other GF documents
- Communication (2005) 324 "External actions through thematic programmes under the future financial perspectives 2007-2013"
- Communication (2005) 489 "EU strategy for Africa: towards a Euro-African pact to accelerate Africa's development"
- "The European Consensus"- Joint statement by the Council and the representatives of Governments of the Member States meeting with the Council, the European parliament and the Commission" – Official Journal C 46(2006)
- Communication (2005) 654 'Combating HIV/AIDS within the EU and in the neighbouring countries 2006-2009
- COM (2006) 870 final - A European Programme for Action to tackle the critical shortage of health workers in developing countries (2007–2013)
- EU Code of Conduct on Complementarity and Division of Labour in Development Policy, 2007
- "Investing in People" – Strategy Paper for the Thematic Programme 2007-2013
- Communication on Global Health, related staff working documents, Council Conclusions and the reference documents in them.

Programming and monitoring tools

- Common Framework for Country Strategy Papers and Common Framework and Procedure for Strategy Papers for Thematic Programmes 2007-2013
- Methodology to assess partner countries' performance in education and health for the purposes of the 2004 Mid-Term Review and the 2006 End of Term Review of the 9th European Development Fund (EDF)
- Toolkit on mainstreaming gender equality in EC development cooperation http://ec.europa.eu/europeaid/sp/gender-toolkit/index.htm
- On programming, the EC interservice Quality Support Group (iQSG) intranet web page is to be used (accessible within EC computer network only) http://www.cc.cec/home/dgserv/dev/newsite/index.cfm?objectid=95E08920-E0CF-8351-805A6B642803AD28
- ROM (Results oriented monitoring) reports on health, available in CRIS database, including ex-post ROM reports

Other key documents

- Paris Declaration on aid effectiveness OECD (2 March 2005)
- WHO International Health Regulations
- WHO global strategy on non communicable diseases

Related evaluations and assessments

Essentially the following:

- The European Court of Auditors special report on Health in Africa
- 5 year evaluation of the Global Fund
- Recent key academic publications relating to development aid in health
- EU health and education expenditure study (ongoing – managed by AIDCO F3)
- HATS ("Health as a Tracer Sector") – ongoing study by the OECD-DAC working party on aid effectiveness
- "IHP+Results" - annual independent monitoring and evaluation review of the International Health Partnership (IHP+)
- EC project evaluations and country evaluations where health is focal sector.
  For Evaluation reports commissioned by the Evaluation Unit see http://ec.europa.eu/europeaid/how/evaluation/evaluation_reports/index_en.htm
- European evaluation inventory http://ec.europa.eu/comm/dg/aidco/ms_ec_evaluations_inventory/evaluationslist.cfm?start=101
- Recent sector evaluations done by MS
- Relevant reports issued by the WB, UNDP, WHO, the European Court of Auditors, the Global Fund as well as e.g. the Norwegian Development Cooperation etc.

Publication and sources on Budget Support

- Guidelines on the Programming, Design & Management of General Budget Support, EC, 2007
- The Joint Evaluation of General Budget Support 1994–2004, Burkina Faso, Malawi, Mozambique, Nicaragua, Rwanda, Uganda, Vietnam, Evaluation of General Budget Support: Synthesis Report IDD and Associates, May 2006
- Note on Approach and Methods for the Evaluation of General Budget Support, IDD and Associates, January 2007
- European Court of Auditors. Information note by the European Court of Auditors on Special Report No 2/2005 concerning EDF budget aid to ACP countries: the Commission's management of the public finance reform aspect. (September 13, 2005) European Court of Auditors: Luxembourg
- Revue du Programme d'Appui Budgétaire Conjoint pour la Réduction de la Pauvreté (2004-2006) de la Commission Européenne au Bénin, Novembre 2006, ADE s.a.
- The European Court of Auditor special report on General Budget Support and all other recent evaluations of Budget Support should be extensively used

Useful web sites

http://www.cc.cec/dgintranet/europeaid/activities/evaluation/impact-indicators/index_en.htm (working paper)

http://www.who.int/en/

http://www.un.org/millenniumgoals/

http://www.undp.org

http://www.hlfhealthmdgs.org/

http://www.theglobalfund.org/en/

http://www.theglobalfund.org/en/terg/evaluations/sa3/?lang=en

http://www.idrc.ca/index_en.html

http://web.worldbank.org

http://data.worldbank.org/

http://www.oecd.org/dac

http://ec.europa.eu/europeaid/what/health/index_en.htm

http://www.cc.cec/dgintranet/europeaid/activities/evaluation/impact-indicators/index_en.htm

http://www.cc.cec/dgintranet/europeaid/activities/thematic/e3/health/index_en.htm

http://www.cc.cec/dgintranet/europeaid/activities/evaluation/health/sec_hea_en.htm

http://ec.europa.eu/development/index_en.cfm

http://ec.europa.eu/world/enp/policy_en.htm

http://unstats.un.org/unsd/mi/mi_goals.asp

http://www.gapminder.org/

http://www.internationalhealthpartnership.net/en/home

Annex 2. Guidance on the country notes for the country case studies[10]

Length: The country note should be maximum 20 pages (excluding annexes).

This evaluation is partly based on a number of country case studies. These case studies allow the evaluation team to gather information on the Commission support (to the sector/theme of the evaluation) at the country level, which together with the desk phase findings should feed the global assessment reported in the synthesis report. This reporting is needed for transparency reasons, i.e. to clearly account for the basis of the evaluation, and also to be able to have a factual check with the concerned EU Delegations and other stakeholders.

This reporting should be seen as building blocks for the evaluation and as documents to be circulated with the Reference Group and the Delegations involved. In the end of the evaluation the country notes will be published as part of the overall evaluation exercise in annexes to the synthesis report (so editing is required). These notes should respect the agreed structure and they should go further than the oral presentations conducted at the end of the missions. Furthermore, the evaluation questions are formulated to be answered on the global level using the sum of the information collected from the different case studies and the desk study, and should hence not be answered at the country case study level.

Indicative structure:

1. Introduction:
   - The purpose of the evaluation;
   - The purpose of the note;
   - The reasons for selecting this country as a case study country.

2. Data collection methods used (its limits and possible constraints)

3. Short description of the sector in the country

4. Findings on the sector (focused on facts and not going into analysis)

5. Conclusions at two levels: (1) covering the main issues on this sector in the context of the country and (2) covering the elements confirming or not confirming the desk phase hypothesis.

Annexes:
- The list of people interviewed;
- The list of documents consulted;
- The list of the projects and programmes specifically considered;
- Any database produced;
- All project assessment fiches;
- All questionnaires;
- Acronyms and abbreviation.

[10] In this particular case, the data collected during the field missions of the refused Health evaluation have to be used and therefore relevant country notes shall be annexed to the evaluation report, both desk phase and final.

Annex 3. Outline Structure of the Final Evaluation Report

Length: The overall length of the final evaluation report should not be greater than *60 pages* (including the executive summary). Additional information on overall context, programme or aspects of methodology and analysis should be confined to annexes (which however should be restricted to the important information).

1. Executive Summary

Length: 5 pages maximum

This executive summary must produce the following information:

1.1 – Purpose of the evaluation;
1.2 – Background to the evaluation;
1.3 – Methodology;
1.4 – Analysis and main findings for each Evaluative Question; short overall assessment;
1.5 – Main conclusions;*
1.6 – Main recommendations.*

** Conclusions and recommendations must be ranked and prioritised according to their relevance to the evaluation and their importance, and they should also be cross-referenced back to the key findings. Length-wise, the parts dedicated to the conclusions and recommendations should represent about 40 % of the executive summary*

2. Introduction

Length: *5 pages*

2.1. Synthesis of the Commission's Strategy and Programmes: their objectives, how they are prioritised and ordered, their logic both *internally* (i.e. the existence – or not – of a logical link between the Commission policies and instruments and expected impacts) and *externally* (i.e. Within the context of the needs of the country, government policies, and the programmes of other donors); the implicit assumptions and risk factors; the intended impacts of the Commission's interventions.*

2.2. Context: brief analysis of the political, economic, social and cultural dimensions, as well as the needs, potential for and main constraints.*

2.3. Purpose of the Evaluation: presentation of the evaluative questions

** Only the main points of these sections should be developed within the report. More detailed treatment should be confined to annexes*

3. Methodology

Length: 10 pages

In order to answer the evaluative questions a number of methodological instruments must be presented by the consultants:

3.1. Judgement Criteria: which should have been selected (for each Evaluation Question) and agreed upon by the steering group;

3.2. Indicators: attached to each judgement criterion. This in turn will determine the scope and methods of data collection;

3.3. Data and Information Collection: can consist of literature review, interviews, questionnaires, case studies, etc. The consultants will indicate any limitations and will describe how the data should be cross-checked to validate the analysis.

3.4. Methods of Analysis: of the data and information obtained for each Evaluation Question (again indicating any eventual limitations);

3.5. Methods of Judgement

4. Main Findings and Analysis

Length: 20 to 30 pages

4.1. Answers to each Evaluative Question, indicating findings and conclusions for each;

Overall assessment of the Commission Strategy. This assessment should cover:

– Relevance to needs and overall context, including development priorities and co-ordination with

other donors;

- Actual Impacts: established, compared to intended impacts, as well as unforeseen impacts or deadweight/substitution effects;
- Effectiveness in terms of how far the intended results were achieved:
- Efficiency: in terms of how far funding, personnel, regulatory, administrative, time and other resource considerations contributed or hindered the achievement of results;
- Sustainability: whether the results can be maintained over time.
- Commission value added

5. A Full Set of Conclusions and Recommendations

Length: 10 pages

A Full set of Conclusions* and Recommendations* (i) for each evaluation question; (ii) as an overall judgement. (As an introduction to this chapter a short mention of the main objectives of the country programmes and whether they have been achieved)

**All conclusions should be cross-referenced back by paragraph to the appropriate findings. Recommendations must be ranked and prioritised according to their relevance and importance to the purpose of the evaluation (also they shall be cross-referenced back by paragraph to the appropriate conclusions).*

Annexes should include logical diagrams of Commission strategies; judgement criteria forms; list of the projects and programmes specifically considered; project assessment fiches; list of people met; list of documentation; Terms of Reference; any other info (also in the form of tables) which contains factual basis used in the evaluation; etc.

- Power point presentation with 4 slides for each evaluation question illustrating in a synthetic and schematic way the evaluation process: 1st slide) logical diagram with the evaluation question, 2nd slide) judgment criteria, indicators and target level, 3rd slide) findings and their limitations, and 4th slide) conclusions and recommendations.

Annex 4. Quality assessment grid

Concerning these criteria, the evaluation report is:	Unacceptable	Poor	Good	Very good	Excellent
1. Meeting needs: Does the evaluation adequately address the information needs of the commissioning body and fit the terms of reference?					
2. Relevant scope: Is the rationale of the policy examined and its set of outputs, results and outcomes/impacts examined fully, including both intended and unexpected policy interactions and consequences?					
3. Defensible design: Is the evaluation design appropriate and adequate to ensure that the full set of findings, along with methodological limitations, is made accessible for answering the main evaluation questions?					
4. Reliable data: To what extent are the primary and secondary data selected adequate? Are they sufficiently reliable for their intended use?					
5. Sound data analysis: Is quantitative information appropriately and systematically analysed according to the state of the art so that evaluation questions are answered in a valid way?					
6. Credible findings: Do findings follow logically from, and are they justified by, the data analysis and interpretations based on carefully described assumptions and rationale?					
7. Validity of the conclusions: Does the report provide clear conclusions? Are conclusions based on credible results?					
8. Usefulness of the recommendations: Are recommendations fair, unbiased by personnel or shareholders' views, and sufficiently detailed to be operationally applicable?					
9. Clearly reported: Does the report clearly describe the policy being evaluated, including its context and purpose, together with the procedures and findings of the evaluation, so that information provided can easily be understood?					
Taking into account the contextual constraints on the evaluation, the overall quality rating of the report is considered.					

(For details on how criteria are rated refer to:
http://ec.europa.eu/comm/europeaid/evaluation/methodology/guidelines/gui_qal_flr_trg_en.htm)

Annex 5: Evaluation criteria and key issues

(1) Definitions (or links leading to the definitions) of the **five OECD-DAC evaluation criteria** (sometimes adapted to the specific context of the Commission) can be found in the glossary page of the Joint Evaluation Unit's website, at the following address:

http://ec.europa.eu/europeaid/evaluation/methodology/glossary/glo_en.htm

(2) As regards **coherence** (considered as a specific Commission's evaluation criterion) and the **3Cs**, their meaning and definition can be found in Annex 6.

(3) **Value added of the Commission's interventions**: The criterion is closely related to the principle of subsidiarity and relates to the fact that an activity/operation financed/implemented through the Commission should generate a particular benefit.

There are practical elements that illustrate possible aspects of the criterion:

1) The Commission has a particular capacity, for example experience in regional integration, above that of EU Member States;

2) The Commission has a particular mandate within the framework of the '3Cs' and can draw Member States to a greater joint effort; and

3) The Commission's cooperation is guided by a common political agenda embracing all EU Member States.

Annex 6: note on the criterion of coherence and on the 3Cs

Practice has shown that the use of the word "COHERENCE" brings a lot of questions from both Consultants and Evaluation Managers. This situation arises from the use of the same word "COHERENCE" in two different contexts.

Indeed, coherence is one of the two evaluation criteria that the Commission is using in addition to the 5 criteria from DAC/OECD but coherence is also a specific concept in the development policy, as defined in the Maastricht Treaty. The definitions of the same word in the two different contexts do not overlap and can lead to misinterpretation. To solve this problem the following decision has been taken.

Decision:

The definitions of relevance and coherence from Commission's budget glossary must be used for the evaluation criteria[11]:

- **Relevance**: the extent to which an intervention's objectives are pertinent to needs, problems and issues to be addressed;
- **Coherence**: the extent to which the intervention logic is not contradictory/the intervention does not contradict other intervention with similar objectives, in particular within the Commission's external assistance policies; and
- **The notion of complementarity as evaluation criteria has to be deleted**.

The definition of the 3Cs has to be given with reference to the Maastricht Treaty modified by the Amsterdam Treaty (articles 177 up to 181, to be adapted if necessary with the Lisbon Treaty):

Coordination (article 180):

The Community and the Member States will coordinate their policies on development cooperation and will consult each other on their aid programmes including in international organisations and during international conferences. They may undertake joint action. Member States will contribute if necessary to the implementation of Community aid programmes.

The Commission may take any useful initiative to promote the coordination referred to in paragraph 1.

Complementarity (article 177):

The Community policy in the sphere of development cooperation, which is complementary to those pursued by Member States, shall foster: (……)[12]

Coherence (article 178):

The Community shall take into account of the objectives referred to in article 177 (Community policy in the sphere of development cooperation) in the policies that it implements which are likely to affect developing countries.

The 3Cs have to be dealt with as key issues for the Community policy in development cooperation and have never been seen as evaluation criteria.

[11] According to the DAC Glossary the **relevance** is the extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies. The terms 'relevance and coherence' as Commission's evaluation criteria cover the DAC definition of 'relevance'.

[12] The Lisbon Treaty foresees reciprocal relations between the Community and the Member States and not anymore univocal direction Member States towards the Commission.

Annex 7: Principles regarding the drafting of evaluation questions

Main principles to follow when asking evaluations questions (EQ)

(1) Limit the total number of EQ to 10 for each evaluation.

(2) In each evaluation, more than half of EQ should cover specific actions and look at the chain of results.
- Avoid too many questions on areas such as cross cutting issues, 3Cs and other key issues, which should be covered as far as possible in a transversal way, introducing for example specific judgement criteria in some EQs.

(3) Within the chain of results, the EQs should focus at the levels of results (outcomes) and specific impacts.
- Avoid EQs limited to outputs or aiming at global impact levels; and
- In the answer to EQs, the analysis should cover the chain of results preceding the level chosen (outcomes or specific impacts).

(4) EQ should be focused and addressing only one level in the chain of results.
- Avoid too wide questions where sub-questions are needed (questions à tiroirs); and
- Avoid questions dealing with various levels of results.

(For example looking at outcomes and specific impacts in the same EQ.)

(5) The 7 evaluation criteria should not be present in the wordings of the EQ.

(6) General concepts such as sustainable development, governance, reinforcement, etc. should be avoided.

(7) Each key word of the question must be addressed in the answer.
- Check if all words are useful;
- Check that the answer cannot be yes or no; and
- Check that the questions include a word calling for a judgement.

(8) EQ must be accompanied by a limited number of judgement criteria; some of them dealing with cross cutting and some key issues (see point 2 above).

(9) A short explanatory comment should specify the meaning and the scope of the question.

2 Annex 21: Evaluation matrix

EQ #	Evaluation Matrix
EQ1	**Quality of health services : To what extent has EC support contributed to enhancing the quality of health services?**
JC11	***Availability of essential drugs improved due to EC support***
I-111	National health policies guaranties access to drugs, officially recognised as essential.
I-112	Average availability of selected essential medicines in public and private health facilities, incl pharmacies.
JC12	***Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support***
I-121	Improvement in the mix of primary and secondary health facilities
I-122	Increased proportion of health facilities with appropriate equipment
JC13	***Improved availability of qualified human resources for health due to EC support***
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
JC 14	***Increased or maintained quality of service provision due to EC support***
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
EQ2-	**Affordability of health: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor?**
JC21	***The cost of basic health care services are reduced for households due to EC support***
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
JC22	***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***
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
JC23	***Improvements in health finance policies to enhance affordability of services supported by the EC***
I-231	EC supported technical assistance, provides expertise on health care finance
I-232	EC supports enhanced communication, cooperation between MoH and MoF with regards to health finance
JC24	***Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC***
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

EQ #	Evaluation Matrix
	new medicines and treatments
EQ 3-	**Health facilities availability : To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?**
JC31	***Increase in availability of primary health care facilities due to EC support***
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.
JC32	***Increase in availability of secondary health care facilities due to EC support***
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
EQ4-	**Health service utilisation related to MNCH : To what extent has EC support to health contributed to improving health service utilisation related to MNCH?**
JC41	***Increased use of appropriate ante-natal and maternal health care supported by the EC***
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
I-413	Increased proportion of women using modern family planning
JC42	***Increased use of services and facilities to support health care for children supported by the EC***
I-421	Percentage of children under 5 receiving regular growth monitoring
I-422	Immunisation rate
JC43	***Children better protected from key health threats as a result of EC support***
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)
EQ 5-	**Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?**
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.
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)

EQ #	Evaluation Matrix
I-523	EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement
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)**
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
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.
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?**
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
JC 72	***JC 72 Contribution of EC GBS and SBS to policy based resource allocations and inclusive objectives in the health sector***
I-721	Evidence that indicators of SBS/GBS related to health have been ambitious, achievable and helped address core issues related to the health sector in partner countries (design
I-722	Evidence of the contribution to improved capacity building support and enhanced framework of policy dialogue in the health sector (including on PFM and accountability) (direct output)
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)
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)

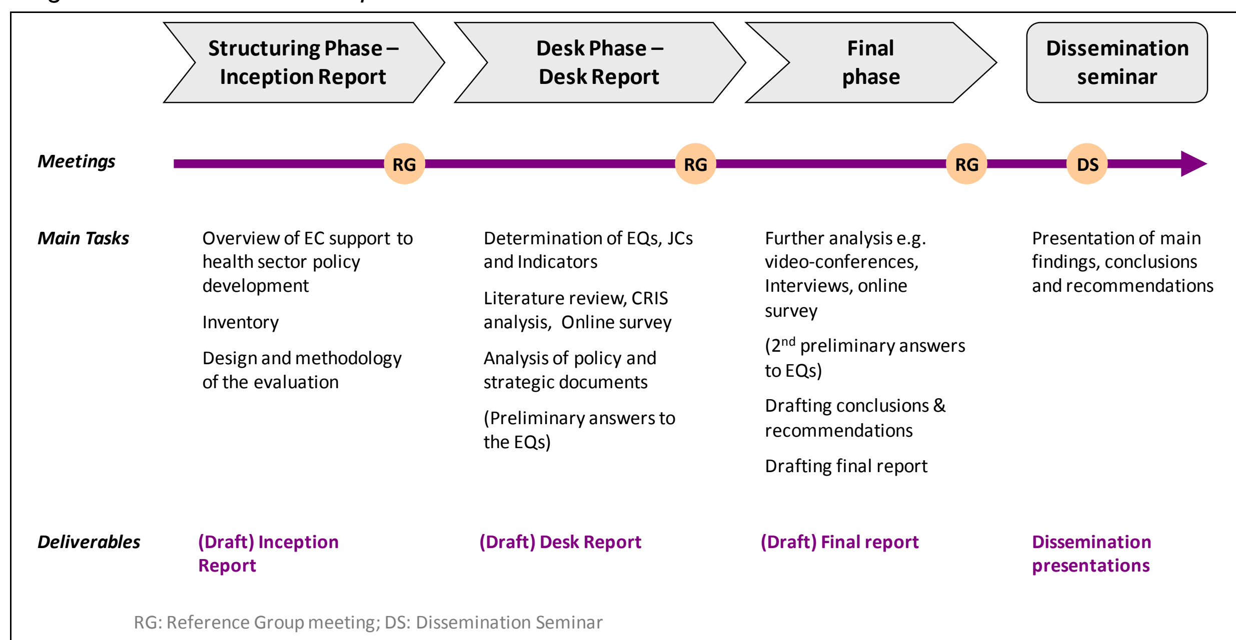
3 Annex 22: Methodology and tools used for the evaluation

The methodology applied for this evaluation is based on the methodological guidelines developed by the DG DEVCO Evaluation Unit. The guidelines give precise indication on the design of the study, the structure the evaluation process in its different phases and provide an array of tools that can be used for evaluations.[13]

3.1 Evaluation process

The evaluation has been conducted in **three main phases**, as summarised in the figure below. It was managed and supervised by the Evaluation Unit of DG DEVCO. Evaluation progress was closely followed by a Reference Group (RG) chaired by the Evaluation Unit and consisting of members of different DGs, in particular DG DEVCO and EEAS. The figure also lists the main tasks in each phase[14], the RG meetings held and the deliverables for each phase. In line with the ToR, each phase has started after formal approval of the deliverables of the previous phase by the Evaluation Unit.

Figure 1: Evaluation process



The evaluation process adopted a systematic approach that uses different building blocks to gradually construct an answer to the Evaluation Questions (EQs) and to formulate conclusions and recommendations. The various phases and subsequent “stages” coincide with the different methodological steps undertaken within the framework of the evaluation:

- First, it was essential to have a clear understanding and overview of the object of the evaluation, by producing an inventory and typology of EC support to the health sector falling within the scope of the evaluation (for more details on the inventory, see Annex 1 – Volume IIb). Once this overview was available, the team built the methodological framework for the entire exercise during the **inception stage**.
- On the basis of the established methodological framework, **data collection** could take place. It must be noted that no field phase was foreseen for this evaluation. The report is based on an extensive and systematic documentary review, web-surveys, interviews and phone interviews with selected stakeholders (EC headquarter staff, person in charge of health in EUDs, Ministries of health and lead donors in the countries). The detailed methodological approach is presented in the next chapter.

[13] General information on these guidelines can be found online at: *http://ec.europa.eu/europeaid/how/evaluation/methodology/index_en.htm*
[14] The lists include some major tasks carried out in each phase, but they are not meant to be exhaustive.

- The **synthesis phase** was devoted to further fine-tuning answers to the evaluation questions and formulating conclusions and recommendations on the basis of the data collected throughout the process.
- The final step will consist of a **dissemination seminar**, which gathers stakeholders and the interested public to discuss the evaluation results, conclusions and recommendations.

It should be noted that this evaluation is a re-launch of an evaluation of EC support to the health sector, carried out in 2008-2009. The final report of this former evaluation was rejected and it was decided to re-launch the evaluation, however with a reduced budget and excluding field visits.

To avoid confusion, it is also important to note that the present re-launched evaluation had a different and narrowed-down scope, excluding in particular the discussion on PRDs. Moreover, it is based on completely new evaluation design which is used to collect and analysis data. However, findings from the former evaluation have been included in the present evaluation report, whenever fitting in the new evaluation design.

3.1.1 Developing the methodological framework (Structuring Phase)

One of the key step of the evaluation process consisted in defining the design of the evaluation and its corresponding methodological framework which served as a basis for the entire evaluation exercise.

Given the purpose and conditions of the evaluation, the most appropriate design for the evaluation was a **multiple case study with literal replication** based on the use of a **mixed-methods approach**. The elaboration of the methodological framework was based upon several tasks.

- One of the first tasks was to define the **intervention logic** (see **Error! Reference source not ound.**) underlying the rationale of EC support to the health sector. This was a prerequisite for the evaluation, since it facilitates understanding of the hierarchy of the objectives with a view to contributing to the overall objectives of the EC's development policy. It therefore constituted the basis for formulating the Evaluation Questions (EQs) and served as the benchmark against which to evaluate the activities financed.
- Moreover, an **inventory** of EC support to the health sector was prepared (see chapter **Error! eference source not found.**): The inventory provides an overview of interventions financed worldwide by the EC in the health sector during the period 2002 and 2010 also specifying sub-sectors and regions supported. The analysis served for formulating EQs and Judgement Criteria as well as for the final selection of the country cases for which in-depth data collection was applied.
- A **set of evaluation questions** was defined and structured. The purpose of an evaluation is to verify to what extent the EC's intended objectives have materialised as envisaged. Accordingly, the EQs of this evaluation were established based on the analysis of the interventions logic and a number of key issues identified in the ToR as well as on discussion with the reference group. A set of *seven EQs* has been defined, so as to shed light on some critical points of the intervention logic and provide more concrete content to the evaluation criteria and key issues. The EQs therefore cover the different evaluation criteria, including the five Development Assistance Committee (DAC) criteria and EC specific criteria, such as 'added value and '3Cs'. For more details on the evaluation questions, see chapter 3.1.1.1).
- The **evaluation matrix** was drafted. With a view to facilitate data collection as well as the responses to these questions at a later stage, each question has been further structured. To this end, appropriate Judgement Criteria (JC) and related indicators were defined. Furthermore, potential information sources were identified for each indicator, as well as appropriate methods and techniques for collecting and analysing the information.
- Given the purpose and conditions of the evaluation, the most appropriate cases to be analysed during the desk phase were deemed to be "country cases". Thus, a number of relevant "**country cases"** was selected. In order to reach a reasonable balance between generating a rich evidence base and keeping the study feasible, it was decided to focus on *25 countries* during the desk phase for a broad overview. Out of this desk sample*, 12 countries* were further selected for an *in-depth case study* (see country case studies in Volume IIc and d). Overall, the country cases were selected to reflect the diversity of EC partner countries and EC programmes and approaches.

3.1.1.1 The Evaluation Questions

The focus of the evaluation questions has been directed at aspects that would permit provision of information and analytical material contributing to an analysis of a number of issues that become apparent from desk work done during the production of the inception report and from the inventory. As

indicated above, the EQs were discussed and agreed upon with the Evaluation Unit and the Reference Group.

Table 1: Overview of evaluation questions

Code EQ	Evaluation question
EQ1: Quality of health services	To what extent has EC support contributed to enhancing the quality of health services?
EQ2: Affordability of health	To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor?
EQ3: Health facilities availability	To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?
EQ4: Health service utilisation related to MNCH	To what extent has EC support to health contributed to improving health service utilisation related to MNCH?
EQ5: Management and Governance	To what extent has EC support to health contributed to strengthening the management and governance of the health system?
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)
EQ7: 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?

The EQs can also be linked to one or several of the five DAC evaluation criteria (relevance, effectiveness, efficiency, impact and sustainability) and/or to the visibility and value-added themes identified in the terms of reference of this evaluation. These linkages are illustrated in the following table.

Table 2: Coverage of the evaluation criteria by the evaluation questions

Criteria	DAC criteria					EC criteria			
Question	Relevance	Effectiveness	Efficiency	Impact	Sustainability	Coherence	Added value	3Cs	Cross-cutting issues
EQ1- Quality of health services	✓✓✓	✓✓✓		✓✓✓	✓✓✓				✓✓
EQ2- affordability of health	✓✓✓			✓✓✓	✓✓✓				✓✓
EQ3- health facilities availability	✓✓	✓✓✓	✓✓	✓✓✓	✓✓✓				✓✓
EQ4-health service utilisation related to Mother and Child Health (MCH)	✓✓✓	✓✓✓		✓✓✓	✓✓✓				✓✓
EQ5- Governance and Management	✓✓	✓✓✓	✓✓	✓✓✓	✓✓✓				
EQ6- co-ordination & complementarity	✓✓✓	✓✓✓	✓✓	✓✓✓		✓✓	✓✓✓	✓✓✓	
EQ7- Modalities	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓✓	✓✓	

✓✓✓	The criterion is largely covered by the EQ
✓✓	The criterion is partially covered in the EQ

The answers to the Evaluation Questions are presented in chapter **Error! Reference source not ound.**. The findings on which they are based and the related analyses, are also set out in that chapter. Detailed findings and analysis can be found in Volume IIa.

3.1.1.2 Selection of case study countries and main interventions

Prior to the Desk Phase, 25 case study countries were selected, based on a set of rigorous criteria in order to ensure a certain representativeness of the sample[15]. **These countries should be regarded as representing and reflecting the broad range of EC support to health.**

Subsequently and by adjusting the weighting of the set of criteria, 12 countries were selected for the country case studies, considering the following elements:

- The geographical distribution of the selected countries: it should approximately reflect the regional financial distribution of the total funds.
- The sectoral distribution along the three main sub-sectors: basic health, health general and sexual and reproductive health: the funds allocated to the selected countries should reflect the percentage of total funds going to these three sectors.
- Data availability in the countries: e.g. countries where there has been a County Level Evaluation with at least one related to health, countries which received a field visit in the course of the previous, rejected health evaluation.

The selection of countries has been discussed and agreed with the RG. The table below shows the 25 desk study countries and the 12 in-depth study countries.

Table 3: Countries selected for country case study

Africa, Caribbean and Pacific Countries (ACP)	*ASIA*	*European Neighbourhood Policy (ENP) - South*	*ENP - East*	*LATIN AMERICA*
Burkina Faso	**Afghanistan**	**Egypt**	**Moldova**	El Salvador
DRC	**Bangladesh**	Morocco		**Ecuador**
Ghana	India	Syria		
Mozambique	Myanmar			
Nigeria	**Philippines**			
South Africa	**Lao PDR**			
Tanzania	Vietnam			
Zambia	Yemen			
Zimbabwe				
Barbados *(Caribbean)*				
Timor-Leste (*Pacific)*				

***Legend**: country selected for the in-depth country cases =* **Country**

In total, the sample of 25 desk countries covers 40% of total support to the health sector in the evaluation period and 65% of support directly contracted for individual countries, i.e. excluding regional or worldwide allocations. It included the 10 top-ranked beneficiary countries of direct support to the health sector.

Furthermore, the sample included 11 ACP countries (representing 36% of total country support to ACP countries[16], 7 Asian countries (71% of total support going to Asia), 2 countries of ENP South (80% of total support going to ENP South) and Latin America (36% of total support going to Latin America) and 1 country of the ENP East region (40% of total support going to ENP East).

In terms of modalities, the sample covers 84% of SBS interventions, 78% of SSP interventions and 48% of GBS programmes. Moreover, the sample covers 57% of funds going to countries with a low Human Development Index (HDI), but 78% of funds going to countries with a medium HDI and 18% of funds contracted for countries with a high or very high HDI.

[15] Sets of criteria were: the absolute EC financial contribution per country as well as amount per capita; amount delivered through different aid modalities as well as channels.

[16] For the ACP region, the so-called “intra-regional allocations” (e.g. GFATM contribution) represent substantial amounts (namely 38% of all funds to the ACP region), which cannot be allocated to one single country. Discounting these regional allocations from the total amount of funds contracted for the ACP region shows that the support going solely to one country accounts for 36% of funds.

In order to be able to implement a more focused and systematic review of the projects and programmes in the health sector financed by the EC, the team proceeded to a selection of interventions per country, based on the following selection criteria:

- Projects and programmes with the highest EC support: this includes all SBS and Support to sector programmes (SSP) and large individual projects in the desk study countries.
- A selection of small individual projects for each country of the desk study sample, capturing the thematic focus of the EC funding in the country and taking into account the different EC budget lines used in the country.
- Furthermore, all relevant GBS operations in the 25 sample countries over the evaluation period have been taken into consideration, as well as all SBS programmes for the 25 countries.

The table in Annex 23 provides an overview of the interventions selected in the 12 case study countries.

Acknowledging that 38% of the total funds are going to regions or multiple countries, the evaluation team addressed this characteristic of EC support through three thematic case studies (see Annex 17, Volume 19).

3.1.2 Collecting data (Desk Study): Overview of process and tools

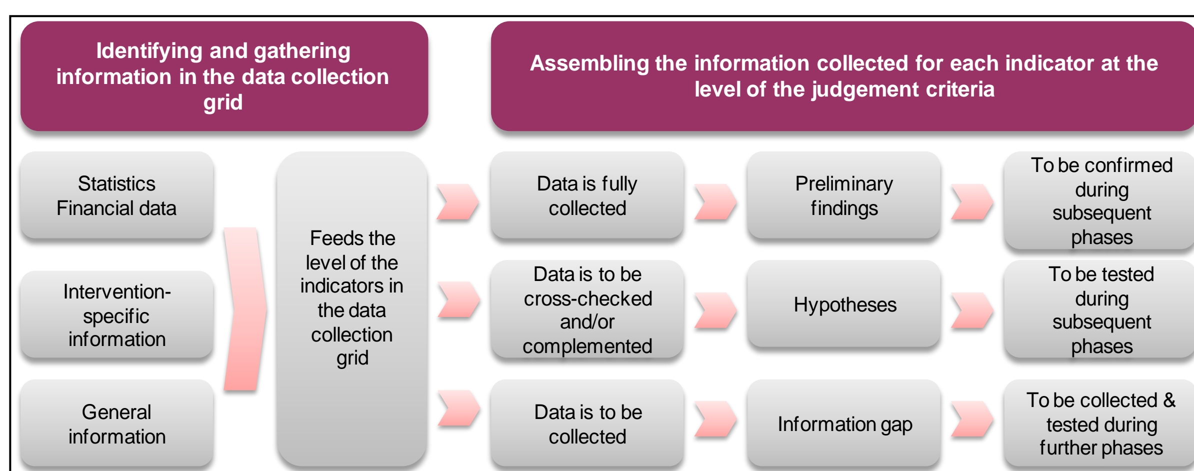
3.1.2.1 Data collection process

The **combination of data collection methods** and techniques varies according to the different JCs. As a principle, data collected through different means was cross-checked. Moreover, where possible, the evaluation team combined the use of qualitative and quantitative data and relied both on primary and secondary data sources while taking into account resources and time constraints. The evaluation team checked that the final set of methods and techniques consisted in a sufficiently wide mix to ensure a high level of data reliability and validity of conclusions.

At the end of the desk phase, the team assessed the overall data collection process in order to identify preliminary findings and information gaps to be filled. The main objective of the synthesis phase was to fill these gaps but also to validate preliminary findings. In order to do so, the evaluation team focused on selected key issues and specific topics to study in detail through targeted further literature review and phone interviews with EUDs, MoHs and donors. However, as no field phase could be implemented only a limited amount of primary data could be gathered, e.g. through online surveys and various forms of interviews.

The process of data collected is exemplified by the figure below.

Figure 2: Data collection process



3.1.2.2 Overview of tools used during the evaluation

The table below provides an overview of the data collection strategy and corresponding tools used during the evaluation, was well as their output.

Table 4: Overview of tools used during the evaluation

Level of research	*Tool*	*Purpose*	*Individual analysis*
World-wide level	**Literature review** related to health in general, Millennium Development Goals (MDGs), different aid modalities, etc.	To identify general trends in support to health	No
World-wide level	Statistical analysis of the **inventory** of EC support to health	To identify trends in financing and disbursement, sectoral emphasis, geographical distribution	Yes *Annex 2*
World-wide level	**Interviews with EC** staff in Brussels	To discuss specific topics related to the inventory and management of the health sector at headquarter level (channels, budget lines, strategic priorities)	No
25 desk study countries	Online **survey to EUDs**	To gauge perceptions of a major stakeholder group on a number of JCs and indicators, as well as on general issues of concern	Yes *Annex 3*
25 desk study countries	Online **survey to MoHs**	To gauge perceptions of a major stakeholder group on a number of JCs and indicators, as well as on general issues of concern	No
25 desk study countries	Review of two sets of **Country Strategy Papers (CSPs)** (2002/03, 2007/2008)	To identify information and produce findings related to a limited number of indicators	Yes *Annex 4*
25 desk study countries	Extraction of selected **health indicators** for the years 2002 to 2010. Aggregation of most relevant sources, such as: WHO World Health Statistics, United Nations Children's Fund (UNICEF) (Multiple Indicator Cluster Survey (MICS)/State of World's Children Report), United Nations Population Fund (UNFPA) State of World Population, MDG indicators	To generate figures and general trends for the period 2002 to 2010 for selected indicators. Data extraction at various levels, e.g. for all desk study countries, extraction according to regions and according to income level	Yes *Annex 23*
25 desk study countries	Analysis of main **SBS and GBS** operations.	To answer indicators related, among others, to EQ 7 on aid modalities. Discuss specific topics related to the inventory	

Level of research	Tool	Purpose	Individual analysis
12 case study countries	**In-depth country case studies:** • **Country fiche** with the overview of EC funds to the health sector in the country and short description of main interventions • **Literature review*** of selected interventions, • **Telephone interviews** with selected EUDs. MoHs and donors	To inform JCs and indicators of the evaluation and gather information on EC contribution and achievement of EC objectives in health on country level, mainly for all impact EQ (EQ 1-5) Complete the aggregated information of the worldwide and regional level; Allow for comparison across countries Fill data gaps and validate preliminary findings	Yes *Annex 5-16*
Analysis of relevant documentation, including thematic evaluations	**Thematic case studies:** • Study on Global public goods: JC 24 • Study on GFATM: mainly EQ6 • Study on Health situation in Fragile States: crosscutting issues.	To produce in-depth findings related to a limited number of JCs and indicators, for which the cases have been selected	Yes *Annex 17-19*

**The literature review for the in-depth case studies has been focusing on the following types of documentation:*

- Review of available project/programme documentation for selected interventions. This includes:
    - Financing proposals and agreements, including technical and administrative provisions
    - Internal project assessments documents: progress reports, interim and final project reports; for budget support operations: assessment of performance tranches, joint annual reviews (JAR), disbursement assessments and decisions, EUD correspondence
    - External monitoring and evaluation: Result-Oriented Monitoring (ROM), Mid-term-evaluations and final evaluations, mission reports
- Review of specific country documentation focusing on EC interventions in the health sector (depending on availability
    - EC Country Strategy/Level Evaluations
    - EUD External Assistance Management Reports (EAMR)
    - Field visit country notes of the previous EC evaluation of the health sector
    - Special reports of the European Court of Auditors
    - Other evaluations such as: Country Evaluation of the Paris Declaration Evaluation and thematic country case studies of the Paris Declaration Evaluation (Untied aid case studies), Joint Budget Support evaluation, etc.

General country literature in the health sector, e.g. WHO Country reports.

3.1.3 Analysing and judging: Synthesis Phase

During the second half of the Synthesis Phase, after completing the additional data collection, the information collected was analysed and synthesised, so as to answer the EQs, provide overall conclusions and recommendations and reach an overall judgement on the EC support to the health sector.

This work resulted in a Draft Final Report, which was discussed with the RG, and updated following comments received.

The factual information on which the evaluation is based is provided in detail in Volume II which includes: details on the Inventory; the results of the CSP review, the results of the survey to EU Delegations and the in-depth country case studies which included the findings from the phone interviews with EUDs, MoHs and donors.

Information from various sources was combined, cross-referenced and cross-checked, as illustrated below; this served as a basis for developing the argumentation. For each EQ, the team thus constructed balanced answers using the building bricks that are the indicators and the JCs. Regular consultations were held between team members to ensure coherence in filling the grids. Information on all JCs and indicators was provided to each team member, who then collated the information and ensured coherence of the answer.

Table 5: Cross-checking information

EQ 1	Indicators	CSP analysis	Inventory	EUD survey	Country case studies	Thematic case studies	International and national statistics	Interviews	MoH survey	Other literature
JC11	I-111									
	I-112									
JC12	I-121									
	I-122									

The combination of answers to the different EQs (see chapter **Error! Reference source not found.**) n the main report, allowed the team to formulate more general judgements in the form of Conclusions (see chapter **Error! Reference source not found.**), on that basis, propose a set of Recommendations see chapter **Error! Reference source not found.**). This approach allowed for a clear linkage between EQs (findings), conclusions and recommendations.

3.1.4 Dissemination

A dissemination seminar is foreseen in Brussels after approval of the final report.

3.2 Challenges and limitations

3.2.1 Overall challenge of a strategy level evaluation

A strategy-level evaluation of this kind is a challenge *per se*. It goes beyond a mere summation of evaluations of multiple operations and tackles many high-level issues. It also covers different dimensions and areas of support, periods and countries and simultaneously focuses on individual interventions. This challenge has been tackled mainly through the specific structured methodological approach, based primarily on the definition of Evaluation Questions, Judgement Criteria and Indicators and the choice of countries and interventions for the data collection phase.

3.2.2 Availability of primary sources

This evaluation is unique because it is the follow-up to a rejected evaluation exercise. The approach of the team has been to start from scratch with a new inventory and set of EQs, Judgement Criteria and Indicators in order to avoid past mistakes. The existence of the previous evaluation provided both opportunities and constraints. As a direct consequence of the former exercise, the current Terms of Reference do not foresee any field visits. This fact automatically led to reduced availability of relevant primary information from the programme level and from national stakeholders. The team has strived to counterbalance this gap, by using tools such as the online survey to EUDs and MoHs or telephone interviews, which allow retrieving information from the stakeholders at national level.

The response rate of EUDs to the online survey was very high with all of the 25 targeted EUDs responding at least partially[17] to the survey. They also showed considerable and highly appreciated willingness to collaborate and to provide supplementary information or explanation where needed. Furthermore, all 12 EUDs commented the in-depth country case studies and provided supplementary documentation not accessible to the evaluation team before.

The MoH survey did not yield the same high response rate as the EUD survey, with only eight MoH answering the questionnaire, out of 19 MoHs that were targeted.[18] Due to this rather low response rate, information provided was used to complement and cross-check qualitative information collected from other sources, as the sample was too small for quantitative analysis.

Unfortunately, as the scope of the evaluation has changed considerably from the scope of the former evaluation, the information from the field visit reports of the previous exercise could only be used to a very limited extent in this evaluation.

The phone interviews with selected EUDs, MoH and donors proved to be a rich source of information, especially to validate findings and highlight the specific focus of an in-country situation, a problem or a

[17] Due to the specific country situation and a low involvement of the EUD in the health sector, the EUDs of Tanzania and Ghana only completed certain parts of the survey, mainly related to financing modalities and coordination of donors.
[18] The reason for not targeting all 25 MoH of the desk sample was that 1) EUDs did not recommend asking the MoH for a contribution; 2) no contact person was provided by the EUDs.

best practice. 18 persons have been interviewed by phone in eight countries. The list of people interviewed can be found in Annex 28.

3.2.3 Heterogeneity of secondary data

The data collection phase had the aim to screen the existing literature in order to answer the evaluation questions. The literature was mainly provided through the following sources:

- Generally available statistics, such as from the Worldbank, the WHO databases; UN MDG Indicators database;
- EC documentation from the European Commission's Common RELEX Information System (CRIS) database;
- EC documentation provided by the EUDs;
- Literature from the web, including other donors and from the libraries of the individual team members.

To a considerable extent, the analysis of EC project documentation had to rely on documentation provided in the EC CRIS database. As the amount and types of documentation uploaded are under the responsibility of EC HQ and Delegation staff, the information retrieved by the team varies considerably from programme to programme and between countries. The feedback from the EUDs on the draft case studies also included new documentation, which was incorporated in the revised the country case studies, together with the comments of the EUDs (see Annexes 5 to 16). A detailed list of available documentation per intervention can be found in the annex of each country case study.

3.2.4 Building an inventory of EC support to the health sector

Challenges and limits relating to the inventory are presented in detail in Volume IIb - Annex 2.

One of the key challenges that had to be tackled in constructing the inventory and typology for this evaluation is common to all mapping exercises for thematic evaluations and relates to the information source on which they are based. It is recognised and explicitly stated in the Terms of Reference and Launch Note for this evaluation, that CRIS is deficient in a number of regards. It is an information system that is mainly used by EC staff in Brussels and in partner countries for the day-to-day management of EC's interventions. The main limitation for conducting an inventory is that, in many cases, no DAC sector code has been attributed to the interventions. Mostly for this reason, the EC, evaluators and others have recognised for years that strict logic alone is not enough when dealing with CRIS. A fuzzier, more subjective and more innovative approach, such as that outlined in the methodology of the inventory (Annex 2), was required, including tedious line-by-line review of interventions.

With respect to the approach for the inventory of the **"direct" EC support** to health, the following limitations need to be highlighted:

- The method of filtering data by keywords is limited by the identification of the keywords themselves; however, the data cross-checking with previous health inventories and internal work of the EC services in charge of health helped the team to obtain the most comprehensive inventory.
- Some areas of intervention, e.g. water and sanitation, road safety and air pollution to take only three, contribute to human health in beneficiary countries but are not even remotely covered by the DAC definitions of health interventions. We have proposed this limited set in order to make the evaluation manageable, to the point and in line with the Terms of Reference.

The approach developed and applied to identifying interventions receiving **indirect suppo**rt has the following specific limitations:

- GBS programmes are not always labelled with a clear DAC code and the retrieval of GBS programmes from the CRIS database is a tedious exercise. The evaluation team has developed a method to clearly identify possible GBS programmes, but is aware that some GBS, especially outside the ACP area, might not have been identified. To the extent possible, cross-checking with specific EC databases on GBS, produced by EC staff, have been carried out.
- It is not possible to estimate reliably how much GBS funding went to support the health sector. However, it was possible, to determine whether a GBS programme was relevant to the health sector, by looking at the performance indicators of the FAs. It is important to underline that no Judgement can be made of the amount that effectively went to the health sector of GBS with health related indicators. It can only be stated that the amount refers to those GBS for which the EC in one way or another pursued goals for the health sector, among other sectors.

3.2.5 Assessment of EC contribution

The scope of the evaluation includes health policies and their translation into results/impacts. Therefore, many indicators specifically investigated in the course of this evaluation refer to achievements at a global level. It also looked at specific country achievements, progress made and constraints encountered, through specific case studies at country level. At the country level, as well, it is difficult to isolate the EC impact in a multi-donor environment. None of the identifiable dynamics and effects at country level is solely dependent on EC contributions, but results of an interplay of various stakeholders and contextual factors. This makes it rather difficult to correlate a **specific contribution of the EC** directly to the current situation in the health sector in a given country, or at the regional or **global level**.

The **use of some aid modalities**, especially GBS, adds to the complexity of assessing EC contributions. While there are often health-related indicators in governing agreements, approaches in terms of how to assess this modality at a general level are still subject to discussions.

In order to better assess possible EC contribution[19] to progress related to a huge number of indicators, depending on the EQ, a specific focus has been placed on:

- Gathering information on output and impact indicators;
- Completing quantitative data with qualitative assessments on the role played by the EC;
- Cross-checking the information being gathered through different tools and from different actors.

[19] Keeping in mind the limitations of such an exercise concerning thematic evaluations and especially assessing effects and impact due to variety of donors, regional and national situations and availability of information.

4 Annex 23: Overview of sources used per indicator

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
EQ1	**Quality of health services**												
JC11	***Availability of essential drugs improved due to EC support***												
I-111	National health policies guaranties access to drugs, officially recognised as essential.		x		x				x				
I-112	Average availability of selected essential medicines in public and private health facilities, incl pharmacies.	x	x					x	x				
JC12	***Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support***												
I-121	Improvement in the mix of primary and secondary health facilities	x	x		x			x	x				
I-122	Increased proportion of health facilities with appropriate equipment		x		x			x				x	

[20] incl. project docs, EAMR,, ROM, CSEs
[21] EC HQ staff, EUDs, MoH, donors
[22] CSEs of non-case study countries, other evaluations; for indicators not included in the country case studies: project documentation, CSEs and other related documentation

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
JC13	***Improved availability of qualified human resources for health due to EC support***												
I-131	Increased number of key health workers (doctors; nurse/midwives) per 10,000 population		x		x			x	x	x		x	
I-132	Improved availability and standards of health worker training	x	x									x	
I-133	High health worker attrition addressed		x		x				x	-			
JC14	***Increased or maintained quality of service provision due to EC support***												
I-141	Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)		x			x			x				
I-142	Clinical treatment guidelines available, disseminated and applied		x										
I-143	Client satisfaction with the quality of health care services		x										
EQ2	**Affordability of health**												
JC21	***The cost of basic health care services are reduced for households due to EC support***												
I-211	Change in proportion of health spending out of pocket		x		x					x	x		

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
I-212	Change in share of health expenditure financed by social security schemes		x		x				x			x	
I-213	Change in proportion of the population covered by public health insurance / enrolled in the public health scheme		x		x			x				x	
JC22	***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***												
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		x		x								
I-222	Health care financing schemes result in additional health care consumption by households		x		x								
JC23	***Improvements in health finance policies to enhance affordability of services supported by the EC***												
I-231	EC supported technical assistance, provides expertise on health care finances,		x		x				x				
I-232	EC supports enhanced communication, cooperation between MoH and		x						x		x	x	

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
	MoF/planning												
JC24	***Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC***												
I-241	Evidence of EU supported dialogue between major stakeholders and pharmaceutical industry to encourage R&D targeted at diseases of poor countries					x						x	
I-242	North-South medical and public health research partnerships supported by EU to produce new medicines and treatments					x							
EQ 3	**Health facilities availability**												
JC31	***Increase in availability of primary health care facilities due to EC support***												
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	(x)	x		x			x		-			
I-312	Change in the proportion of rural population living in a radius of 1 hour of a primary health care		x		x			x		-		x	

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
	facility.												
JC32	***Increase in availability of secondary health care facilities due to EC support***												
I-321	Change in number of hospital beds per 10,000 population (to >10 per 10,000 population)	(x)	x		x			x		x		x	
I-322	Change in the proportion of population living in a radius of 2 hours of a secondary health care facility				x			x					
I-323	Increased number of Caesarean Sections		x							x			
EQ4	**Health service utilisation related to MNCH**												
JC41	***Increased use of appropriate ante-natal and maternal health care supported by the EC***												
I-411	Increase in proportion of deliveries supervised by a skilled attendant		x					x	x	x	x	x	
I-412	Increased percentage of women receiving 4 or more ante-natal check-ups		x					x		x	x	x	x
I-413	Increased proportion of women using modern family planning	x	x					x	x	x			
JC42	***Increased use of services and facilities to support health care for children supported by the EC***												
I-421	Percentage of children under 5 receiving regular	(x)	x	x				x		x		x	

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
	growth monitoring												
I-422	Immunisation rate	x	x			x				x	x	x	x
JC43	***Children better protected from key health threats as a result of EC support***												
I-431	Increased proportion of children sleeping under a bednets		x							x			
I-432; I-433	Reduction in rate of child deaths from diarrhoeal disease AND Improved household management of diarrhoea based on oral rehydration salts (ORS)		x					x		x			
EQ5	**Management and Governance**												
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)		x	x	x			x					x
I-512	EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector		x		x				x		x	x	x
I 513	EC contributed to decentralized capacity building to strengthen		x		x							x	x

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
	health policy capabilities at provincial, district, and local levels.												
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).		x		x				x			x	x
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)		x		x							x	
I-523	EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement		x		x			x	x			x	

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
EQ6	**Coordination, complementarity and synergy**												
JC61	**Level of health sector-related coordination in place with active role/contribution of the EC**												
I-611	EC participation and value added in functioning coordination mechanisms between donors			x	x		x		x			x	
I-612	Partner government leadership and EC value added in functioning coordination mechanisms between government and donors			x	x							x	
I-613	Change in number of project implementation units running parallel to government institutions within the health sector				x		x			x		x	x
JC62	**Increased complementarity of EC support, and between EC support and support of other donors**												
I-621	EC programming and planning process related to health has been co-ordinated with other (EU) donors (as e.g. evidenced by EC programming documents such as CSPs, NIPs)			x								x	
I-622	Evidence of joint activities enhancing			x	x							x	

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	International Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
	complementarity												
I-623	Degree of complementarity of EU supported health-specific global and country-level trust funds with other EC support to the health sector in the country	x			x							x	
EQ7	**Financing modalities, funding channels and instruments**												
JC71	**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.			x							x	x	x
I-712	Appropriateness of aid delivery methods used with regard to capacities of implementing partners			x	x			x	x			x	
I-713	Aid delivery methods were aligned to national systems and procedures and adjusted to evolving contexts			x	x		x					x	
JC72	**JC 72 Contribution of EC GBS and SBS to policy based resource allocations and inclusive objectives in the health sector**												
I-721	SBS/GBS indicators related to health have been ambitious, achievable and helped address core				x			x			x	x	x

		Inventory	Country Case Studies[20]	CSP review	EUD survey	Thematic case studies	Analysis of Paris Decl.	MoH survey	Interviews[21]	Internatio nal Statistics	SBS/GBS analysis/	Selected literature analysis[22]	ECA reports
	issues related to the health sector in partner countries												
I-722	Improved capacity building support and enhanced framework of policy dialogue in the health sector (including on PFM and accountability)				x						x	x	x
I-723	Contribution to improved budgeting and policy processes (including policy based resource allocations, inclusive objectives in sector strategies, MTEF)				x		x		x		x	x	x
JC73	**JC 73 Increased cost-effectiveness and internal consistency of EC support**												
I-731	Disbursement rates by aid modality and channel	x											x
I-732	Thematic programmes provide distinctive added-value from programmes of geographic nature			x	x				x			x	x
I-733	Choice of specific aid modalities has led to reduced transaction costs (both on donor and partner country side)	x			x						x	x	x

5 Annex 24: Selection of 12 country case studies

		Barbados	***Burkina Faso***	***DRC***	***Ghana***	Mozambique	Nigeria	***South Africa***	Tanzania	Timor-Leste	***Zambia***	Zimbabwe	***Afghanistan***	***Bangladesh***	India	***Lao PDR***	Myanmar	***Philippines***	Vietnam	Yemen	***Moldova***	***Egypt***	Morocco	Syria	***Ecuador***	El Salvador
	Scoring levels	***ACP***											***Asia***								***ENP East***	***ENP South***			***Latin America***	
Distribution of support																										
Sub-sectoral distribution																										
Basic health (70% of total EC support)	over 10% of total of sample go in this sub sector=3							3					3										3			
Health General (28 % of total EC support)	over 10% of total of sample go in this sub sector=3																	3			3	3				
Sexual and Reproductive health (2 % of total EC support	over 10% of total of sample go in this sub sector=3													3						3						
Countries receiving highest amount of support	6 for countries among 5 highest; 3 for countries amoung 10 highest			3		3	3	6				3	6	6	3							6	6			
GBS with health related indicators	3 for the countries among the 5 highest GBSs (of the sample) and 1 for all other receiving GBS		3		3	3			3		3						1		1							1
Countries receiving highest amount of SBS and SSP	3 for the countries SBS/SPS (of the sample) and 1 for all other receiving SBS/SPS	1			1	3		1		1	1	1	3	3	3			1	1	1	1	3	3	1	1	
Countries receiving the highest amount of support through NGOs	country receiving more than 10% of NGO support, 1 for the 5 highest countries		3					1				1	3				1									
Fragile states	3			3						3		3	3				3			3						
French speaking Sub-saharian country.	3		3	3																						
Availability of data sources																										
Countries with field visit in former health evaluaion	6		6	6				6			6			6							6		6		6	

		Barbados	***Burkina Faso***	***DRC***	***Ghana***	Mozambique	Nigeria	***South Africa***	Tanzania	Timor-Leste	***Zambia***	Zimbabwe	***Afghanistan***	***Bangladesh***	India	***Lao PDR***	Myanmar	***Philippines***	Vietnam	Yemen	***Moldova***	***Egypt***	Morocco	Syria	***Ecuador***	El Salvador
	Scoring levels	***ACP***											***Asia***								***ENP East***	***ENP South***			***Latin America***	
Countries where a CSE has been undertaken after 2004	3 for JEU CSE, 2 for CSE of DG DEV		3	2	3	3	3		3		2		3		3	3		3	**3**		**3**	**3**				3
Country with a recent health sector evaluation/review	3				3				3																	
Total points		***1***	***18***	***17***	***10***	**12**	**6**	***17***	**9**	**4**	***12***	**8**	***21***	***18***	**9**	***3***	**2**	***7***	**5**	**7**	***13***	***15***	**18**	**1**	***7***	**4**

6 Annex 25: Overview of selected interventions in the 12 case study countries

Country	Period	Individual projects	SSP (not SBS)	SBS	GBS
Afghanistan	2002-06/07	Reconstruction Programme for Afghanistan (2002, 2003, 2004) ASIE/2002/003-024 ASIE/2003/004-847 ASIE/2004/016-775	Support to the Afghan public health sector (2005, 2006) (ASIE/2005/017-681 & ASIE/2006/018-370)		
↑↑	2007/08-13	(ASIE/2006/018-300) Contract 144737 Technical assistant to the disability Unit of the Ministry of public health	Support to the Afghan Public Health and Nutrition Sector (2008) (DCI-ASIE/2008/019-898)		
Bangladesh	2002-06/07	(ONG-PVD/2004/006-239) Contract 112170 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, (ASIE/2000/002-464) Contract 158701 Advocacy for Poor''s Access to the Local Public Health Services			
↑↑	2007/08-13	(DCI-NSAPVD/2009/021-105) Improving Maternal and Newborn Health through Public-Private Partnership	Support to the national Health, Nutrition and Population Sector Programme (2006) (ASIE/2005/017-585)		
Burkina Faso	2002-06/07	(SANTE/2004/006-082) Prévention et prise en charge des IST/VIH/SIDA auprès des femmes vulnérables des villes de Ouagadougou, Bobo-Dioulasso et PÔ (SANTE/2004/006-082) Projet d'approche solidaire en santé génésique			Appui budgétaire pour la réduction de la pauvreté ABRP 2002-2004 FED/2002/015-886 Appui budgétaire pour la réduction de la pauvreté 2005-2008 **FED/2005/017-744**
≈	2007/08-13	N/A			Contrat OMD : 2009-2013 FED/2008/020-972
Congo (DRC)	2002-06/07	PROGRAMME SANTE 9ème FED (2005…)			

Country	Period	Individual projects	SSP (not SBS)	SBS	GBS
		(FED/2005/017-858)			
↑↑	2007/08-13	Réhabilitation et réintégration socio-économique dans les régions de l'est (2006) FED/2003/016-469			
Ecuador	2002-06/07	(ONG-PVD/2002/001-092) Contract 20583 Promoting a holistic health response to HIV/AIDS and human rights through education, advocacy and training in Ecuador. Programa de apoyo al sector salud en Ecuador – PASSE (2005…) (ALA/2004/016-916)			
↓	2007/08-13				
Egypt	2002-06/07		Support to health sector reform (1998) (MED/1998/004-295)	Support to health sector reform (2006…) (MED/2006/018-249)	
↑↑	2007/08-13	(MED/2006/018-252) Contract 213554 Evidence based telemedicine and decision support system for remote and rural undeserved regions in egypt using e-health platforms (MED/2006/018-252) Contract 213666 Development of anti-hepatitis C virus (HCV) drug from blue green algae		HSPSPII-Health Sector Policy Support Programme II (2010) ENPI/2009/020-494	
Ghana	2002-06/07			Health sector support (1998) (FED/1998/014-061)	Support To Structural Adjustment Sasp Vii FED/2001/015-662 Poverty Reduction Budget Support 2 (2004-2006) FED/2004/016-608
↓	2007/08-13				Poverty Reduction Budget Support 3 (PRBS 3) FED/2007/020-799 MDG Contract (MDG-C)

Country	Period	Individual projects	SSP (not SBS)	SBS	GBS
					FED/2008/020-951
Lao PDR	2002-06/07	(ONG-PVD/2003/004-562) Contract 62434 Better health: empowering indigenous women and children, attrapeu province, lao pdrhealth Contract 19950 Education a la sante et amelioration des conditions sanitaires, laos			
↑	2007/08-13	Rural community empowerment through health promotion, dialogue and capacity building of local Red Cross and local authorities (2009) Support to government's Capacity Development in the Health Sector, Lao PDR (2009) (DCI-NSAPVD/2008/020-081) 226050 Rural community empowerment through health promotion, dialogue and capacity building of local Red Cross and local authorities (2009) (DCI-ASIE/2008/019-518) 219886 Support to government's Capacity Development in the Health Sector, Lao PDR (2009)	y		Support to the Third Poverty Reduction Support Operation DCI-ASIE/2007/019-166 Second General Budget Support to Lao PDR DCI-ASIE/2008/019-518
Moldova	2002-06/07	Health promotion and disease prevention (MO0101 Moldova AP 2001) TACIS/2003/005-604 Contract 121354 Increasing the social and professional integartion of young people with mental disabilities - graduates of four auxiliary boarding schools in Moldova Contract121354 TACIS/2003/005-604 Public Health Reform in Moldova (2005) Contract 101051			
↑↑	2007/08-13	Public Health Reform (2008) TACIS/2005/017-094 Contract 27523 Health Sector Budget Support Related TA (2010) - WHO		Sector Policy Support Programme Health (2009) (ENPI/2008/019-655) 203887	
Philippines	2002-06/07	(REH/2005/017-108) Contract 111156		Health Sector Policy Support Program (2006)	

Country	Period	Individual projects	SSP (not SBS)	SBS	GBS
		"Bringing Health into the People's Hands: A Health Improvement Program for the Internally Displaced People of Mindanao"		(ASIE/2005/017-638)	
↑↑	2007/08-13	(DCI-NSAPVD/2007/019-404) Contract 172232 Engaging Multi-Stakeholder participation in Health Advocacy towards Sustainable and Innovative Information and Services in Reproductive Health (EMPHASIS-RH)		Mindanao Health Sector Policy Support Programme (2007) (ASIE/2006/018-016)	
South Africa	2002-06/07	SuCoP for HIV/AIDS (2004): was changed into SBS end of 2007 (AFS/2004/016-827) (ONG-PVD/2004/006-239) Contract 114076 Capacity Building Initiative for Organisations engaged in HIV/AIDS Treatment, Care & Support	Partnership for the delivery of primary health care including HIV/AIDS (2003) (AFS/2001/000-706)		
↑↑	2007/08-13	(AFS/2006/018-197) Contract 219014 Réseau S&T Afrique Caraïbe de soutien α la lutte contre les maladies infectieuses		Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II") (AFS/2006/018-368)	
Zambia	2002-06/07	(ONG-PVD/2003/004-562) Contract 65311 Integration of HIV/AIDS/STD Interventions into Reproductive Health and Child Survival Programs in ZAMBIA	Health sector supp. Programme (1998…) FED/1998/ 014-062		Structural adjustment and Sysmin support programme FED/2000/015-065 Poverty Reduction Budget Support Programme 2003-2006 (PRBS01) FED/2003/016-366
↑↑	2007/08-13	(DCI-NSAPVD/2008/020-081) Contract 226017 Strenghtening the inclusion and influencing capacity of Civil Society Organisations working with People Living with HIV and AIDS in the Central Province of Zambia		Retention for Human Resources for Health (2007) (FED/2006/018-559) Supporting public health service delivery in Zambia (2009) (FED/2008/020-950)	PRBS 02 (2007-2008) FED/2006/018-569# PRBS 3 - MDG Contract 1 - CRIS REF. 2008/199-76 FED/2008/020-949

Legend:

↑↑	**Support to the health sector increased considerably between CSP 1 and CSP 2 period**
↑	**Support to the health sector increased between CSP 1 and CSP 2 period**

↓	**Support to the health sector decreased between CSP 1 and CSP 2 period**

7 Annex 26: Overview of selected Budget Support interventions in the 25 desk study countries

Country	Period	SBS	Interventions title	GBS	Interventions title
Afghanistan					
Bangladesh					
Barbados	CSP1		n/a		
	CSP2		Barbados Health Programme		
Burkina Faso	CSP1				Appui budgétaire pour la réduction de la pauvreté ABRP 2002-2004
	CSP2				Appui budgétaire pour la réduction de la pauvreté 2005-2008
	CSP2				Contrat OMD : 2009-2013
Congo (DRC)					
Ecuador					
Egypt	CSP1		Support to health sector reform		
	CSP2		HSPSP II-Health Sector Policy Support Programme II		
El Salvador	CSP1				Programa de alivio a la pobreza en El Salvador (PAPES)
	CSP2				Programa de Recuperación Economica para El Salvador - PARE-ES
Ghana	CSP1		Health Sector Support		Poverty Reduction Budget Support 2 (2004-2006)
	CSP2				Support To Structural Adjustment Sasp Vii
					MDG Contract (MDG-C)
					Poverty Reduction Budget Support 3 (PRBS 3)
India	CSP1		n/a		
	CSP2		Health Sector Support Programme India		
Lao PDR	CSP1		n/a		
	CSP2				Support to the Third Poverty Reduction Support Operation
					Second General Budget Support to Lao PDR
Moldova	CSP1		n/a		
	CSP2		Health Sector Policy Support Programme		
			Health Sector Policy Support Programme		
Morocco	CSP1		n/a		
	CSP2		Programme d'appui à la consolidation de la Couverture Médicale de Base (CMB) au Maroc		
			Programme d'appui sectoriel à la réforme du système de santé au Maroc - partie II		
Mozambique	CSP1		Rural Development Programme		Poverty Reduction Budget Support Ii (PRBS II) 2002-2005
			Health Sector Support Programme II		Poverty Reduction Budget Support Programme (PRBS III)

Country	Period	SBS	Interventions title	GBS	Interventions title
	CSP2		Health And HIV Sector Policy Support Programme		MDG Contract 1 Mozambique
Myanmar					
Nigeria					
Philippines	CSP1		Philippine Health Sector Policy Support Programme		
	CSP2		Mindanao Health Sector Policy Support Programme (MHSPSP)		
South Africa	CSP1				
	CSP2		Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II")		
Syria					
Tanzania	CSP1				Poverty Reduction Budget Support FAS 2000
					Poverty Reduction Budget Support Programme 2003-2006
	CSP2				PRBS03 Poverty Reduction Budget Support Programme 2006-2008 See Also Numbers 9 ACP TA 20 and 9 ACP TA 21
					MDG Contract (2009/2015) for Tanzania
Timor-Leste					
Vietnam	CSP1				Support to Vietnam's Poverty Reduction and Growth Strategy under PRSC-3
	CSP2				Poverty Reduction Support Credit 6
Yemen					
Zambia	CSP1				Structural adjustment and Sysmin support programme
					Poverty Reduction Budget Support Programme 2003-2006 (PRBS01)
	CSP2		Retention for Human Resources for Health		PRBS 02 (2007-2008)
			Supporting Public Health Service Delivery In Zambia CRIS Ref. 2008/198-54		PRBS 3 - MDG Contract 1 - CRIS REF. 2008/199-76
Zimbabwe					

Legend:

Underlined countries: Countries for which a country case study has been done.

8 Annex 27: Statistical Tables

Table 6 Diarrhea treatment (% of children under 5 receiving oral rehydration and continued feeding), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		47,3			42,4				
Congo, Dem. Rep.						42,3			
Ghana		39,9			28,6		44,6		
Mozambique		46,6					46,9		
Nigeria		27,7					24,9		
South Africa									
Tanzania				53,0					
Timor-Leste									
Zambia	47,8					56,1			
Zimbabwe					46,7			34,9	
Asia									
Afghanistan		48,1							
Bangladesh			52,5		48,9	68,0			
India					32,7				
Lao PDR					49,2				
Myanmar		65,0							
Philippines		75,8					59,6		
Vietnam	39,4				64,8				
Yemen, Rep.		18,0			47,6				
ENP									
Egypt, Arab Rep.				27,0			18,9		
Moldova				48,2					
Morocco			45,8						
Syrian Arab Republic					34,2				
Latin America									
Ecuador									
El Salvador									
Regions									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia								37,0	
Sub-Saharan Africa (developing only)								33,0	
Income level									
Heavily indebted poor countries (HIPC)								35,0	
Least developed countries: UN classification								39,0	

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Low & middle income									
Middle income									

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

Indicator Name	Diarrhea treatment (% of children under 5 receiving oral rehydration and continued feeding)
Short definition	Children with diarrhea who received oral rehydration and continued feeding refer to the percentage of children under age five with diarrhea in the two weeks prior to the survey who received either oral rehydration therapy or increased fluids, with continued feeding.
Long definition	Children with diarrhea who received oral rehydration and continued feeding refer to the percentage of children under age five with diarrhea in the two weeks prior to the survey who received either oral rehydration therapy or increased fluids, with continued feeding.
Source	UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 7 Births attended by skilled health staff (% of total), 2002-2010

Country_Name	2003	2004	2005	2006	2007	2008	2009	2010
ACP								
Barbados	100,0	100,0	100,0	100,0	100,0			
Burkina Faso	37,8		53,5	53,5				
Congo, Dem. Rep.					74,0			
Ghana	47,1			49,7	55,2	57,1		
Mozambique	47,7					55,3		
Nigeria	35,2					38,9		
South Africa	91,2							
Tanzania			43,4					
Timor-Leste	18,4							
Zambia					46,5			
Zimbabwe				68,5			60,2	
Asia								
Afghanistan	14,3			18,9		24,0		
Bangladesh	14,0	13,2		20,1	18,0		24,4	
India				46,6		52,7		
Lao PDR				20,3				
Myanmar	67,5				63,9			
Philippines	59,8					62,2		
Vietnam		90,0		87,7				
Yemen, Rep.	26,8			35,7				
ENP								
Egypt, Arab Rep.	69,4		74,2			78,9		
Moldova			99,5					
Morocco		62,6						
Syrian Arab Republic		89,7		93,0				
Latin America								
Ecuador		98,2						
El Salvador	92,4					95,5		
Regional								
Arab World							71,7	
East Asia & Pacific (developing only)							88,7	
Europe & Central Asia (developing only)							96,9	
Latin America & Caribbean (developing only)							89,4	
Middle East & North Africa (developing only)							80,0	
South Asia							46,9	
Sub-Saharan Africa (developing only)							44,4	
Income								
Heavily indebted poor countries (HIPC)							44,8	
Least developed countries: UN classification							40,1	
Low & middle income							64,1	
Middle income							71,3	

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

Indicator Name	Births attended by skilled health staff (% of total)
Short definition	Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; to conduct deliveries on their own; and to care for newborns.
Long definition	Births attended by skilled health staff are the percentage of deliveries attended by personnel trained to give the necessary supervision, care, and advice to women during pregnancy, labor, and the postpartum period; to conduct deliveries on their own; and to care for newborns.
Source	UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 8 Health expenditure per capita (current US$), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	717.78	742.79	780.69	826.06	893.24	932.37	973.73	1041.44	
Burkina Faso	13.25	18.35	23.49	27.32	26.89	30.49	37.19	38.08	
Congo, Dem. Rep.	3.83	4.66	5.87	6.40	8.71	9.64	13.32	15.58	
Ghana	19.64	24.01	25.97	35.01	40.40	52.98	55.45	45.05	
Mozambique	13.09	13.33	14.25	17.19	16.48	17.75	20.53	24.72	
Nigeria	17.64	38.02	44.44	52.61	56.94	59.36	73.44	69.30	
South Africa	209.72	318.05	412.55	452.94	457.89	491.87	458.68	485.43	
Timor-Leste	34.61	35.95	45.21	57.35	60.77	62.09	71.36	73.24	
Zambia	22.45	25.66	31.36	42.82	56.40	54.61	68.36	47.06	
Zimbabwe									
Tanzania	9.52	11.84	11.95	14.10	23.32	19.60	22.15	25.31	
Asia									
Afghanistan	21.77	25.48	29.62	32.52	34.57	41.65	47.48	50.89	
Bangladesh	10.01	10.58	11.59	12.07	13.18	15.04	16.52	18.43	
India	22.36	24.72	26.52	29.97	33.93	42.07	45.27	44.80	
Lao PDR	12.82	16.96	19.32	20.84	23.03	26.87	33.99	35.82	
Myanmar	2.91	3.84	4.74	4.92	5.56	7.19	9.96	12.47	
Philippines	28.11	33.09	36.83	42.12	48.40	57.23	68.03	66.88	
Yemen, Rep.	27.07	35.58	37.45	41.49	50.79	56.61	66.50	64.00	
Vietnam	22.65	25.79	30.92	37.57	46.91	58.34	75.78	79.71	
ENP									
Egypt, Arab Rep.	70.86	55.89	56.61	63.39	72.34	81.34	97.26	113.30	
Moldova	34.27	42.09	55.76	69.67	92.59	123.22	180.65	180.89	
Morocco	72.74	87.74	98.51	99.05	111.35	124.66	149.48	155.68	
Syrian Arab Republic	55.72	58.87	58.94	60.63	64.42	63.35	70.86	72.01	
Latin America									
Ecuador	97.33	109.62	129.87	146.93	166.42	185.17	215.90	255.50	
El Salvador	183.06	182.87	189.28	201.52	203.00	207.47	216.93	228.57	
Regional									
Arab World	100.23	105.22	120.34	133.55	156.40	173.60	219.12	230.13	
East Asia & Pacific (developing only)	47.57	54.71	61.84	69.68	81.81	97.92	124.92	148.27	
Europe & Central Asia (developing only)	117.45	145.28	185.19	235.76	291.98	380.98	448.25	386.20	
Latin America & Caribbean (developing only)	221.17	228.50	263.34	334.02	392.16	468.09	541.99	543.27	
Middle East & North Africa (developing only)	78.98	78.54	92.06	104.87	118.84	140.66	176.10	182.06	
South Asia	20.29	22.32	24.18	27.05	30.49	37.19	40.00	40.00	
Sub-Saharan Africa (developing only)	28.36	41.14	51.18	57.07	61.72	67.51	74.47	75.44	
Income									
Heavily indebted poor countries (HIPC)	15.40	17.40	20.36	22.82	27.37	32.12	39.21	38.34	
Least developed countries: UN classification	11.94	13.58	15.86	17.90	21.94	25.88	32.65	34.49	
Low & middle income	62.40	69.95	81.60	97.52	114.05	137.46	162.82	166.75	
Middle income	70.60	79.27	92.51	110.84	129.82	157.12	186.19	190.25	

source: Worldbank July 2011

Indicator Name	Health expenditure per capita (current US$)
Short definition	Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in current U.S. dollars.
Long definition	Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in current U.S. dollars.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 9 Health expenditure, private (% of GDP), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	2.30	2.39	2.48	2.48	2.51	2.51	2.44	2.44	
Burkina Faso	2.81	2.96	2.83	2.71	2.70	2.51	2.43	2.44	
Congo, Dem. Rep.	3.41	3.48	3.72	3.54	3.64	3.46	3.36	4.68	
Ghana	4.16	4.10	4.06	4.09	3.30	3.79	3.89	3.78	
Mozambique	1.50	1.56	1.56	1.50	1.49	1.30	1.16	1.52	
Nigeria	2.91	5.85	4.68	4.68	3.76	3.63	3.28	3.71	
South Africa	5.35	5.36	5.68	5.44	5.13	5.00	4.97	5.09	
Timor-Leste	2.43	2.48	4.35	3.88	3.61	3.48	3.66	3.58	
Zambia	2.40	2.53	2.83	3.17	2.49	2.58	2.23	2.25	
Zimbabwe									
Tanzania	1.94	2.15	2.27	2.00	2.68	1.31	1.27	1.35	
Asia									
Afghanistan	6.01	6.82	6.66	6.64	5.77	5.77	5.77	5.77	
Bangladesh	1.87	1.89	1.91	2.09	2.16	2.27	2.28	2.29	
India	3.58	3.40	3.20	3.10	2.98	2.88	2.82	2.80	
Lao PDR	2.86	3.67	3.67	3.53	3.22	3.24	3.29	3.28	
Myanmar	2.01	2.00	1.97	1.93	1.76	1.72	1.83	1.82	
Philippines	1.77	2.05	2.19	2.22	2.32	2.30	2.40	2.49	
Yemen, Rep.	2.28	3.11	3.31	3.23	3.60	3.73	3.71	4.06	
Vietnam	3.66	3.67	4.15	4.42	4.43	4.31	4.46	4.42	
ENP									
Egypt, Arab Rep.	3.66	3.47	3.26	3.12	2.95	2.90	2.78	2.93	
Moldova	3.43	3.71	3.55	4.21	5.02	5.09	5.26	5.53	
Morocco	3.93	3.86	3.79	3.62	3.52	3.30	3.39	3.61	
Syrian Arab Republic	2.70	2.66	2.34	2.05	2.04	1.84	1.87	2.02	
Latin America									
Ecuador	3.08	2.99	3.02	3.09	2.97	3.11	3.07	3.14	
El Salvador	4.09	3.86	3.66	3.38	2.51	2.54	2.43	2.51	
Arab World	1.92	1.81	1.66	1.49	1.45	1.48	1.45	1.87	
Regional									
East Asia & Pacific (developing only)	2.69	2.73	2.65	2.60	2.46	2.18	2.15	2.18	
Europe & Central Asia (developing only)	2.19	2.04	2.01	2.02	2.02	2.02	1.85	2.01	
Latin America & Caribbean (developing only)	3.27	3.34	3.29	3.64	3.64	3.66	3.57	3.83	
Middle East & North Africa (developing only)	2.89	2.77	2.61	2.59	2.43	2.42	2.38	2.66	
South Asia	3.28	3.17	3.03	2.95	2.83	2.77	2.70	2.69	
Sub-Saharan Africa (developing only)	3.57	4.16	4.21	4.05	3.74	3.67	3.49	3.72	
Income									
Heavily indebted poor countries (HIPC)	3.02	2.99	3.11	3.02	3.16	3.31	3.39	3.54	
Least developed countries: UN classification	2.58	2.58	2.68	2.57	2.66	2.68	2.67	2.89	
Low & middle income	2.92	2.94	2.86	2.92	2.82	2.70	2.59	2.72	
Middle income	2.93	2.95	2.86	2.92	2.82	2.69	2.58	2.71	

source: Worldbank July 2011

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

Table 10 Health expenditure, private (% of total health expenditure), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	2.30	2.39	2.48	2.48	2.51	2.51	2.44	2.44	
Burkina Faso	2.81	2.96	2.83	2.71	2.70	2.51	2.43	2.44	
Congo, Dem. Rep.	3.41	3.48	3.72	3.54	3.64	3.46	3.36	4.68	
Ghana	4.16	4.10	4.06	4.09	3.30	3.79	3.89	3.78	
Mozambique	1.50	1.56	1.56	1.50	1.49	1.30	1.16	1.52	
Nigeria	2.91	5.85	4.68	4.68	3.76	3.63	3.28	3.71	
South Africa	5.35	5.36	5.68	5.44	5.13	5.00	4.97	5.09	
Timor-Leste	2.43	2.48	4.35	3.88	3.61	3.48	3.66	3.58	
Zambia	2.40	2.53	2.83	3.17	2.49	2.58	2.23	2.25	
Zimbabwe									
Tanzania	1.94	2.15	2.27	2.00	2.68	1.31	1.27	1.35	
Asia									
Afghanistan	6.01	6.82	6.66	6.64	5.77	5.77	5.77	5.77	
Bangladesh	1.87	1.89	1.91	2.09	2.16	2.27	2.28	2.29	
India	3.58	3.40	3.20	3.10	2.98	2.88	2.82	2.80	
Lao PDR	2.86	3.67	3.67	3.53	3.22	3.24	3.29	3.28	
Myanmar	2.01	2.00	1.97	1.93	1.76	1.72	1.83	1.82	
Philippines	1.77	2.05	2.19	2.22	2.32	2.30	2.40	2.49	
Yemen, Rep.	2.28	3.11	3.31	3.23	3.60	3.73	3.71	4.06	
Vietnam	3.66	3.67	4.15	4.42	4.43	4.31	4.46	4.42	
ENP									
Egypt, Arab Rep.	3.66	3.47	3.26	3.12	2.95	2.90	2.78	2.93	
Moldova	3.43	3.71	3.55	4.21	5.02	5.09	5.26	5.53	
Morocco	3.93	3.86	3.79	3.62	3.52	3.30	3.39	3.61	
Syrian Arab Republic	2.70	2.66	2.34	2.05	2.04	1.84	1.87	2.02	
Latin America									
Ecuador	3.08	2.99	3.02	3.09	2.97	3.11	3.07	3.14	
El Salvador	4.09	3.86	3.66	3.38	2.51	2.54	2.43	2.51	
Regional									
Arab World	1.92	1.81	1.66	1.49	1.45	1.48	1.45	1.87	
East Asia & Pacific (developing only)	2.69	2.73	2.65	2.60	2.46	2.18	2.15	2.18	
Europe & Central Asia (developing only)	2.19	2.04	2.01	2.02	2.02	2.02	1.85	2.01	
Latin America & Caribbean (developing only)	3.27	3.34	3.29	3.64	3.64	3.66	3.57	3.83	
Middle East & North Africa (developing only)	2.89	2.77	2.61	2.59	2.43	2.42	2.38	2.66	
South Asia	3.28	3.17	3.03	2.95	2.83	2.77	2.70	2.69	
Sub-Saharan Africa (developing only)	3.57	4.16	4.21	4.05	3.74	3.67	3.49	3.72	
Income									
Heavily indebted poor countries (HIPC)	3.02	2.99	3.11	3.02	3.16	3.31	3.39	3.54	
Least developed countries: UN classification	2.58	2.58	2.68	2.57	2.66	2.68	2.67	2.89	
Low & middle income	2.92	2.94	2.86	2.92	2.82	2.70	2.59	2.72	
Middle income	2.93	2.95	2.86	2.92	2.82	2.69	2.58	2.71	

source: Worldbank July 2011

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

Table 11 Health expenditure, private (current US$), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	5700	6450	7000	7450	8000	8550	9000	9522	
Burkina Faso	9244	12634	14462	15194	16502	17833	23197	22979	
Congo, Dem. Rep.	18907	19712	24215	25162	31133	34431	39227	50465	
Ghana	25655	31323	36058	43924	49581	56968	64790	59069	
Mozambique	6312	7256	8871	9842	10540	10426	11416	15191	
Nigeria	172033	396110	411455	524952	559716	601956	703192	682483	
South Africa	594043	902053	1245165	1343387	1338217	1431126	1374603	1456417	
Timor-Leste	833	833	1473	1359	1272	1578	2082	2409	
Zambia	8905	11052	15364	22683	26642	29741	32797	28624	
Zimbabwe									
Tanzania	18944	22079	25773	28322	38468	21981	26416	29233	
Asia									
Afghanistan	38384	46795	53625	60378	64668	83666	101422	112452	
Bangladesh	88072	97844	106999	120372	130168	155630	181212	204128	
India	1807699	2011695	2287651	2607722	2821652	3450917	3617810	3609047	
Lao PDR	5231	7043	9213	10135	11225	13274	17388	18337	
Myanmar	11673	16051	19676	21655	23201	31177	45022	56319	
Philippines	136244	162870	189982	218850	272537	331185	401564	400987	
Yemen, Rep.	25443	38258	47546	57682	75178	88561	106559	108723	
Vietnam	128200	145104	187832	234071	270131	304817	405995	430297	
ENP									
Egypt, Arab Rep.	308567	247594	255231	290288	317367	382813	458376	548068	
Moldova	5700	7348	9229	12567	17121	22421	31858	29879	
Morocco	158822	192155	215606	215423	231025	247842	300981	326795	
Syrian Arab Republic	52692	54694	56771	57384	66612	74408	92076	108765	
Latin America									
Ecuador	76594	85529	98579	114960	123926	142553	168060	179598	
El Salvador	58570	58020	57860	57740	46810	51680	53720	55740	
Regional									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia									
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries									

Country_Name	***2002***	***2003***	***2004***	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***
(HIPC)									
Least developed countries: UN classification									
Low & middle income									
Middle income									

source: Worldbank July 2011

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

Table 12 Health expenditure, public (% of GDP), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	4.99	4.55	4.50	4.48	4.60	4.45	4.31	4.40	
Burkina Faso	2.20	2.56	3.28	3.98	3.55	3.81	3.51	3.93	
Congo, Dem. Rep.	0.32	1.09	1.45	1.78	2.56	2.60	3.98	4.86	
Ghana	2.36	2.49	2.21	3.06	2.85	4.28	3.88	3.09	
Mozambique	4.50	4.10	3.52	3.95	3.47	3.53	3.50	4.13	
Nigeria	1.00	1.69	2.28	1.93	1.76	1.66	1.90	2.12	
South Africa	3.37	3.50	3.26	3.38	3.41	3.45	3.27	3.41	
Timor-Leste	6.31	7.24	8.35	12.37	14.13	11.09	10.11	8.76	
Zambia	4.23	4.06	3.80	3.85	3.85	3.25	3.64	2.53	
Zimbabwe									
Tanzania	1.57	2.10	1.73	1.89	3.84	3.50	3.26	3.77	
Asia									
Afghanistan	1.46	1.63	2.03	2.12	2.06	1.78	1.58	1.58	
Bangladesh	1.23	1.14	1.21	1.12	1.24	1.19	1.04	1.06	
India	1.19	1.18	0.93	0.93	1.13	1.21	1.35	1.37	
Lao PDR	1.07	1.36	0.78	0.74	0.73	0.76	0.70	0.78	
Myanmar	0.36	0.28	0.31	0.19	0.30	0.23	0.18	0.20	
Philippines	1.18	1.38	1.37	1.43	1.27	1.23	1.27	1.33	
Yemen, Rep.	2.40	2.63	2.02	1.65	1.66	1.58	1.60	1.57	
Vietnam	1.57	1.68	1.52	1.55	2.12	2.79	2.79	2.79	
ENP									
Egypt, Arab Rep.	2.47	2.35	2.21	2.13	2.33	2.03	2.03	2.09	
Moldova	4.04	3.97	4.18	4.18	4.72	4.92	5.39	6.41	
Morocco	1.38	1.39	1.43	1.46	1.71	1.88	1.93	1.89	
Syrian Arab Republic	2.28	2.48	2.15	2.09	1.86	1.37	1.19	0.91	
Latin America									
Ecuador	1.86	1.90	2.12	2.07	2.29	2.28	2.25	2.94	
El Salvador	3.58	3.46	3.57	3.77	4.11	3.68	3.59	3.84	
Regional									
Arab World	2.62	2.62	2.48	2.32	2.39	2.36	2.34	2.77	
East Asia & Pacific (developing only)	1.67	1.75	1.76	1.77	1.81	1.91	2.01	2.22	
Europe & Central Asia (developing only)	3.63	3.64	3.48	3.51	3.57	3.64	3.54	3.95	
Latin America & Caribbean (developing only)	3.15	3.11	3.23	3.26	3.31	3.44	3.60	3.92	
Middle East & North Africa (developing only)	2.39	2.44	2.43	2.43	2.56	2.51	2.67	2.69	
South Asia	1.18	1.14	0.96	0.96	1.14	1.21	1.31	1.32	
Sub-Saharan Africa (developing only)	2.27	2.60	2.63	2.62	2.61	2.64	2.65	2.89	
Income									
Heavily indebted poor countries (HIPC)	2.11	2.22	2.21	2.34	2.50	2.61	2.61	2.59	
Least developed countries: UN classification	1.82	1.94	1.88	1.89	2.12	2.13	2.30	2.50	
Low & middle income	2.40	2.44	2.45	2.49	2.57	2.64	2.72	2.87	
Middle income	2.42	2.45	2.46	2.50	2.57	2.65	2.74	2.89	

source: Worldbank July 2011

Indicator Name	Health expenditure, public (% of GDP)
Short definition	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.
Long definition	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 13 Health expenditure, public (% of government expenditure), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	12.38	12.31	12.34	11.83	12.20	11.83	10.83	10.83	
Burkina Faso	11.94	12.52	15.34	18.66	16.21	14.85	16.26	16.26	
Congo, Dem. Rep.	3.06	10.61	9.44	8.98	12.16	13.82	17.55	16.97	
Ghana	9.05	8.67	6.73	10.01	7.12	10.68	8.54	9.18	
Mozambique	15.42	15.07	13.90	17.25	12.90	12.55	12.55	12.55	
Nigeria	3.11	5.11	7.83	6.41	6.41	6.41	6.41	6.41	
South Africa	11.53	11.17	10.30	10.42	10.71	11.06	10.39	9.27	
Timor-Leste	41.19	35.46	36.65	41.66	25.46	21.30	11.89	9.76	
Zambia	13.61	13.25	14.24	14.74	16.38	13.39	15.29	10.84	
Zimbabwe									
Tanzania	10.10	11.29	8.48	9.27	14.40	18.40	18.04	18.08	
Asia									
Afghanistan	28.48	24.85	29.31	4.08	4.26	3.73	3.67	3.67	
Bangladesh	8.23	7.86	8.17	7.46	8.44	8.41	7.38	7.52	
India	3.50	3.41	2.92	3.19	3.87	4.06	4.41	4.06	
Lao PDR	5.45	7.41	4.04	3.76	3.73	3.73	3.73	3.73	
Myanmar	1.47	1.14	1.25	0.77	1.20	0.93	0.71	0.79	
Philippines	5.04	5.94	6.28	6.80	6.16	6.15	6.13	6.09	
Yemen, Rep.	7.71	7.62	6.24	4.80	4.87	4.30	4.30	4.30	
Vietnam	5.66	5.67	5.06	5.04	6.42	8.68	9.29	8.91	
ENP									
Egypt, Arab Rep.	7.61	7.30	7.01	6.73	6.44	6.20	5.94	5.94	
Moldova	11.80	11.98	11.91	11.28	11.75	11.73	12.97	14.07	
Morocco	5.04	5.04	5.14	4.81	5.93	6.91	6.63	6.96	
Syrian Arab Republic	6.49	6.31	6.06	6.80	4.62	4.62	4.62	4.62	
Latin America									
Ecuador	9.73	8.81	7.78	7.96	7.29	7.41	6.86	8.43	
El Salvador	11.24	14.64	14.87	15.34	15.83	15.57	11.91	12.33	
Regional									
Arab World									
East Asia & Pacific (developing only)	8.50	7.97	8.05						
Europe & Central Asia (developing only)		11.24	11.11		10.81	10.76	10.31	10.00	
Latin America & Caribbean (developing only)	8.85	8.19	8.96						
Middle East & North Africa (developing only)					8.59	8.59	8.64	8.59	
South Asia	3.76	3.63	3.36	3.53	4.14	4.25	4.49	4.16	
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)									
Least developed countries: UN classification									
Low & middle income	8.43	8.21	8.41						
Middle income	8.42	8.49	8.77						

source: Worldbank July 2011

Indicator Name	Health expenditure, public (% of government expenditure)
Short definition	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.
Long definition	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 14 Health expenditure, public (% of total health expenditure), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	68.42	65.54	64.50	64.39	64.72	63.97	63.78	64.27	
Burkina Faso	43.91	46.43	53.68	59.54	56.86	60.27	59.05	61.70	
Congo, Dem. Rep.	8.48	23.86	28.02	33.49	41.22	42.89	54.18	50.95	
Ghana	36.20	37.74	35.23	42.75	46.34	52.99	49.96	45.00	
Mozambique	74.97	72.50	69.35	72.53	70.05	73.15	75.16	73.16	
Nigeria	25.58	22.40	32.69	29.17	31.86	31.36	36.68	36.35	
South Africa	38.69	39.46	36.43	38.30	39.91	40.83	39.66	40.13	
Timor-Leste	72.23	74.47	65.74	76.11	79.65	76.12	73.44	70.98	
Zambia	63.85	61.61	57.30	54.87	60.70	55.77	61.98	52.97	
Zimbabwe									
Tanzania	44.66	49.48	43.18	48.51	58.88	72.83	71.93	73.59	
Asia									
Afghanistan	19.58	19.31	23.38	24.23	26.33	23.60	21.50	21.50	
Bangladesh	39.68	37.65	38.78	34.90	36.49	34.39	31.44	31.73	
India	25.00	25.73	22.51	23.05	27.55	29.58	32.36	32.76	
Lao PDR	27.14	27.02	17.52	17.30	18.55	18.91	17.56	19.13	
Myanmar	15.24	12.33	13.51	8.98	14.37	11.72	8.79	9.72	
Philippines	40.01	40.23	38.53	39.23	35.36	34.77	34.66	34.86	
Yemen, Rep.	51.25	45.81	37.85	33.86	31.59	29.75	30.08	27.96	
Vietnam	30.00	31.36	26.83	25.90	32.33	39.32	38.49	38.66	
ENP									
Egypt, Arab Rep.	40.26	40.37	40.46	40.64	44.18	41.21	42.19	41.72	
Moldova	54.09	51.67	54.07	49.83	48.44	49.13	50.60	53.68	
Morocco	25.97	26.56	27.41	28.68	32.76	36.33	36.29	34.38	
Syrian Arab Republic	45.77	48.25	47.97	50.50	47.75	42.71	38.78	31.05	
Latin America									
Ecuador	37.66	38.92	41.25	40.10	43.60	42.30	42.26	48.41	
El Salvador	46.65	47.27	49.37	52.71	62.08	59.22	59.63	60.43	
Regional									
Arab World	57.84	59.60	59.87	60.75	62.28	61.32	61.82	61.42	
East Asia & Pacific (developing only)	38.56	39.18	40.00	40.62	42.47	46.76	48.24	50.37	
Europe & Central Asia (developing only)	62.41	64.00	63.29	63.38	63.70	64.15	65.44	66.02	
Latin America & Caribbean (developing only)	48.79	48.18	49.47	47.20	47.63	48.52	50.28	51.68	
Middle East & North Africa (developing only)	45.29	47.27	48.25	48.47	51.27	50.78	53.01	50.70	
South Asia	26.48	26.42	24.09	24.45	28.71	30.32	32.60	32.92	
Sub-Saharan Africa (developing only)	38.93	38.38	38.51	39.27	40.96	41.73	42.85	43.89	
Income									
Heavily indebted poor countries (HIPC)	40.75	42.19	41.29	43.41	43.65	43.16	42.74	41.99	
Least developed countries: UN classification	40.71	41.86	40.37	41.42	43.39	43.24	44.83	45.92	
Low & middle income	45.10	45.38	46.14	46.08	47.60	49.45	51.15	51.77	
Middle income	45.22	45.48	46.28	46.20	47.73	49.62	51.36	52.03	

source: Worldbank July 2011

Indicator Name	Health expenditure, public (% of total health expenditure)
Short definition	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds. Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.
Long definition	Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds. Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	In some cases, the sum of public and private expenditures on health may not add up to 100% because of rounding. All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 15 Health expenditure, total (% of GDP), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	7.29	6.95	6.98	6.96	7.11	6.96	6.75	6.84	
Burkina Faso	5.01	5.52	6.11	6.69	6.25	6.33	5.94	6.37	
Congo, Dem. Rep.	3.73	4.57	5.17	5.33	6.20	6.05	7.34	9.54	
Ghana	6.52	6.59	6.27	7.15	6.15	8.07	7.77	6.87	
Mozambique	6.00	5.65	5.08	5.45	4.96	4.83	4.66	5.65	
Nigeria	3.91	7.55	6.96	6.60	5.52	5.29	5.18	5.82	
South Africa	8.72	8.86	8.94	8.81	8.53	8.45	8.24	8.51	
Timor-Leste	8.74	9.72	12.69	16.25	17.74	14.58	13.77	12.35	
Zambia	6.63	6.58	6.63	7.02	6.33	5.83	5.87	4.77	
Zimbabwe									
Tanzania	3.51	4.25	4.00	3.89	6.53	4.81	4.53	5.12	
Asia									
Afghanistan	7.47	8.45	8.69	8.76	7.84	7.56	7.36	7.36	
Bangladesh	3.09	3.04	3.12	3.21	3.40	3.46	3.32	3.35	
India	4.77	4.58	4.13	4.03	4.12	4.10	4.17	4.17	
Lao PDR	3.93	5.02	4.45	4.27	3.95	4.00	3.99	4.06	
Myanmar	2.37	2.28	2.28	2.12	2.06	1.95	2.01	2.02	
Philippines	2.96	3.42	3.56	3.65	3.59	3.52	3.68	3.82	
Yemen, Rep.	4.67	5.74	5.33	4.88	5.26	5.31	5.31	5.63	
Vietnam	5.22	5.34	5.67	5.97	6.55	7.11	7.25	7.21	
ENP									
Egypt, Arab Rep.	6.13	5.82	5.47	5.25	5.28	4.93	4.81	5.02	
Moldova	7.47	7.68	7.73	8.38	9.74	10.01	10.65	11.94	
Morocco	5.31	5.25	5.22	5.07	5.23	5.18	5.32	5.50	
Syrian Arab Republic	4.97	5.15	4.49	4.14	3.90	3.21	3.06	2.93	
Ecuador	4.93	4.89	5.14	5.16	5.26	5.40	5.32	6.08	
Latin America									
El Salvador	7.67	7.31	7.23	7.15	6.62	6.22	6.02	6.35	
Arab World	4.55	4.43	4.14	3.80	3.84	3.84	3.79	4.65	
Regional									
East Asia & Pacific (developing only)	4.36	4.48	4.41	4.37	4.27	4.09	4.16	4.40	
Europe & Central Asia (developing only)	5.82	5.69	5.50	5.54	5.61	5.68	5.41	5.97	
Latin America & Caribbean (developing only)	6.42	6.46	6.52	6.90	6.95	7.10	7.17	7.75	
Middle East & North Africa (developing only)	5.28	5.20	5.04	5.02	4.99	4.93	5.05	5.35	
South Asia	4.46	4.31	3.99	3.90	3.98	3.97	4.01	4.02	
Sub-Saharan Africa (developing only)	5.84	6.76	6.84	6.68	6.35	6.31	6.13	6.61	
Income									
Heavily indebted poor countries (HIPC)	5.13	5.21	5.32	5.36	5.66	5.92	6.00	6.12	
Least developed countries: UN classification	4.40	4.52	4.55	4.46	4.77	4.81	4.97	5.38	
Low & middle income	5.33	5.38	5.31	5.41	5.39	5.34	5.32	5.59	
Middle income	5.34	5.40	5.33	5.42	5.39	5.34	5.32	5.60	

source: Worldbank July 2011

Indicator Name	Health expenditure, total (% of GDP)
Short definition	Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.
Long definition	Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 16 Health expenditure, total (current US$), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	181	187	197	209	227	237	249	266	
Burkina Faso	165	236	312	376	383	449	567	600	
Congo, Dem. Rep.	207	259	336	378	530	603	856	1029	
Ghana	402	503	557	767	924	1212	1295	1074	
Mozambique	252	264	289	358	352	388	460	566	
Nigeria	2312	5105	6113	7411	8214	8769	11105	10722	
South Africa	9688	14900	19587	21774	22271	24187	22782	24325	
Timor-Leste	30	33	43	57	63	66	78	83	
Zambia	246	288	360	503	678	672	863	609	
Zimbabwe									
Tanzania	342	437	454	550	936	809	941	1107	
Asia									
Afghanistan	477	580	700	797	878	1095	1292	1432	
Bangladesh	1460	1569	1748	1849	2050	2372	2643	2990	
India	24103	27087	29520	33888	38944	49003	53485	53674	
Lao PDR	72	97	112	123	138	164	211	227	
Myanmar	138	183	227	238	271	353	494	624	
Philippines	2271	2725	3091	3601	4216	5077	6146	6156	
Yemen, Rep.	522	706	765	872	1099	1261	1524	1509	
Vietnam	1831	2114	2567	3159	3992	5024	6600	7015	
ENP									
Egypt, Arab Rep.	5165	4152	4287	4891	5686	6512	7930	9404	
Moldova	124	152	201	250	332	441	645	645	
Morocco	2146	2617	2970	3021	3436	3893	4724	4980	
Syrian Arab Republic	972	1057	1091	1159	1275	1299	1504	1577	
Latin America									
Ecuador	1229	1400	1678	1919	2197	2471	2911	3481	
El Salvador	1098	1100	1143	1221	1235	1267	1331	1409	
Regional									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia									
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)									
Least developed countries: UN classification									
Low & middle income									

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Middle income									

source: Worldbank July 2011

Indicator Name	Health expenditure, total (current US$)
Short definition	Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.
Long definition	Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 17 Hospital beds (per 1,000 people), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados		7.30	7.30	6.70	6.60		7.60		
Burkina Faso					0.90				
Congo, Dem. Rep.				1.10	0.80				
Ghana				0.90				0.93	
Mozambique					0.80	0.80			
Nigeria			0.53						
South Africa				2.84					
Timor-Leste									
Zambia			2.00				1.90		
Zimbabwe					3.00				
Tanzania					1.10				
Asia									
Afghanistan		0.40				0.42	0.42	0.40	
Bangladesh	0.34			0.40					
India	0.69	0.90		0.90					
Lao PDR	0.90			1.20					
Myanmar	0.63				0.60				
Philippines	0.50				0.50				
Yemen, Rep.				0.60	0.70	0.70	0.70	0.70	
Vietnam	1.40		2.80	2.60	2.66		2.87		
ENP									
Egypt, Arab Rep.		2.20		2.20	2.10	2.08		1.70	
Moldova		6.70		6.40	6.30	6.12			
Morocco	0.80		0.90		0.87	1.10		1.10	
Syrian Arab Republic		1.50	1.30		1.40	1.47	1.54	1.50	
Latin America									
Ecuador	1.50	1.70					1.50		
El Salvador				0.90	0.90	0.70	0.80	1.10	
Regional									
Arab World					1.50	1.54			
East Asia & Pacific (developing only)	2.18	2.20	2.96	2.44	2.11			4.02	
Europe & Central Asia (developing only)		7.63		7.19	7.31				
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)				1.76	1.58				
South Asia	0.68	0.87		0.88					
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)									
Least developed countries: UN classification									
Low & middle income	1.65			2.25					
Middle income	1.64	2.25		2.40					

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

Indicator Name	Hospital beds (per 1,000 people)
Short definition	Hospital beds include inpatient beds available in public, private, general, and specialized hospitals and rehabilitation centers. In most cases beds for both acute and chronic care are included.
Long definition	Hospital beds include inpatient beds available in public, private, general, and specialized hospitals and rehabilitation centers. In most cases beds for both acute and chronic care are included.
Source	World Health Organization, OECD, supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 18 Immunization, BCG (% of one-year-old children), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso	81.00	85.00	88.00	92.00	92.00	92.00	92.00	92.00	
Congo, Dem. Rep.	50.00	61.00	68.00	72.00	72.00	79.00	74.00	80.00	
Ghana	92.00	92.00	92.00	99.00	99.00	99.00	99.00	99.00	
Mozambique	87.00	87.00	87.00	87.00	87.00	87.00	87.00	87.00	
Nigeria	38.00	42.00	45.00	49.00	52.00	53.00	53.00	53.00	
South Africa	84.00	81.00	81.00	81.00	81.00	81.00	81.00	81.00	
Timor-Leste	75.00	72.00	72.00	70.00	72.00	74.00	85.00	71.00	
Zambia	94.00	93.00	93.00	92.00	92.00	92.00	92.00	92.00	
Zimbabwe	81.00	79.00	78.00	76.00	81.00	86.00	91.00	91.00	
Tanzania	88.00	91.00	91.00	91.00	90.00	89.00	89.00	93.00	
Asia									
Afghanistan	59.00	56.00	65.00	73.00	77.00	77.00	85.00	82.00	
Bangladesh	95.00	95.00	92.00	96.00	98.00	98.00	98.00	99.00	
India	75.00	80.00	81.00	81.00	87.00	87.00	87.00	87.00	
Lao PDR	65.00	65.00	60.00	65.00	61.00	56.00	68.00	67.00	
Myanmar	82.00	80.00	85.00	76.00	85.00	89.00	88.00	93.00	
Philippines	85.00	86.00	91.00	91.00	91.00	90.00	93.00	90.00	
Yemen, Rep.	76.00	68.00	65.00	66.00	67.00	64.00	60.00	58.00	
Vietnam	97.00	97.00	96.00	95.00	95.00	94.00	92.00	97.00	
ENP									
Egypt, Arab Rep.	98.00	98.00	98.00	98.00	99.00	98.00	98.00	98.00	
Moldova	99.00	99.00	99.00	99.00	99.00	99.00	99.00	96.00	
Morocco	92.00	92.00	95.00	95.00	95.00	96.00	99.00	99.00	
Syrian Arab Republic	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	
Latin America									
Ecuador	99.00	99.00	99.00	99.00	99.00	99.00	99.00	99.00	
El Salvador	92.00	91.00	94.00	84.00	93.00	99.00	99.00	87.00	
Regional									
Arab World	86.58	87.00	85.93	87.52	88.68	89.21	88.57	87.79	
East Asia & Pacific (developing only)	84.79	85.30	87.10	86.98	91.32	92.45	94.68	95.52	
Europe & Central Asia (developing only)	94.59	94.68	92.87	92.56	94.69	95.63	96.28	95.66	
Latin America & Caribbean (developing only)	95.67	96.70	96.51	96.61	96.53	96.28	96.80	94.34	
Middle East & North Africa (developing only)	92.06	92.36	92.27	93.04	93.65	93.02	92.89	92.59	
South Asia	77.89	81.40	81.82	82.70	88.28	88.18	88.51	88.50	
Sub-Saharan Africa (developing only)	68.83	70.70	72.07	74.12	76.33	78.47	78.36	77.83	
Income									
Heavily indebted poor countries (HIPC)	73.87	76.24	77.40	80.08	81.82	83.55	84.37	84.16	
Least developed countries: UN classification	76.51	77.64	78.50	80.29	82.73	84.19	84.77	84.54	
Low & middle income	81.07	82.77	83.50	84.21	87.63	88.32	88.98	88.75	
Middle income	81.66	83.50	84.28	84.68	88.36	89.08	89.84	89.68	

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

Indicator Name	Immunization, BCG (% of one-year-old children)
Short definition	Child immunization rate, BCG is the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey for BCG. A child is considered adequately immunized after one dose.
Long definition	Child immunization rate, BCG is the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey for BCG. A child is considered adequately immunized after one dose.
Source	WHO and UNICEF (http://www.who.int/immunization_monitoring/routine/en/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 19 Immunization, DPT (% of children ages 12-23 months, 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	87.00	89.00	93.00	92.00	84.00	93.00	85.00	93.00	
Burkina Faso	61.00	68.00	75.00	82.00	82.00	82.00	82.00	82.00	
Congo, Dem. Rep.	38.00	41.00	54.00	60.00	62.00	72.00	68.00	77.00	
Ghana	80.00	80.00	80.00	84.00	84.00	94.00	87.00	94.00	
Mozambique	76.00	76.00	76.00	76.00	76.00	76.00	76.00	76.00	
Nigeria	25.00	29.00	33.00	36.00	40.00	42.00	42.00	42.00	
South Africa	70.00	69.00	69.00	69.00	69.00	69.00	69.00	69.00	
Timor-Leste	54.00	55.00	57.00	55.00	67.00	70.00	79.00	72.00	
Zambia	84.00	83.00	83.00	82.00	81.00	81.00	81.00	81.00	
Zimbabwe	73.00	70.00	68.00	65.00	68.00	72.00	75.00	73.00	
Tanzania	89.00	95.00	95.00	90.00	90.00	83.00	86.00	85.00	
Asia									
Afghanistan	48.00	54.00	66.00	76.00	77.00	83.00	85.00	83.00	
Bangladesh	86.00	87.00	99.00	93.00	94.00	94.00	94.00	94.00	
India	58.00	61.00	64.00	67.00	66.00	66.00	66.00	66.00	
Lao PDR	53.00	49.00	45.00	49.00	57.00	57.00	57.00	57.00	
Myanmar	79.00	78.00	82.00	73.00	82.00	86.00	85.00	90.00	
Philippines	79.00	84.00	88.00	89.00	88.00	87.00	91.00	87.00	
Yemen, Rep.	53.00	48.00	59.00	65.00	65.00	67.00	67.00	66.00	
Vietnam	75.00	99.00	96.00	95.00	94.00	92.00	93.00	96.00	
ENP									
Egypt, Arab Rep.	97.00	98.00	97.00	98.00	98.00	98.00	97.00	97.00	
Moldova	97.00	98.00	98.00	98.00	97.00	96.00	95.00	85.00	
Morocco	94.00	91.00	97.00	98.00	97.00	95.00	99.00	99.00	
Syrian Arab Republic	83.00	82.00	81.00	80.00	80.00	80.00	80.00	80.00	
Latin America									
Ecuador	76.00	75.00	75.00	75.00	75.00	75.00	75.00	75.00	
El Salvador	81.00	94.00	90.00	89.00	96.00	99.00	98.00	91.00	
Regional									
Arab World	80.27	80.76	81.89	83.28	83.77	84.90	84.87	84.35	
East Asia & Pacific (developing only)	82.00	83.99	84.91	84.85	88.65	89.10	92.35	93.22	
Europe & Central Asia (developing only)	90.71	87.38	92.33	94.53	94.45	95.52	95.35	95.36	
Latin America & Caribbean (developing only)	90.99	91.64	91.58	92.45	92.90	93.05	91.38	91.79	
Middle East & North Africa (developing only)	87.07	86.26	87.07	87.28	88.47	88.67	88.51	88.37	
South Asia	62.50	64.94	68.41	72.01	72.09	72.13	70.88	72.41	
Sub-Saharan Africa (developing only)	55.72	58.24	62.19	64.68	66.64	69.35	69.43	70.23	
Income									
Heavily indebted poor countries (HIPC)	61.20	64.70	69.60	72.66	73.99	76.00	76.83	77.94	
Least developed countries: UN classification	63.84	66.63	72.91	73.67	75.49	77.83	78.58	79.05	
Low & middle income	71.73	73.32	75.70	77.50	78.99	79.81	80.06	80.95	
Middle income	73.04	74.59	76.13	78.23	79.54	80.22	80.51	81.30	

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

Indicator Name	Immunization, DPT (% of children ages 12-23 months)
Short definition	Child immunization measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized against diphtheria, pertussis (or whooping cough), and tetanus (DPT) after receiving three doses of vaccine.
Long definition	Child immunization measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized against diphtheria, pertussis (or whooping cough), and tetanus (DPT) after receiving three doses of vaccine.
Source	WHO and UNICEF (http://www.who.int/immunization_monitoring/routine/en/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 20 Immunization, HepB3 (% of one-year-old children), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	66.00	91.00	93.00	92.00	84.00	93.00	85.00	93.00	
Burkina Faso					76.00	81.00	81.00	81.00	
Congo, Dem. Rep.						72.00	68.00	77.00	
Ghana	80.00	80.00	80.00	84.00	84.00	94.00	87.00	94.00	
Mozambique	72.00	72.00	72.00	72.00	72.00	72.00	72.00	72.00	
Nigeria				18.00	27.00	42.00	41.00	41.00	
South Africa	68.00	67.00	67.00	67.00	67.00	67.00	67.00	67.00	
Timor-Leste							79.00	72.00	
Zambia				82.00	80.00	80.00	80.00	80.00	
Zimbabwe	73.00	70.00	67.00	64.00	68.00	71.00	75.00	73.00	
Tanzania	89.00	95.00	95.00	90.00	90.00	83.00	86.00	85.00	
Asia									
Afghanistan						83.00	85.00	83.00	
Bangladesh		5.00	11.00	44.00	83.00	95.00	95.00	95.00	
India			6.00	8.00	6.00	6.00	21.00	21.00	
Lao PDR		50.00	45.00	49.00	57.00	50.00	61.00	67.00	
Myanmar		8.00	39.00	62.00	75.00	85.00	84.00	90.00	
Philippines	42.00	52.00	48.00	49.00	77.00	87.00	88.00	85.00	
Yemen, Rep.	24.00	29.00	32.00	66.00	65.00	67.00	67.00	66.00	
Vietnam		78.00	94.00	94.00	93.00	67.00	87.00	94.00	
ENP									
Egypt, Arab Rep.	97.00	98.00	97.00	98.00	98.00	98.00	97.00	97.00	
Moldova	99.00	99.00	99.00	99.00	99.00	98.00	98.00	89.00	
Morocco	92.00	90.00	95.00	96.00	95.00	95.00	97.00	98.00	
Syrian Arab Republic	77.00	77.00	77.00	77.00	77.00	77.00	77.00	77.00	
Latin America									
Ecuador	85.00	58.00	75.00	75.00	75.00	75.00	75.00	75.00	
El Salvador	81.00	94.00	90.00	89.00	96.00	99.00	98.00	91.00	
Regional									
Arab World	80.27	80.51	81.05	75.08	80.69	84.28	84.58	84.13	
East Asia & Pacific (developing only)	68.06	70.01	74.76	78.66	85.48	86.63	90.72	91.74	
Europe & Central Asia (developing only)	74.52	83.09	88.97	91.29	91.43	94.58	92.40	92.82	
Latin America & Caribbean (developing only)	88.02	88.14	90.13	91.50	93.31	93.24	86.66	88.69	
Middle East & North Africa (developing only)	81.82	82.24	81.92	85.46	85.81	86.54	87.04	86.99	
South Asia			15.11	21.82	26.33	29.58	39.06	40.67	
Sub-Saharan Africa (developing only)				57.95	64.32	70.13	68.66	69.94	
Income									
Heavily indebted poor countries (HIPC)						78.18	76.91	78.29	
Least developed countries: UN classification					78.31	79.82	78.90	79.57	
Low & middle income		70.46	56.36	58.63	63.49	66.08	69.14	70.46	
Middle income		76.52	56.48	57.04	60.42	62.37	66.47	67.63	

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

Indicator Name	Immunization, HepB3 (% of one-year-old children)
Short definition	Child immunization rate, hepatitis B is the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized after three doses.
Long definition	Child immunization rate, hepatitis B is the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized after three doses.
Source	WHO and UNICEF (http://www.who.int/immunization_monitoring/routine/en/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 21 Immunization, measles (% of children ages 12-23 months), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	91.00	90.00	98.00	93.00	92.00	75.00	94.00	94.00	
Burkina Faso	56.00	62.00	69.00	75.00	75.00	75.00	75.00	75.00	
Congo, Dem. Rep.	42.00	49.00	57.00	61.00	63.00	69.00	67.00	76.00	
Ghana	81.00	80.00	83.00	83.00	85.00	95.00	86.00	93.00	
Mozambique	77.00	77.00	77.00	77.00	77.00	77.00	77.00	77.00	
Nigeria	30.00	34.00	37.00	41.00	44.00	41.00	41.00	41.00	
South Africa	65.00	62.00	62.00	62.00	62.00	62.00	62.00	62.00	
Timor-Leste	56.00	55.00	55.00	48.00	64.00	63.00	73.00	70.00	
Zambia	84.00	84.00	85.00	85.00	85.00	85.00	85.00	85.00	
Zimbabwe	72.00	70.00	68.00	66.00	67.00	69.00	70.00	76.00	
Tanzania	89.00	97.00	94.00	91.00	93.00	90.00	88.00	91.00	
Asia									
Afghanistan	44.00	50.00	61.00	64.00	68.00	70.00	75.00	76.00	
Bangladesh	77.00	76.00	74.00	88.00	78.00	89.00	89.00	89.00	
India	56.00	59.00	61.00	64.00	71.00	71.00	71.00	71.00	
Lao PDR	55.00	42.00	36.00	41.00	48.00	40.00	52.00	59.00	
Myanmar	77.00	76.00	78.00	72.00	78.00	81.00	82.00	87.00	
Philippines	82.00	87.00	92.00	92.00	92.00	92.00	92.00	88.00	
Yemen, Rep.	54.00	56.00	65.00	65.00	57.00	63.00	62.00	58.00	
Vietnam	96.00	93.00	97.00	95.00	93.00	83.00	92.00	97.00	
ENP									
Egypt, Arab Rep.	97.00	98.00	97.00	98.00	98.00	97.00	92.00	95.00	
Moldova	94.00	96.00	96.00	97.00	97.00	95.00	94.00	90.00	
Morocco	94.00	90.00	95.00	97.00	95.00	95.00	96.00	98.00	
Syrian Arab Republic	82.00	82.00	81.00	81.00	81.00	81.00	81.00	81.00	
Latin America									
Ecuador	68.00	66.00	66.00	66.00	66.00	66.00	66.00	66.00	
El Salvador	93.00	90.00	93.00	99.00	98.00	99.00	95.00	95.00	
Regional									
Arab World	80.43	80.90	81.66	81.70	82.03	83.27	81.41	82.26	
East Asia & Pacific (developing only)	83.10	83.69	85.29	85.14	89.76	90.29	91.29	91.38	
Europe & Central Asia (developing only)	92.03	90.03	92.38	95.22	96.73	96.24	96.14	95.62	
Latin America & Caribbean (developing only)	92.54	93.50	92.98	92.67	92.47	92.03	93.63	93.11	
Middle East & North Africa (developing only)	87.28	87.14	87.17	86.85	87.64	87.64	86.05	86.70	
South Asia	59.40	61.47	63.67	68.75	73.33	74.38	75.15	74.51	
Sub-Saharan Africa (developing only)	55.72	58.29	61.13	62.52	64.95	67.01	66.79	68.41	
Income									
Heavily indebted poor countries (HIPC)	59.87	63.46	66.89	68.89	70.96	72.92	73.42	75.68	
Least developed countries: UN classification	61.95	64.32	67.03	69.73	70.46	74.62	74.97	76.72	
Low & middle income	71.28	72.53	74.22	76.08	79.27	80.10	80.53	80.69	
Middle income	73.04	74.17	75.68	77.35	81.14	81.38	81.87	81.53	

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

Indicator Name	Immunization, measles (% of children ages 12-23 months)
Short definition	Child immunization measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized against measles after receiving one dose of vaccine.
Long definition	Child immunization measures the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized against measles after receiving one dose of vaccine.
Source	WHO and UNICEF (http://www.who.int/immunization_monitoring/routine/en/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 22 Immunization, Pol3 (% of one-year-old children), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	86.00	90.00	93.00	91.00	85.00	93.00	85.00	93.00	
Burkina Faso	70.00	75.00	79.00	84.00	84.00	84.00	84.00	84.00	
Congo, Dem. Rep.	40.00	47.00	52.00	60.00	62.00	71.00	61.00	74.00	
Ghana	80.00	80.00	81.00	85.00	84.00	94.00	86.00	94.00	
Mozambique	75.00	75.00	75.00	75.00	75.00	75.00	75.00	75.00	
Nigeria	40.00	42.00	43.00	45.00	46.00	54.00	54.00	54.00	
South Africa	70.00	70.00	70.00	70.00	70.00	70.00	70.00	70.00	
Timor-Leste	38.00	55.00	57.00	55.00	66.00	70.00	79.00	78.00	
Zambia	85.00	85.00	84.00	84.00	83.00	83.00	83.00	83.00	
Zimbabwe	74.00	72.00	69.00	67.00	70.00	72.00	75.00	69.00	
Tanzania	91.00	97.00	95.00	91.00	91.00	88.00	89.00	88.00	
Asia									
Afghanistan	48.00	54.00	66.00	76.00	77.00	83.00	85.00	83.00	
Bangladesh	89.00	90.00	79.00	85.00	92.00	93.00	93.00	94.00	
India	57.00	58.00	60.00	55.00	67.00	67.00	67.00	67.00	
Lao PDR	55.00	52.00	46.00	50.00	56.00	46.00	60.00	67.00	
Myanmar	78.00	77.00	82.00	73.00	82.00	84.00	85.00	90.00	
Philippines	77.00	85.00	85.00	90.00	88.00	87.00	91.00	86.00	
Yemen, Rep.	51.00	48.00	58.00	65.00	64.00	66.00	66.00	65.00	
Vietnam	92.00	96.00	96.00	94.00	94.00	92.00	93.00	97.00	
ENP									
Egypt, Arab Rep.	97.00	98.00	97.00	98.00	98.00	98.00	97.00	97.00	
Moldova	98.00	98.00	98.00	99.00	98.00	97.00	97.00	87.00	
Morocco	94.00	91.00	97.00	98.00	97.00	95.00	99.00	99.00	
Syrian Arab Republic	85.00	84.00	84.00	83.00	83.00	83.00	83.00	83.00	
Latin America									
Ecuador	73.00	72.00	72.00	72.00	72.00	72.00	72.00	72.00	
El Salvador	81.00	93.00	90.00	89.00	96.00	99.00	98.00	91.00	
Regional									
Arab World	80.78	81.42	82.40	83.91	84.18	85.45	84.91	84.68	
East Asia & Pacific (developing only)	84.43	85.97	86.14	86.04	90.32	90.56	95.78	95.59	
Europe & Central Asia (developing only)	91.18	87.29	93.26	94.61	94.52	95.96	95.62	95.91	
Latin America & Caribbean (developing only)	92.06	93.11	91.93	92.51	93.19	92.77	93.13	91.17	
Middle East & North Africa (developing only)	87.66	87.04	87.70	88.01	89.27	89.11	89.06	88.90	
South Asia	62.46	63.29	63.53	62.84	72.64	72.74	72.55	73.12	
Sub-Saharan Africa (developing only)	59.72	62.15	64.26	65.98	67.15	71.19	69.95	71.66	
Income									
Heavily indebted poor countries (HIPC)	62.97	66.43	69.82	72.44	73.30	75.76	74.56	77.14	
Least developed countries: UN classification	65.34	68.23	69.83	72.15	74.78	77.37	76.89	78.57	
Low & middle income	73.40	74.38	75.08	75.31	79.79	80.82	81.76	82.11	
Middle income	74.58	75.36	76.07	75.87	80.74	81.69	83.05	82.97	

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

Indicator Name	Immunization, Pol3 (% of one-year-old children)
Short definition	Child immunization rate, Polio is the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized after three doses.
Long definition	Child immunization rate, Polio is the percentage of children ages 12-23 months who received vaccinations before 12 months or at any time before the survey. A child is considered adequately immunized after three doses.
Source	WHO and UNICEF (http://www.who.int/immunization_monitoring/routine/en/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 23 Improved sanitation facilities (% of population with access), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	99.00		100.00	100.00			100.00		
Burkina Faso				11.00			11.00		
Congo, Dem. Rep.				20.00			23.00		
Ghana				11.00			13.00		
Mozambique				15.00			17.00		
Nigeria				32.00			32.00		
South Africa				75.00			77.00		
Timor-Leste				44.00			50.00		
Zambia				47.00			49.00		
Zimbabwe				44.00			44.00		
Tanzania				24.00			24.00		
Asia									
Afghanistan				35.00			37.00		
Bangladesh				50.00			53.00		
India				28.00			31.00		
Lao PDR				43.00			53.00		
Myanmar				81.00			81.00		
Philippines				73.00			76.00		
Yemen, Rep.				46.00			52.00		
Vietnam				68.00			75.00		
ENP									
Egypt, Arab Rep.				93.00			94.00		
Moldova				79.00			79.00		
Morocco				68.00			69.00		
Syrian Arab Republic				93.00			96.00		
Latin America									
Ecuador				90.00			92.00		
El Salvador				85.00			87.00		
Regional									
Arab World				74.58			75.52		
East Asia & Pacific (developing only)				56.68			59.01		
Europe & Central Asia (developing only)				88.65			89.09		
Latin America & Caribbean (developing only)				78.27			79.31		
Middle East & North Africa (developing only)				82.97			84.26		
South Asia				32.60			35.71		
Sub-Saharan Africa (developing only)				30.27			31.31		
Income									
Heavily indebted poor countries (HIPC)				26.13			27.38		
Least developed countries: UN classification				34.77			36.54		
Low & middle income				51.95			53.59		
Middle income				54.94			56.72		

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

Indicator Name	Improved sanitation facilities (% of population with access)
Short definition	Access to improved sanitation facilities refers to the percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.
Long definition	Access to improved sanitation facilities refers to the percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.
Source	World Health Organization and United Nations Children's Fund, Joint Measurement Programme (JMP) (http://www.wssinfo.org/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 24 Improved sanitation facilities, rural (% of rural population with access), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	100.00		100.00	100.00			100.00		
Burkina Faso				6.00			6.00		
Congo, Dem. Rep.				19.00			23.00		
Ghana				6.00			7.00		
Mozambique				4.00			4.00		
Nigeria				29.00			28.00		
South Africa				64.00			65.00		
Timor-Leste				35.00			40.00		
Zambia				41.00			43.00		
Zimbabwe				37.00			37.00		
Tanzania				22.00			21.00		
Asia									
Afghanistan				29.00			30.00		
Bangladesh				48.00			52.00		
India				18.00			21.00		
Lao PDR				30.00			38.00		
Myanmar				79.00			79.00		
Philippines				65.00			69.00		
Yemen, Rep.				29.00			33.00		
Vietnam				61.00			67.00		
ENP									
Egypt, Arab Rep.				90.00			92.00		
Moldova				74.00			74.00		
Morocco				50.00			52.00		
Syrian Arab Republic				90.00			95.00		
Latin America									
Ecuador				81.00			84.00		
El Salvador				79.00			83.00		
Regional									
Arab World				61.15			63.06		
East Asia & Pacific (developing only)				51.88			54.24		
Europe & Central Asia (developing only)				79.10			80.20		
Latin America & Caribbean (developing only)				51.85			54.48		
Middle East & North Africa (developing only)				73.14			75.70		
South Asia				23.38			26.55		
Sub-Saharan Africa (developing only)				23.52			24.13		
Income									
Heavily indebted poor countries (HIPC)				20.67			21.67		
Least developed countries: UN classification				29.66			31.20		
Low & middle income				39.35			41.28		
Middle income				41.29			43.41		

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

Indicator Name	Improved sanitation facilities, rural (% of rural population with access)
Short definition	Access to improved sanitation facilities refers to the percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.
Long definition	Access to improved sanitation facilities refers to the percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.
Source	World Health Organization and United Nations Children's Fund, Joint Measurement Programme (JMP) (http://www.wssinfo.org/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 25 Improved sanitation facilities, urban (% of urban population with access), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	99.00		99.00	100.00			100.00		
Burkina Faso				32.00			33.00		
Congo, Dem. Rep.				23.00			23.00		
Ghana				17.00			18.00		
Mozambique				37.00			38.00		
Nigeria				36.00			36.00		
South Africa				83.00			84.00		
Timor-Leste				68.00			76.00		
Zambia				59.00			59.00		
Zimbabwe				57.00			56.00		
Tanzania				31.00			32.00		
Asia									
Afghanistan				56.00			60.00		
Bangladesh				57.00			56.00		
India				54.00			54.00		
Lao PDR				77.00			86.00		
Myanmar				86.00			86.00		
Philippines				78.00			80.00		
Yemen, Rep.				89.00			94.00		
Vietnam				88.00			94.00		
ENP									
Egypt, Arab Rep.				97.00			97.00		
Moldova				85.00			85.00		
Morocco				83.00			83.00		
Syrian Arab Republic				96.00			96.00		
Latin America									
Ecuador				95.00			96.00		
El Salvador				89.00			89.00		
Regional									
Arab World				88.54			88.52		
East Asia & Pacific (developing only)				63.86			64.37		
Europe & Central Asia (developing only)				94.03			94.02		
Latin America & Caribbean (developing only)				85.88			86.29		
Middle East & North Africa (developing only)				91.51			91.75		
South Asia				56.85			56.88		
Sub-Saharan Africa (developing only)				43.23			43.44		
Income									
Heavily indebted poor countries (HIPC)				38.89			39.20		
Least developed countries: UN classification				49.09			49.72		
Low & middle income				69.17			68.88		
Middle income				71.58			71.38		

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

Indicator Name	Improved sanitation facilities, urban (% of urban population with access)
Short definition	Access to improved sanitation facilities refers to the percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.
Long definition	Access to improved sanitation facilities refers to the percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.
Source	World Health Organization and United Nations Children's Fund, Joint Measurement Programme (JMP) (http://www.wssinfo.org/).
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 26 Maternal mortality ratio (modeled estimate, per 100,000 live births), 2002-2010

Country_Name		2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP										
Barbados	BRB				62.00			64.00		
Burkina Faso	BFA				600.00			560.00		
Congo, Dem. Rep.	ZAR				740.00			670.00		
Ghana	GHA				400.00			350.00		
Mozambique	MOZ				640.00			550.00		
Nigeria	NGA				900.00			840.00		
South Africa	ZAF				440.00			410.00		
Timor-Leste	TMP				420.00			370.00		
Zambia	ZMB				560.00			470.00		
Zimbabwe	ZWE				830.00			790.00		
Tanzania	TZA				860.00			790.00		
Asia										
Afghanistan	AFG				1500.00			1400.00		
Bangladesh	BGD				420.00			340.00		
India	IND				280.00			230.00		
Lao PDR	LAO				650.00			580.00		
Myanmar	MMR				250.00			240.00		
Philippines	PHL				110.00			94.00		
Yemen, Rep.	YEM				250.00			210.00		
Vietnam	VNM				66.00			56.00		
ENP										
Egypt, Arab Rep.	EGY				90.00			82.00		
Moldova	MDA				25.00			32.00		
Morocco	MAR				130.00			110.00		
Syrian Arab Republic	SYR				50.00			46.00		
Latin America										
Ecuador	ECU				140.00			140.00		
El Salvador	SLV				120.00			110.00		
Regional										
Arab World	ARB				250.00			240		
East Asia & Pacific (developing only)	EAP				100.00			88.73		
Europe & Central Asia (developing only)	ECA				35.63			32.00		
Latin America & Caribbean (developing only)	LAC				90.71			85.53		
Middle East & North Africa (developing only)	MNA				98.18			87.55		
South Asia	SAS				330.00			290.00		
Sub-Saharan Africa (developing only)	SSA				710.00			650.00		
Income										
Heavily indebted poor countries (HIPC)	HPC				710.00			640.00		
Least developed countries: UN classification	LDC				650.00			590.00		
Low & middle income	LMY				320.00			290.00		

Middle income	MIC				230.00			200.00		

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

Indicator Name	Maternal mortality ratio (modeled estimate, per 100,000 live births)
Short definition	Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births. The data are estimated with a regression model using information on fertility, birth attendants, and HIV prevalence.
Long definition	Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births. The data are estimated with a regression model using information on fertility, birth attendants, and HIV prevalence.
Source	Trends in Maternal Mortality: 1990-2008. Estimates Developed by WHO, UNICEF, UNFPA and the World Bank.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 27 Maternal mortality ratio (national estimate, per 100,000 live births), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso					307.30				
Congo, Dem. Rep.						549.00			
Ghana						451.00			
Mozambique		408.00							
Nigeria							545.00		
South Africa		165.50							
Timor-Leste									
Zambia						591.00			
Zimbabwe	1100.00				555.00				
Tanzania				578.00					
Asia									
Afghanistan	1600.00								
Bangladesh						351.00	348.00		
India		301.00			254.00				
Lao PDR				405.00					
Myanmar				316.00					
Philippines					162.00				
Yemen, Rep.		365.00							
Vietnam					162.00		75.00		
ENP									
Egypt, Arab Rep.							55.00		
Moldova		22.00		18.60	16.00	15.80	38.40		
Morocco		227.00						132.00	
Syrian Arab Republic									
Latin America									
Ecuador			107.00			59.80			
El Salvador	170.00				71.20		58.50		
Regional									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia									
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)									
Least developed countries: UN classification									
Low & middle income									
Middle income									

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

Indicator Name	Maternal mortality ratio (national estimate, per 100,000 live births)
Short definition	Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births.
Long definition	Maternal mortality ratio is the number of women who die during pregnancy and childbirth, per 100,000 live births.
Source	UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 28 Met need for contraception (% of married women ages 15-49), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		32.3							
Congo, Dem. Rep.									
Ghana		42.5							
Mozambique		58.1							
Nigeria		42.7							
South Africa									
Timor-Leste									
Zambia	55.5								
Zimbabwe									
Tanzania									
Asia									
Afghanistan									
Bangladesh			84.2						
India									
Lao PDR									
Myanmar									
Philippines		74.7							
Yemen, Rep.									
Vietnam	94.3								
ENP									
Egypt, Arab Rep.									
Moldova									
Morocco			86.6						
Syrian Arab Republic									
Latin America									
Ecuador									
El Salvador									
Regional									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia									
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)									
Least developed countries: UN classification									
Low & middle income									
Middle income									

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

Indicator Name	Met need for contraception (% of married women ages 15-49)
Short definition	Met need for contraception shows the percentage of married women ages 15-49 whose need for family planning is satisfied.
Long definition	Met need for contraception shows the percentage of married women ages 15-49 whose need for family planning is satisfied.
Source	Demographic and Health Surveys by Macro International.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 29 Unmet need for contraception (% of married women ages 15-49), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		28.80			31.10				
Congo, Dem. Rep.						24.40			
Ghana		34.00					35.30		
Mozambique		18.40							
Nigeria		16.90							
South Africa									
Timor-Leste									
Zambia	27.40					26.50			
Zimbabwe					12.80				
Tanzania			21.80						
Asia									
Afghanistan									
Bangladesh			11.10			17.10			
India					12.80				
Lao PDR									
Myanmar									
Philippines		17.30					22.00		
Yemen, Rep.					23.60				
Vietnam	4.80								
ENP									
Egypt, Arab Rep.				10.30			9.20		
Moldova				6.70					
Morocco			10.00						
Syrian Arab Republic					11.00				
Latin America									
Ecuador									
El Salvador									
Regional									
Arab World								11.17	
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia							14.13	14.83	
Sub-Saharan Africa (developing only)							23.57		
Income									
Heavily indebted poor countries (HIPC)							25.64	25.60	
Least developed countries: UN classification							21.63	23.90	
Low & middle income									
Middle income									

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

Indicator Name	Unmet need for contraception (% of married women ages 15-49)
Short definition	Unmet need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception.
Long definition	Unmet need for contraception is the percentage of fertile, married women of reproductive age who do not want to become pregnant and are not using contraception.
Source	Household surveys, including Demographic and Health Surveys by Macro International and Multiple Indicator Cluster Surveys by UNICEF.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 30 Proportion of women using modern family planning (contraceptive prevalence rate / UNFPA: contraceptive prevelance rate - modern methods), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	53.00				53.00				N/A
Burkina Faso	5.00	13.80			9.00				13.00
DRC	2.00				4.00				6.00
Ghana	13.00	25.20			19.00				17.00
Mozambique	5.00	16.50			12.00				12.00
Nigeria	4.00	12.60			8.00				8.00
South Africa	55.00				55.00				60.00
Tanzania	17.00				17.00				20.00
Timor-Leste	N/A	10.00			9.00				22.30
Zambia	14 / 34,2				23.00				27.00
Zimbabwe	50.00				50.00				58.00
Asia									
Afghanistan	4.00				4.00				16.00
Bangladesh	43.00		58.10		47.00				48.00
India	43.00				43.00				49.00
Lao PDR	29.00				29.00				29.00
Myanmar	28.00				33.00				33.00
Philippines	28.00	48.90			33.00				34.00
Vietnam	56 / 78,2				57.00				69.00
Yemen	10.00				10.00				19.00
ENP									
Egypt	54.00	60.00			57.00				58.00
Moldova	43.00				43.00				43.00
Morocco	42.00		63.00		55.00				52.00
Syria	28.00				28.00				43.00
Latin America									
Ecuador	50.00				50.00				58.00
El Salvador	54.00	67.30			61.00				66.00
Regional									
African Region	20.00				20.00				23.00
Region of the America	60.00				63.00				64.00
South-East Asia Region	49.00				51.00				53.00
European Region	49.00				50.00				55.00
Eastern Mediterranean Region	N/A				N/A				N/A
Western Pacific Region	58.00				57.00				59.00

Source: UNFPA State of World Population - indicator: contraceptive prevelance rate - MODERN METHODS

Indicator Name / explenatory notes to the ratio and definition	Proportion of women using modern family planning (contraceptive prevalence rate / UNFPA: contraceptive prevelance rate - modern methods)

Table 31 Midwives (per 1,000 people), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso									
Congo, Dem. Rep.									
Ghana									
Mozambique									
Nigeria			0.67						
South Africa									
Timor-Leste									
Zambia									
Zimbabwe									
Tanzania		0.07							
Asia									
Afghanistan									
Bangladesh									
India									
Lao PDR									
Myanmar									
Philippines									
Yemen, Rep.									
Vietnam	0.19								
ENP									
Egypt, Arab Rep.									
Moldova			0.23						
Morocco									
Syrian Arab Republic									
Latin America									
Ecuador									
El Salvador									
Regional									
Arab World									
East Asia & Pacific (developing only)	0.04								
Europe & Central Asia (developing only)			0.50						
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia									
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)									
Least developed countries: UN classification									
Low & middle income									
Middle income									

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

Indicator Name	Midwives (per 1,000 people)
Short definition	Midwives are professional midwives, auxiliary midwives, and enrolled midwives.
Long definition	Midwives are professional midwives, auxiliary midwives, and enrolled midwives.
Source	World Health Organization, Global Atlas of the Health Workforce. For latest updates and metadata, see http://apps.who.int/globalatlas/.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 32 Mortality rate, infant (per 1,000 live births), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados				11.00	10.70	10.40	10.10	9.80	
Burkina Faso				95.80	94.50	93.30	92.10	90.80	
Congo, Dem. Rep.				125.80	125.80	125.80	125.80	125.80	
Ghana				55.40	53.10	50.80	48.70	46.70	
Mozambique				109.10	106.00	101.90	99.20	95.90	
Nigeria				97.30	94.40	91.40	88.60	85.80	
South Africa				52.40	48.90	46.90	44.70	43.10	
Timor-Leste				61.40	58.00	54.40	51.10	48.10	
Zambia				93.80	92.00	90.80	87.90	86.30	
Zimbabwe				62.90	61.60	59.90	58.20	56.30	
Tanzania				76.80	74.80	72.60	69.90	68.40	
Asia									
Afghanistan				139.80	138.20	136.70	135.20	133.70	
Bangladesh				50.70	48.20	45.80	43.40	41.20	
India	64.00			57.20	55.40	53.60	51.90	50.30	
Lao PDR				52.90	51.00	49.20	47.50	45.80	
Myanmar				57.50	56.60	55.60	54.70	53.80	
Philippines				27.50	27.20	26.80	26.50	26.20	
Yemen, Rep.				59.30	57.00	54.90	52.80	50.80	
Vietnam				21.30	20.80	20.40	19.90	19.50	
ENP									
Egypt, Arab Rep.				25.20	23.30	21.40	19.80	18.20	
Moldova				17.10	16.50	15.90	15.20	14.60	
Morocco				38.60	37.10	35.80	34.60	33.20	
Syrian Arab Republic				16.00	15.60	15.10	14.60	14.20	
Latin America									
Ecuador				23.50	22.60	21.90	21.10	20.40	
El Salvador				19.50	18.20	16.90	15.60	14.60	
Regional									
Arab World				40.76	39.49	38.51	37.84	36.74	
East Asia & Pacific (developing only)				25.56	24.48	23.47	22.44	21.43	
Europe & Central Asia (developing only)				24.09	22.68	21.34	20.12	18.98	
Latin America & Caribbean (developing only)				22.30	21.38	20.51	19.68	18.91	
Middle East & North Africa (developing only)				32.28	30.85	29.62	28.56	27.35	
South Asia				61.13	59.42	57.73	56.12	54.62	
Sub-Saharan Africa (developing only)				88.26	86.30	84.40	82.50	80.77	
Income									
Heavily indebted poor countries (HIPC)				90.46	88.84	87.24	85.64	84.19	
Least developed countries: UN classification				84.21	82.53	80.90	79.27	77.76	
Low & middle income				52.25	50.86	49.51	48.21	46.94	
Middle income				43.83	42.41	41.05	39.74	38.44	

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

Indicator Name	Mortality rate, infant (per 1,000 live births)
Short definition	Infant mortality rate is the number of infants dying before reaching one year of age, per 1,000 live births in a given year.
Long definition	Infant mortality rate is the number of infants dying before reaching one year of age, per 1,000 live births in a given year.
Source	Level & Trends in Child Mortality. Report 2010. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA, UNPD).
Topic	Health: Mortality
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 33 Mortality rate, under-5 (per 1,000), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados				12.40	12.00	11.70	11.30	11.00	
Burkina Faso				175.50	173.20	170.90	168.70	166.40	
Congo, Dem. Rep.				198.60	198.60	198.60	198.60	198.60	
Ghana				83.80	79.70	75.80	72.00	68.50	
Mozambique				162.30	157.70	152.10	146.80	141.90	
Nigeria				159.00	153.50	148.10	142.90	137.90	
South Africa				78.50	74.60	69.40	65.30	61.90	
Timor-Leste				73.90	69.10	64.60	60.30	56.40	
Zambia				155.30	152.50	149.60	145.10	141.30	
Zimbabwe				103.70	100.80	96.90	93.40	89.50	
Tanzania				122.80	119.40	115.80	111.40	107.90	
Asia									
Afghanistan				208.40	205.90	203.50	201.00	198.60	
Bangladesh				66.20	62.30	58.70	55.20	52.00	
India				76.50	73.60	70.80	68.20	65.60	
Lao PDR				69.70	66.70	63.90	61.30	58.60	
Myanmar				77.00	75.50	74.00	72.60	71.20	
Philippines				35.00	34.50	34.00	33.50	33.10	
Yemen, Rep.				79.80	76.20	72.80	69.50	66.40	
Vietnam				26.00	25.40	24.80	24.20	23.60	
ENP									
Egypt, Arab Rep.				30.00	27.50	25.10	23.00	21.00	
Moldova				19.70	18.90	18.20	17.40	16.70	
Morocco				44.50	42.60	40.90	39.20	37.50	
Syrian Arab Republic				18.40	17.80	17.30	16.70	16.20	
Latin America									
Ecuador				28.20	27.20	26.10	25.10	24.20	
El Salvador				22.70	21.00	19.40	17.90	16.60	
Regional									
Arab World				55.72	53.90	52.53	51.66	50.11	
East Asia & Pacific (developing only)				31.73	30.24	28.80	27.42	26.12	
Europe & Central Asia (developing only)				27.57	25.84	24.23	22.76	21.37	
Latin America & Caribbean (developing only)				26.77	25.62	24.55	23.50	22.54	
Middle East & North Africa (developing only)				39.35	37.44	35.77	34.31	32.75	
South Asia				81.32	78.59	75.98	73.55	71.16	
Sub-Saharan Africa (developing only)				143.03	139.59	136.11	132.72	129.55	
Income									
Heavily indebted poor countries (HIPC)				145.12	142.34	139.55	136.80	134.19	
Least developed countries: UN classification				132.16	129.40	126.68	123.98	121.40	
Low & middle income				74.60	72.47	70.40	68.43	66.47	
Middle income				59.41	57.28	55.20	53.26	51.31	

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

Indicator Name	Mortality rate, under-5 (per 1,000)
Short definition	Under-five mortality rate is the probability per 1,000 that a newborn baby will die before reaching age five, if subject to current age-specific mortality rates.
Long definition	Under-five mortality rate is the probability per 1,000 that a newborn baby will die before reaching age five, if subject to current age-specific mortality rates.
Source	Level & Trends in Child Mortality. Report 2010. Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN DESA, UNPD).
Topic	Health: Mortality
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 34 Newborns protected against tetanus (%), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso						80.00	79.00		
Congo, Dem. Rep.					77.00	81.00	75.00		
Ghana						88.00	86.00		
Mozambique					85.00	82.00	83.00		
Nigeria					71.00	53.00	64.00		
South Africa					88.00	72.00	75.00		
Timor-Leste					63.00	59.00	66.00		
Zambia					90.00	89.00	90.00		
Zimbabwe					80.00	78.00	76.00		
Tanzania						88.00	81.00		
Asia									
Afghanistan					88.00	73.00	83.00		
Bangladesh					92.00	91.00	91.00		
India					83.00	86.00	86.00		
Lao PDR					52.00	47.00	47.00		
Myanmar					87.00	91.00	93.00		
Philippines					57.00	65.00	58.00		
Yemen, Rep.						52.00	63.00		
Vietnam					61.00	86.00	84.00		
ENP									
Egypt, Arab Rep.					86.00	85.00	85.00		
Moldova									
Morocco						85.00	86.00		
Syrian Arab Republic					87.00	92.00	94.00		
Latin America									
Ecuador					66.00	67.00	73.00		
El Salvador					91.00	87.00	87.00		
Regional									
Arab World						75.87	76.26		
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)					84.13	82.90	81.31		
Middle East & North Africa (developing only)						78.28	79.83		
South Asia					83.74	85.33	85.52		
Sub-Saharan Africa (developing only)					76.35	75.40	77.62		
Income									
Heavily indebted poor countries (HIPC)					78.89	80.82	81.21		
Least developed countries: UN classification					82.01	81.29	81.51		
Low & middle income						80.64	81.06		
Middle income									

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

Indicator Name	Newborns protected against tetanus (%)
Short definition	Newborns protected against tetanus are the percentage of births by women of child-bearing age who are immunized against tetanus.
Long definition	Newborns protected against tetanus are the percentage of births by women of child-bearing age who are immunized against tetanus.
Source	UNICEF, State of the World's Children, Childinfo.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 35 Nurses (per 1,000 people), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso			0.32						
Congo, Dem. Rep.			0.53						
Ghana			0.74						
Mozambique			0.21						
Nigeria		1.03							
South Africa			4.08						
Timor-Leste			1.79						
Zambia			1.56						
Zimbabwe			0.72						
Tanzania	0.30								
Asia									
Afghanistan									
Bangladesh			0.14						
India			0.80						
Lao PDR									
Myanmar			0.20						
Philippines									
Yemen, Rep.			0.64						
Vietnam									
ENP									
Egypt, Arab Rep.			1.98						
Moldova		6.06							
Morocco			0.72						
Syrian Arab Republic									
Latin America									
Ecuador									
El Salvador	0.80								
Regional									
Arab World			1.52						
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)		6.37							
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)			1.44						
South Asia			0.67						
Sub-Saharan Africa (developing only)									
Income									
Heavily indebted poor countries (HIPC)			0.54						
Least developed countries: UN classification			0.38						
Low & middle income									
Middle income									

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

Indicator Name	Nurses (per 1,000 people)
Short definition	Nurses are professional nurses, auxiliary nurses, enrolled nurses, and other nurses, such as dental nurses and primary care nurses.
Long definition	Nurses are professional nurses, auxiliary nurses, enrolled nurses, and other nurses, such as dental nurses and primary care nurses.
Source	World Health Organization, Global Atlas of the Health Workforce. For latest updates and metadata, see http://apps.who.int/globalatlas/.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 36 Out-of-pocket health expenditure (% of private expenditure on health), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	77.19	79.07	80.00	80.54	81.25	80.70	80.56	80.56	
Burkina Faso	94.27	92.23	95.15	94.25	91.28	93.73	92.95	92.96	
Congo, Dem. Rep.	84.58	85.00	86.04	85.52	85.70	86.04	85.49	76.24	
Ghana	79.44	79.35	79.27	79.07	77.46	78.62	78.80	78.59	
Mozambique	46.70	48.11	49.30	46.78	45.38	36.18	28.20	43.56	
Nigeria	90.43	96.22	95.34	95.80	95.57	95.53	95.40	95.55	
South Africa	23.13	23.17	28.75	29.83	30.05	29.71	29.68	29.63	
Timor-Leste	25.57	25.57	25.57	25.57	25.57	25.57	25.57	25.57	
Zambia	76.96	75.54	71.36	60.69	67.15	67.63	74.50	74.50	
Zimbabwe									
Tanzania	83.47	87.31	79.41	77.64	54.31	65.12	65.12	65.12	
Asia									
Afghanistan	98.94	98.94	98.94	98.94	98.94	98.94	98.94	98.94	
Bangladesh	96.00	95.72	95.92	96.22	96.31	96.52	96.52	96.52	
India	92.34	91.77	89.55	87.91	82.65	75.88	74.38	74.38	
Lao PDR	68.76	76.64	75.69	75.44	76.12	76.12	75.92	75.80	
Myanmar	98.37	98.19	98.22	99.19	94.90	95.13	95.50	95.50	
Philippines	77.97	78.43	80.23	80.92	80.87	83.32	82.49	82.81	
Yemen, Rep.	94.83	96.18	97.28	97.95	92.48	98.44	98.53	98.57	
Vietnam	90.42	89.57	89.07	89.54	90.20	90.23	90.23	90.23	
ENP									
Egypt, Arab Rep.	98.39	98.44	98.43	98.37	98.24	98.03	97.70	97.72	
Moldova	93.24	94.05	96.40	97.20	97.50	97.56	97.77	97.79	
Morocco	81.74	81.66	81.38	83.48	86.25	86.31	86.31	86.31	
Syrian Arab Republic	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	
Latin America									
Ecuador	85.68	84.18	85.23	85.25	85.53	85.93	87.29	87.29	
El Salvador	93.38	93.30	92.53	91.67	88.93	88.99	88.78	87.93	
Regional									
Arab World	84.64	83.33	83.40	83.00	82.62	83.27	82.29	82.16	
East Asia & Pacific (developing only)	87.79	85.69	84.92	83.84	81.80	81.40	81.59	81.79	
Europe & Central Asia (developing only)	79.42	80.77	82.46	83.19	82.65	82.89	82.42	82.25	
Latin America & Caribbean (developing only)	77.58	77.15	76.69	74.13	73.05	70.34	69.05	68.76	
Middle East & North Africa (developing only)	91.84	90.95	91.71	92.57	93.47	94.24	94.23	94.43	
South Asia	91.29	90.98	89.00	87.67	83.29	77.68	76.45	76.94	
Sub-Saharan Africa (developing only)	53.86	55.45	54.86	56.75	58.45	60.31	63.82	63.06	
Income									
Heavily indebted poor countries (HIPC)	85.17	85.59	85.65	84.28	82.65	84.44	85.09	85.19	
Least developed countries: UN classification	86.82	87.29	86.16	84.85	83.13	85.99	86.57	86.54	
Low & middle income	81.92	80.70	80.03	78.89	77.64	76.32	76.27	76.42	
Middle income	81.82	80.57	79.92	78.78	77.57	76.16	76.10	76.25	

Source: Worldbank 2010

Indicator Name	Out-of-pocket health expenditure (% of private expenditure on health)
Short definition	Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.
Long definition	Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.
Source	World Health Organization National Health Account database (www.who.int/nha/en) supplemented by country data.
Topic	Health: Health services
Periodicity	Annual
Aggregation method	Weighted average
Notes from original source	All the indicators refer to expenditures by financing agent except external resources which is a financing source. When the number is smaller than 0.05%, the percentage may appear as zero. In countries where the fiscal year begins in July, expenditure data have been allocated to the later calendar year (for example, 2008 data will cover the fiscal year 2007–08), unless otherwise stated for the country. For 2008, the use of yearly average exchange rates (compared to year-end exchange rates) may not fully represent the impact of the global financial crisis.
General comments	The latest updates on these data are accessible in WHO's National Health Accounts (NHA) website (http://www.who.int/nha/en/).

Table 37 Physicians (per 1,000 people), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados				1.81					
Burkina Faso			0.05				0.06		
Congo, Dem. Rep.			0.11						
Ghana	0.09		0.15				0.11	0.09	
Mozambique			0.03		0.03				
Nigeria		0.28					0.40		
South Africa			0.77						
Timor-Leste			0.10						
Zambia			0.12		0.06				
Zimbabwe	0.06		0.16						
Tanzania	0.02				0.01				
Asia									
Afghanistan				0.20				0.21	
Bangladesh			0.26	0.30		0.30			
India			0.60	0.60					
Lao PDR			0.35	0.27					
Myanmar			0.36				0.46		
Philippines	1.15		1.15						
Yemen, Rep.			0.33					0.30	
Vietnam	0.56						1.22		
ENP									
Egypt, Arab Rep.				2.43				2.83	
Moldova		2.64			2.66	2.67			
Morocco			0.51			0.56		0.62	
Syrian Arab Republic					0.53		1.50		
Latin America									
Ecuador									
El Salvador	1.24				1.50		1.60		
Regional									
Arab World								1.36	
East Asia & Pacific (developing only)								1.17	
Europe & Central Asia (developing only)								3.15	
Latin America & Caribbean (developing only)								2.16	
Middle East & North Africa (developing only)								1.46	
South Asia								0.57	
Sub-Saharan Africa (developing only)								0.19	
Income									
Heavily indebted poor countries (HIPC)								0.11	
Least developed countries: UN classification								0.16	
Low & middle income								1.10	
Middle income								1.25	

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

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

Table 38 Pregnant women receiving prenatal care (%), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	100.00	100.00	100.00	100.00	100.00			100.00	
Burkina Faso		73.40			85.00				
Congo, Dem. Rep.						85.30			
Ghana		91.90			92.20	96.10	90.10		
Mozambique		84.50					89.10		
Nigeria		58.00					57.70		
South Africa		91.90							
Timor-Leste	43.00	60.50							
Zambia	93.40					93.70			
Zimbabwe					94.20			93.40	
Tanzania				78.20			75.80		
Asia									
Afghanistan		16.10			30.30		36.00		
Bangladesh		40.00	48.70		47.70	51.20			
India					74.20		75.20		
Lao PDR					35.10				
Myanmar						79.80			
Philippines		87.60					91.00		
Yemen, Rep.		41.40			47.00				
Vietnam	86.40				90.80				
ENP									
Egypt, Arab Rep.		69.00		69.60			73.60		
Moldova				98.00					
Morocco			67.80						
Syrian Arab Republic					84.00				
Latin America									
Ecuador			84.20						
El Salvador		86.00					94.00		
Regional									
Arab World								74.28	
East Asia & Pacific (developing only)								90.67	
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)								95.00	
Middle East & North Africa (developing only)								82.59	
South Asia								70.13	
Sub-Saharan Africa (developing only)								71.05	
Income									
Heavily indebted poor countries (HIPC)								71.70	
Least developed countries: UN classification								64.16	
Low & middle income								82.34	
Middle income								84.96	

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

Indicator Name	Pregnant women receiving prenatal care (%)
Short definition	Pregnant women receiving prenatal care are the percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy.
Long definition	Pregnant women receiving prenatal care are the percentage of women attended at least once during pregnancy by skilled health personnel for reasons related to pregnancy.
Source	UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 39 Pregnant women receiving prenatal care of at least four visits (% of pregnant women), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		17.60							
Congo, Dem. Rep.						46.70			
Ghana		69.40					78.20		
Mozambique		53.10							
Nigeria		47.40					44.80		
South Africa		56.10							
Timor-Leste		29.60							
Zambia	71.60					60.30			
Zimbabwe					71.10				
Tanzania				61.50					
Asia									
Afghanistan									
Bangladesh			16.70			20.60			
India					37.00		51.10		
Lao PDR									
Myanmar						73.40			
Philippines		70.40					77.80		
Yemen, Rep.		13.90							
Vietnam	29.30								
ENP									
Egypt, Arab Rep.				58.50			66.00		
Moldova				88.80					
Morocco			30.50						
Syrian Arab Republic									
Latin America									
Ecuador			57.50						
El Salvador		71.20					78.00		
Regional									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)								86.09	
Middle East & North Africa (developing only)									
South Asia								45.39	
Sub-Saharan Africa (developing only)								44.07	
Income									
Heavily indebted poor countries (HIPC)								44.21	
Least developed countries: UN classification								36.06	
Low & middle income									
Middle income									

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

Indicator Name	Pregnant women receiving prenatal care of at least four visits (% of pregnant women)
Short definition	Pregnant women receiving prenatal care, at least four times, are the percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to pregnancy.
Long definition	Pregnant women receiving prenatal care, at least four times, are the percentage of women attended at least four times during pregnancy by skilled health personnel for reasons related to pregnancy.
Source	UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.
Topic	Health: Reproductive health
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 40 Use of insecticide-treated bed nets (% of under-5 population), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		1.90			9.60				
Congo, Dem. Rep.						5.80			
Ghana		4.00			21.80		28.20		
Mozambique							22.80		
Nigeria		1.20					5.50		
South Africa									
Timor-Leste	8.30								
Zambia	7.30				22.80	28.50	41.10		
Zimbabwe					2.90			17.30	
Tanzania			10.00	16.00			25.70		
Asia									
Afghanistan									
Bangladesh									
India									
Lao PDR					40.50				
Myanmar									
Philippines									
Yemen, Rep.									
Vietnam				13.00	5.00				
ENP									
Egypt, Arab Rep.									
Moldova									
Morocco									
Syrian Arab Republic									
Latin America									
Ecuador									
El Salvador									
Regional									
Arab World									
East Asia & Pacific (developing only)									
Europe & Central Asia (developing only)									
Latin America & Caribbean (developing only)									
Middle East & North Africa (developing only)									
South Asia									
Sub-Saharan Africa (developing only)								20.25	
Income									
Heavily indebted poor countries (HIPC)								22.69	
Least developed countries: UN classification									
Low & middle income									
Middle income									

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

Indicator Name	Use of insecticide-treated bed nets (% of under-5 population)
Short definition	Use of insecticide-treated bed nets refers to the percentage of children under age five who slept under an insecticide-treated bednet to prevent malaria.
Long definition	Use of insecticide-treated bed nets refers to the percentage of children under age five who slept under an insecticide-treated bednet to prevent malaria.
Source	UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.
Topic	Health: Disease prevention
Periodicity	Annual
Aggregation method	Weighted average
http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=	

Table 41 Number/% of children sleeping under a bednets, 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		20.00			18.00				
DRC						19.00			
Ghana		15.00			33.00		41.00		
Mozambique		10.00				16.00	42.00		
Nigeria		6.00					12.00		
South Africa									
Tanzania			31.00			36.00			
Timor-Leste	48.00							45.00	
Zambia					27.00	33.00	48.00		
Zimbabwe				7.00				23.00	
Asia									
Afghanistan									
Bangladesh									
India									
Lao PDR					87.00				
Myanmar									
Philippines									
Vietnam				95.00	95.00				
Yemen									
ENP									
Egypt									
Moldova									
Morocco									
Syria									
Latin America									
Ecuador									
El Salvador									
Regional									
African Region									
Region of the America									
South-East Asia Region									
European Region									
Eastern Mediterranean Region									
Western Pacific Region									
Africa									
SubSaharan Africa									
Eastern and Southern Africa									
West and Central Africa									
Middle East and North Africa									
Asia									
South Asia									
East Asia and Pacific									
Latin America and Caribbean									
CEE/CIS									
Income									
Industrialized countries									

Developing countries									
Least developed countries									
Unicef Regions									

Source: http://www.childinfo.org/malaria_netsusage.php

Indicator Name / explenatory notes to the ratio and definition	Number/% of children sleeping under a bednets
http://www.childinfo.org/malaria_netsusage.php	

Table 42 Median availability of selected generic medecines in private sector%", 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso								72.10	
DRC						65.40			
Ghana			44.60						
Mozambique									
Nigeria			36.40						
South Africa				26.50					
Tanzania			47.90						
Timor-Leste									
Zambia									
Zimbabwe									
Asia									
Afghanistan									
Bangladesh									
India			75.40						
Lao PDR									
Myanmar									
Philippines				26.50					
Vietnam									
Yemen					90.00				
ENP									
Egypt									
Moldova									
Morocco			52.50						
Syria			98.20						
Latin America									
Ecuador							71.70		
El Salvador					69.20				
Regional									
African Region									
Region of Americas									
South-East Asia Region									
European Region									
Eastern Mediterranean Region									
Western Pacific Region									

Source: http://apps.who.int/ghodata/#

Indicator Name / explenatory notes to the ratio and definition	Median availability of selected generic medecines in private sector%"
http://apps.who.int/ghodata/#	

Table 43 Private prepaid plans as a percentage of private expenditure on health, 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	22.70	22.80		21.40	21.40	19.30	19.40		
Burkina Faso	1.00	0.90		2.30	2.10	2.00	3.40		
DRC	0.00	N/A		N/A	N/A	0.00	0.20		
Ghana	6.10	0.00		6.20	6.00	5.90	6.20		
Mozambique	1.00	0.50		0.60	0.60	1.50	1.90		
Nigeria	5.10	6.70		6.70	6.70	3.10	3.10		
South Africa	69.90	77.70		77.30	77.70	66.20	66.20		
Tanzania	4.50	5.40		4.50	7.70	10.40	14.50		
Timor-Leste	0.00	0.00		0.00	0.00	0.00	0.00		
Zambia	0.70	N/A		0.60	3.70	3.70	4.10		
Zimbabwe	34.30	21.00		29.70	28.80	28.80	0.00		
Asia									
Afghanistan	0.00	0.00		0.00	0.00	0.00	0.00		
Bangladesh	0.10	0.10		0.10	0.10	0.00	0.30		
India	1.00	0.90		0.80	1.10	2.10	2.30		
Lao PDR	0.00	9.80		0.50	0.40	0.40	0.40		
Myanmar	0.00	0.00		0.00	0.00	0.00	0.00		
Philippines	11.10	10.50		10.50	9.70	9.80	12.20		
Vietnam	4.10	3.10		2.50	2.60	2.70	2.70		
Yemen	2.20	N/A		N/A	N/A	1.60	1.10		
ENP									
Egypt	0.40	0.30		0.20	0.20	0.20	1.70		
Moldova		N/A		0.80	0.40		0.40		
Morocco	23.40	23.90		24.00	22.70	13.70	13.70		
Syria	0.00	0.00		0.00	0.00	0.00	0.00		
Latin America									
Ecuador	4.80	2.20		5.60	5.70	5.20	5.40		
El Salvador	5.40	6.30		8.80	11.10	11.00	11.20		
Regional									
African Region	39.10		40.60	41.20	39.60	32.50	30.80		
Region of the America	56.80		59.40	59.90	60.40	59.40	61.90		
South-East Asia Region	2.70		2.50	2.50	2.80	3.40	3.50		
European Region	25.50		22.40	23.00	22.10	24.30	21.40		
Eastern Mediterranean Region	7.20		7.80	7.80	8.10	7.60	6.10		
Western Pacific Region	4.30		6.10	8.00	9.30	11.70	9.60		

Source:

Indicator Name / explenatory notes to the ratio and definition	Private prepaid plans as a percentage of private expenditure on health

Table 44 % of routine EPI vaccines financed by government, 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados	94	94	94	94	100	N/A	N/A	100	
Burkina Faso	100	100	100	100	17	23	21	30	
DRC	6	0	17	0	25	0	0	1	
Ghana	28	28	62	55	N/A	100	20	N/A	
Mozambique	21	21	67	47	100	N/A	100	100	
Nigeria	100	100	100	100	100	N/A	90	74	
South Africa	100	100	100	100	100	100	N/A	100	
Tanzania	20	30	23	62	83	75	93	21	
Timor-Leste	0	0	0	0	0	N/A	N/A	100	
Zambia	0	5	10	10	85	24	73	95	
Zimbabwe	100	0	0	1	0	0	0	0	
Asia									
Afghanistan	0	0	0	0	0	0	0	2	
Bangladesh	100	100	100	16	63	60	85	30	
India	98	100	100	100	100	100	100	N/A	
Lao PDR	0	0	0	0	0	13	9	7	
Myanmar	0	0	0	0	N/A	N/A	N/A	N/A	
Philippines	100	3	100	100	100	100	100	100	
Vietnam	50	55	70	70	80	87	88	80	
Yemen	100	100	100	13	100	31	18	35	
ENP									
Egypt	100	100	100	100	100	100	100	100	
Moldova	37	49	86	86	N/A	N/A	56	54	
Morocco	100	100	100	100	100	100	100	100	
Syria	100	100	100	100	100	100	100	100	
Latin America									
Ecuador	100	100	100	100	100	N/A	100		
El Salvador	100	100	100	100	100	N/A	100	N/A	
Regional									
Sub Saharan Africa	66	45	47	50	49	31	47	48	
Eastern and Southern Africa	N/A	N/A	24	36	43	32	48	58	
West and Central Africa	N/A	N/A	68	64	55	30	51	46	
Middle east and North Africa	85	89	88	80	88	81	80	79	
Latin America and Caribbean	95	92	95	96	96	N/A	96	99	
South Asia	95	96	90	81	91	83	94	N/A	
East Asia ans Pacific	89	84	90	91	N/A	N/A	N/A	95	

Source: UNICEF State of World's Children Report

Indicator Name / explenatory notes to the ratio and definition	% of routine EPI vaccines financed by government

Table 45 Median availability of selected generic medecines in public sector%, 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso								87.1	
DRC						55.6			
Ghana			17.9						
Mozambique									
Nigeria			26.2						
South Africa									
Tanzania			23.4						
Timor-Leste									
Zambia									
Zimbabwe									
Asia									
Afghanistan									
Bangladesh									
India			20.5						
Lao PDR									
Myanmar									
Philippines				15.4					
Vietnam									
Yemen					5				
ENP									
Egypt									
Moldova									
Morocco			0.0						
Syria									
Latin America									
Ecuador							41.7		
El Salvador					53.8				
Regional									
African Region									
Region of Americas									
South-East Asia Region									
European Region									
Eastern Mediterranean Region									
Western Pacific Region									

Source: http://apps.who.int/ghodata/#

Indicator Name / explenatory notes to the ratio and definition	Median availability of selected generic medecines in public sector%"
http://apps.who.int/ghodata/#	

Table 46 Social security expenditure on health as a percentage of general government expenditure on health, 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
Barbados	0	0	0	0	0	0.2	0		
Burkina Faso	0.8	1	0.4	0.2	0.2	0.3	0.4		
DRC	0	0	0	0	0	0	0		
Ghana	0	N/A	N/A	N/A	N/A	48.6	37.5		
Mozambique	0.3	0	0	0	0	0.3	0.3		
Nigeria	0	0	0	0	0	0	0		
South Africa	3.3	4.6	4.3	4.1	4.3	0	3		
Tanzania	0	2.6	1.8	1	0.9	3.3	3.3		
Timor-Leste	0	N/A	0	0	0	0	0		
Zambia	0	0	0	0	0	0	0		
Zimbabwe	0	0	0	0	0	0	N/A		
Afghanistan	0	0	0	0	0	0	0		
Bangladesh	0	0	0	0	0	0	0		
India	16.9	4.2	5.6	4.7	4.9	17.2	17.2		
Lao PDR	1.4	1	12.1	12.9	11.5	12.1	12.1		
Myanmar	3.1	1.3	3.2	2.2	1.8	1.6	1.7		
Philippines	14.7	21.8	23.8	31.6	25.8	22.3	21.7		
Vietnam	19.7	16.6	16.9	33.5	38.8	32.3	32.2		
Yemen	0	N/A	N/A	N/A	N/A	0	0		
Egypt	24.3	27.1	26.7	26.3	26.4	26.8	21.6		
Moldova	0	1.1	70.2	75.9	75.0	67.6	75.8		
Morocco	0	0	0	0	0	26.9	25		
Syria	0	0	0	0	0	0	0		
Ecuador	28.0	31.9	39.2	37.5	41.4	40.1	42.8		
El Salvador	44.2	44.1	41.7	46	47.7	43.5	40.7		
African Region	7.1		6.3	6.2		8.3	9.4		
Region of the America	31.9		25.1	28.2		26.0	27.0		
South-East Asia Region	12.1		7.3	9.0		13.8	13.7		
European Region	52.9		49.9	50.3		49.5	50.7		
Esatern Mediterranean Region	9.9		18.4	25.9		14.0	25.8		
Western Pacific Region	72.9		61.6	61.1		63.0	66.6		

Source: WHO Health Statistics 2010

Indicator Name / explenatory notes to the ratio and definition	Social security expenditure on health as a percentage of general government expenditure on health

Table 47 Births by caesarean section (%), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		1							
DRC									
Ghana		4							
Mozambique									
Nigeria		2							
South Africa									
Tanzania									
Timor-Leste									
Zambia									
Zimbabwe									
Asia									
Afghanistan									
Bangladesh									
India									
Lao PDR									
Myanmar									
Philippines		7							
Vietnam	10								
Yemen									
ENP									
Egypt									
Moldova									
Morocco									
Syria									
Latin America									
Ecuador									
El Salvador									
Regional									
African Region									
Region of the America									
South-East Asia Region									
European Region									
Eastern Mediterranean Region									
Western Pacific Region									

Source: WHO World Health Statistics 2006 Health Service Coverage

Indicator Name / explanatory notes to the ratio and definition	Births by caesarean section (%)
WHO World Health Statistics 2006 Health Service Coverage	

Table 48 household management of diarrhoea based on oral rehydration salts (ORS), 2002-2010

Country_Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso		47.0			42.0				
DRC						42.0			
Ghana		40.0			29.0				
Mozambique		47.0					47.0		
Nigeria		28.0							
South Africa									
Tanzania			53.0						
Timor-Leste									
Zambia						56.0			
Zimbabwe				47.0					
Asia									
Afghanistan									
Bangladesh			52.0		49.0	68.0			
India				33.0					
Lao PDR					49.0				
Myanmar		65.0							
Philippines		76.0							
Vietnam					65.0				
Yemen					48.0				
ENP									
Egypt		26.0		27.0			19.0		
Moldova				48.0					
Morocco		46.0							
Syria					34.0				
Latin America									
Ecuador									
El Salvador									
Regional									
African Region									
Region of the America									
South-East Asia Region									
European Region									
Western Pacific Region									
Sub-Saharan Africa									
Eastern and Southern Africa									
West and Central Africa									
Middle East and North Africa									
South Asia									
East Asia and Pacific									
Latin America and Carribbean									
CEE/CIS									
Income									
Industrialized Countries									
Developing countries									
Least developed countries									

World									
Unicef regions									

Source: CHILDINFO http://www.childinfo.org/diarrhoea_stattable.php

Indicator Name / explenatory notes to the ratio and definition	household management of diarrhoea based on oral rehydration salts (ORS)
CHILDINFO http://www.childinfo.org/diarrhoea_stattable.php	

Table 49: Pregnant women receiving prenatal care of at least four visits (% of pregnant women), 2002-2010

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

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

Table 50: Prevalence of underweight children under-five years of age 2002-2010

Country Name	2002	2003	2004	2005	2006	2007	2008	2009	2010
ACP									
Barbados									
Burkina Faso			35.2			37.4			26
Congo. Dem. Rep.	33.6						28.2		
Ghana			18.8			13.9		14.3	
Mozambique			21.2						
Nigeria			27.2					26.7	
South Africa									
Timor-Leste		40.6	41.5						
Zambia	23.3						14.9		
Zimbabwe					14				
Tanzania				16.7					
Asia									
Afghanistan				32.9					
Bangladesh				42.7			41.3		
India					43.5				
Lao PDR						31.6			
Myanmar			29.6						
Philippines			20.7						
Yemen. Rep.			43.1						
Vietnam						20.2			
ENP									
Egypt. Arab Rep.			8.7		5.4			6.8	
Moldova					3.2				
Morocco			9.9						
Syrian Arab Republic	11.1					10			
Latin America									
Ecuador				6.2					
El Salvador		6.1							

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

9 Annex 28: Specific features of EC support to health in partner country regions

Given the fact that there exist various financing instruments for support to the different regions, it is evident that there also exist regional policy foci for co-operation. Based on a review of the main regional policy documents, these are the main regional specificities to be highlighted:

Table 51: Major health-related regional specificities of EC policies

Region	Main issues
ACP	Article 26 of the second revision of the Cotonou Agreement (social sector development) specifies that "Cooperation should support ACPs states efforts at developing general and sectoral policies and reforms which improve the coverage, quality and access to basic social infrastructure and services and take account of local needs and specific demands of the most vulnerable and disadvantaged, thus reducing the inequalities of access to these services. Special attention should be paid to ensuring adequate levels of public spending in the social sectors. In this context, cooperation should aim at: (…) (b) improving health systems, **in particular equitable access to comprehensive and quality health care services**, and nutrition, eliminating hunger and malnutrition, ensuring adequate food supply and security, **including through supporting safety nets;**" The EU strategy for Africa: Towards a *Euro-African pact to accelerate Africa's development COM (2005)489* confirms commitment to health within MDGs. However, it recognises the challenges and the special institution-building needed, for example in **fragile states** that are still some way from the MDGs, where the EU should focus on prerequisites including peace and security; governance; and creating the economic environment for achieving the MDGs and targeted support for social cohesion, decent work and gender equality. The EU Strategy for Africa notes that the European Council agreed to **double aid between 2004 and 2010** and allocate half of it to Africa. This is reiterated by the Resolution on speeding up progress towards achieving the MDGs *(COM 2005/ 132).* The strategy also emphasises: "The EU should therefore help to make health, education and basic social services available for the poorest people in Africa (MDGs 1-6), contributing to the establishment of a social safety net for the most vulnerable: women, elderly, children and disabled people. (…) Specific action should include: **Deliver decent health care**. The strengthening of national health systems and capacity, including the improvement of health infrastructures and the provision of essential, universal and equitable health services is key and requires sustained financing. The EU is developing a coherent and coordinated response to the crisis in human resources for health, which will support the needs identified in the NEPAD Health Strategy. The EU is also supporting the replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria with a view to maximising benefits for Africa. In addition, the EU is contributing to the development of new drugs and vaccines against communicable diseases, inter alia through the European and Developing countries Clinical Trials Partnerships (EDCTP). In response to the Council's request, the Commission should, together with the Member States, develop a roadmap on possible joint action based on the European Programme for Action to confront HIV/AIDS, malaria and tuberculosis. The EU should, in this context, promote synergies and provide a coherent and coordinated response to the three diseases across relevant policy areas. In this sense, the Commission intends to put forward a Communication on combating HIV/AIDS within the European Union and the Neighbouring countries later this year. The EU has been at the forefront of international efforts to ensure access to essential medicines for developing countries. These efforts contributed to the adoption of the Doha Declaration on TRIPs and public health in November 2001, which confirms the right of WTO members to use flexibilities in the TRIPs Agreement, including issuing compulsory licenses of pharmaceutical products, for reasons of public health."
Asia	The *Asia Regional Strategy Paper 2007-2013 and Multi-Annual Indicative Programme 2007-2010* is the strategic framework for the Commission's action in Asia is based on the Commission's Communication 'Europe and Asia' of 2001. The legal basis of the Regional Programming Document and the Regional Indicative Programme for Asia is the financing Instrument for the Development Cooperation (DCI), of which the overarching objective is the eradication of poverty. Regional Cooperation during 2007-2013 will focus on three priority areas: 1) Support to Regional Integration; 2) Policy and Know-How based Cooperation in (i) Environment, Energy and Climate Change, through Sustainable Consumption and Production (SCP-Asia) and the Forest Law Enforcement, Governance and Trade (FLEGT) programme; (ii) Higher Education and Support to Research Institutes; (iii) **Cross-border Cooperation in Animal and Human Health**; 3) Support to Uprooted People. Further to the three priority areas, cross-cutting issues (such as the promotion of human rights and democracy, gender equality, good governance, the rights of the child and indigenous peoples' rights, environmental sustainability and **combating HIV/AIDS**) will, in addition to being addressed in thematic programmes and instruments, be streamlined in each component of the Regional Programme, when relevant.
Latin America	• *European Union – Latin America Development Cooperation Guide Update 2010*, no specific mention is done as regards to the support of health. In Latin America the EU focuses on

Region	Main issues
	social cohesion and regional integration, the improvement of good governance and the reinforcement of public institutions, the development of a common EU-Latin America higher education area, and the promotion of sustainable development. • The Latin America Regional Strategy Paper 2002-2006 stated that poverty, marginalisation, lack of access to basic social services, health problems (HIV/AIDS) particularly affect certain groups of society such as women and young people, especially those belonging to the indigenous population and of African origin. These two population groups are lagging behind the rest of the population in terms of access to health, and education. "Reducing inequalities must be the priority, which involves: encouraging investment in social infrastructure (education, health)" beside others. "The scientific priorities to be developed include: improving the health of societies and their quality of life, (…)"
ENP-Tacis	The *TACIS Regulation 99/2000*, which sets out the objectives of promoting the transition to a market economy and reinforcing democracy and the rule of law in partner states, seeks in its objective "assistance in addressing the social consequences of transition (reform of the health, pension, social protection and insurance systems, assistance for social reconstruction and retraining, etc.)". The *Strategic Paper and Indicative Programme 2004-2006*, adopted by the Commission in 2003, acknowledged that all countries were affected by the breakdown of social services, mainly health and education, due to the collapse of the Soviet regime. Furthermore, increased poverty led to reduced access to health. But the paper does not mention specific health targets to improve the fragile health system in the NIP countries, beside the short mentioning of "improving environment and health conditions" within one of the focus areas of sustainable management of natural resources, and "reduced health and environment impacts" as a result in the overall economic development policies.
ENP - MEDA	The *MEDA Strategy Paper 2002-2006* did not mention health development per se, only briefly in the section of social dimension of sustainable development, that the EU should "enhancing the role of Mediterranean women in economic development, and of designing modern social safety nets as well as methods of co-operating on health matters".

10 Annex 29: Consideration of cross-cutting issues in EC policies related to support to the health sector

One of the reasons why progress on the health MDGs has been slow is that heath is a sector embedded in a dense network of links with other sectors. Examples include linkages between education and health and water and sanitation, nutrition, and health. Cross-cutting themes, such as gender, ethnic minority rights, environment, and others play an important role. Yet, experience has shown that special effort must be made to effectively mainstream cross-cutting issues. The EC has attempted to position itself in the forefront of the growing trend to recognise the central role of cross-cutting issues in health.

It is able to build on a long history related to mainstreaming cross-cutting issues. The 2005 *European Consensus* identifies issues that are to be mainstreamed in all development work:

- human rights, including gender equality, and democracy
- good governance,
- children's rights and indigenous peoples, and
- environmental sustainability.

Each has implications and areas of potential action for the health sector. The list has since expanded to include, for example, climate change.

10.1 Human rights, including gender equality and democracy

The European Union respects and promotes the universal principles as laid down in the Universal Declaration on Human Rights. It recognises the right to good health as fundamental human right as recognised by Article 25 of the Declaration, and which has been denied to over a fifth of the world population. The Union's activities are also based on the main international and regional instruments for the protection of human rights, including the Europe*an Convention on Human Rights*. The EU promotes respect for democracy, the rule of law and human rights as a fundamental element of its external relations.

The Commission's actions in the field of external relations are guided by compliance with the rights and principles contained in the *EU Charter of Fundamental Rights (2000)* and are aimed at promoting coherence between the EU's internal and external approaches. The Communication on the *EU's Role in Promoting Human Rights & Democratisation in Third Countries (May 2001)* concentrates mainly on developing a coherent strategy in this field for EU external assistance. It sets a policy in the context of the Commission's overall strategic approach in external relations for the coming years. "*Rather, it reflects the fact that significant material support for the promotion of social, economic and cultural rights should generally be pursued through the Community's main development assistance programmes (e.g. health, education and food security)."*

The Communication on *Governance and Development (COM(2003) 615)* focuses on capacity building and dialogue on governance in different types of situations, such as effective partnerships or post-conflict situations. Among others, it aims to identify practical ways "to contribute to the protections of human rights and to the spreading of democracy, good governance and the rule of law. It recognises that governance has become an ingredient for development cooperation and an integral part of the Poverty Reduction Strategy processes, and that it is essential for poverty reduction and reaching the MDGs, which includes health development: "*Focusing on governance implies working with governments, contributing to building their capacities in all sectors of co-operation, such as health, education, transport, rural development, etc.*"

The EU also participates in initiatives to reduce gender inequalities and promote women's rights, such as the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979) that includes actions against discrimination against women in the field of health care, the *Cairo Programme of* Action (1994), the *Beijing Platform of Action* (1995) and as part of the MDGs.

For example the *"Regulation on Promoting Gender Equality in Development Co-operation (2004-2006)" (No 806/2004)* defined that specific measure were related to access to, monitoring of, resources and services for women, in particular, in the areas of health, education, etc. Particular attention should be paid to efforts made to promote synergies with policies and programmes targeting reproductive and sexual health and rights and poverty diseases, in particular HIV/AIDS programmes, measures to combat violence, girl-child issues, the education and training of women of all ages, beside others. On March 8 2007, the European Commission proposed a new European strategy to promote gender equality in development co-operation entitled **"Gender Equality and Women's Empowerment in Development Co-operation"** *(COM(2007) 100)*. The strategy suggests actions in five key areas for the promotion of

gender equality: governance, employment, education, health and domestic violence. The document contains guidelines how to improve the integration of gender equality into development policy and the different budget lines available to promote it. The *2010 Staff Working Document EU Plan of Action on Gender Equality and Women's Empowerment in Development (2010-2015) (SEC(2010) 265*) implements the above 2007 Communication and Council Conclusions. It is an operational document that seeks to accelerate the achievement of the MDGs, especially MDG 3 and MDG 5.

10.2 Good governance

The structures and the quality of governance are critical determinants of social cohesion or social conflict, the success or failure of economic development, the preservation or deterioration of the natural environment as well as the respect or violation of human rights and fundamental freedoms. These linkages are widely recognised throughout the international community and show how governance matters for development. While there is no official recognised international definition of good governance, the concept has gained importance, and over the last ten years all development partners have expanded their work in that field.

The *Communication on Governance and Development (COM(2003) 615)* stressed upon the fact that weaknesses in governance are partially responsible for widening the gap between the rich and the poor, within and between regions and within countries. According to the Commission, good governance is first and foremost a domestic issue. The communication therefore aims at identifying practical ways to contribute to the protection of human rights and to the spreading of democracy, good governance and the rule of law. “Governance has become an essential ingredient of development co-operation and is now an integral part of the Poverty Reduction Strategy processes.”

The Communication on *“The EU Role in Global Health” of the year 2010 (COM(2010) 128)* promoted good governance and stability, inclusive leadership, and democracy as essential factors for healthy societies and vice versa. Health is a critical element to reduce poverty and promote sustainable growth. The EU policy on *Health and Poverty Reduction (COM(2002) 129)* addressed these links too. In particular, at the country level, “increased ownership, good governance and stewardship are critical pre-requisites for development effectiveness and efficiency” and “good governance is first and foremost an issue at the national level”. At the national level, EU will reinforce its political dialogue with countries on key issues relating to leadership and governance, for instance in the *COM (2005) 179, “A European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)”* and *SEC(2008) 2476, “European programme for action to tackle the critical shortage of health workers in developing countries (2007 – 2013) Progress report on implementation”.* Subjects for dialogue include children’s rights, women’s rights, and sexual and reproductive health and rights, appropriate balance between prevention, treatment and care, beside others. Further the EC will analyse the impact of HIV/AIDS, malaria and TB on human security, e.g. in terms of access to basic services and stability at state-level, including the impact of these diseases on governance and institutional performance (COM(2005) 179), and over a wide range of issues, including production, assignment, management and retention of health workers (COM(2008)2467.

10.3 Children's rights and indigenous peoples

The period under evaluation has seen increasing importance to the Convention on the Rights of the Child. The Convention on the Rights of the Child (CRC) was adopted by the UN in 1989 and has been ratified by all countries of the UN (except Somalia). States Parties recognise that every child has the inherent right to life. Further, the convention claims the universal access of children to health services, to treatment, the right of a healthy life. The external policy commitment that is explicitly referenced in framing the EU interventions in education is the 1989 Convention on the Rights of the Child (CRC). Policy references to children’s rights are most often made within general commitments to human rights and the outreach of education services to marginalised groups, particularly indigenous people. Article 6 of the Convention, the right to life, survival and development, is defined as: “Children have the right to live. Governments should ensure that children survive and develop healthily.” And “The government should protect children from work that is dangerous or might harm their health or their education” (Article 32, child labour).

The *World Summit of Children* in 1990 was bringing together heads of state and government to commit to a set of goals to improve the well-being of children worldwide. The Summit called for a series of actions at the national and international levels to support the achievement of 27 specific goals relating to children's survival (infant and under-5 mortality rates), health, nutrition, education and protection, to be reached by 2000. The Summit had an extraordinary mobilising power, generating a high level of commitment on behalf of children around the world, and created new partnerships between Governments, NGOs, donors, the media, civil society and international organisations in pursuit of a common purpose. The *Global Strategy for Infant and Young Child Feeding*, endorsed by

WHO Member States and the UNICEF Executive Board in 2002, aims to revitalise efforts to protect, promote and support appropriate infant and young child feeding.

The *Convention concerning Indigenous and Tribal Peoples*, convened at Geneva by the Governing Body of the International Labour Office in 1989, stated that improvements in the living of indigenous people should include health and education in participation with the communities of concern.

10.4 Environmental sustainability and climate change

The European Union has been a driving force in international negotiations that led to agreements on two United Nations climate treaties, the UN Framework Convention on Climate Change (UNFCCC) in 1992 and the Kyoto Protocol in 1997. During the UN Climate Conference in Copenhagen (COP 15), participants have acknowledged the need for scaled-up, new and additional resources to support developing countries' capacity to deal with the negative effects of climate change as well as to prepare for the effective and efficient implementation of a new climate regime. The Copenhagen Accord included a number of new financial elements: "A long term finance commitment by developed countries to jointly mobilise USD 100 billion a year by 2020 to address the needs of developing countries, and in the context of meaningful mitigation actions and transparency on implementation. Funding will come from a variety of sources, public and private, bilateral and multilateral, including alternative sources of finance."

Climate change has impacts on human health through extreme weather conditions (heat waves, floods, droughts, fire), heat related mortality and morbidity, infectious diseases (vector-, water-, food- and air-borne diseases), cardio-respiratory diseases (air quality, air allergens), water-related issues (access, availability), ultraviolet radiation, etc. And the health effects in between and within countries will be unevenly distributed. Certain sections of society (the elderly, disabled, low-income households) are also expected to suffer more.

Climate change related policy documents are The *"EU Health Strategy (2008-2013)" (COM(2007) 630)*, *"The European Environment and Health Action Plan (2004-2010)" (COM(204) 416)*, "White Paper: Adapting to climate change. *Towards a European framework of action" (COM(2009) 147),* and *"Commission Staff Working document Human, Animal and Plant Health Impacts of Climate Change (2009)" (SEC(2009) 416)*. The "EU Health Strategy" stated that "Action is also needed on emerging health threats such as those linked to climate change, to address its potential impact on public health and healthcare systems". *The "European Environment and Health Action Plan 2004-2010" (COM(2004) 416)* stressed upon the importance of health effects of climate change. The Council in its conclusions urged to develop tools for anticipating, preventing and responding to potential threats from climate change. The *"White Paper: Adapting to climate change. Towards a European framework of action" (COM(2009) 147)* stated that preventive action brings clear economic, environmental and social benefits by anticipating potential impacts and minimising threats to ecosystems, human health, economy and infrastructure. Therefore it concluded that the EU and the member states should develop guidelines and surveillance mechanisms on the health impacts of climate change.

Climate change, not explicitly addressed in the communications on health and development. But the most recent Communication *"The EU Role in Global Health"* of the year 2010 *(COM(2010) 128)* recognised that "The five priority areas recently agreed by the EU in addressing Policy Coherence for Development cover the main factors that influence global health. These are: trade and financing, migration, security, food security and climate change."

11 Annex 30: List of people interviewed

Name	First name	Institution	Position	Country
GENTY	Karine	EC HQ, Bruxelles	Geographical Coordination Asia and Pacific; Aid Coordinator Cambodia & the Philippines	Belgium
KODSI	Suzanne	EC HQ, Bruxelles	Geographical Coordination Neighbourhood South	Belgium
LANE		EC HQ, Bruxelles	Senior Health Policy Adviser DEVCO D4	Belgium
WILLE	Susanne	EC HQ, Bruxelles	DEVCO E2: Budget Support	Belgium
SEIDEL	Walter	EC HQ, Bruxelles		Belgium
COLLARD	Christian	EC HQ, Bruxelles	Social and Human Development and Migration, Unit E.3:	Belgium
LIPPONEN	Marianna	EC HQ, Bruxelles	Investing in People, Unit F3,	Belgium
FOUNTAINE	Sylvie	EC HQ, Bruxelles	Social and Human Development and Migration, Food facility BL, Unit F.3	Belgium
TORRES	Cristina	EC HQ, Bruxelles	Health and education expenditure study; Unit F.3	Belgium
KHAN	Dr	CIDA	Advisoe	Afghanistan
PROVENCHER	Marie-France.Provencher	CIDA	Responsible for Afghanistan at CIDA HQ	Afghanistan
RASOOLI	Zahidullah, Dr.	MoPH	Project Task Force Performance Based Grant Contract Manager , Health Economics &Financing Directorate	Afghanistan
SAFI	Najeebullah	WHO	PHC Advisor	Afghanistan
RASHID	Nadia	EUD	Programme Officer Health	Bangladesh
GALLAGHER	Lorraine	EUD	Chargé de Programmes Secteurs Sociaux	Burkina Faso
ZOMBRE	Duago Sosthene, Dr.	WHO	WHO officer seconded to MoH	Burkina Faso
AGUILAR	Marcelo, Dr.	MoH	Deputy Secretary National Public Health	Ecuador
JATIVA	Monica	EUD	Task Manager Health Area	Ecuador
DESTEXHE	Pierre	EUD	Programme Manager Health Sector Development	Egypt
LABIB	Desiree	MoH	Central Administration of TSO	
DE LOOF	Filip	EUD	Programme Officer	Laos
KHAMPHET	Manivong, Dr	MoH	Director Department of Finance and Planning, MoH	Laos
LOCK	Stephan	EUD		Bangkok/ Laos
VONGSALY	Chindavanh	EUD		Laos
SLOBOZIAN	Vitalie.	MoH	Strategic department.	Moldova
BAUER	Anja	EUD		Philippines
BUSTAMANTE	Rita	EUD	Programme Officer	Philippines

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