

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

Final Report  
Volume I

August 2012

*Evaluation for the European Commission*







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***This evaluation is carried out by***



This report has been prepared by Particip GmbH. The opinions ex-  
pressed in this document represent the views of the authors, which  
are not necessarily shared by the European Commission or by the au-  
thorities of the countries concerned.



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The evaluation is 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 of two volumes:

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### List of acronyms

ACP	Africa, Caribbean and Pacific Countries
ACSM	Advocacy, Communication and Social Mobilisation
ALA	Budget Line for Latin American countries, before 2007
ANC	Antenatal care
ARV	Antiretroviral drugs
ASIE	Budget Line for Asian countries until 2007
BPHS	Basic Package of Health Services
CCM	Country Co-ordinating Mechanism (of the GFATM)
CoA	Commission on Audit
CRIS	European Commission's Common RELEX Information System
CSE	Country Strategy Evaluation
CSP	Country Strategy Paper
DAC	Development Assistance Committee
DCI	Development Co-operation Instrument
DCI-ALA	Budget Line for Latin American countries, from 2007
DCI-ASIE	Budget Line for Asian countries from 2007 on
DCI-SANTE	Budget line for health, after 2007
DG DEVCO	EC Directorate on Development and Co-operation – EuropeAid
DG ECHO	EC Directorate on Humanitarian Aid & Civil Protection
DoH	Department of Health
DPA	Development Partnership in Action
DPT3	Three doses of the combined diphtheria/ pertussis/ tetanus vaccine
DRC / RDC	Democratic Republic of Congo
EAMR	External Assistance Monitoring Reports
EC	European Commission
ECA	European Court of Auditors
EDF	European Development Fund (for ACP countries)
EEAS	European External Action Service
ENP	European Neighbourhood Policy
ENPI	European Neighbourhood and Partnership Instrument
EQ	Evaluation Question
EU	European Union
EUD	European Union Delegation
EUR	Euro (currency)
FA	Financing Agreement
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support
GCMU	Grants and Contract Management Unit
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
H5N1	Avian influenza
HDI	Human Development Index
HIV-AIDS	Human Immunodeficiency Virus - Acquired Immunodeficiency Syndrome
HNPSP	National Health, Nutrition and Population Sector Programme, Bangladesh
HPAI	Highly pathogenic avian influenza
HQ	Headquarter
HR	Human Resources
HRH	Human Resources for Health
HSP	Health Sector Policy
HSPD	Health Sector Policy Dialogue
HSPM	Health Sector Performance Monitoring
HSPSP	Health Sector Policy Support Programme
HSS	Health System Strengthening
HSWG	Health Sector Working Groups
IL	Intervention logic
IPPF	International Planned Parenthood Federation
ITN	Insecticide-Treated Bednet

JANS	Joint assessment of national health strategies
JAR	Joint Annual Review
JAS	Joint Assistance Strategy
JASZ	Joint Assistance Strategy for Zambia
JC	Judgement Criterion/Criteria
MDBS	Multi-Donor-Budget-Support
MDG	Millennium Development Goals
MED	Budget Line for Mediterranean/ENP South countries, before 2007
MICS	Multiple Indicator Cluster Survey (household survey programme developed by UNICEF)
MNCH	Maternal Neonatal and Child Health
MoH	Ministry of Health
MPH/MoPH	Ministry of Public Health
MS	Member States
MTCT	Mother-to-child-transmission (vertical transmission)
MTEF	Medium-Term Expenditure Framework
MTR	Mid-term review
NGO	Non-Governmental Organisation
NID	National Immunisation Day
OECD	Organisation for Economic Co-operation & Development
ORS	Oral Rehydration Salts
PASSE	Programa de Apoyo al Sector Salud in Ecuador
PFM	Public Financial Management
PHC	Primary Health Care
PIU	Project Implementation Units
PPP	Public-private Partnership
PRD	Poverty Related Diseases
PRS(P)	Poverty Reduction Strategy (Paper)
RELEX	Directorate Generals of External Relations
RG	Reference Group
RH	Reproductive health
RI	Routine Immunisation
ROM	Results-Oriented Monitoring
SANTE	Budget line for health, before 2007
SBS	Sector Budget Support
SMART	Specific, measurable, attainable, relevant, timely
SPSP	Sector Policy Support Programme
SRH	Sexual and reproductive health
SSP	Support to sector programmes
STD	Sexually Transmitted Diseases
SWAp	Sector-Wide Approach
TA	Technical Assistance
TB	Tuberculosis
ToR	Terms of Reference
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNOPS	United Nations Office for Project Services
USD	US Dollar (currency)
WB	World Bank
WHO	World Health Organisation

**Note:** The Evaluation uses the common acronym "EC" to refer to either the "Commission of the European Union" (post-Lisbon Treaty) or the "European Commission" (pre-Lisbon Treaty), as applicable. In some specific cases related to the overall EU policy framework or the post-Lisbon Treaty context, the acronym EU refers to the Commission of the European Union as well as other EU services in charge of the European external action and its relations with third countries.

## Executive Summary

### Purpose and scope of the evaluation

This final report presents the outcome of the “*Thematic evaluation of EC support to the health sector*”. It was commissioned by the Evaluation Unit of DG DEVCO<sup>1</sup> and implemented between January 2011 and May 2012.

The evaluation provides an independent assessment of the European Commission’s (EC’s) past and current support to the health sector by looking at the relevance, efficiency, effectiveness, impact and sustainability of the EC support provided. It also assesses the coherence of EC health support with other EC/European Union (EU) and donor policies and activities, as well as the specific EC added value within the health sector. The evaluation ultimately aims at identifying relevant key lessons, in order to provide recommendations for future EC support.

The evaluation covers EC aid delivery over the period 2002 to 2010, including all geographical programmes (EDF, DCI, ENPI and predecessors<sup>2</sup>) and thematic budget lines. It comprises all countries under the mandate of DG DEVCO<sup>3</sup> and assesses every aid modality used in the health sector, including Sector Budget Support (SBS) and General Budget Support (GBS), as well as funds channelled through multilateral organisations or global initiatives, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) or the Global Alliance for Vaccines and Immunisation (GAVI).

### Methodology

The evaluation follows the methodology developed by DG DEVCO’s Evaluation Unit and is divided into three main phases: structuring phase, desk research and synthesis phase. The design chosen was a multiple case study approach. However, no field visits were carried out.

A Reference Group consisting of representatives of DG DEVCO and the European External Action Service (EEAS) accompanied the evaluation process. In close collaboration with the group, the

<sup>1</sup> EC Directorate on Development and Co-operation – EuropeAid

<sup>2</sup> European Development Fund, Development Co-operation Instrument, European Neighbourhood Partnership Instrument

<sup>3</sup> This excludes countries under the mandate of DG Enlargement as well as EC support provided through the EC Directorate on Humanitarian Aid & Civil Protection (DG ECHO).

evaluation team formulated seven Evaluation Questions (EQs). The questions and the related Judgement Criteria (JC) and indicators were based on analysis of the EC policy framework and activities in the health sector, which was summarised by the reconstructed intervention logic. Moreover, an inventory of the whole EC financial support to the health sector was carried out.

Further data collection was based on a sample of 25 country case studies, of which 12 were selected for in-depth research. The sample countries were selected to reflect, as far as possible, the diversity of EC partner countries and EC programmes and approaches. Furthermore, three thematic case studies illustrated a selection of regional or thematic specificities of EC support more in depth.

The evaluation used a combination of tools and techniques for primary and secondary data collection, such as: online-survey to EU Delegations (EUDs) and ministries of health; analysis of Country Strategy Papers (CSPs); literature review and meta-analysis of evaluations or audits, such as EC country strategy evaluations or European Court of Auditors’ reports; as well as (phone) interviews with stakeholders at the EC Headquarters (HQ) and in the sample countries.

### Main findings of the evaluation

During the evaluation period, the EC supported the health sector with direct support amounting to EUR 4.1 billion. This represents 6% of total EC support to all sectors during the period. Moreover, EUR 5 billion of indirect support, i.e. GBS, with a link to the health sector was provided by the EC during the same period.

Within the direct support, the basic health sub-sector as defined by DAC received most of the funds, 73% of the total (this category includes interventions aiming at basic health care, infrastructure, or the fight against PRDs). Other sub-sectors are ‘Health general’, comprising mainly policy and administrative management (22%) and sexual and reproductive health (5%).

The main beneficiary of direct support was the ACP region (46%), followed by Asia (18%) and the ENP South region<sup>4</sup> (13%). Most direct EC support to the health sector was channelled through the individual project modality (45% of

<sup>4</sup> European Neighbourhood Policy-South

total support), followed by 'Support to sector programmes, excluding sector budget support' (18%) and SBS (16%). 21% of EC funds were channelled through global trust funds, the main recipient being GFATM. Over the evaluation period, funds allocated to the health sector tended to increase.

Although actual attribution of impact is difficult, the EC has contributed to progress in the health sector. Three key themes that emerge from the evaluation have limited its impact: (i) the persistent under-resourcing of the health sector by beneficiary governments, (ii) the human resource (HR) crisis in health, and (iii) the need for better health technical capacity in EUDs.

**EQ1- Quality of health care:** EC support has contributed to an improved quality of health care in beneficiary countries. The modalities were varied, including direct provision of basic health care in troubled settings to supporting ministry of health reform designs in more stable environments. In all three main areas examined – essential medicines, infrastructure and HR – the evaluation team has recognised that, while the EC's impact may have been high at a micro level, the total amount of money in play for pharmaceuticals, infrastructure and health worker salaries dwarfs the EC's resources.

**EQ2- Affordability of health care:** Increasing access and utilisation by reducing cost has been a central concern of all EC interventions in the field of health. Overall, the EC made some contribution to reducing the cost of basic health services to households in the countries where it provided support, e.g. through the direct financing of health care services. The EC has contributed in a range of settings to cost reduction of health care to those with special needs, such as children, the elderly, persons living with HIV/AIDS and the disabled. In most countries, the EC provided at least some Technical Assistance (TA) and participated in policy dialogue related to health care finance. However, there appear to be few success stories in the area of health care finance.

**EQ3- Availability of health infrastructure especially for the poor:** EC contribution to infrastructure is moderate, especially in comparison to other donors, such as the World Bank. EC interventions aimed at expanding, reconstructing and equipping the network of primary health facilities, especially in disadvantaged and remote areas and/or post-conflict areas. The sustainability of interventions, together with lasting inequities between rural and urban populations, remains a challenge.

**EQ4- Improved health service utilisation related to Maternal, Neonatal and Child Health (MNCH):** The EC has financed basic health care provision programmes (e.g. in *Egypt, Afghanistan* and

*South Africa*), GBS programmes with indicators related to maternal health, (e.g. Millennium Development Goals (MDG) contracts), and has also contributed to global initiatives (e.g. GFATM, GAVI, polio eradication). These efforts have been successful in improving maternal health and, to a lesser extent, in increasing the utilisation of health facilities by children. This resulted in higher immunisation rates and better monitoring of the growth and nutrition status. Considerable gaps remain between rural and urban areas related to MNCH, and the EC approach to prioritise under-privileged areas and communities can be seen as relevant.

**EQ5- Strengthening the management and governance of the health sector:** The majority of the EC's work addressed public financial management (PFM). Most of this support has been in the form of TA to support the drafting of health sector plans, Medium-Term Expenditure Frameworks (MTEFs) and development of indicators; while EUDs have been active in establishing health co-ordination mechanisms. Evidence also indicates that there has been a good level of dialogue in health sector forums related to PFM, accountability and capacity building measures in most countries. However, it is not always clear to what extent this dialogue has resulted in strengthened capacity in these areas. The EC has undertaken limited work on decentralised capacity building to strengthen health policy capabilities, which is an issue as capacity at provincial and district level remains low. Procurement is the governance area which has seen the least EC contribution and there appears to be little focus in EC health programmes on this aspect.

**EQ6- Co-ordination, complementarity, synergy with donors and partner governments:** Overall donor co-ordination in the health sector has improved over the period and can be judged as good in 2010. Specifically related to EU Member States (MS) co-ordination, the EC has played a key role, has usually chaired these groups, and has thus provided added value. A number of Joint Assistance Strategies (JAS) were developed during the evaluation period. However, they are not necessarily complete nor applied in all areas of support. The increasing role of partner governments in donor-government coordination mechanisms demonstrates a step towards closer alignment, as set down in the Paris Declaration. However, there is little evidence on EC support in the health sector affecting government's capacity to steer and co-ordinate donor assistance. Progress has been made in increasing the number of joint donor field missions and analytical work shared between them. The EC has provided financial contributions to global trust funds (GAVI, GFATM), as well as trust funds at country level. While complementarity of these funds with other

EC support at country level can be assessed as good, problems remain related to heavy administrative procedures or incoherence of strategic goals.

**EQ7- Appropriate use of financial modalities and channels to deliver health support:** EC aid delivery modalities were increasingly well adapted to recipient countries' national contexts over the evaluation period. This was accompanied by an increasingly thorough analysis of the different dimensions of the health sector in partner countries. This trend corresponded to greater use being made of budget support, especially SBS, although its use is still at a relatively low level compared to other sectors. In most countries analysed, the EC has had reasonably ambitious health-related indicators for both SBS and GBS programmes, although there are exceptions. Most programmes used outcome indicators linked to the health MDGs. Evidence suggests that the achievement of indicator targets used by the EC varies, indicating that not all have been easily achievable. In particular, the GBS health performance indicators have tended to be overambitious compared to those of other donors, leading to low rates of disbursement. The EC, both on its own and in conjunction with other donors, has made a contribution through GBS and SBS to inclusive objectives in the health sector. SBS has resulted in increased levels of capacity building support for health. However, this does not seem to have been translated into improved policy-based resource allocations. Transaction costs have been decreasing for recipient governments through the move to SBS/GBS, reduction of Project Implementation Units (PIUs) and increasing use of joint missions. In contrast, for some EUDs the move to budget support increased transaction costs, particularly as sufficient health PFM expertise was not always available in-house. High transaction costs are also generated by EC projects implemented by other agencies or donors.

### Overall assessment of EC support

**Relevance:** EC co-operation in health was relevant to needs and coherent with EC development policy. In general, the poverty focus of health co-operation was well maintained over the evaluation period. The theme of access to quality health care cuts across all EC interventions. EC assistance in health was also in line with the observation that many countries are off track on the health MDGs. In covering health care finance, HR for health and improved governance in health, the EC has been in line with the pillars of universal health care access. However, a few caveats apply:

(a) Few concrete interventions sought to directly alleviate the HR crisis. What was accomplished, by contrast, was the strengthening of HR plan-

ning, improved data and analysis and the sharing of regional experiences.

(b) While the concentration of projects on rural, geographically remote and disadvantaged areas was appropriate for the focus on poverty, growing urbanisation was scarcely taken into account.

(c) TA and policy dialogue regarding finance were highly relevant and in line with the goal of universal access, even if impact was limited.

(d) EC support in fragile states was relevant, but the small portion of EC funding allocated to fragile states is not in line with its recent policy commitment.

EC participation in various initiatives related to provision of global public goods for health, some related to pharmaceuticals and implemented under DG Research framework programmes, was relevant to needs and coherent with the EC's role as a supranational organisation.

**Efficiency:** Overall, EC support to the health sector was no more or less efficient than support in comparable sectors such as education. The efficiency of EC interventions providing infrastructure and equipment was impaired by an inadequate attention to maintenance and operating costs. In answering EQ4, it was found that in almost all regional interventions (implemented by partner organisations such as United Nations (UN) agencies and international Non-Governmental Organisation (iNGOs)), co-ordination weaknesses and differences in procedure limited efficiency. In general, the EC has made progress in aligning with national systems, which is e.g. exemplified by the decreasing use of parallel PIUs. However, the EC has been slower to move to SBS than in comparable sectors, such as education. The HR crisis, leading to high staff turnover and shortages, impaired the efficiency of interventions across the board, from capacity building to direct provision of services.

**Effectiveness:** EC co-operation in the health sector has been generally effective. However, in a few areas, such as health finance reform and HR, results have been found to be small compared to the scope of the challenges. A factor limiting effectiveness throughout has been the chronic shortage of technical expertise in EUDs.

**Impact:** Impact is difficult to assess, but there is no doubt that overall, EC health assistance contributed to progress towards health MDGs, not only in the particular areas of maternal and child health and HIV/AIDS, but also more broadly in terms of promoting better health outcomes, especially among the poor. By contrast, EC impact in health care finance and in HR has been modest. Health care finance is ultimately the responsibility of governments and all the EC can do is to provide TA and, through policy dialogue, encouragement. With a few exceptions, it is difficult to see

hard evidence that EC SBS and GBS resulted in increased resources for the health sector. Regarding the closely-related area of health sector PFM, there is evidence of EC capacity building, but less evidence of tangible improvements.

In the area of HR, the basic problem is the gap between salaries and working conditions in the public health sector and those available by emigration or by working in the private sector or a donor-financed project. Under such circumstances, a significant share of capacity built is lost due to attrition. Some EC programmes and policies have sought to address this issue, but the scope of the problem has been too large for substantial mitigation.

Most governments have schemes in place to improve health care access for the very poor or those with special needs. In some cases, the EC had a significant impact. In other cases, general EC support may have had some impact.

With a few exceptions, the share of out-of-pocket expenses in total health spending remained high or increased. This reflects a combination of limited impact on health sector finance and, closely related, the continuing low quality of public health service in many countries. EC programmes directly providing health services, such as in *Afghanistan* and *DRC*, have had a major impact, even if their sustainability questionable. In several settings, EC support for improved MNCH has contributed to significant progress, even if the related MDGs are proving elusive.

Apart from projects in disadvantaged areas, infrastructure supply is not a focus of EC assistance. However, in interventions that were geographically targeted, the EC had significant impact on access to health via infrastructure and equipment. Nevertheless, the problem of operations and maintenance remains unresolved.

There is mixed evidence on the degree to which EC assistance has contributed to strengthening the management and governance of health systems. In some areas there has been a clear contribution such as in strengthening health policy strategy, planning and processes. There is, however, little evidence as to how successful EC support was in strengthening health systems themselves - a priority goal of the recent EC health strategy.

The EC's selection of aid modalities and channels was made on the basis of a sound analysis of the health sector and of partner country needs and capacities, although this analysis was weaker in the early period of the evaluation. However, the indicators themselves have not always been achieved, while problems have been experienced finding sufficient data to assess whether indicators have been met. In most countries analysed, the EC has had reasonably ambitious health-related

indicators for both SBS and GBS programmes. Regional instruments and regional applications of thematic instruments were used when cross-border and regional aspects were prominent.

There is no strong evidence of a significant positive impact of budget support on national health expenditures and on budget processes at both central and decentralised levels. There is, however, evidence that SBS has resulted in increased levels of capacity building support for health, including all EC financed SBS and in some instances GBS.

**Sustainability:** The sustainability of EC health impacts has remained limited. A major theme is the persistent and continuing under-resourcing of health sectors by beneficiary governments. If the economic growth, good governance, sound public financial management and stability required for solid fiscal accounts are not present and combined with a policy commitment to providing adequate health care, the current situation will prevail. EC assistance, like all donor assistance, can seek to break countries out of this low-level equilibrium trap, but this evaluation has found no clear examples of national health sector-wide success stories. While the evaluation has found some clear evidence of successful impacts, it is unclear whether many of these will persist once donor support is withdrawn.

**EU added value:** One way of approaching the question of added value is to ask what the EC was able to provide that other donors would have been incapable or less capable of providing. The EC, with its wide range of health policy styles in its Member States and its close linguistic and historical ties with some developing regions, has a comparative advantage in TA and it provided a great deal in the health sector. Another area in which the EC clearly added value was in promoting global public goods for health, an area in which, nation-states under-provide and joint action is required. In most other areas, it is hard to define a unique EC contribution, which is, of course, not to downplay the massive financial resources that it has supplied.

**Co-ordination, complementarity and coherence:** The Paris Declaration of 2005 and health-sector specific initiatives such as the International Health Partnership Initiative (IHP+) and Joint Assessments of National Health Strategies (JANS) have strengthened joint efforts between donors and governments. The EC has played a key role especially in MS co-ordination as well as in co-ordination mechanisms including partner governments. While, the role of partner governments in donor-government co-ordination mechanisms has increased, weak capacity and low government leadership continue to be bottlenecks. The persistence of projects is testimony to governments'

continuing tendency, widely reported although not established by any specific findings in this evaluation, to accept whatever interventions are offered.

There could be better co-ordination and complementarity between the multiple interventions that are supported by the EC through multiple instruments, modalities and channels. The strategic relationship between thematic budget lines projects (managed from Brussels and not tailored to country strategies), GFATM projects and bilateral geographical programmes was often not clear. There was no sign of co-ordination between regional and bilateral programmes. Under such circumstances, there were overlap and lack of coherence.

### Main conclusions of the evaluation

For analytical clarity we have grouped the conclusion into three clusters.

#### Cluster 1: Strategic focus

##### **Conclusion 1: The EC still lacks a clearly articulated and implemented global strategy for health co-operation with developing countries**

The EC was involved in almost every aspect of health, using a wide range of financing instruments, modalities and aid channels. While a strong anti-poverty focus was successfully maintained, it is difficult to identify any single, coherent and focused strategy in health with clearly defined priorities. At field level, CSPs were aligned with national health priorities for the most part, but coherence with an overall EC vision was lacking. The absence of sufficient technical expertise in many EUDs worsened the situation.

##### **Conclusion 2: EC health strategies have tended to focus on the present, not the longer term over which health sector development takes place (such as urbanisation and the demographic and epidemiological transitions)**

Because of its development co-operation cycle, the EC is in a weak position to take long-term trends into account. Some health challenges are immediate, and EC co-operation has effectively addressed many of these (as detailed below in Cluster 2). Yet, others are closely linked to demographic, economic and social development, so they emerge and evolve over the long term. The EC's global health strategy, to the extent that it can be identified, focused primarily on near-term problems and solutions, paying insufficient attention to the longer time frame over which health sector development occurs (one, if not several, decades).

##### **Conclusion 3: The magnitude and sustainability of impacts of EC support to health system strengthening are limited**

Despite the clear link with poverty, its prominent role in the MDGs, and donor (including EC) pressure to pay more attention to the social sectors, health remains a low budgetary priority sector in most co-operation partner countries. In some of the poorest, the share of total health expenditure that is donor-financed is unsustainably high. Long-term progress towards better health in poor countries, which requires durable health sector reform, is dependent on increasing national resource allocations to the sector. This requires economic growth, better governance, stability and absence of conflict, in addition to shifts in policy attitudes and priorities.

#### Cluster 2: EC support to specific thematic issues

##### **Conclusion 4: EC direct support to infrastructure / equipment has had limited impact and sustainability**

EC direct support to infrastructure and equipment provision has increased access to health care in specific geographical areas (disadvantaged areas in some countries), but has been limited overall. While policy dialogue through SBS improved policy making, planning and management related to infrastructure and equipment, issues of maintenance and operating cost were neglected. These are most closely tied to the under-resourcing of public health systems, and there is little evidence that the EC made progress in addressing this problem.

##### **Conclusion 5: EC commitment to addressing the HR crisis in health has not much concrete impact at country level**

Through its 2006 Communication, the EC has pledged to take actions to tackle the HR crisis in health and EC project documents and SBS / GBS policy matrices regularly cite the HR crisis, as called for by policy. However, the shortage and attrition of trained health personnel remain serious in most countries and EC actions have been limited.

##### **Conclusion 6: The EC's support to health care finance only yielded mixed success in reducing out-of-pocket payments as a share of total health care spending**

In a number of countries, EC TA has supported overall health sector financial reform. Unsustainable financing policies have been addressed (e.g. in Moldova), new strategies have been proposed and piloted (e.g. in Egypt and Lao PDR), and existing health insurance schemes have been reformed (e.g. in the Philippines). In many cases, despite policy changes, the key indicator of out-of-pocket payments as a share of total health expenditure has remained high or has increased. Overall evidence for SBS / GBS contribution to

increased public budgetary resources in health is thin. Nevertheless, some countries that received GBS did experience significant declines in out-of-pocket payments.

***Conclusion 7: Geographically targeted interventions improved access to health care for the poorest populations***

When it was geographically targeted, EC assistance concentrated on rural regions where health was poorest and access to quality health care was lowest. The EC scored some successes in worst-off regions. However, in concentrating its resources on rural areas – a strategy that responds to the broad-urban-rural gap in health – the EC did not take into account the fact that health challenges are gradually shifting from urban to rural areas because of urbanisation.

***Conclusion 8: EC support to MNCH resulted in significant progress in many settings***

The EC provided support to improved MNCH, mostly through its support to primary health care (the number of interventions exclusively devoted to MNCH has been low). In a wide range of settings, there has been progress against maternal mortality and under-five mortality - the two MDGs directly related to MNCH. However, progress towards these MDGs has been disappointing due to the problem's complex nature. In addition, the goals set were unrealistically ambitious.

***Conclusion 9: EC contribution to health improvements has remained modest in the case of fragile states***

One of the largest EC health programmes was that in Afghanistan, with a well-documented impact on health status. Support to other fragile states, however, has remained much more modest. In such settings, the EC was also more bound by procedural constraints than other donors, and would need to be more innovative to contribute significantly to progress.

***Conclusion 10: Although the EC has contributed to improved health sector policy and management, impact on resource availability has been modest***

In most countries where the EC has been involved in health co-operation, EC support, especially SBS, has led to improved health sector policy making capacities and improved management practices. While capacity for better PFM has been increased, the ultimate impact on health sector PFM has often not been seen. Not only PFM capacity, but also increased national resource allocations to the health sector are needed.

***Conclusion 11: The EC significantly contributed to the production of global and regional public goods for health***

Through support to research, infectious disease control (much of it through the Global Fund, GAVI and the initiative to eliminate polio, but also in emerging areas such as cross-border veterinary health and pandemic influenza), the EC contributed to the production of global and regional public goods for health. This is appropriate in view of its status as a supranational organisation. In the case of GFATM and GAVI, the significant role of EC HQ stands in contrast to the limited role played by most EUDs, meaning that co-ordination with other EC programmes was lacking.

***Cluster 3: EC interaction with donors and partner governments in the health sector***

***Conclusions 12 & 13: While increasingly honouring Paris Declaration commitments, the lack of technical expertise in EUDs has limited the EC's potential co-ordination role***

The EC has exploited its role as a supranational organisation and its special relationship with the EU MS. However, the shortage of technical expertise in EUDs placed it at a comparative disadvantage relative to other donors and governments.

The EC contributed to reducing health co-operation transaction costs for recipient governments through a reduction in PIUs and, despite the persistence of the project approach, moved towards sector support through SBS and GBS. However, one of the most recent instruments for this, Delegated Co-operation, was little utilised as of the end of the evaluation period. Moreover, EC effectiveness and impact were weakened by under-staffing in EUDs.

***Conclusions 14 - 16: While participation in policy dialogue in the context of sector-wide approach (SWAp) / SBS / GBS has contributed to better health sector policies and management, concrete increases in resources allocated to health were rare***

Despite capacity shortages, EUD policy dialogue as part of the wider donor dialogue related to GBS and sector support has contributed to improved capacity. However, strong evidence was not found that this has resulted in higher budget allocations for health.

The indicators chosen to form the SBS and GBS performance assessment frameworks were in most cases reasonably well specified and addressed the core health sector issues. In some instances, however, a lack of data made it difficult to track progress of chosen indicators.

In many settings (e.g. the Philippines, Vietnam), EC participation in multi-donor trust funds at country level has proven effective. The main factors of success in the implementation of such funds were a regular and transparent dialogue between do-

nors and partner governments, and the active participation of EUDs in the steering and co-ordination committees. Once more, however, limited technical capacity of Delegations has been a constraining factor.

**Conclusion 17: The mix of EC aid modalities could be more coherent and strategic**

In the health sector, the EC uses a wide range of aid modalities, which are increasingly aligned with recipient government systems. However, it is often not clear why alternative aid modalities and funding channels were not chosen and how those chosen were meant to be complementary. This has led to a lack of coherence and consistency between programmes.

**Main recommendations of the evaluation**

Eleven recommendations have been derived from the established conclusions. They are presented under the headings: *strategic recommendations and operational recommendations*. Recommendations 1, 5, 6 and 8 are considered both most important and most urgent.

**Strategic level**

**Recommendation 1: Consolidate various global policy statements and approaches into a comprehensive health co-operation strategy that can be effectively operationalised at the field level in conformity with national sector development plans**

Conclusion 1 found that the EC's global health strategy, which seeks to cover all fronts at once, does not result in sound country-level strategies, especially since thinly staffed EUDs lack the capacity to absorb the potential workload. In order to rise above the current activity-driven approach, the EU should review, consolidate and synthesise its health co-operation strategies, possibly in the form of a White Paper. Major dimensions of a comprehensive approach should be identified, including an anti-poverty focus, primary health care (PHC), health systems strengthening, health care finance, global public goods, HR, etc. The goal should not be a one-size-fits-all approach. Instead, the approach should be sufficiently broad and well-articulated to allow individual components to be matched to country priorities and other donors' activities, and to identify priority interventions while ensuring that major issues are covered. In this way, capacity building, for instance, will need to be matched with HR policy; infrastructure and equipment needs with health care finance via maintenance and operating budgets; support for vertical programmes with health systems strengthening; etc.

The persistent fragmentation of health aid and the need for improved co-ordination with national

health sector plans and budget cycles argues for a continued strong role for both SBS and GBS. In providing budget support, account must be taken of countries' policy commitments and resource allocation decisions related to social sector reform. Governments should be asked to make a credible case for how budget support has contributed to making available additional resources for inclusive and equitable health sector development, including health finance and social protection reform, where needed. This will serve EU accountability and increase country ownership. The hallmarks of the approach should be (i) identification, prioritisation and choice of interventions while maintaining enough breadth to allow consistency with national programmes; and (ii) avoidance of overlaps with other agencies such as GFATM, UNFOPA and UNICEF. It would translate overarching policy commitments into a menu of choices from which to choose in line with individual national strategic priorities.

**Recommendation 2: When defining the focus of support, take the shifting burden of disease and structural shifts such as urbanisation more carefully into account**

Little notice has been taken of the challenges associated with urbanisation and non-communicable diseases. The EC should take these into account when formulating global and country health strategies. The impact of climate change on health is another area in need of consideration. The health-poverty focus has rightly led the EC to concentrate on rural areas, but poverty is increasingly an urban phenomenon and the EC's health strategy should be pro-active along this dimension.

With its emphasis on primary health care and poverty focus, the EC is perhaps not in a strong position to directly address chronic conditions and non-communicable diseases, which often require secondary-and tertiary-level care. There are, however, several areas where the EC can nevertheless intervene. One is encouraging health planners to ~~squarely~~ address road trauma and mental disease. Integrated PHC programmes - a clear and continuing focus of the EC - can be adapted to play an important role in doing so (e.g. through health promotion, blood pressure monitoring, routine screening procedures, etc.). Addressing non-communicable diseases does not compete with primary health care, but leverages it.

**Recommendation 3: While continuing to support global initiatives such as GFATM and GAVI, the EC should use its influence to encourage further moves towards the health system's strengthening components of such vertical programmes and in particular address HR consequences**

The EC should continue supporting global initiatives such as the Global Fund and GAVI. However, the Health System Strengthening (HSS) components of the GFATM and GAVI proposals (since Round 8) provide an entry point for HSS support and should therefore be prioritised. The EC's considerable role in financing these initiatives gives it a strong say in pushing them in the direction of systems strengthening. In addition to aligning more closely with country priorities, this will help address the HR crisis, which is significant, partly due to health professionals having been absorbed by vertical programmes. The HSS approach is crosscutting and horizontal in addressing the weakest aspects of health systems, including service delivery, and more in line with the goal to create a strong PHC framework.

***Recommendation 4: In order to improve coherence, the EC should be more strategic regarding the choice of instruments***

The EC needs to be more strategic regarding which aid instruments to use in which contexts. Thematic programmes need to be coherent with geographic programmes, while consideration needs to be given as to how GBS, SBS and other sector support and projects can be complementary. GBS is the modality most likely to succeed in raising key health sector issues to a higher level of dialogue, with the achievement of objectives supported through a coherent series of interventions through sector support programmes and projects aimed at improving service delivery. SBS and other sector support can support dialogue aimed at better health sector management and related strategic interventions. A greater use of SBS should also be considered, with capacity building support given prior to SBS to ensure that the EC pre-requisites can be met.

Fragile states present a special challenge. Though relatively little EC assistance has gone to such countries, impacts have been substantial. In fragile states, emphasis should be put on strengthening basic service provision as a means of confidence building and, in situations of conflict or near-conflict, building bridges. Operations in fragile states should be innovative, flexible and adaptable, as situations may change rapidly.

***Recommendation 5: The EC should strengthen the technical health capacity of EUDs or, in countries where this is impossible, consider either reducing its direct participation in the health sector, delegating to others by participating in pooled funding, or drawing on expertise in EU MS embassies***

Most EUDs, even in countries with significant health engagement, are short of technical capacity. In order for policy dialogue related to sector SPSP and budget support to be effective, EUDs must have sufficient in-house expertise in health

and PFM. EUD participation in co-ordination exercises and multi-donor trust funds, input into policy dialogue and EC visibility suffer if credible expertise is lacking. The planned tightening of focus on only three focal areas per country is an opportunity for doing an inventory of HR needs and formulating a staffing plan. Where needed, if technical expertise cannot be mobilised, delegated co-operation may be employed to access the skilled staff of EU MS embassies.

***Recommendation 6: More explicit actions are called for in favour of HR for health***

In many developing countries, ministries of health struggle to attract and retain sufficient numbers and types of health personnel to provide quality services, especially in rural and remote areas. The EC should pay more attention to this issue, e.g. through HR planning in consultation with key stakeholders to provide a framework and strategic directions to guide the development of an effective workforce that can meet the challenges facing in countries' health systems. One of the key pillars of the strategy should be to ensure appropriate incentives for health workers based on national policy and legislation.

Moreover, the EC should ensure that human resources for health (HRH) are taken into account in SBS / GBS policy matrices. It should act in concert with other donors and government to reduce HR "poaching" from the public health system.

The EC should also explore the links between problems experienced in Third Countries and the burgeoning demand for health worker immigrants in EU MS. In so doing, co-ordination and liaison with the MS and WHO would be especially valuable.

***Operational recommendations, specific themes***

***Recommendation 7: Take greater account of complementarities, synergies and inter-sectoral links***

The EC's country programmes should take into greater account the synergies, complementarities and cost-efficiency potentials that exist between different sectors such as health, rural development, food security, water and sanitation, and transport. In many settings, seemingly separate policies can in reality be closely tied, such as the provision of effective community-level health care, a referral system based on mobile telephony and emergency transport availability, deserve consideration. Particularly in MNCH and in dealing with remote regions, integrated approaches may be important in accelerating progress. In addition, EUDs should ensure that, in aligning with national sector development plans, co-operation is also aligned with EU policies on climate change, migration and environment.

As education, health and social protection are priority sectors and since the new approach is to limit assistance in three priority sectors, if one of these is selected, then aspects of the other two should be mainstreamed into the support package.

**Recommendation 8: The EC should undertake a systematic review of its health system finance support to identify lessons learned and directions for further action**

In view of the EC's (and other donors') generally weak record in effectively, sustainably and equitably reforming health system finance and the crucial importance of increasing resources available to the health sector, the EC should conduct a thematic review specifically devoted to this area, in order to identify lessons learned and new strategic directions. The EU MS, having succeeded in delivering reasonably affordable health care in a financially sustainable manner in their own countries, are in a unique position to provide policy advice in this central area. The role of the private sector – which accounts for more than half of health spending in many developing countries – should be given more attention than in the past. Where out-of-pocket payments remain high despite health system finance reform, causes should be identified and shared with partners and stakeholders. The actuarial sustainability of mandatory public health insurance should be analysed in a selection of partner countries and income distribution and poverty consequences of health system finance should be assessed.

**Recommendation 9: Regardless of the modality chosen, EC support to health infrastructure should more realistically assess operations and maintenance requirements**

While infrastructure and equipment are not and should not be EC priorities, in those cases where the EC does provide these, it should more carefully assess the operations and maintenance requirements that arise. Whenever the EC is involved in support to infrastructure and equipment (e.g. vehicles, medical equipment, cold chain technologies) an amount of the project/programme budget should be allocated to a simple ad hoc maintenance strategy and plan. From the effectiveness, efficiency and sustainability perspectives, the EC needs to tighten the link between facilities and health system finance. The EC clearly cannot itself finance operations and maintenance. However, through sector support and, to the extent possible, GBS, it should support the strengthening of ad hoc maintenance strate-

gies following WHO guidelines on performance inspections, preventive maintenance and corrective maintenance. Monitoring and data collection regarding the state of infrastructure and equipment need to be improved.

**Recommendation 10: Pay greater attention to innovative approaches to target remote, isolated and vulnerable population and minorities**

The worst health outcomes are increasingly concentrated in remote areas, often populated by ethnic minorities and affected by conflict. These are difficult areas to work in, incurring high operational costs. Therefore, the EC should help to develop comprehensive strategies at country level that are tailored to local circumstances. Where needed, the EC should support data gathering and mapping exercises in MoHs. In some cases, traditional provision of infrastructure and equipment, typically through NGO projects, will be appropriate. In others, supporting government in putting in place an HR policy that relieves staff shortages will be more effective. In addition, innovative approaches involving mobile telephony and community health workers, bush ambulance services, medical evacuation, etc. may be more cost effective. Improving health system performance in remote and disadvantaged regions could be added to SBS / GBS policy matrices. Moreover, in these regions, the EC should consider the role of health in other sectors—such as rural development, roads and water and sanitation. Geographical division of labour may be called for in some countries.

**Recommendation 11: Pay increased attention to data needs, particularly in designing sector and GBS interventions**

There exists almost everywhere a solid core of data regarding key indicators such as mortality and vaccination. However, data needed to guide government policy, donor policy dialogue and resource allocation now include a much wider range of issues: e.g. infrastructure, budgets and health outcomes and expenditure data disaggregated by income, poverty status, household structure, sex, age, etc., as well as geographical disaggregation. In the context of its sector support, the EC should continue to strengthen data collection, stressing not only disaggregation, but timeliness, as data five or more years old are of little use. This may require co-operation with statistical agencies as well as the EC's traditional MoH partners.



## 1 Introduction

This final report presents the outcome of the “Thematic evaluation of the European Commission support to the health sector”. The evaluation was commissioned by DG DEVCO’s Evaluation Unit<sup>5</sup> and was implemented between January 2011 and July 2012.

### 1.1 Overall objective and scope of the evaluation

The EC recognises the health of individuals and populations as one of the major determinants of economic growth and social development and acknowledges that ill health is both a cause and effect of poverty. Its support to health related sectors is thus an integral part of its development policies and programmes, which is consistent with the development efforts of the larger international community.

Systematic and timely evaluation of its expenditure programmes is an established priority for the EC as a mean of accounting for the management of allocated funds and as a way of promoting a lesson-learning culture throughout the organisation. To be in line with its priorities, the EC has commissioned the evaluation of EC support to the health sector.

According to the Terms of References (ToR) of this evaluation, the purpose of the evaluation is to assess to what extent the EC assistance:

- has been **relevant, effective, efficient** and **sustainable** in providing the expected **impacts** in the health sector;
- is **co-ordinated and complementary** with other donors activities, other relevant EC policies, the partner governments' priorities and activities and with international legal commitments in health;
- provides specific **EU added-value**.

In answering these questions, the evaluation will mainly inform the implementation of the EC health policy and shall give indication of bottlenecks and challenges to be addressed in the future support to the health sector and could – as foreseen in the ToR – be used as a baseline for future EC support to the health sector.

The main objectives of this evaluation thus are:

- to provide the users of the evaluation with an overall independent assessment of EC’s past and current support to the health sector policy development;
- to identify key lessons and to provide recommendations for policy decision-making and project management purposes, in order to improve current and future strategies for continued support to the health sector policy development in partner countries.

In terms of **temporal scope**, the evaluation covers aid implementation over the period 2002-2010. The **geographical scope** of the evaluation covers all countries benefitting from EC co-operating support, excluding the countries under the mandate of DG Enlargement as well as the activities financed under DG ECHO.

The evaluation takes into account all aid modalities that are used in the health sector, including sector and general budget support as well as funds channelled through multilateral organisations or global initiatives, such as GFATM or GAVI. Furthermore, all bilateral health support is taken into account, covering geographical budget lines (financed by the EDF and the geographical DCI) and all relevant thematic budget lines.

The evaluation focuses on health policy development and the choice was made to **explicitly exclude EC support to poverty related diseases (PRDs)**, namely Malaria, Tuberculosis and HIV/AIDS **from the scope of this evaluation**. This choice is grounded on the need to keep the evaluation focused in order to be able to achieve meaningful results, taking into account time and resource constraints.

### 1.2 Structure of the final report

Volume 1 of the Final Report is structured as follows:

- Chapter 1 - Introduction: this chapter presents a brief overview of the evaluation purpose and scope, as well as background and context information.
- Chapter 2 - Methodology: this chapter includes the final EQs and details the methodological approach, the tools and the sources of information used during the evaluation.

<sup>5</sup> Former Joint Evaluation Unit common to Directorates General of External Relations (RELEX), of Development (DEV) and the EuropeAid Co-operation Office.

- Chapter 3 - Background: this chapter presents a brief overview of the international and EC background on the development aid to the health sector.
- Chapter 4 - Inventory: this chapter presents a short résumé of EC financial contribution to the health sector between 2002 and 2010.
- Chapter 5 - Answers to the Evaluation Questions: this chapter presents, for each of the seven Evaluation Questions, a summary box and the detailed answer.
- Chapter 6 - Conclusions and recommendations: this chapter presents a full set of conclusions and recommendations (clustered in groups).

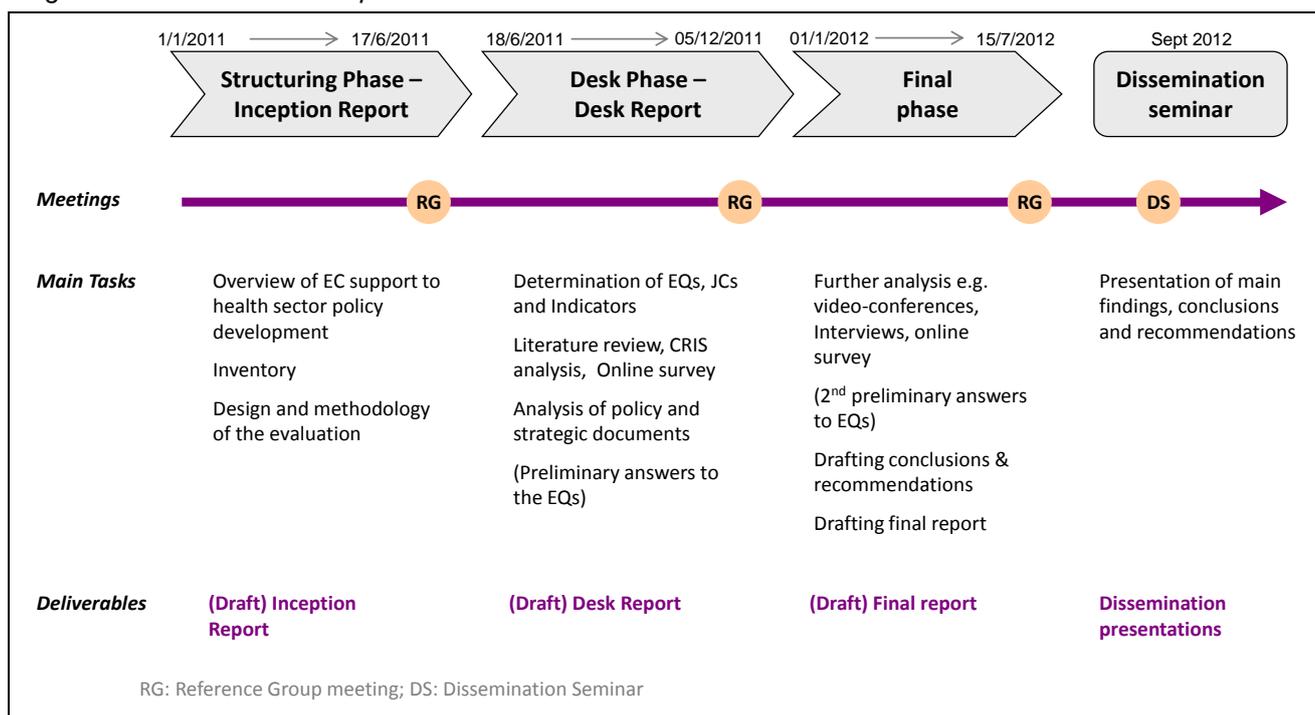
## 2 Methodology

### 2.1 Key steps of the evaluation process

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.<sup>6</sup>

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<sup>7</sup>, 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 and are described more in detail in the next paragraphs.

<sup>6</sup> General information on these guidelines can be found online at: [http://ec.europa.eu/europeaid/how/evaluation/methodology/index\\_en.htm](http://ec.europa.eu/europeaid/how/evaluation/methodology/index_en.htm)

<sup>7</sup> The lists include some major tasks carried out in each phase, but they are not meant to be exhaustive.

*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 has been 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.*

**The methodology and tools used in each of the three phases as well as further details regarding the challenges can be found in Annex 22.**

### 2.1.1 Inception phase

At the beginning of the evaluation 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). Moreover, the intervention logic (see figure 3) underlying the rationale of EC support to the health sector was reconstructed. Once these two overviews were available, the team built the methodological framework for the entire exercise during the inception stage.

The evaluation is structured around **seven evaluation questions** (see Table 5) 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 DAC criteria and EC specific criteria, such as ‘added value and ‘3Cs’.

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 (**evaluation matrix**). 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 design for the evaluation was a **multiple case study with literal replication** based on the use of a **mixed-methods approach**.

**A sample of 25 countries** was selected on which the in-depth data collection would be focused on. These countries should be regarded as representing and reflecting the broad range of EC support to health. The selection criteria used and final country selection can be found in Annex 24 which also provides an overview of priority interventions per country. 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, 18, 19).

### 2.1.2 Collecting Data (Desk study phase)

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 head-quarter staff, person in charge of health in EUDs, Ministries of health and lead donors in the countries).

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 overview of tools used during the evaluation is provided in Annex 22.

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 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.

### 2.1.3 Synthesis phase

The synthesis phase was devoted to further **fill gaps** detected during the desk study phase, to **validate preliminary findings** to the evaluation questions and **formulating conclusions and recommendations** on the basis of the data collected throughout the process. 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.

The combination of answers to the different EQs (see Chapter 5) in the main report allowed the team to formulate more general judgements in the form of Conclusions (see Chapter 6.1) and, on that basis, to propose a set of Recommendations (see Chapter 6.2). This approach allowed for a clear linkage between EQs (findings), conclusions and recommendations.

#### **2.1.4 Dissemination seminar,**

The final step will consist of a **dissemination seminar**, which gathers stakeholders and the interested public to discuss the evaluation results, conclusions and recommendations.

## **2.2 Challenges and limitations**

### **2.2.1 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.

### **2.2.2 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<sup>8</sup> 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.<sup>9</sup> 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 best practice. 18 persons have been interviewed by phone in eight countries. The list of people interviewed can be found in Annex 30.

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<sup>8</sup> 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 co-ordination of donors.

<sup>9</sup> 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.

### 2.2.3 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.

### 2.2.4 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, in particular the non-systematic classification of interventions. In order to retrieve the interventions belonging to a specific sector a fuzzier, more subjective and more innovative approach, including tedious line-by-line review of interventions, s, was required to elaborate a comprehensive inventory of EC support to the health sector. The detailed methodology used is outlined in Annex 2.

### 2.2.5 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<sup>10</sup> 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.

<sup>10</sup> 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.

## 3 Background and context of EC support to the health sector

### 3.1 Current international development co-operation and health sector framework

#### 3.1.1 Development Co-operation context

##### **Aid effectiveness and MDG contracts**

After a lot of criticism from inside and outside, the international development aid system has witnessed a number of initiatives and changes, with the aim of increasing the effectiveness of aid. In terms of policy commitments, the international efforts to increase and assure financial support while at the same time improving aid-effectiveness have led to different declarations, starting with the Monterrey accord in 2002, followed by the declarations of Rome (2003), Paris (2005), Accra (2008) and Busan (2011). All these subsequent declarations aimed at enforcing the principles of ownership, harmonisation, alignment, results-based management and mutual accountability in development partnership in the aid delivery system.

On a European level, the principle of harmonisation with other development partners is, highlighted in the 2005 European Consensus on Development. The EU has recognised the challenges of, yet also opportunities for, harmonisation with (and between) Member States at policy and country operational levels by improving donor co-ordination practices. The development of protocols around the 3Cs (Co-ordination, Coherence and Complementarity) as principles for the development activities of the EU and Member States reflects this.

Since 2000, the EC has become a proponent and leading actor in joint approaches towards increasing resources and improving the processes to deliver development assistance, which has accelerated over recent years. In this sense, it has strongly committed itself to sector or general budget support as the financial modality that augurs best for country ownership, alignment with country priorities and accountability, reduce transaction costs and to improve harmonisation and coherence with other partners as well as reinforce the predictability of aid. With the MDG Contract, introduced in 2008 in ACP countries<sup>11</sup>, the EC intended to provide more long-term and predictable support.

In many countries, the health sector has been at the forefront of these initiatives as well as a testing ground due to its specific characteristics, namely to be a service delivery sector with a huge budget and complex dependencies and in which there is usually many interested development partners, often with a tradition of fragmented support and strong donor suspicion of crowding out and/or lack of additionality.

##### **Poverty reduction strategies (PRS)**

The PRS initiative, introduced in World Bank (WB) and International Monetary Fund (IMF) operations in 1999, has become a key element in the international development aid architecture.<sup>12</sup> It requires a comprehensive country-based strategy for poverty reduction, the Poverty Reduction Strategy Paper (PRSP). These strategies should be genuinely country-owned and reflect the outcome of an open participatory process involving governments, civil society and relevant international institutions and donors. PRS seeks to link and bridge national public actions and external support with development outcomes in order to meet the development goals, such as the MDGs. PRSPs, as the reflexion of the partner country's policy priorities are and will further be a major point of reference for EC co-operation with its partner countries, as highlighted in the 2011 Communication *Global Europe: A New Approach to financing EU external action*<sup>13</sup>. Health is usually an element covered by a PRSP, especially in least developed countries.

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<sup>11</sup> "The MDG Contract – An approach for longer-term and more predictable General Budget Support" (2008)

<sup>12</sup> <http://go.worldbank.org/OA7M2IKHL0>.

<sup>13</sup> COM(2011)865: Joint Communication to the European Parliament and the Council. *Global Europe: A New Approach to financing EU external action*.

### 3.1.2 International health commitments and initiatives

#### **Millennium Development Goals Initiative (MDGs)**

Adopted by world leaders in the year 2000 and set to be achieved by 2015, the MDGs provide concrete, numerical benchmarks for tackling extreme poverty in its many dimensions. They have set the policy priority for most donors and partner countries. The health related MDGs are:

- MDG 4: Reduce Child Mortality
- MDG 5: Improve Maternal Health
- MDG 6: Combat HIV/AIDS, malaria and other diseases
- MDG 8: Develop a global partnership for development, Target 8e: 'In co-operation with pharmaceutical companies, provide access to affordable essential drugs in developing countries'

Both early and more recent reviews have concluded that the health MDGs are among those where there has been the least progress, in particular in Sub-Saharan Africa. Based on current trends, most human development MDGs – especially for child and maternal mortality, but also for primary school completion, nutrition and sanitation – are unlikely to be met at the global level.

Lacklustre progress on the health MDGs is closely related to the aid effectiveness issue. It is in this context that questions about the effectiveness of health spending and the integrity of the aid architecture in health have arisen.<sup>14</sup> In addition to issues common to all sectors, such as aid predictability and the need for monitoring, aid in the health sector is characterised by some specific problems. One is insufficient funding of holistic policy approaches; another is the fact that health is characterised by a multitude of stakeholders and interested agencies, raising the difficulty of adequate co-ordination. The multiplication of disease-specific initiatives has proven to be a double-edged sword as, for example, the increase in the share of health aid devoted to HIV/AIDS was accompanied by a decline in the share devoted to primary health.

#### **Major global initiatives**

The last decade has seen the growth and emergence of a number of major initiatives in the area of global health. Among these are (to quote only a selection, which will also be further analysed in the evaluation

- GFATM - The Global Fund to Fight AIDS, Tuberculosis and Malaria,
- GAVI – The Global Alliance for Vaccines and Immunisation,
- The Global Polio Eradication Initiative,
- International Health Partnership HIP+.

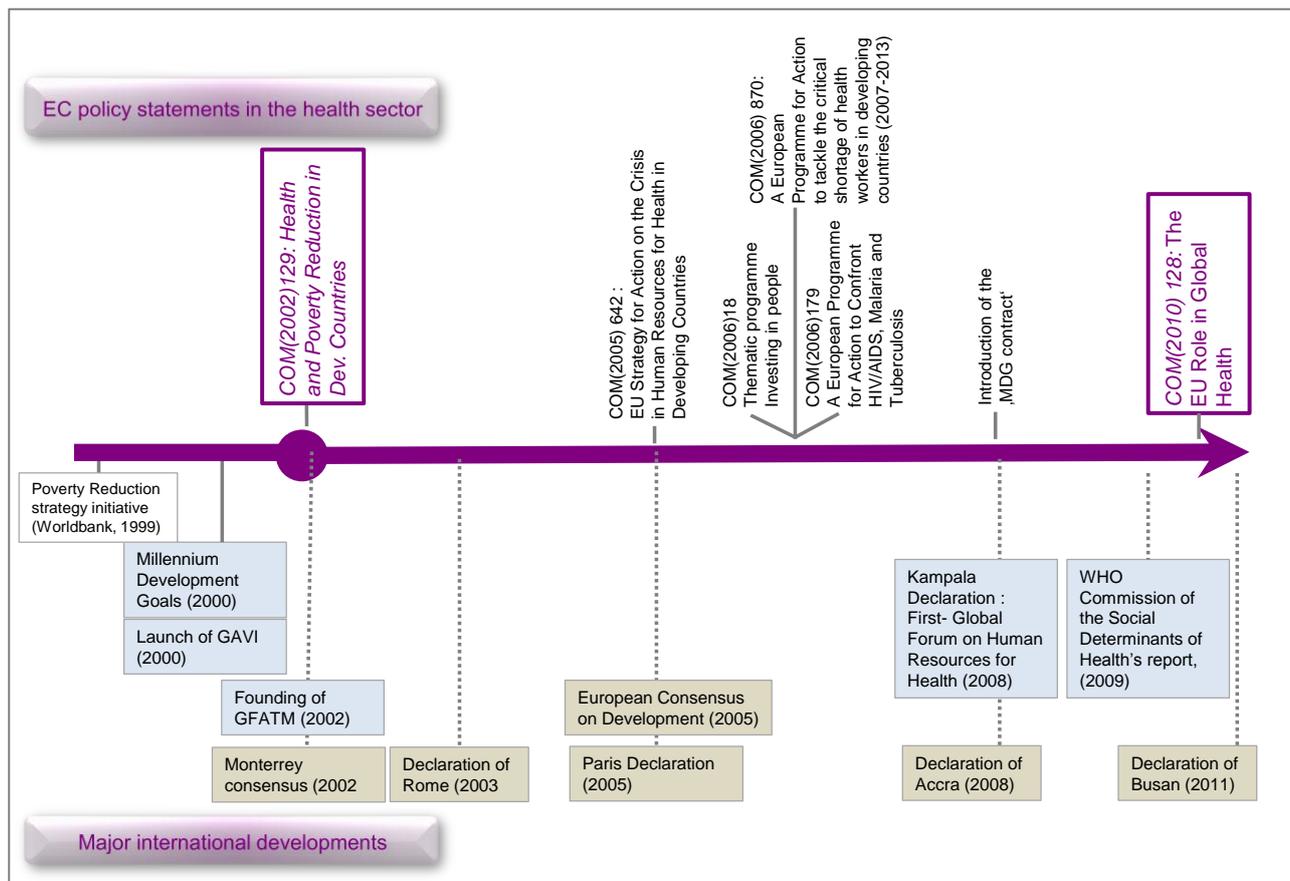
The next chapter describes more in detail how these international developments have contributed to shaping the EC support to the health sector.

## 3.2 EC strategy and support to the health sector over the period 2002-2010

This chapter sets out the main elements of EC policy related to health in communications, as spelled out in overarching policy documents that are of relevance for support to health in all partner countries. The EC policy statements in the health sector are closely linked to the developments (global discussion on development co-operation as well as sector specific developments) that have been briefly discussed above. The following figure gives an overview on the main strategic events in the evaluation period.

<sup>14</sup> Dodd, Rebecca, George Schieber Andrew Cassels, Lisa Fleisher and Pablo Gottret. 2002. *Aid Effectiveness and Health*. Geneva: Making Health Systems Work: Working Paper No.9, WHO/HSS/healthsystems/2007.2, World Health Organisation.

Figure 2: Synthetic timeline of most important events/strategies at global and EC level



Legend:

Aid effectiveness conferences

Annex 28 provides further information about some regional specificities relevant for supporting the health section, e.g. in the ACP countries; Annex 29 focuses on further details related to the consideration of cross-cutting issues in EC policies related to supporting the health sector in partner countries.

### 3.2.1 Overview on major EC policy statements in the health sector

EU Communications and other policy pronouncements confirm that co-operation policy in health has resonated both with the changing international co-operation framework and the global health and development landscape, sketched above. During the evaluation period of concern, the EC priorities for the health sector were defined through specific references that have successively focused on the links between health and poverty and between health and development; population issues; social protection; and financial and technical co-operation instruments.

Landmark documents include:

- Communication on “*Health and Poverty Reduction in Developing Countries*”, COM (2002)129;
- Communication on “*A European Program for Action to tackle the critical shortage of health workers in developing countries (2007-2013)*”, (COM(2006)870);
- Communication on “*Thematic programmes for human and social development and the financial perspective*”, COM(2006)18;
- Communication on “*The EU Role in Global Health*”, COM (2010) 128.

Furthermore, different communications related to poverty related diseases have been published<sup>15</sup> and a significant share of EC's external policy efforts in the area of health are concentrated on the fight against major

<sup>15</sup> The main communications are (list not exhaustive):

PRDs, HIV/AIDS, malaria and tuberculosis. However, as PRDs have been excluded from the scope of the evaluation, these communications have not been further analysed.

The most relevant communications are described in more details in the next paragraphs. The evaluation team has given a special attention to the 2002 and 2010 Communications, as those more or less frame the evaluation period and as such the first served as baseline and policy framework against which EC action would be evaluated.

### **Communication on Health and Poverty (COM 129 2002)**

The basis for all work in health over the evaluation period was the *Communication from the Commission on Health and Poverty Reduction (COM 129 2002)*, which dealt with the new challenges for development and declared that “*improving the health of the poor is both a vital contribution to efforts to reduce poverty and a moral imperative.*” This communication established an EC policy framework to guide investment in health, AIDS and population for attaining the health MDGs. The framework had four strands:

- To improve health, AIDS and population outcomes at country level, especially among the poorest countries;
- To maximise health benefits and minimise the potential negative health effects of EC support for other sectors;
- To protect the most vulnerable from poverty through support for equitable and fair health financing mechanisms;
- To invest in the development of specific global public goods.

Particular challenges identified were the implementation of pro-poor health policies, making health systems more equitable, assuring an environment compatible with a high standard of human health, expanding social protection, the operationalisation of new public/private partnerships for health, the need for greater investment in specific global public goods and the monitoring of performance, results and outcomes.

Although there are no specific other communications explicitly addressing health and poverty, many of the other communications have included poverty reduction strategies on their agenda in order to tackle problems such as health workforce shortages and brain drain, poverty-related diseases and health systems finance in developing countries.

### **Communication on health workers in developing countries (COM(2006) 870 final)**

On May 15 2006, the EU Council adopted the *A European Program for Action to tackle the critical shortage of health workers in developing countries (2007-2013) (COM(2006) 870 final)*. This action programme consisted of a package of action-oriented decisions which included 1) the incorporation of human resources issues into PRDs and health policy discussions and 2) the support and financing of national human resources plans. The Council also adopted an EU Consensus Statement on the Crisis in Human Resources for Health, stating that: “*Europe is committed to supporting international action to address the global shortage of health workers and the crisis in human resources for health in developing countries*”:

- At country level, emphasis was put on several issues, namely: policy dialogue and policy planning; capacity building, including human resources management training; developing south-south and north-south learning communities; linking programmes between professional bodies and regulatory agencies; and the support of research on this topic.
- On a regional level, the EC committed itself to support the mapping, analysis and the technical and political dialogue on human resources necessary for effective advocacy and action.
- At the global level, the internal EU action sought to develop a set of principles to guide recruitment of health workers within the EU and recruitment from third countries; develop guidelines and mechanism for supporting ‘circular migration’ of health workers; and explore the feasibility of supporting partnerships between medical institutions in the EU and in the developing world, beside others.

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COM(2001) 612: Concerning the European Community contribution to the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria

COM(2003) 93: 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) 726: A Coherent European Policy Framework for External Action to Confront HIV/AIDS, Malaria and Tuberculosis;

COM(2005) 179 final: European Program for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action.

**Communication “Investing in People” (COM(2006) 18)**

The communication on *Investing in People* (COM(2006) 18) focuses on six core themes. (1) good health for all, (2) knowledge and skills, (3) culture, (4) employment and social cohesion, (5) gender equality and (6) children and youth. It drew attention to the critical lack of personnel in many developing countries' health care systems and to the leading poverty-related diseases HIV/AIDS, malaria and tuberculosis. 56% of the budget of *Investing in People* goes to the pillar *Good health for all*, with a focus on the two afore mentioned topics as well as to neglected or emerging diseases and the promotion sexual and reproductive health and rights. In order to ensure access to health care for all, the programme sets out to: a) mobilise global public goods to combat and prevent diseases; b) support innovative health measures; c) improve the regulatory framework; d) increase political and public awareness and education; e) improve technical resources.

**Communication “The EU Role in Global Health” (COM(2010) 128)**

In the communication on *The EU Role in Global Health of 2010* (COM(2010) 128), the EC emphasises again the need for a key position of health within the MDG framework. Taking into account the central role of health, a specific attention needs to be paid to multi-sectoral thinking and approaches, as health risks in developing countries are also depended on achievement of targets, not primarily health-related, such as the MDGs on nutrition (MDG 1), on gender equality (MDG 3), on environmental sustainability, including access to safe water and sanitation (MDG 7) and on the co-operation with the pharmaceutical industry concerning the provision of essential drugs (MDG 8). Five years before the targets of the MDGs are to be achieved, the EC recognised that many challenges had to be faced to reach these targets in a world of globalisation and global economic crisis. According to the Communication on Global Health, especially four challenges needs a specific attention. These are:

- Global governance on health: The EU should defend a single position within UN agencies and work to reduce the multiplicity of health projects.
- The challenge of universal coverage: The EU should ensure that development aid supports developing countries' efforts to build sustainable health systems and should promote division of labour among all actors, public and private, bringing knowledge and funding to the health sector.
- The challenge of policy coherence between EU internal and external policies: The EU will combine its leading role in trade and development to create a coherent approach to global health, including also issues such as migration, security, food security and climate change.
- The challenge of global health knowledge: The EU will strive to ensure that research and innovation produce accessible and affordable products and services and that no diseases are neglected.

Further, the communication recommended that the EC should:

- concentrate its aid to serve the most fragile populations and countries;
- strengthen the effectiveness and equity of health systems, as well as its functioning in terms of workforce, access to medicines, infrastructure, logistics and decentralised management;
- have recourse to global initiatives and existing international financial institutions, but also to innovative funding sources and mechanisms.

The Communication on Global Health is followed by three Commission staff working documents that draft response strategies for specific issues.

The first staff working document, entitled *Global health - responding to the challenges of globalisation*<sup>16</sup> outlines the seven pillars of the EU global health policy and strategy: coherence in development; promotion of Fundamental Rights and Public Goods; research and knowledge management; co-operation, co-ordination and export of experience and knowledge; foreign policy and governance; security; and Response to Globalisation (Market/Services).

The second staff document with the title *“European research and knowledge for global health”*<sup>17</sup> recognises medical knowledge as a global public good for health and focus strongly on supporting the research necessary to achieve the health-related millennium development goals. Specific research foci are: Specific International Co-operation Actions (SICAs); international public health and health systems; HIV/AIDS, malaria, tu-

<sup>16</sup> SEC(2010)380: Global health – responding to the challenges of globalization, accompanying document to the Communication COM(2010)128 on the EU Role in Global Health.

<sup>17</sup> SEC(2010) 381: European research and knowledge for global health; accompanying document to the Communication COM(2010)128 on the EU Role in Global Health.

berculosis; neglected infectious diseases; the European and Developing Countries Clinical Trials Partnership (EDCTP); and the Innovative Medicines Initiative.

The third staff working document “Contributing to universal coverage of health services through developing policy”<sup>18</sup> emphasised again the central role of health for poverty reduction and sustainable development. In particular, this communication calls for a better distribution of health aid across countries and health services, increased country ownership and better linking between poverty and health.

### 3.2.2 Intervention logic of the EC support to the health sector for the period 2002-2010

Based on analysis of the above policy documents, the intervention logic (IL) of the EC support to health has been reconstructed by the evaluation team; it is represented graphically in the impact diagram in Figure 3.

It summarises, across five columns, the hierarchy of objectives, starting from clusters of expected outputs of the EC financed activities in the health sector and leading to the results and impacts that those activities should have on human health, health systems and health policy development as well on national, regional and international level and which should eventually lead to the global impact of enhanced development and poverty reduction.

Further to the vertical reading, four horizontal strands, related to different EC policy, have been identified by the evaluation team.

#### **Strand 1: Institutional, policy and governance strengthening**

The EC had identified a strong need to improve policy making and governance and to strengthen public health institutions, notably Ministries of Health of aid-recipient countries. Better decision making, translating into improved resource allocation, was needed to ensure that drugs, vaccines and treatments were available and affordable.

In this strand, the EC put emphasis on health care finance reform, improvement of health information systems, regulatory reform and general institution strengthening as key outputs of this cluster. The strand was grounded on the EC Communication “Health and Poverty Reduction in Developing Countries”<sup>19</sup> which prioritised pro-poor health financing instruments, developing better indicators of health system performance and the need to include human resource strengthening as a metric of health system performance and budget support financing. The Communication ‘*The EU Role in Global Health*’<sup>20</sup> re-iterated the role of health care finance, this time in the form of a call for improved social protection and universal coverage.

#### **Strand 2: Infrastructure, human resources and pharmaceuticals / equipment**

Since the oil crisis of the 1970s, multiple causes have led to resource crises in the health sectors of poor countries and resulting in, what is called, the “implosion”. Fiscal pressures caused health ministries to forget needed investment causing the deterioration of physical infrastructure and resulting in outdated equipment. The growing need in developed countries for health care workers, gave rise to brain drain. Development co-operation in health, as well as the explosion of HIV/AIDS programmes, attracted skilled health professionals into donor programmes, to the detriment of public health programmes. Trade-related aspects of intellectual property rights (TRIPS) requirements limited the ability of poor countries to produce generic drug equivalents and led to the poor being forced to pay higher prices, while continuing progress in pharmaceutical research produced entire new classes of pharmaceuticals that poor countries could not afford.

Improved resourcing of the health system should result in improved health coverage, in particular including the poor living in remote areas. Coverage has to do with “availability” and in turn corresponds to the supply side. At the same time, the availability of good, accessible, affordable infrastructure, well endowed with human resources, equipment and needed drugs, will elicit more utilisation, i.e. the demand side. The EC addressed these topics in different, specific communications, e.g. in several Communications on health workers<sup>21</sup> or in the Communication related to the availability of key pharmaceuticals<sup>22</sup>.

<sup>18</sup> SEC(2010)382: Contributing to universal coverage of health services through developing policy, accompanying document to the Communication COM(2010)128 on the EU Role in Global Health.

<sup>19</sup> COM(2002) 129 (p.12)

<sup>20</sup> COM(2010) 128 (p.4,5)

<sup>21</sup> COM(2006) 870

<sup>22</sup> COM(2000) 585 (p.19) “Accelerated action targeted at major communicable diseases within the context of poverty reduction” and COM (2001) 96 “Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction”.

**Strand 3: Health behaviour**

The 'health production approach'<sup>23</sup>, claims that health results are not only linked to the input of public health interventions, but are also influenced by a broad range of individual health behaviours linked in complex fashion to income, social relations, culture and values. Through support for Advocacy, Communication and Social Mobilisation (ACSM), EC has attempted to raise health awareness, leading not only directly to increased health service utilisation but to improved health behaviours. ACSM is therefore a critical feature in HSS especially in disease control efforts but can also help mobilise communities and individual towards early health-seeking behaviour and treatment adherence. ACSM has gained momentum in recent years as the collaboration and interaction between the public sector and private health sector has risen and become more efficient and effective. Behavioural aspects are especially important in the complex nexus of gender, culture and sexual and reproductive health including MNCH, as recognised in the EC COM(2005) 179<sup>24</sup>.

**Strand 4: Regional and global added value**

The increased attention to public good aspects of health was another major trend in the years under consideration, reasons being the globalisation of infectious disease and the increased pace in the emerging of new infectious diseases. The "Global Public Good" concept, covering notably health R&D and infectious disease control, is now accepted as a major rationale underpinning development aid in the area of health. The EC is traditionally a big supporter of global research (e.g. support to GAVI or the EC Framework Research Programmes). It is furthermore recognised as a high value-added partner, due to its experience with and promotion of regional integration, an approach leading naturally to increased connectivity.

In this strand, the EC aimed at focusing particularly on actions that increased global knowledge for health and developed new means of addressing communicable and emerging diseases. The EC commitments to these topics were found in several communications, such as the Communication "Accelerated action on HIV/AIDS, malaria and Tuberculosis (TB) in the context of poverty reduction" that called for a global action on affordability and investment in the development of public goods.<sup>25</sup> One of the four objectives of the Communication "Health and Poverty" was "to invest in the development of specific global public goods"<sup>26</sup> and the Communication further highlighted the need to invest and to finance development and research. The Communication *Investing in People*<sup>27</sup> reinforced the need for development and improvement of the availability of and equal access to global public goods.

The following figure illustrates the different strands and the linkages between the different level of results and impacts. Furthermore, the impact diagram shows on which levels the Evaluation Questions are grounded.

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<sup>23</sup> The World Bank (1993) World Development Report "Investing in Health".

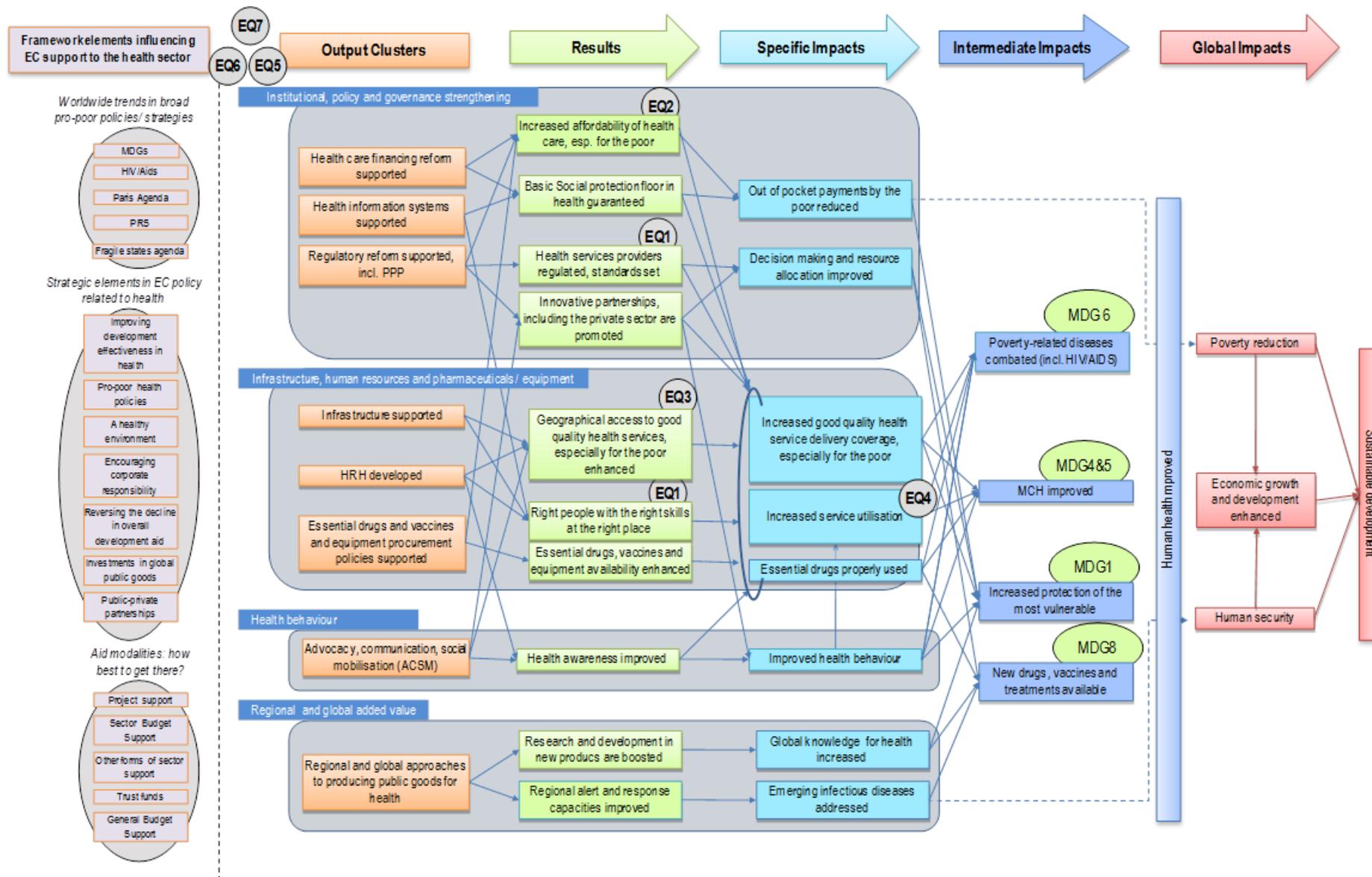
<sup>24</sup> COM(2005) 179 "A European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)" called for support to national authorities in collecting disaggregated data related to the three poverty-related diseases through behavioural surveillance surveys (para.15) and supported social-behavioural research (para. 28).

<sup>25</sup> COM (2001) 96 "Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, p.7.

<sup>26</sup> COM(2002) 129 : "Health and Poverty Reduction in Developing Countries", pp.2, 11, 12 and 15.

<sup>27</sup> COM(2006) 18 "Investing in people".

Figure 3: Impact diagram: Reconstructed intervention logic of the EC support to the health sector (2002-2010)



## 4 Inventory: Overview on EC resources to support health

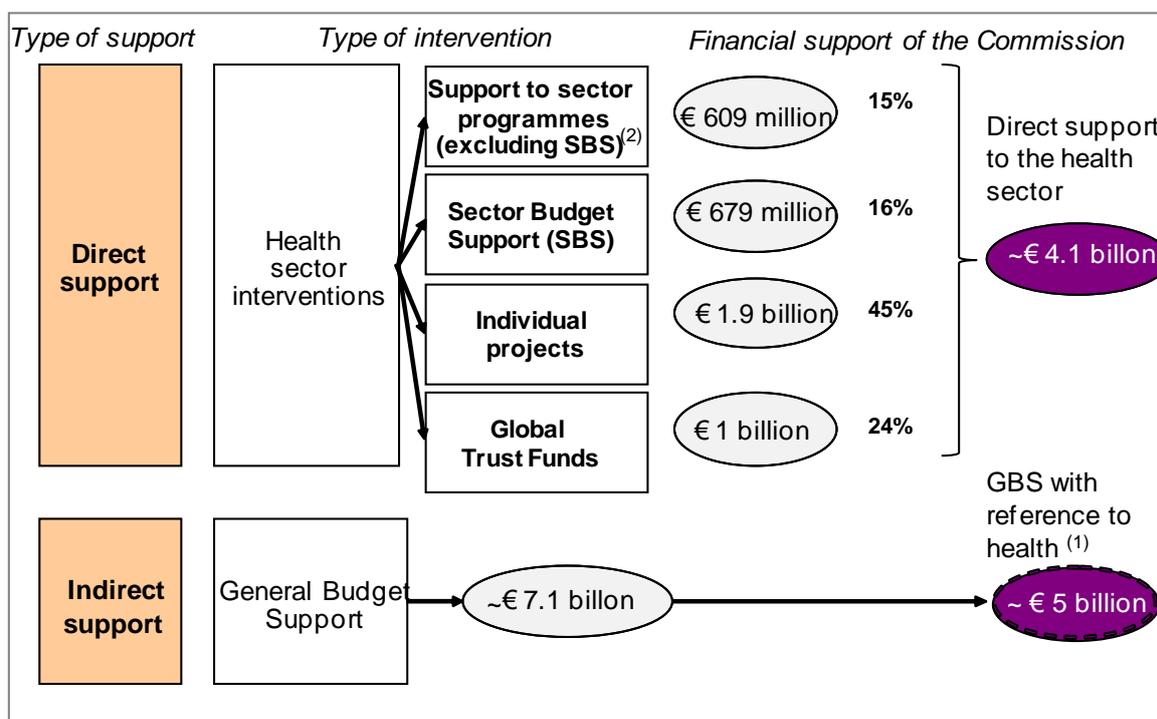
The inventory of the EC’s support to the health sector provides an overview of interventions financed by the EC in the countries covered by the evaluation during the period 2002 to 2010. The analysis of the captured interventions gives a grasp of the funding, in terms of temporal evolution of funds committed and disbursed, financial instruments applied, sectors, channels and aid modalities used, as well as the regional and country breakdown of EC support.

The inventory is based on data from the EC’s CRIS database. The data was extracted in February 2011 and processed to obtain the best possible overview of the EC’s support to the health sector during the evaluation period. A number of challenges were faced by the evaluation team in compiling this data due to inherent limitations of the CRIS database. A specific and systematic methodology was therefore developed in order to ensure that all relevant interventions within the scope of this evaluation were identified. This methodology as well as the detailed results are presented in Annex 2.

### 4.1 EC support to health between 2002 and 2010: Global overview

EC supported the health sector through two different means: the first was what the evaluation team called “direct support”, which includes all types of interventions that are clearly earmarked to the health sector; the second type of support referred to General Budget Support, which was labelled as “indirect support”, as funds could not clearly and solely be attributed to the health sector.

Figure 4: Global overview of EC financial commitments to the health sector, 2002-2010



<sup>(1)</sup> GBS which refers to the health sectors among other sectors, through performance indicators or objectives stated in the Financing Agreements (FA). Taking into account the nature of GBS as un-earmarked funds, no statement can be made on the share of the 5 € billion that went effectively to the health sector. See for more detail Chapter 4.3 and Annex 2

<sup>(2)</sup> SSP: As defined by the EC under the sector approach but excluding SBS – “includes the modalities EC procurement and grant award procedures” “Common Pool Funds” and “National Trust Funds”

Source: CRIS and Particip GmbH analysis

The box below gives a brief overview of the key findings of the inventory. The following chapters provide further details.

*Box 1: Key findings of the inventory*

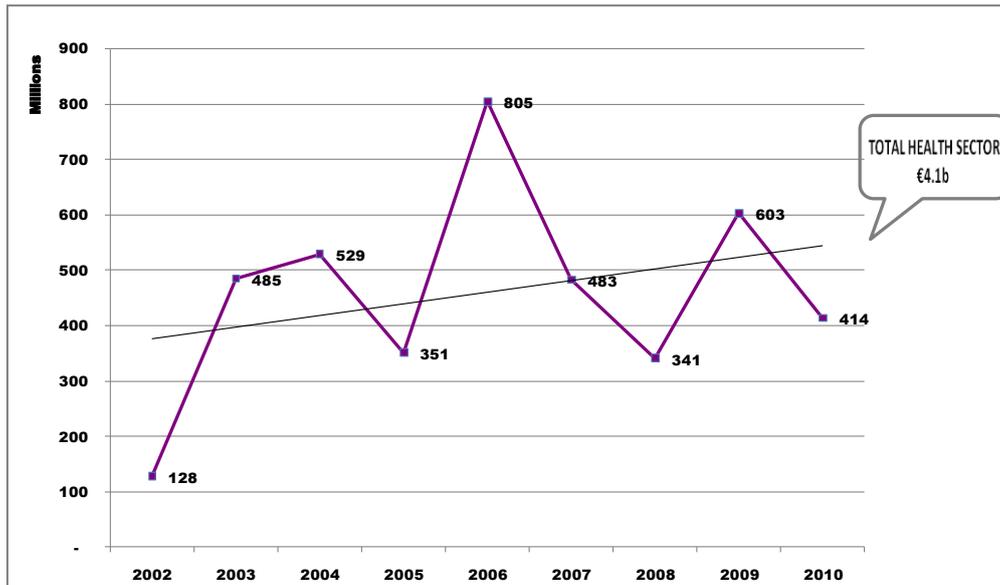
Direct support	Indirect support (GBS referring to the health sector)
<ul style="list-style-type: none"> <li>The EC's direct support to the health sector amounted to around <b>EUR 4.1 billion</b> during the period 2002-2010;</li> <li>This EUR 4.1 billion represented <b>6%</b> of the <b>total support to all sectors</b> over the same period;</li> <li>Direct support shows a serrated pattern, but with a trend <b>towards increase</b> (from levels of EUR 128 million in 2002 to EUR 805 million in 2006 and EUR 414 million in 2010);</li> <li><b>Basic health</b> was the sub-sector supported most, receiving <b>73%</b> of the funds, of which 43% concern the delivery of basic health care and infrastructure and 27% the fight against the three PRDs. The second focus was on <b>Health general (22%)</b>, out of which 70% concern the sub-sector policy and administrative management. <b>Sexual and reproductive Health (SRH)</b> received less attention, representing only <b>5%</b> of the total funds;</li> <li>The <b>main beneficiary regions</b> in absolute terms for direct support were the ACP states (46%), followed by Asia (18%) and European Neighbourhood Policy-South (ENP-South – 13%);</li> <li>The financing of individual projects (45%), followed by SBS (16%), were the main modalities used by the EC to deliver direct support to the health sector. Other modalities used were: support to sector programmes excluding SBS (18%)<sup>28</sup> and the financing of Global Trust Funds such as the GFATM (21%).</li> <li>The trend towards an increased use of SBS can clearly be seen during the evaluation period (from almost no funds at the beginning to EUR 180 million in 2010). In parallel, a decline in the use of the project modality can be noted.</li> </ul>	<ul style="list-style-type: none"> <li>The EC's indirect support referring to the health sector (i.e. GBS with health related indicators) amounted to around <b>EUR 5 billion</b> over the period 2002-2010. It is not possible to estimate how much of this was actually assigned to health;</li> <li>This support represents <b>72% of the total GBS funds</b> transferred to partner countries during the evaluation period;</li> <li>The support concerned a total of 45 countries, out of which 39 are located in the ACP region, four in Latin America, two in Asia, but none in the ENP region;</li> <li>The <b>six main beneficiary</b> countries accounted for more than 50% of the GBS referring to health, among other sectors.</li> </ul>

## 4.2 Direct support to the health sector

Although the evolution over the whole period shows considerable year-to-year variation, there is a global upward trend of amounts contracted for direct support to the health sector. Between 2002 and 2010 the amounts evolved from EUR 128 million to EUR 414 million for the health sector. This reflects the EC commitment to provide increase health aid, such as reflected in the 2002 "Communication on health and poverty".

<sup>28</sup> This is not an official category of EC aid delivery methods, but, as a clear categorisation of SPSPs was lacking in the CRIS database, the evaluation team used it as category for the analysis. See the methodology chapter of the inventory in Annex 2 for further details.

Figure 5: Direct EC support to the health sector: Trend in the amount contracted between 2002 and 2010 (EUR million) for the health sector

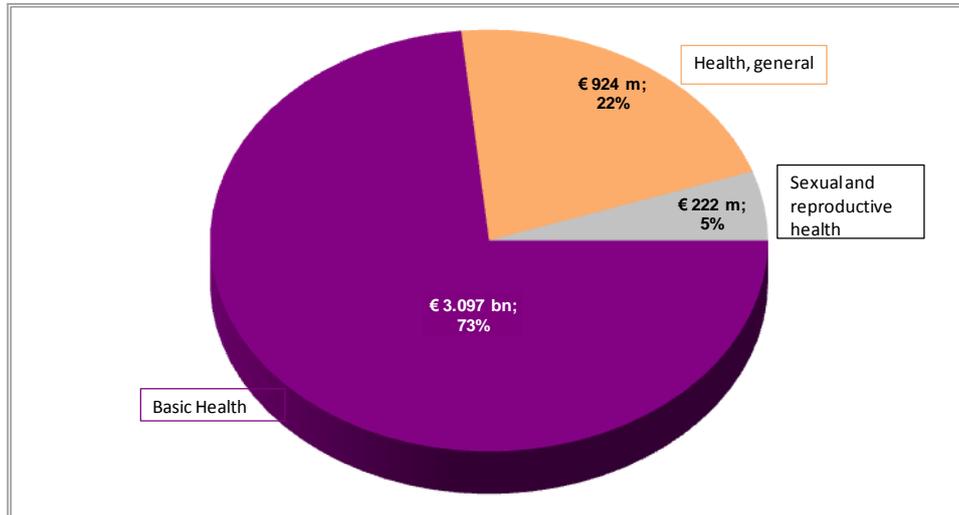


Source: CRIS and Particip GmbH analysis

#### 4.2.1 Sector breakdown

Based on the sector and sub-sector classification of the Organisation for Economic Co-operation and Development (OECD)-DAC, the interventions were classified in three main sectors: health general; basic health; sexual and reproductive health.<sup>29</sup>

Figure 6: EC support to the health sector: Breakdown of health sub-sector.



Source: CRIS and Particip GmbH analysis

The main focus over the period 2002-2010 was on “**Basic Health**”. The EC contracted an amount of EUR 3 billion which represented 73% of the total amount contracted. This sector included (as defined by the DAC sector classification) interventions for: basic health care and infrastructure, basic nutrition programmes and infectious diseases control including the three poverty related diseases HIV/AIDS, malaria and Tuberculosis. The figure below provides a detailed overview of the interventions financed in the sector ‘Basic Health Care’

<sup>29</sup> A detailed description on how the interventions have been classified and the DAC sector codes in each of the three categories can be found in Annex 2.

Table 1: Direct EC support to the health sector: Breakdown of the subsector 'primary health care', 2002-2010

Sector/Subsectors	Contracted amount (€)
<b>Subsector Basic health</b>	<b>3,009,926,722</b>
3PRDs <sup>30</sup> : Malaria/TB/HIV/AIDS	1,248,213,070
Administrative, Evaluation, Audits, TA	29,029,768
Basic health care	870,623,697
Basic nutrition	138,458,935
Essential drugs	33,528,663
Infectious disease control (IDCs)	329,390,094
Infrastructure	360,682,494

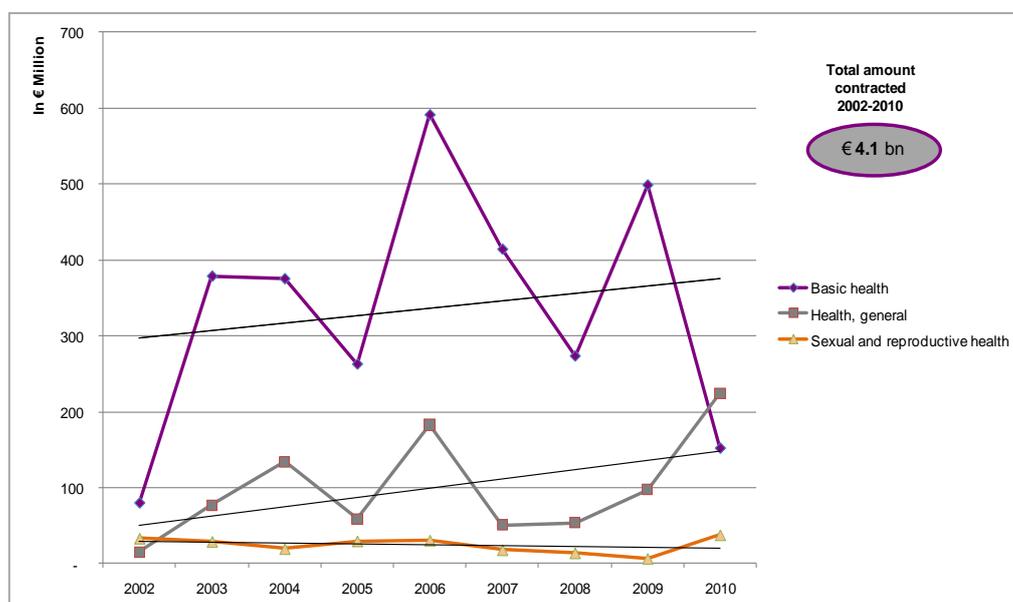
Source: CRIS database, Particip analysis

The second focus was on so-called “**Health General**”. The EC contracted EUR 895 million which represented 22% of the total contracted amount. This sector included (as defined by the DAC sector classification): support of policy and administrative management; medical education and training; health research and development; medical services such as mental health care or non-transmissible diseases.

**SRH** received the smallest contribution, amounting to only 5% or EUR 219 million of the total direct support. However, these data have to be carefully interpreted, as SRH interventions are often “hidden” in larger basic health interventions. The SRH sector includes reproductive health interventions as well as interventions targeting STDs.

The following figure shows the evolutions of sectors over the evaluation period.

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



Source: CRIS and Particip GmbH analysis

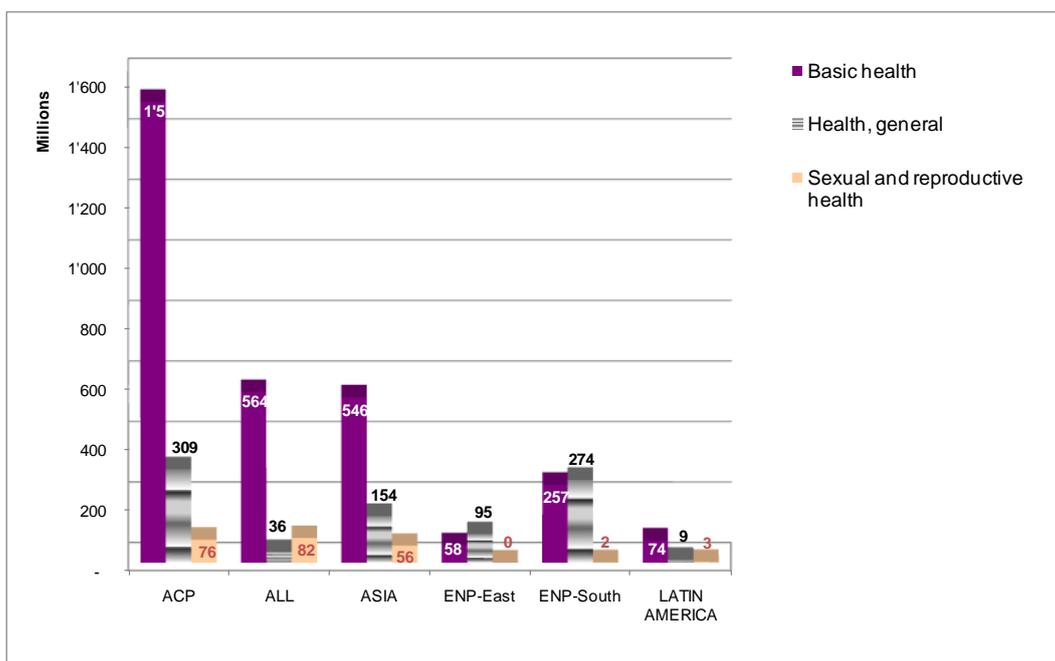
#### 4.2.2 Regional breakdown

The main regional focus of the EC support to the health sector was on the ACP region, which received 46% (or EUR 1.9 billion) of the contracted amounts and Asia, which received 17% (or EUR 715 million). Equally large is the amount contracted for the category “all regions” which received EUR 681 million (17%) of the total funds contracted over the period 2002-2010. ENP South, ENP East

<sup>30</sup> This category includes support to the three poverty related diseases Malaria, TB and HIV/AIDS, either interventions that targets these three diseases together, e.g. support to the GFATM or support to one specific of the three diseases.

and Latin America received the smallest share of EC support to the health sector (EUR 568 million; EUR 163 million and EUR 93 million). The following figure shows the distribution by region and sector.

Figure 8: Direct EC support to the health sector: Regional breakdown by main health sub-sector, contracts (EUR million), 2002-2010

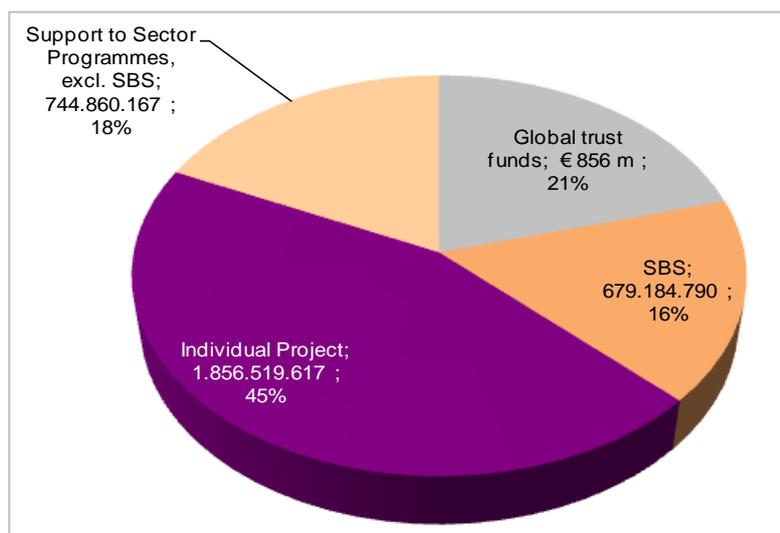


Source: CRIS and Particip GmbH analysis

#### 4.2.3 Breakdown by modalities

The EC delivered its “direct” support to the health sector through four main aid delivery methods: individual projects, support to sector programmes (excluding SBS), SBS and co-financing of Global Trust Funds (e.g. GFATM, GAVI). The following figure shows the breakdown of these four modalities during the evaluation period.

Figure 9: Direct EC support to the health sector: Breakdown of modalities used, contracts (EUR million), health sector, 2002-2010



Source: CRIS and Particip GmbH analysis

The analysis of the evolution of funds between the different modalities and throughout the evaluation period shows an increasing use of SBS from 2008 on. In total, the amounts contracted through SBS increased from about EUR 2 million in 2002 to EUR 200 million in 2009 and EUR 185million in 2010. The growing use of SBS goes in parallel with the decrease of project modality and support to sector

support programmes. However, compared to the education sector, the use of SBS and sector support in general is much less prominent (SBS 47% and support to sector programmes excluding SBS 21%).<sup>31</sup>

For SSP, the largest contracted amounts can be observed in 2004 and in 2008, They are due to large contracts with the private sector such as “*Appui à la gestion du secteur de la santé*” in Morocco and with UN bodies, e.g. in Bangladesh with the contribution to the national trust funds “*National Health, Nutrition and Population Sector Programme (HNPS)*”.

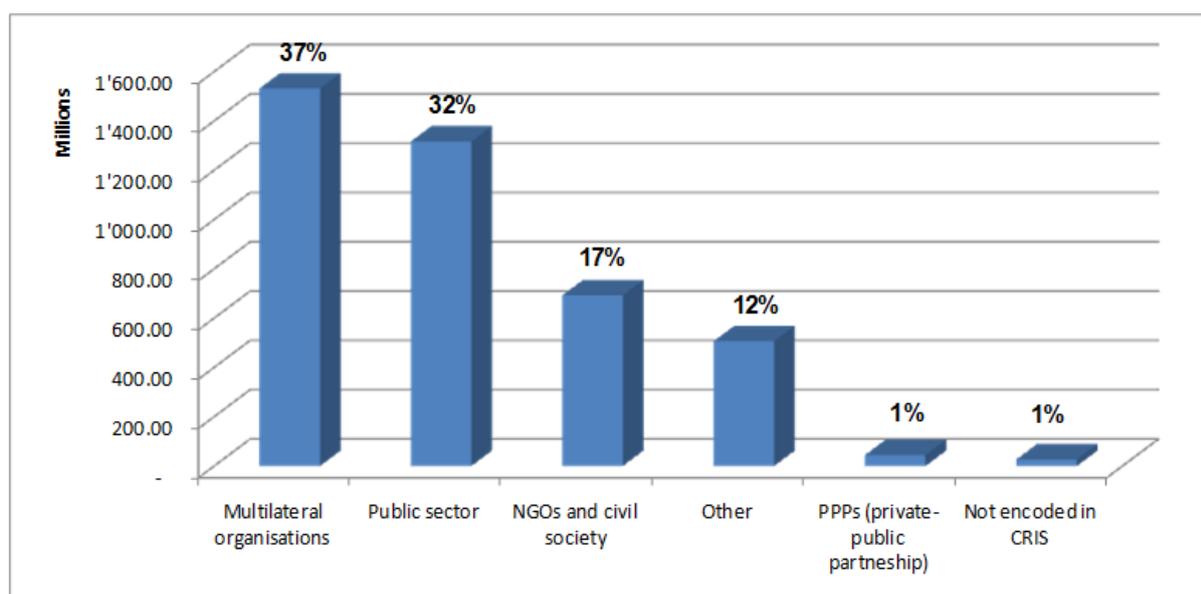
Global Trust Funds were quite steadily used over the evaluation period. Large contributions are observed every three years, in 2003 (EUR 245 million), 2006 (EUR 267 million) and in 2009 (EUR 201 million), the biggest share went to the GFATM.

#### 4.2.4 Breakdown by channels

The EC channelled its support through different types of organisations. A breakdown of channels used is presented in the figure below<sup>32</sup>. It is interesting to note that multilateral organisations are the group receiving most of the contracted budget. This category includes contribution to the national trust funds, managed by World Bank and other development Banks, WHO or UN-Organisations, or contributions to global initiatives, such as GFATM and GAVI. These ratios are in some contrast to figures revealed in the EC’s support to basic and secondary education - one of the other main social sectors supported by the EC - where governments received 52% of EC funding, Development Banks (included in the category multilateral organisations, in the figure above) accounted for 17% and NGOs for 12%.<sup>33</sup>

Moreover, the distribution of channels also provides an explanation why the project modality is the main aid modality used for direct support to health, as for support channelled through multi-lateral organisation the project modality is used.

Figure 10: Direct EC support to the health sector: Breakdown of support by main channel, contracts (EUR million), health sector, 2002-2010<sup>34</sup>



Source: CRIS and Particip GmbH analysis

The following figure gives more details on the distribution within the category “Multilateral organisations”.

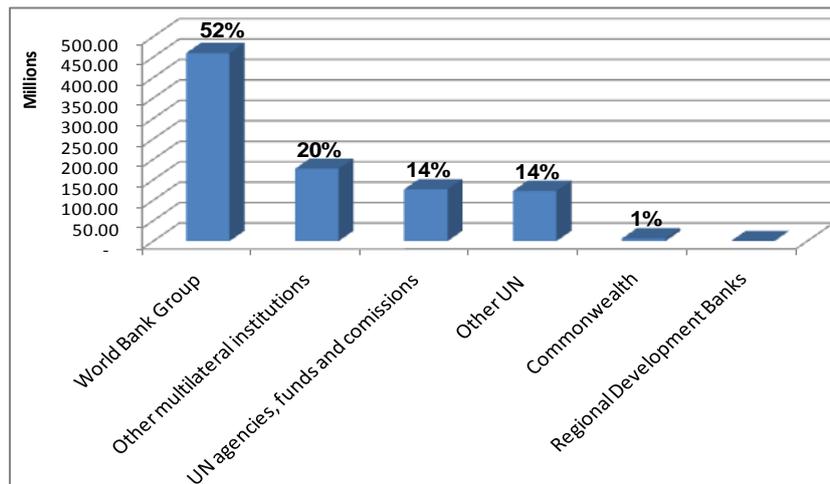
<sup>31</sup> See Particip GmbH (2011): Thematic global evaluation of European Commission support to the education sector in partner countries (including basic and secondary education).

<sup>32</sup> Channels are defined based on the field “contracting party” in the CRIS database. Five categories have been retained: Public Sector, NGOs and Civil Society Organisations (CSOs), Public-Private-Partnership, Multilateral organisations, Other. An exact definition of each channel can be found in Annex 2.

<sup>33</sup> For the period 2000 to 2007. See Particip GmbH (2011): Thematic global evaluation of European Commission support to the education sector in partner countries (including basic and secondary education).

<sup>34</sup> Other included: Private companies-development agencies and Research and educational institutions.

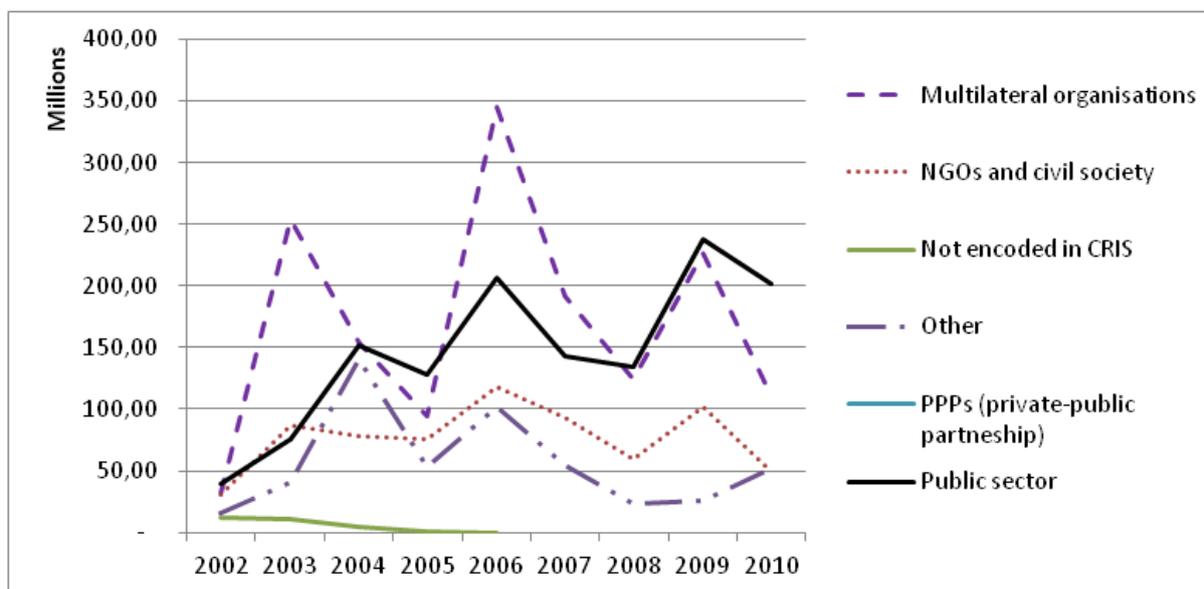
Figure 11: EC support to multilateral organisations, (EUR million) health sector, 2002-2010



Source: CRIS and Particip GmbH analysis

The following figure shows a significant trend towards an increasing channelling of EC funds to the partner government (category: public sector). This coincided with an increased use of SBS as modality. It should be added that the considerable amount contracted with multinational organisations is partly due to large financial contributions to global initiatives such as the GFATM.

Figure 12: Direct EC support to the health sector: Trend in the amounts contracted by main channel, contracts (EUR million), 2002-2010



Source: CRIS and Particip GmbH analysis

#### 4.2.5 Breakdown by budget lines

In terms of financial instruments used, the analysis shows that 74% of funds to the health sector were financed through geographical budget lines, i.e. EDF or DCI-ASIE/ALA or MED. 26% were funded through thematic budget lines, in which the SANTE/DCI-SANTE, with 18 % of the total support to the health sector, accounts for the biggest share. The following table gives an overview of all budget lines.

Table 2: Total amounts contracted related to direct support to health sector through various budget lines (2002-2010)

Domain (budget line)	Contracted amount (EUR)	Domain (budget line)	Contracted amount (EUR)
Geographic Budget Line		Thematic Budget Line	
FED/EDF (European Development Fund)	1.553.787.876	SANTE (Budget line for health, before 2007)	440.775.416
ASIE (Budget Line for Asian countries until 2007)	397.453.332	DCI-SANTE (Budget line for health, after 2007)	298.794.197
MED (Budget Line for Mediterranean/ENP South countries, before 2007)	370.596.741	ONG-PVD (Budget line for NGOs/NSA projects, before 2007)	120.989.780
DCI-ASIE (Budget Line for Asian countries from 2007 on)	216.589.253	DCI-NSAPVD (Budget line for NGOs/NSA projects, after 2007)	97.969.594
ENPI (Budget Line for Neighbourhood countries)	210.400.242	REH (Budget line for rehabilitation projects before 2007)	28.726.159
AFS (Budget Line for South Africa)	123.558.244	DCI-FOOD (Budget line for Food security projects, after 2007)	14.400.845
TACIS (Budget Line for former ENP East countries, before 2007)	114.927.280	DDH (Budget line for Human Rights projects before 2007)	8.231.908
ALA (Budget Line for Latin American countries, before 2007)	57.291.705	Other <sup>35</sup>	39.981.045
DCI-MED (Budget Line for Mediterranean/ENP South countries, from 2007)	22.277.767		
DCI-ALA (Budget Line for Latin American countries, from 2007)	3.019.170		
<b>Total</b>	<b>3.069.901.611</b>	<b>Grand Total</b>	<b>1.052.609.615EUR</b>

Source: CRIS and Particip GmbH analysis

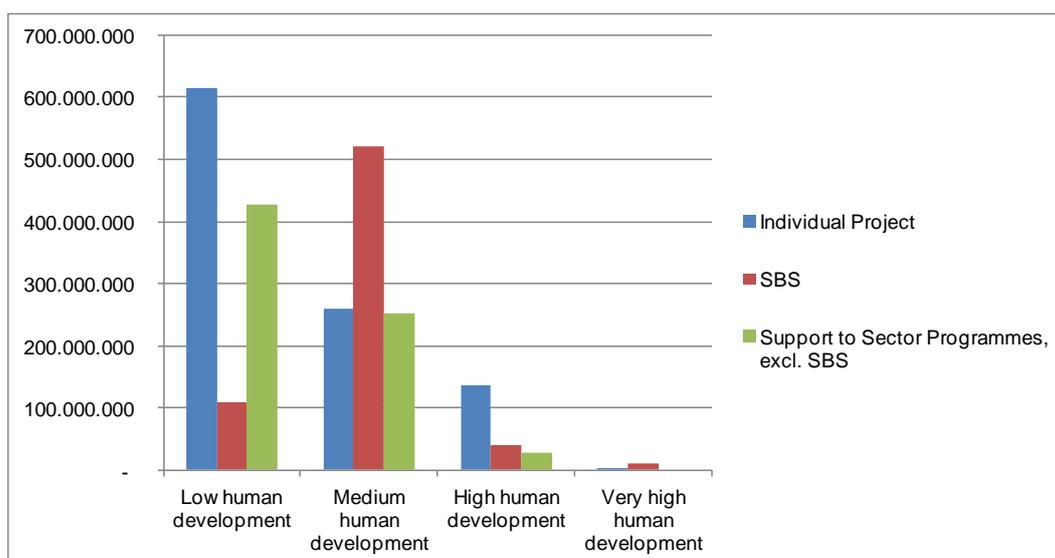
#### 4.2.6 Breakdown by human development level

When looking at the distribution of EC support according to the HDI, it appeared that the majority of EC funds go to countries with a low HDI (28%) or medium HDI (26%). Only 7% went to countries with high or very high HDI or to countries with no classification.<sup>36</sup> The following picture gives an overview on the distribution of aid modality per HDI-classification. It appeared that SBS is preferably used in countries with a medium HDI, while in countries with a low HDI support via individual project support prevailed, followed by SSP.

<sup>35</sup> Other includes: EIDHR, DCI-MIGR, FOOD, PP-AP, DRG, DCI-HUM, IFS-RRM, ONG-ED, DCI-MULTI, RRM, NSI, ENV, CDC, BAN, EVA, INFCO, DCI-NSA.

<sup>36</sup> 38% of EC funds are not country specific, a classification according to HDI was thus not possible.

Figure 13: Direct EC support to the health sector: Breakdown of financing modality by country according to the Human Development Index, 2002-2010



Source: CRIS and Particip GmbH analysis

Furthermore, 15% of EC support to the health sector is directed to so-called “fragile states”<sup>37</sup>. Almost half of all funds have been contracted to fragile states (48%) are used by only four countries. In their order of importance, these countries are: *Afghanistan, Nigeria, DRC and Zimbabwe*.

### 4.3 EC ‘indirect’ support to the health sector: General Budget Support

During the period 2002-2010, the EC has financed a total of 158 GBS programmes in 59 countries<sup>38</sup> falling within the geographical scope of this evaluation. Out of these 158 GBS programmes, 93 programmes had a reference to the health sector expressed by health performance indicators or by objectives related to health in the Financing Agreements.

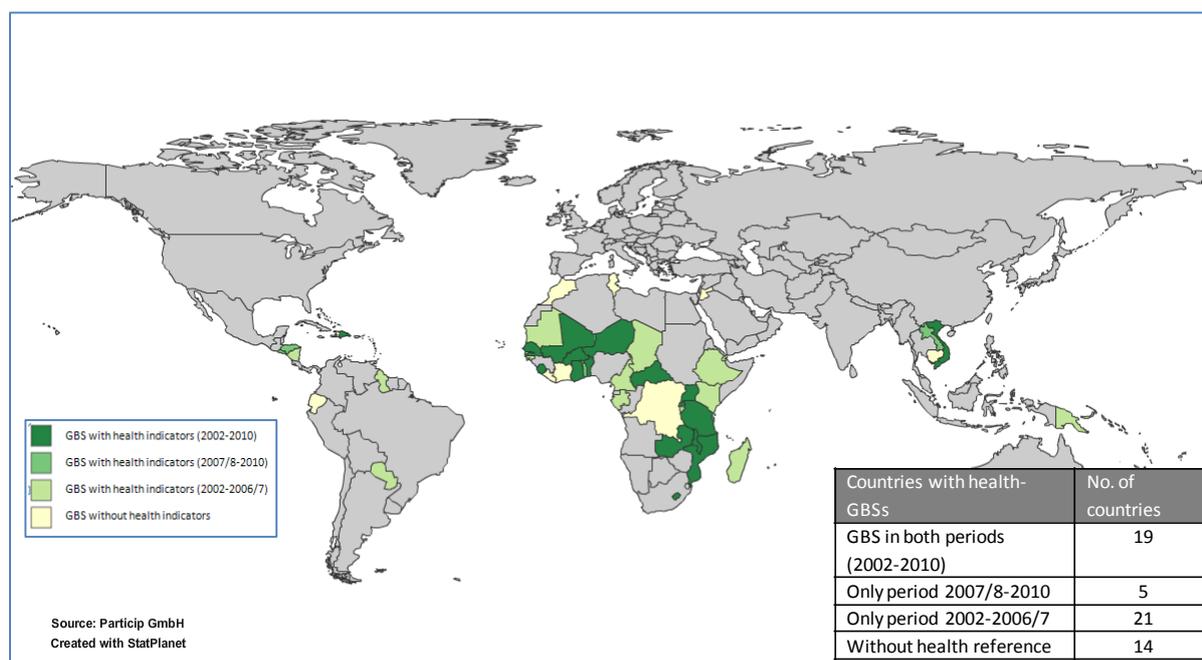
These 93 programmes with a clear reference to the health sector were implemented in **45 countries** and represented around **EUR 5 billion**, i.e. **72% of the total GBS funds** transferred by the EC between 2002 and 2010. The following picture shows the geographical distribution of GBS during the evaluation period.

***It is important to underline that it cannot be stated which percentage of the EUR 5 billion actually went to the health sector.***

<sup>37</sup> It is to be noted that no “official list” of fragile states is available. Here we use the definition adopted by the OECD definition and its “list” of fragile countries, which it uses as the base for an annual report on resource flows to Fragile States (OECD-DAC Conflict and Fragility dossier at [www.oecd.org/dac/incaf](http://www.oecd.org/dac/incaf)). These includes the following states: Afghanistan, Angola, Burundi, Cameroon, CAR, Chad, Comoros, Côte d'Ivoire, DRC, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Iraq, Kenya, Kiribati, Liberia, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Republic of Congo, Rwanda, São Tomé & Príncipe, Sierra Leone, Solomon Islands, Sudan, Tajikistan, Timor-Leste, Togo, Tonga, Uganda, Yemen, Zimbabwe.

<sup>38</sup> The term “programme” in this inventory refers to a GBS decision, as found in the CRIS-database. One decision includes GBS funds, as well as the contracts related to technical assistance or other support, such as evaluation, audits or formulation mission. A country could have several GBS decisions during the evaluation period.

Figure 14: Indirect EC support to the health sector: Countries having benefited from GBS, both with and without health-related indicators (CSP periods 2002/3 to 2006 and 2007/8-2010)



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

The majority of GBS funds with a link to health went to Sub-Saharan countries, receiving 78%, followed by ENP and Caribbean countries, with respectively 11% and 6%. The six main beneficiaries of EC-GBS account for themselves to 53.3% of the total GBS funds with a reference to the health sector.

Table 3: GBS with reference to the health sector: The top-20 recipients (in million EUR 2002 – 2010)

Region/Country	Financial support committed	% of total GBS amount (only financial support) <sup>39</sup>	Region/Country	Financial support committed	% of total GBS amount (only financial support)
Mozambique	644	9.13%	Niger	162	2.30%
Burkina Faso	508	7.20%	Senegal	145	2.06%
<b>Tanzania</b>	477	6.77%	<b>Sierra Leone</b>	126	1.79%
<b>Zambia</b>	445	6.31%	<b>Madagascar</b>	123	1.75%
<b>Mali</b>	321	4.56%	<b>Kenya</b>	120	1.70%
<b>Ghana</b>	306	4.34%	<b>Ethiopia</b>	94	1.33%
<b>Uganda</b>	276	3.91%	<b>Dominican Republic</b>	92	1.30%
<b>Malawi</b>	215	3.04%	<b>Jamaica</b>	56	0.80%
<b>Benin</b>	187	2.65%	<b>Nicaragua</b>	68	0.96%
<b>Rwanda</b>	180	2.55%	<b>Honduras</b>	59	0.84%

Source: Inventory data, Particip GmbH analysis

<sup>39</sup> Excluding funds committed under GBS decision but for TA or evaluation, etc.

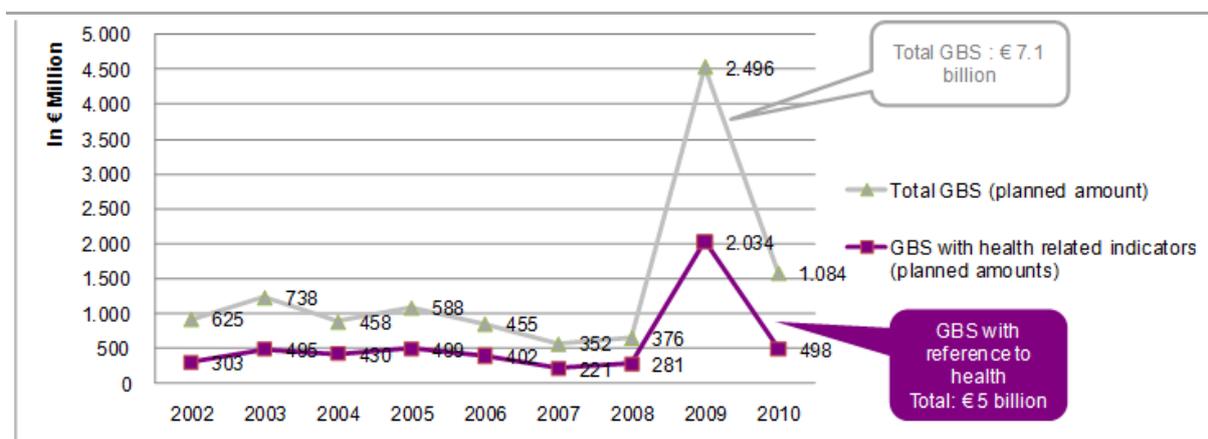
*Table 4: Indirect EC support to the health sector: Regional breakdown of GBS health related GBS (in million EUR, 2002-2010)*

Region/Country	# of GBS decisions	Financial support	% of total amounts per region
Sub-Saharan Africa	72	4,629	65.65%
Caribbean	11	217	3.08%
Pacific	2	2.4	0.03%
Asia	4	51	0.73%
Latin America	4	172	2.44%
<b>Total</b>	<b>93</b>	<b>5,072</b>	<b>71.93%</b>

Source: Inventory data, Particip GmbH analysis

The figure below shows the trend in the amounts transferred through GBS between 2002 and 2010. It presents separately all GBS operations and those referring explicitly to the health sector. Health-related GBS followed the overall trend of the GBS development which is slightly decreasing from 2002 to 2008 before reaching a disbursement peak in 2009. The considerable increase in 2009 is due to the introduction of the **MDG contracts**. A budget of EUR 1.5 billion is foreseen for this type of GBS contract and it amounts to 42% of the GBS provided through the 10<sup>th</sup> EDF which target especially MDG-relevant social sectors, such as health and education.

*Figure 15: Indirect EC support to the health sector: Trend in the amounts transferred through GBS (EUR million), 2002-2010*



Source: CRIS database; Particip GmbH analysis

## 5 Answers to the Evaluation Questions

This part of the report presents a summary of the work in progress related to the seven evaluation questions listed below.

The focus of the evaluation questions has been directed at the most relevant issues that became apparent from desk work done during the production of the inception report and from the inventory. The EQs were discussed and agreed upon with the Evaluation Unit and the Reference Group.

Table 5: Overview of evaluation questions

Code EQ	Evaluation question
<b>EQ1: Quality of health services</b>	To what extent has EC support contributed to enhancing the quality of health services?
<b>EQ2: Affordability of health</b>	To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor?
<b>EQ3: Health facilities availability</b>	To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?
<b>EQ4: Health service utilisation related to MNCH</b>	To what extent has EC support to health contributed to improving health service utilisation related to MNCH?
<b>EQ5: Management and Governance</b>	To what extent has EC support to health contributed to strengthening the management and governance of the health system?
<b>EQ6: Co-ordination, complementarity and synergy</b>	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)
<b>EQ7: Financing modalities, funding channels and instruments</b>	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 6: Coverage of the evaluation criteria by the evaluation questions

Criteria Question	DAC criteria					EC criteria			
	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 (MNCH)	✓✓	✓✓		✓✓	✓✓				✓
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								

Volume IIa provides detailed findings for each evaluation question. These findings were arrived at during the evaluation through the approach and with the tools described in Chapter 2 and in Annex 23.

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

The question focuses on the quality of health services. Quality in health care is a multi-dimensional attribute, but it concerns elements such as access to essential medicines, availability of good infrastructure, being treated by well-trained health professionals

The delivery of quality health services is central to improving the health status of the population not only because it results in decreased case fatality rates and complication rates, but also because it translates into health care-seeking behaviour, including preventive care, by those in need of it. Furthermore, satisfied patients and clients are more likely to follow advice and prescribed treatments. This becomes increasingly important in situations where the prescribed therapy is complex and in settings where clients have to pay for services. Quality of care is linked to poverty, as well, as when public health care is perceived to be of low quality; even low-income households will seek expensive treatment in the private sector.

In recent years countries have begun to introduce comprehensive, continuous quality monitoring mechanisms. Quality Assurance Models or Total Quality Management Tools are increasingly used to assist organisations, such as hospitals and health centres to look at all aspects of performance and quality of services. The World Health Organisation has an important role in safeguarding quality in technical aspects, setting standards and ensuring patient safety. WHO develops guidelines and best practice recommendations based upon regional working contexts which Ministries of Health around the world can refer to for guidance.

The question thus tries to capture to what extent the EC contributed to the amelioration of the quality of health service delivery. It has been addressed through four JCs:

- JC 11 Availability of essential drugs improved due to EC support
- JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support
- JC 13 Improved availability of qualified human resources for health due to EC support
- JC 14 Increased or maintained quality of service provision due to EC support

The answer to the question is based on several sources; a detailed list of sources used per indicator can be found in Annex 23.

- Country Case Studies
- Inventory
- EUD survey
- MoH survey
- Selected Evaluations (CSEs not included in the case study countries, thematic evaluations)
- International statistics
- Interviews

### EQ1 on quality of health services – Summary Answer Box

In general, evidence from the sources mentioned above suggests that there have been improvements in health care quality and that the EC has made a significant contribution in countries where it has provided support. This support and its impact on quality, takes many forms – from the virtual provision of primary health care in fragile states such as *Afghanistan* to the encouragement of family medicine in countries like *Moldova* and *Egypt*, to high-level technical assistance and capacity building in the context of sector budget support in countries like the *Philippines*, to the difficult to nail down impact of GBS.

In order to get a view of the overall situation it is useful to cite evidence from the EUD survey. Virtually all responding EUDs viewed the overall quality of health care as “unsatisfactory” or “completely unsatisfactory” in 2002-2004. Yet, only half of responding EUDs had the same negative view regarding 2010. In that year, fully two-thirds of respondents believed that health care quality in urban areas was “satisfactory” or better. However, while most EUDs saw some improvement over the evaluation period in rural areas, they still cited wide rural-urban differences in quality. For instance, the EUD *Philippines* highlighted important geographical variation across provinces and EUD *Moldova* and EUD *Ecuador* commented that the differences in the quality of the health provision between rural and urban area are still an issue to be resolved. A theme that comes through strongly is that, in many countries, it is not merely the simple rural-urban dimension that must be considered, but the less tangible dimension of remoteness. The *Philippines* and *Lao PDR* are strong instances of this. In such countries, simply sup-

**EQ1 on quality of health services  
– Summary Answer Box**

plying health infrastructure and human resources may be prohibitively expensive and alternative strategies such as road development and integrated rural livelihoods development may have strong spill-over effects on access to health care.

Ministries of Health who responded to the survey generally reported an improvement in the availability of infrastructure in both rural and urban areas. However, relating this to actual improvements in access by the poorest population has proven difficult even for in-depth investigations (e.g. the 2007 India Country Strategy Evaluation).

While the EC has not had much impact on **promoting essential medicine guarantees** – these are often enshrined in national health policies and it they are frequently worthless – it has ensured **essential medicine supply** through provision of basic benefit packages in a number of settings. In settings such as *Afghanistan* (ten provinces), *Egypt* (pilot Governorates), *Ecuador* (three under-served provinces) and Mindanao Province of the *Philippines* (including conflict zones) the EC has financed a full package of primary care. In *Afghanistan*, NGOs implemented; in the other cases, the Ministry of Health. EC support to the Global Fund and for the Global Alliance for Vaccines and Immunisation has also served to improve the availability of essential medicines. This said, it must be recognised that the EC can have significant direct impact only in very limited areas. Compared to the total amount of pharmaceuticals consumed in poor countries, the EC's contribution is miniscule. In a number of countries, the EC's possibly more significant contribution has been to support improved procurement of medicine and strengthen the supply chain. The EC supported an initiative with WHO to improve pharmaceuticals policy in ACP states but, at least based on the mid-term review, results were less than expected.

As with pharmaceuticals, the EC has nowhere near the financial resources to be a major player in the provision of **health infrastructure**. That said, in many countries, the EC has financed clinics in under-served regions, either through NGO-supported projects (*Lao PDR*), sector support (*Egypt* and *Ecuador*), NGO projects (*Afghanistan*), or multi-donor GBS (*Ghana*). In countries such as *Moldova* and the *Philippines*, EC sector support has been the vehicle for helping ministries of health to assess their infrastructure needs and re-tool as necessary. Much the same may be said for medical equipment. In limited settings, EC direct provision has improved the quality of health care; in other settings, EC sector support has helped countries to improve procurement and better analyse needs. Many rural clinics were equipped in *India*. Maintenance of infrastructure and **medical equipment** is an essential part health quality improvement and has received insufficient attention and support.

We have noted that the **human resource issue** was ranked first by EUDs when asked what constrained progress on improving the quality of health care. We would expect the EC to pay particular attention to this issue, in part, as well, because the EU is a major destination of international health professional migrants and the problem of “diversion” of health professionals from the public health service to donor-supported projects is a perennial subject of discussion. A surprising lack of data was encountered in this area, but all qualitative evidence supported the view that the crisis in human resources for health is still unresolved. This despite the fact that most Ministries of Health responding to the survey cited at least some improvement in the availability of staff. We identified perhaps surprisingly few EC interventions directly aimed at relieving the human resource crisis. Examples included regional projects on better managing health professional migration and retention schemes. The barrier may well be that, ultimately, the human resource crisis is one of recurrent expenditure, which cannot be addressed directly by donors. Policy dialogue and indicators for GBS often mention human resources, but we have often found that indicators are not measured. The EC has supported various training initiatives with significant impact; among the signal successes was increasing the availability of qualified female health workers in *Afghanistan*, with documented benefits to women and girls. We can also state with confidence that general support for the health sector, by contributing to better infrastructure, better availability of needed drugs and equipment, etc., improves the work environment and helps to diminish health worker attrition. The Global Fund, often accused of draining human resources from the general health sector, has recently begun to take overall health sector strengthening more seriously, as has GAVI.

When the EC supports facilities, it can generally be assumed that international clinical protocols will be followed and **quality assurance mechanisms** will be in place. In a few countries, we found, as well, that the EC directly supported quality assurance mechanisms. Data on client satisfaction are scarce. However, in two case study countries (*Moldova* and *Egypt*) we found solid evidence that EC support had improved client satisfaction. By contrast, in the *Philippines*, which has been the beneficiary of comprehensive EC support for health sector reform, large numbers of households insured by Phil-Health continue to seek expensive private care, strong evidence of dissatisfaction with the EC-supported public health programme.

**EQ1 on quality of health services  
– Summary Answer Box**

To conclude, EC support has contributed to improved quality of health care in beneficiary countries. The modalities have been varied, from direct provision of basic health care in troubled settings to supporting Ministry of Health reform design in less troubled ones. In all three main areas examined – essential medicines, infrastructure and human resources – we have recognised that, while the EC's impact may be high at a micro-level, the total amount of money in play for pharmaceuticals, infrastructure and health worker salaries dwarfs the EC's resources.

### 5.1.1 JC 11 Availability of essential drugs improved due to EC support

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

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

There is less ambiguity regarding the second indicator. Through a wide range of interventions, the EC has significantly contributed to improving availability of essential drugs. Evidences from the [country cases studies](#) highlights that, in *Afghanistan* and *Egypt*, as mentioned, the EC was involved in direct provision and similar impacts could be found in countries such as *Ecuador* and *Lao PDR* where projects, in the first case sector support in three underserved provinces and, in the second, NGO projects, supported primary health facilities where essential medicines were available. According to the [health inventory](#), the EC contributed Euro 34 million (representing 0,8% of total direct EC support) to drug availability over the evaluation period, as shown in the table below.

*Table 7: Direct EC support to the health sector: Amounts (€ million) contracted for interventions on essential drugs, infrastructure and Human Resources (HR), 2002 and 2010*

<i>Interventions</i>	<i>Contracted amount (€ million)</i>
<b>Essential drugs</b>	<b>34</b>
Infrastructure	361
Human Resources for health	137

*Source: Particip inventory*

To this should be added the indirect contribution through support for the Global Fund. Support for health care finance reform, as in the *Philippines* and *Moldova*, can have the indirect effect of enhancing access to pharmaceuticals because it relieves pressure on medical facilities to generate funds by the sale of drugs.

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

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

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

We assessed this JC based on two related Indicators, the mix of primary and secondary care facilities, the proportion of facilities with appropriate equipment and sufficient budget for maintenance and oper-

ating expenses<sup>40</sup>. The efficiency of EC interventions providing infrastructure and equipment was often impaired by the inadequate attention paid to maintenance and operating costs. As a result, the use-life of EC-financed equipment is lower than could have been achieved.

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

Table 8: Top four factors constraining quality most mentioned by EUDs

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

Source: EUD survey

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

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

Over the evaluation period, according to the [inventory](#), the EC contributed € 361 million directly to infrastructure (see Table 7). Note that this is not, in general, an EC focal area, as donors such as the World Bank, are in a stronger position to offer the major finance needed to finance infrastructure development. However, in assessing Indicator I-121, [country case studies](#) shows a number of countries where the EC financed or supplied infrastructure – *Afghanistan, Ecuador, Egypt, Philippines* and *Ghana* among them. This was generally in under-served areas or serving a particular need (e.g. family clinics in Egypt). In the *Philippines* and *Moldova*, the EC also provided TA which aimed to improve health facility planning and rationalise infrastructure. Respondents to the [EUD survey](#) broadly supported the view that the infrastructure situation had improved over the evaluation period. In *India*, according to the [2007 Country Strategy Evaluation India](#) (Volume 2, page 75), the EC supported the rehabilitation of dilapidated primary health care infrastructure and the provision of a basic package of health services.

Some EC support to infrastructure should be seen in the context of support to decentralisation, in which case the recent [thematic evaluation on decentralisation](#) is relevant. It states that, in most of its support to decentralisation, the EC has contributed to some expansion of local infrastructures, not necessarily specifically in the health sector, but more broadly (e.g. roads), with the effect of improving access to services<sup>41</sup>.

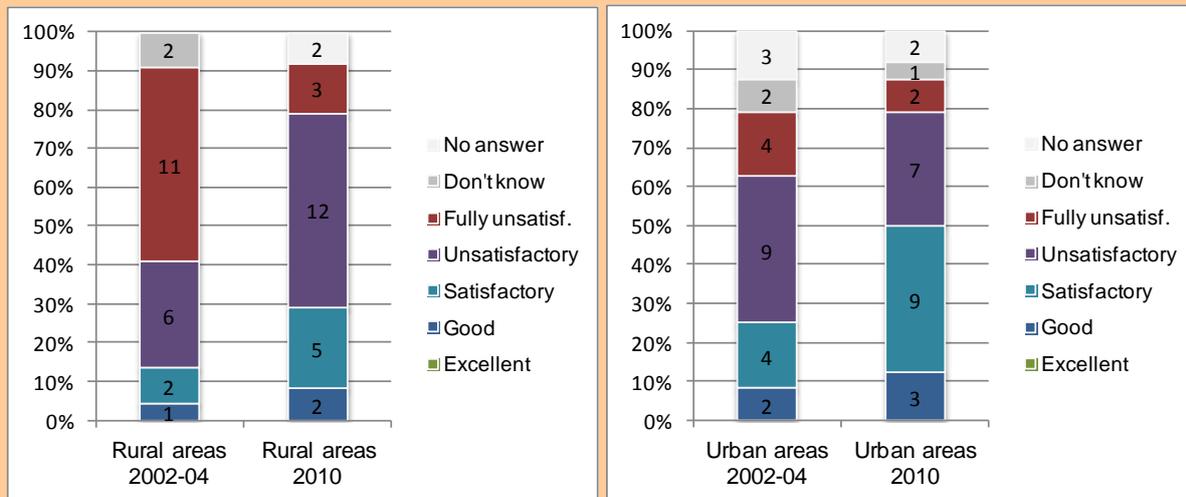
Related to the issue of provision of appropriate equipment, again, [responding EUDs](#) were generally of the view that the equipment situation has improved over the evaluation period, as shown in the next figures.

<sup>40</sup> Initially, the second part of the indicator had been separate, as I-123 Increased proportion of health facilities with adequate budget for maintenance and recurrent expenditures. Given that virtually no evidence was found relating to this Indicator, the two were merged, to be able to use, to a certain extent, the relevant information.

<sup>41</sup> Particip (2012): Thematic global evaluation of the European Commission support to decentralisation processes, 2012, p.48

Box 2: Coverage with primary and secondary facilities having appropriate equipment and budget for maintenance and current expenditure; EUD survey

: Primary health care facilities with appropriate equipment and budget for maintenance and expenditure



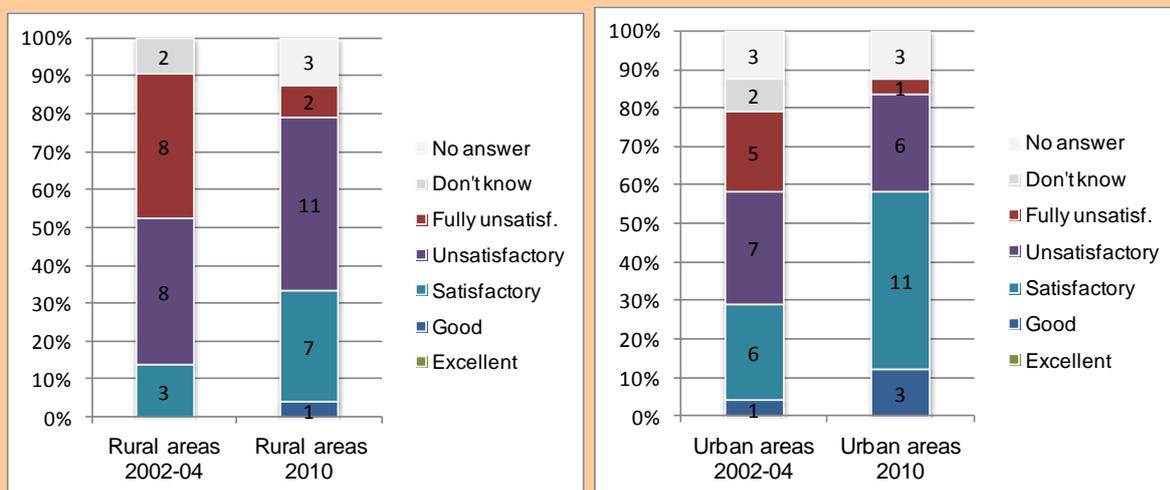
Source: EUD Survey, 2011, Particip GmbH

Explanation of the figure

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

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

Figure 16: Secondary health care facilities with appropriate equipment and budget for maintenance and expenditure



Source: EUD Survey, 2011, Particip GmbH

Explanation of the figure

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

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

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

Reasons cited included GBS which loosened fiscal constraints, changed government priorities and direct EC support for the provision of infrastructure and equipment. The EC provided equipment directly in cases where it financed infrastructure development. While information related to the adequacy of

budget for maintenance and recurrent expenditures has remained scarce, it is possible that EC supported GBS, by means of the policy matrix and increasing budgetary resources, has helped making more current budget available to health facilities. EC support for improved health care finance would have similar results.

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

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

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

Table 9: Human Resources for health – overview of EC support to the sub-sector: Inventory

	Breakdown of the sub-sector: Human Resource for Health (EUR)	% within the HRH sub-sector
Health workers training	120,276,692	88%
Retention Human Resources	12,030,019	9%
Evaluation, Audits, TA	2,300,441	2%
MoH capacity building	1,425,385	1%
<b>Total HRH</b>	<b>136,032,539</b>	<b>100%</b>
<b>Proportion of HRH within total EC support to health</b>		
<b>Total direct support to the health sector</b>	4,118 million	<b>3,3%</b>

Source: CRIS data base, Particip analysis

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

Despite the fact that there is a major global focus on human resources for health, the search for globally consistent data, e.g. from the WHO Global Observatory for Health, did not yield much. At the country level, as well, while country case studies found evidence in almost all countries of problems with human resources for health, consistent data comparing two points in time were scarce. This is perhaps less serious than it might appear, because it is clear that the problem is often not the number of health professionals itself, it is their geographical distribution. Rural areas are clearly disadvantaged and remote areas (e.g. in the *Philippines* or *Lao PDR* among the case study countries) are the most disadvantaged of all.

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

EUDs acknowledge that attrition and absenteeism (on which we have little information) are major problems. In some countries (e.g. *Zambia*), the EC financed health worker retention schemes. They were implemented under the Human Resources for Health Strategic Plan adopted in 2006. The case study cites some evidence that this is resulting in a reduction in high attrition rates. EC sector budget support contributed significantly to financing retention schemes, but data available do not permit a precise statement of impact. Moreover, *Zambia* is the only ACP country for which hard evidence related to absenteeism and the EC response was found. World Bank research has documented the scope and scale of the problem. Through its two programmes supporting public health service delivery (10<sup>th</sup> EDF) and Retention of human resources for health, the EC has contributed directly to reducing absenteeism. However, most EUDs responding to the survey regarded the availability of skilled health pro-

professionals in rural areas to be still “unsatisfactory” or “completely unsatisfactory” in 2010. Asked to describe the main reasons for shortages of human resources, the respondents to the MoH survey cited a familiar range of constraints: low status, salaries and incentives for health workers, poor working conditions encourage health personnel to remain in urban areas (*Syria, Laos, Moldova, Burkina Faso*) or the pay gap between public and private sector (*Afghanistan*).

Following the intensified discussion on HRH within the donor community and with partner countries towards the end of the evaluation period<sup>42</sup>, the EC signed a contribution agreement for the WHO/GHWA-managed programme aiming at ‘Strengthening Health Work Force Development and Tackling the Critical Shortage of Health Workers’. According to the final evaluation report (May 2012), this programme has already “*made an impressive contribution to implementation of the HRH Global Strategy and plan of action agreed at the First Global Forum in Kampala (2008)*”.

**Box 3:** *EC financed programme: Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers*

This programme has been launched in 2009 as an outcome of the 2008 Global Forum on Human Resources for Health held in Kampala and is managed jointly between the WHO and the Global Health Workforce Alliance (GHWA). The EC has signed a contribution agreement with the WHO in order to provide financial support. This ambitious 3.5-year programme (foreseen end: July 2012) targeted 29 countries<sup>43</sup> addressing the global, regional and country level.

#### *Main objectives*

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

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

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

#### *Results of the programme evaluation*

The final evaluation of the programme highlights the important role of the programme in creating a common platform for joint action and, as such, can be regarded as a starting point to strengthen global health governance, thus reacting on the “*plethora of parallel global health institutions*”<sup>44</sup>. However, it also mentions the problem of sustainability. It appears clearly that without further funding achievements of the 3-year period cannot be taken further. Furthermore, lack of clear distribution of roles between WHO and GHWA has hampered the effectiveness of implementation, just as discrepancies between countries with strong HRH leadership capacities (e.g. Cameroon) and countries with less staff availabilities and competences.<sup>45</sup>

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

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

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

<sup>42</sup> The First Global Forum on Human Resources for Health in Kampala in 2008 could be seen as starting point.

<sup>43</sup> Of which 15 have been the focus of support by WHO/AFRO, six by WHO/EMRO and eight by GHWA.

<sup>44</sup> *Strengthening health workforce development and tackling the critical shortage of health workers*. Draft final report, May 2011, p.35.

<sup>45</sup> *Strengthening health workforce development and tackling the critical shortage of health workers*. Draft evaluation report, May 2010; p. 33,

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

Any action that improves working conditions in the health sector will tend to alleviate problems of attrition. Where the EC has financed improved infrastructure and equipment, it will have simultaneously addressed issues of attrition and absenteeism (subject to the cautions above). Training is a double edged sword; on the one hand, EC training contributes to career prospects in the public health sector, but on the other hand, it may promote brain drain into donor-financed projects, into private practice, or abroad. Without better data and in the face of sometimes contradictory evidence from **country case studies**, it is hard to reach a strong conclusion regarding this JC. That the EC is trying to address the issue is without question, as evidenced by the 2006 Communication and the fact that human resources are identified as one of the key foci of EC health sector strategy which has materialised in a EC contribution agreement with two main global stakeholders in this field (WHO and GHWA) aiming at Strengthening Health Workforce Development and tackling the critical shortage of health workers. Yet the situation remains serious, especially in rural areas, in many countries.

Overall, judging from the persistence of the problem, EC interventions to relieve the human resource crisis in health do not appear to have been effective, making generalisations of the “What works?” type difficult to make. EC actions have improved the availability of data, increased the capacity of human resource planners in Ministries of Health, raised awareness and shared experiences at the regional level; however, there is no sign of tangible impact on the basic on-going problem. The reason for weak sustainable impact is that the gap between the salaries and working conditions in the public health sector and those available working in donor-financed projects, in the private sector, or emigrating abroad are so wide. Retention must be measured over a span of years and schemes that are effective in retaining young medical graduates for two to five years may still fail in the longer term. The globalisation of health training – many doctors and nurses from low-income countries will have received significant education or professional training, including certification, abroad – eases the emigration process. Also competing with effectiveness is the fact that, despite pledges and codes of good conduct, destination country health sectors continue to aggressively recruit needed health care workers from poor countries, especially those that are English or Romance language-speaking.

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

We assessed this JC based on indicators covering quality assurance mechanisms, clinical protocols and client satisfaction. The **country case studies** show that, where the EC has supported direct provision of health care, quality assurance mechanisms have been in place, usually implemented by NGOs. This was the case, for example, in *Afghanistan, Egypt* and *Lao PDR*. In a few countries such as *Moldova* and *South Africa*, quality assurance was a significant component of EC support implemented (usually by NGOs). The EC was particularly active in this regard in the *Philippines*, where TA supported efforts to strengthen the capacity of decentralised local authorities to monitor the quality of care provided. A similar conclusion applies to Indicator I-142 on the dissemination and application of clinical protocols – if the EC provided the facility or support to the operation of the facility, such protocols were implemented. However, it needs to be kept in mind that developing treatment protocols is typically the responsibility of agencies such as WHO. In a number of settings, such as *Afghanistan, Egypt* and Mindanao province of the *Philippines*, clinical protocols were implicitly disseminated through the development and provision of basic care packages. In two **country case studies**, *Moldova* and *Egypt*, strong evidence was found that there had been improvements in client satisfaction to which EC support contributed. However and despite strong EC support for health sector reform, it is not possible to document an improvement in client satisfaction in the *Philippines*. It was, however reported in the **Thematic Evaluation of Decentralisation** that EC-supported public-private partnerships (PPPs) improved health care quality at local level<sup>46</sup>. In *South Africa*, by contrast, Public-private partnerships (PPPs) were less successful because national guidelines on PPPs were poorly suited to the needs of local governments and, to a large extent, PPPs were introduced as precondition for EC funding rather than fully appreciated by local stakeholders.

<sup>46</sup> Particip (2012): Thematic global evaluation of the European Commission support to decentralisation processes, 2012, p.66

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

Experience has shown that addressing only addressing the supply side of health – the number of facilities, doctors, etc. – is not sufficient to widen actual access and provision because there must be effective demand for health care, as well. Some of the barriers here are attitudinal and behavioural, or have to do with the quality of services availability. In some settings, geographical access is a limiting factor. Largely, though, the main constraint to increasing utilisation of the health system is financial; the poor do not have enough money to pay. The trend towards cost-recovery and tightening of health budgets has made the problem more serious. With salaries in the public health service being very low, many doctors have either set up private practices, where out-of-pocket charges are high, or have in some countries resorted to receiving under-the-table payments for services that should be provided free or at nominal cost. Affordability is linked to quality and the size of health budgets, as in countries where public health facilities and services have deteriorated drastically, even the poor may prefer to seek expensive private treatment.

An especially serious aspect of affordability is the issue of catastrophic health expenditure – sometimes defined as spending in excess of 25% of income. General literature shows that catastrophic health spending is a common cause of poverty, either preventing poor families from advancing out of poverty or pushing the near-poor over the brink. In some settings, families sell assets and borrow money, entering a debt trap from which they have little likelihood of escape. The existence of a functioning public health financing system, whether of the national health service variety or a variant on the insurance model, is a vital component of health development policy.

This question thus tries to assess the extent to which policies adopted have tended to make health care more affordable, to the general population but most particularly to the poor. To this end, four Judgement criteria have been established:

- JC 21: The cost of basic health care services are reduced for households due to EC support
- JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC
- JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC
- JC 24 Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC

The answer to this question is mainly based on the following sources:

- Country Case Studies
- EUD survey
- Literature analysis (outside case study documentation)
- Interviews
- Thematic case study on EC financing of global public goods

### **EQ2 on affordability of health – Summary Answer Box**

We approached this question based on four JCs, the first having to do with the cost of basic health services and the second the existence of special schemes to ensure availability of health care services to those with special needs, the third improvements in health care finance policies and finally, development and availability of medications and treatments. In considering the latter, we focused on the EC's contribution to the production of global public goods for health.

Increasing access and utilisation by reducing cost has been a central concern of all EC interventions in the field of health. There is evidence from many settings that high out-of-pocket costs for health care are one of the most important factors discouraging households from seeking needed health care. When, as is often the case, households are forced to pay high sums, the result may be indebtedness (common, for example, in India) or impoverishment.

We found that, overall, the EC made some contribution to reducing the cost of basic health services to households in the countries where it provided support. In some cases such as Afghanistan and pilot Governorates of Egypt, this was in the context of direct financing of the provision of health care services.

The EC has contributed significantly in a range of settings to the reducing the cost of health care to those with special needs, with resulting increases (according to respondents to the [EUD survey](#)) in utilisation of health care services. A range of interventions that supported such schemes were identified, however, only about a third of [EUDs responding](#) to the survey felt that health finance policy over-

**EQ2 on affordability of health  
– Summary Answer Box**

all was serving the needs of the poor “satisfactorily or “well.” The handful of responses to the MoH survey was mixed on this subject. There is evidence that EC support for special schemes led to additional utilisation of health care services in most countries, although precise estimates are not available.

In most countries, the EC provided at least some TA and participated in policy dialogue related to health care finance. This included countries such as *Afghanistan*, where the clear focus was on provision, not on finance. In a few countries, such as the *Philippines*, *Egypt* and *Lao PDR*, health care finance was a focus area of sector policy support programmes. In general though, there appear to be few success stories in the area of health care finance. Even in *Moldova*, where the EC helped to support a sweeping reform, the results are not entirely satisfactory, as informal payments remain common and quality remains low.

While we have identified impacts of EC support in most case study countries and while EUD survey results are broadly supportive of the view that EC assistance has had some impact, it is difficult to find systematic evidence of this. Probably the most looked-at statistical indicator of the affordability of health care is the proportion of total health expenditures that is out of pocket (often further decomposed into the share of the total that is private and the share of private that is out of pocket, i.e., not covered by private insurance). In some countries, such as *Ghana* and *Burkina Faso*, there were very significant reductions in the out-of-pocket share and EC GBS may have made some contribution by creating fiscal space. In others, such as *Lao PDR* and *Philippines*, the out-of-pocket share increased despite EC TA related to health care finance. A reverse causation factor can, however, also be cited; one reason for EC concern about health care finance, for example, in the *Philippines* is precisely the strong trend of rising out-of-pocket payments. Out-of-pocket payments also cannot be dissociated from other factors, especially the quality of health care available in the public sector. When this improves, it can be expected that fewer patients will choose to seek more expensive private care. The answer to this EQ must be read together with the answer to EQ 1.

We approached the last JC, on making affordable drugs and treatments available, in the global public goods dimension. We expressly left out the impact of the Global Fund, although EC support has significantly contributed to the availability of treatments and preventive measures for all three of the diseases of poverty. We found that EC support to GAVI has significantly supported the availability of low-cost immunisation. The EC also supported the Global Polio Eradication Initiative and as well devoted bilateral funds to polio control in countries experiencing resurgence or cross-border incursion of the disease. Through framework research programmes, the EC has contributed to the development of treatments for and innovative approaches to malaria and it is active in a network co-ordinating malaria vaccine research. We found concrete example of EC participation in global health research networks, largely but not entirely through Framework Research Programmes, including at least some partnerships with the pharmaceutical industry. These contributions to the production of global public goods for health are solidly in line with the EC’s comparative advantage as a supranational organisation.

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

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

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

lic improvement in health finance. An exception is *Zambia*, where there is stronger evidence that GBS resulted in better communications between social sector ministries and the Ministry of Finance, leading to increased social sector budgets.

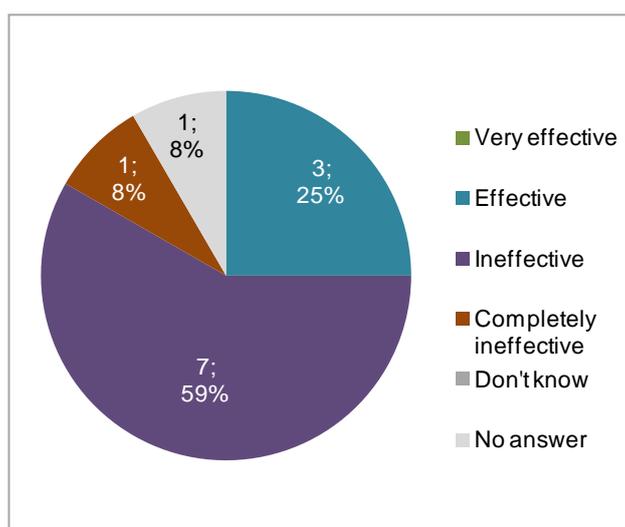
As stated in the [country case studies](#), in a number of countries benefiting from EC support, such as *Zambia* and *Afghanistan*, there is no social security scheme covering health. Interpreting “social security” loosely, the EC has provided support to strengthening and expanding national health insurance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

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

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

Under Indicator I-213, we present general [EU Delegation survey](#) evidence that the proportion of the population benefiting from some form of public health finance guarantee – whether direct access to free health care or an insurance scheme – has increased. This is to some extent a result of EC support to health care reform. However, the EUD survey also shows that the effectiveness of such public schemes is low, as can be seen in the next figure.

Figure 17: Results of the survey to EUDs: Effectiveness of the public health care financing scheme in financing needed care (in absolute figures - number of EUD respondents - and %)



Source: EUD Survey, 2011, Particip GmbH

Overall, from the information gathered, it appears that the EC has made some contribution to reducing the cost of basic health care services for households. In a few cases it has been via direct provision of health care, but that is somewhat outside the scope of this EQ. When it comes to health care financing systems, neither the EC nor any other donor has the resources, or the desire, to finance the large sums required. However, through TA and capacity building, the EC has focused policy makers on the financing issue and supported the strengthening of the range of financing approaches encountered.

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

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

A broad range of subsidy and cost-waiver schemes were identified in the country case studies, some directly supported by the EC, some indirectly supported and some which may be completely unrelated to EC support. The *Egyptian* Family Health Fund was supported both by TA and through direct financial input from the EC in pilot Governorates. In *Afghanistan*, free basic health services have been provided in ten provinces with EC support. In *Ghana*, nearly 70% of the population is theoretically exempt from fees in the compulsory National Health Insurance System; in fact, exempt populations are often denied care, but it is agreed that children, the elderly and pregnant women effectively benefit from exemptions. GBS in Ghana may have helped create fiscal space for these exemptions, just as EC GBS in *Burkina Faso* may have helped to create room to subsidise maternity services in supervised facilities. An important indirect support for subsidised or free services is EC support for the Global Fund, which provides services such as ARV therapy and TB testing / treatment in heavily AIDS-affected countries. Most of the admittedly few respondents to the MoH survey reported that cost waiver and subsidy schemes were in place and reasonably effective. However, there are countries such as *Vietnam* where it is clear from the 2009 CSE Vietnam that difficulties in identifying the poor and social stigma limit the effectiveness of health insurance subsidies.

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

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

Despite these complications, a reasonable amount of evidence from country case documentation indicates that EC support has resulted in additional utilisation of basic health services by households. This is clearly the case in *Afghanistan* where the EC finances distribution of a basic health benefit package in ten provinces and in *Ecuador* where, similarly, the EC supported provision of health care services in three under-served provinces. In *Ghana*, the introduction of compulsory health insurance resulted in an increase in service utilisation, which was one of the elements of the Multi-donor Budget Support programme; unfortunately, MDBS evaluation estimates are grossly lower than National Health Authority estimates. Moreover, in other countries evidence of EC impact is lacking. In *Zambia*, the increase in health care service utilisation when user fees were abolished was unrelated to EC support<sup>47</sup>.

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

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

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

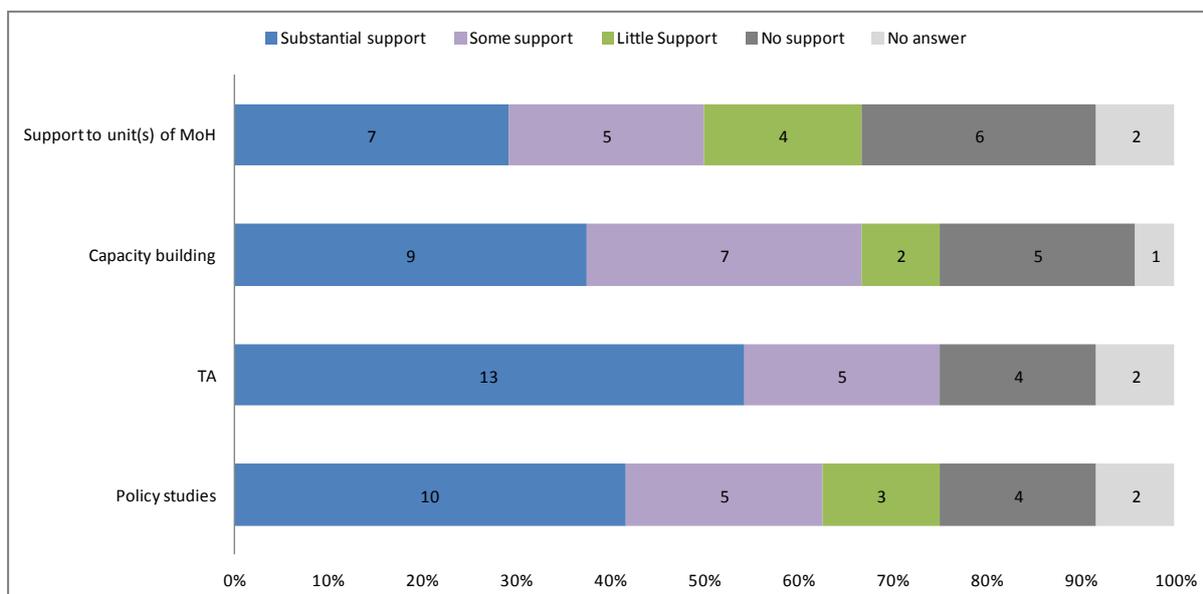
We assessed this Judgement Criterion based on two Indicators, EC support for TA and the provision of expertise in health care finance and EC support for enhanced communication and co-operation between Ministries of Health and Finance.

Regarding the first, evidence was found that, even in countries where health care finance was not a focus in the health sector, the EC supported TA did provide some expertise relevant to finance. For example, even in *Afghanistan*, where the focus was almost entirely on provision, the EC financed some studies (not TA strictly speaking) relevant to health care finance. In other countries, such as

<sup>47</sup> No relevant time series data were found for Moldova.

Egypt, the Philippines, Lao PDR and Moldova, TA on health care finance was a major contribution to health sector reform (source: [country case studies](#)). This is also corroborated by the findings from the [EUD survey](#), where by far the majority of respondents identified TA along with capacity building as a major means of EC contribution in the area of health care finance (see following figure). The EUD Philippines reports greatly improved communications between MoH and MoF due to a united donor position, but while this has resulted in a larger budget for MoH, vertical communication remains poor and local budgets for health low.

Figure 18: Results of the survey to EUDs: Means used by EC to support pro-poor health finance policies



Source: EUD Survey, 2011, Particip GmbH

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

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

The EC's policy relating to research and development on global health issues is set out in the 2010 Commission Staff Working Document "European Research and Knowledge for Global Health"<sup>48</sup>.

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

Regarding the second indicator, our [thematic case study](#) on EC financing of global public goods for health has uncovered evidence of a broad and significant engagement, from framework research programmes to direct finance of initiatives related to immunisation, vaccine development, to pandemic

<sup>48</sup> [http://ec.europa.eu/development/icenter/repository/SEC2010\\_381\\_EN.pdf](http://ec.europa.eu/development/icenter/repository/SEC2010_381_EN.pdf)

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

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

The question focuses on achieved coverage of health service delivery across the population. It specifically looks at coverage of provision of primary health care and secondary (hospital) care.

Health services can contribute to improved population health status provided they reach the great majority of the population, including the poor, with appropriate health interventions. Access to appropriate health services consists of several components: availability of primary and secondary health facilities within geographical reach, financial accessibility, quality of services offered and utilisation of the services by the population.

This EQ looks specifically at the general geographical availability of health services - affordability and quality are dealt with elsewhere, although we recognise that all must be, in some sense, considered together in order to reach an overall assessment.

We have addressed this EQ through two Judgement criteria:

- Increase in availability of primary health care facilities
- Increase in availability of secondary health care facilities

The answer to this question is mainly based on the following sources:

Country Case Studies

- EUD survey
- MoH survey
- International statistics
- Selected further literature
- Inventory

#### **EQ3 on Health facilities availability – Summary Answer Box**

The strong emphasis on primary health care in the EC support can be seen in the distribution of financial volumes dedicated through the EC's direct support to health. With regards to physical availability of health care, this is clearly reflected in the evidence found for the two judgement criteria.

In general, access to both primary and secondary health care is not equitable within countries, not only in terms of affordability for different segments of populations, but also with regard to physical availability of health care units, which was the main focus of this EQ. Rural and remote areas are often underserved and geographical distance to care may result in inability to access care or access may be very costly in terms of time and money spent on transport. The EC has addressed this aspect of health care availability to some degree, more so on primary level than on secondary and in many cases interventions were specifically targeted towards disadvantaged areas.

There is evidence that the EC contributed to improved access to primary health care. Examples can be seen in countries such as *Afghanistan*, where the EC was active in 10 provinces and helped expand the health care network through its co-operation with NGOs, or in *Ecuador*, where health units were built and improved in three provinces with high proportions of indigenous populations, or in the *Philippines*, where access was improved through extending the accreditation of health units to provide a larger array of services. However, it needs to be noted that the interventions to improve access to primary care facilities have not necessarily been translated into the improvement of indicators like number of units per capita and proportion of population living in certain radius of such facility. In some countries, potential gains in infrastructure can be offset by rapid population growth or by loss of existing units, such as in *Burkina Faso*, the *Philippines* and *India*. Moreover, EC support was not solely

**EQ3 on Health facilities availability  
– Summary Answer Box**

aiming at expanding the network of facilities, but in some cases reconstruction or equipment of existing ones, which has been relevant in for instance post-conflict countries such as the *DRC*. In some countries, mainly middle income countries, such as *Moldova* or *Egypt*, the physical availability of health facilities is not an issue, as sufficient numbers of health facilities exist. There, EC support was targeting other aspects of health care such as affordability and quality of care.

In general, EC support for improved primary health care infrastructure targeted rural areas, a reasonable strategy given that access is typically worse in rural areas than in urban ones. A consequence, however, which we have pointed out as well in answering EQ 1, is that EC interventions took little account of the increasing concentration of population and as a consequence health challenges, in urban areas.

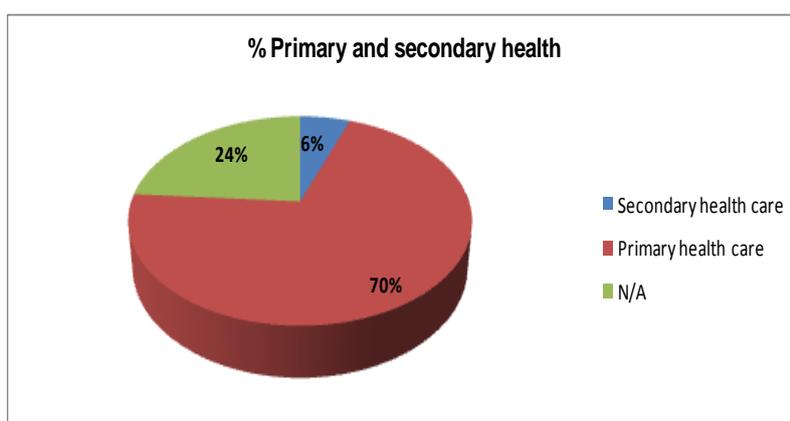
Related to increasing physical access to secondary care, evidence of EC contribution is much less available. This is ascribed not only to the fact that much smaller financial volumes have been dedicated to secondary health care compared to primary care, but also to the problem of obtaining reliable data on the indicator values in developing countries, especially with a time trend. Similarly as in primary care, differences in access persist between rural and urban areas. Some work on increasing functional secondary care facilities has been done e.g. in *DRC*, where hospital rehabilitation has been supported as a part of the 9<sup>th</sup> EDF health programme in the country. *DRC* has also seen the good improvements in road infrastructure made through the investments in the framework of the Support Programme for Rehabilitation, which is likely to have some spill-over effect into the accessibility of health units. Overall however, only little direct evidence has been found of the EC support towards alleviating the problem of insufficient availability of physical secondary care facilities, as most of the EC contributions favoured primary care access.

### 5.3.1 JC 31 Increase in availability of primary health care facilities

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

In general, access to primary care is not equitable within most countries and for many years rural populations were typically the most disadvantaged. It was found in the **inventory** that primary health care has been emphasised strongly in the EC direct support to the health sector in the 2002-10 period, compared to secondary health care and that in many cases the EC support was preferably targeted to rural or poorer segments of population.

Figure 19: *Direct EC support to the health sector: Breakdown of direct support by primary health and secondary health care, 2002-2010*



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

Source: *Particip Inventory*

Within the primary/basis health care sector, approximately 12% (€ 360 million) went to infrastructure projects (see Table 1 in the inventory section).

There is evidence from the **country case studies** that this has translated into improved access to health care facilities and in many cases disproportionately more so for poorer and disadvantaged populations. Examples can be seen e.g. in *Afghanistan*, *Timor Leste* or *Ecuador*. However, it is important to note that the EC support to primary care facilities has not necessarily resulted in a positive change of the indicator (health facility per capita). This is because effort has also been given to the reconstruction of existing facilities, which is often necessary in post-conflict countries or fragile states, such as for example in the *DRC*. Moreover, even an increase in new health units can be offset by loss of existing ones or rapid population growth over the same period and the indicator remains unchanged or even deteriorates, such as in the *Philippines* or *Burkina Faso*. In some countries, e.g. *Egypt* or *Moldova*, the physical availability of health facilities is not an issue, as sufficient numbers of health facilities exist and contributions to primary care focus on quality and affordability of care, which would not have any impact on the indicators under this JC.

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

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

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

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

### 5.3.2 JC 32 Increase in availability of secondary health care facilities

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

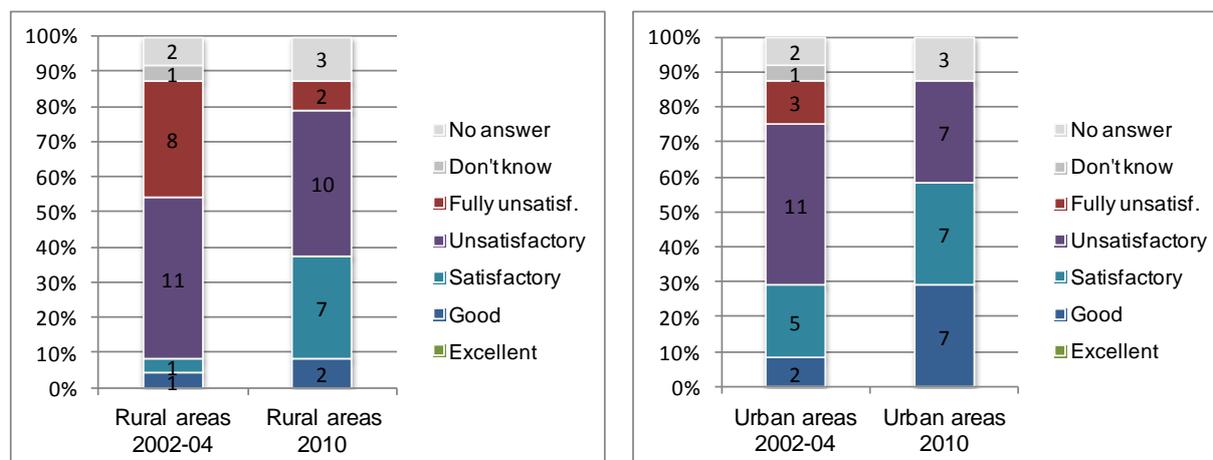
As discussed in JC31 above, the direct EC support to health care strongly prioritised primary care over secondary care and this is also reflected in much less evidence found of the EC contribution to the indicators in this JC.

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

Corresponding to the trends in primary care access, secondary health facilities are less available to rural populations and while the gap between rural and urban service delivery might have become narrower according to the **EUD survey**, unsatisfactory scores made by EUDs were still quite high in 2010

(see figure below). Again, availability of appropriate equipment and adequate maintenance budgets remains an issue for secondary care units and more so for those in rural areas. (I-322)

Figure 20: Results of the EUD survey: Availability of secondary health care facilities



Source: EUD Survey, 2011, Particip GmbH

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

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

#### 5.4 EQ4: To what extent has EC support to health contributed to improving health service utilisation related to MNCH?

This question focuses on those population behaviours that are particularly relevant to health seeking and health promotion with regard to maternal, neonatal and child care. Availability and access to health services is a necessary but insufficient condition to improve population health status. Another important aspect lays in health seeking behaviour and de facto utilisation of those health services. In relation to MDGs 4 and 5 it is of particular importance to assess if pregnant women and children make effective use of a number of key, largely preventive interventions with a well proven major impact on health outcomes.

We have addressed this EQ through three Judgement criteria:

- JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC
- JC 42 Increased use of services and facilities to support health care for children supported by the EC
- JC 43 Children better protected from key health threats as a result of EC support

The answer to this question is mainly based on the following sources:

- Country Case Studies
- MoH survey
- CSP analysis
- Literature analysis (outside case study documentation), incl. ECA reports
- Interviews

- Thematic case study on the GFATM
- International statistics
- Inventory

**EQ4 on Health service utilisation related to MNCH  
– Summary Answer Box**

During the last decade remarkable and constant progress has been made in the field of MNCH, however, the outcomes vary in terms of magnitude between countries, regions and especially between rural and urban areas. While some significant improvements in some aspects of MNCH can be observed, such as in basic immunisation rates, slower progress has been recorded on many other indicators, such as proportion of safe deliveries, use of modern family planning and child nutrition. Looking at the regional distribution, it appears that major improvements have occurred in Asia and Northern Africa, less so in Sub-Saharan Africa.

Nevertheless, MDGs 4 (maternal health) and 5 (child health) are acknowledged to be most off track of all MDGs. Some of this is because of the complexity of the problem area, which involves not only delivery of health services but also dissemination of health behavioural change, gender aspects, water and sanitation, transport, etc.

Availability and, to a certain extent reliability, of statistical data on MNCH indicators is not good overall, especially regarding time trends, which limits the possibility to make sound statements on the change in the indicators. This is not an unknown fact and the claim for stronger accountability and transparency for women's and children's health has been reiterated in different international fora, such as recently in the Conference on Aid Effectiveness in Busan (2011).<sup>49</sup>

Taking the inventory as an entry point, EC support to MNCH has been limited, financially speaking, with only 5% of all EC funds over the evaluation period being committed to the sector SRH. However, as MNCH interventions are rarely financed as self-standing interventions but rather included and "hidden" in more complex and comprehensive interventions labelled as 'basic-health interventions', EC support in the area of MNCH has in fact been higher, although the exact percentage is not identifiable. Although the EC emphasised in various Communications, the importance of sexual and reproductive health<sup>50</sup> as well as its commitments to the MDGs, MNCH, including nutrition, rarely figures as a focal sector in the CSPs for the periods 2002-2007 and 2008-2013.

The EC financed MNCH in the following ways.

- Through including MNCH in programmes aiming directly at the provision of primary and basic health care, such as Basic Health Care Packages or indirectly via GBS or sector support;
- Through individual projects targeting remote and underserved areas and excluded populations. These projects were either small NGO projects or larger-scale regional interventions, implemented by a partner organisation specialised in the area, such as UNPFA, UNICEF or International Planned Parenthood Federation (IPPF).
- Through financial contributions to global initiatives, especially GAVI (immunisation) and GFATM (sexual and reproductive health and maternal health).

An increased utilisation of health facilities by women and children is closely correlated with the availability and quality of the care provided. It appears from the analysis that EC financing of basic health care provision programmes (e.g. in *Egypt, Afghanistan* and *South Africa*) has been highly successful in improving maternal health and, to a lesser extent, in increasing the utilisation of health facilities by children, resulting in higher immunisation rates and better monitoring of the growth and nutrition status.

GBS programmes, especially in MDG contracts and PRS-based GBS, included in most of the cases one or several indicators related to maternal health (e.g. supervised delivery or antenatal care (ANC) visits) and child vaccination. The reviewed GBS (*Ghana* and *Burkina Faso*) show an overall good performance and fulfilment of these indicators. Policy dialogue related to sector budget support was extremely successful in Egypt in promoting the primary health care model, with positive impacts on fami-

<sup>49</sup> OECD, Commission on Information and Accountability for Women's and Children's Health (2011): Progress and Challenges in Aid Effectiveness, What can we learn from the Health sector? 4<sup>th</sup> High Level Forum on Aid Effectiveness (29.11.11-01.12.11, Busan Korea).

<sup>50</sup> Official Journal of the European Union (2003): Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on reproductive and sexual health and rights in developing countries.

## EQ4 on Health service utilisation related to MNCH

## – Summary Answer Box

ly planning and MNCH.

As considerable gaps remains between rural and urban areas for all MNCH indicators analysed in this evaluation, the EC approach in MNCH to prioritise underprivileged areas and communities can be seen as highly relevant. These projects, although mostly geographically too restricted to have an observable impact on national statistics, can however serve as innovative example how to address MNCH behaviour in different and difficult circumstances.

Considerable EC support to SRH and vaccination was channelled through regional programmes or global initiatives in the ACP region and in Asia. Overall, these regional programmes have yielded good results and contributed to an increased number of woman and children being seeking appropriate health care, especially in remote areas or in cultural highly sensitive background on issues such as maternal health and sexual and reproductive rights. Problems highlighted in almost all regional interventions are those related to co-ordination and procedural differences, as regional programmes are mostly implemented by multi-lateral organisations. Especially for vaccination programmes these problems have considerably reduced the outcomes that could have been expected.

While evidence of successful EC support to maternal health could be found, direct EC support addressing children's health was much scarcer, especially related to children's growth monitoring, use of bednets and fight against diarrheal diseases of children. The main EC contribution to children's health can be found in the its support to primary health care interventions, such as the financing of basic health care packages (e.g. *Afghanistan* and *Egypt*) or sector programmes with a clear pro-poor focus (e.g. *Ecuador*, *Bangladesh*). Small project interventions contributed primarily to address specific geographical areas and to raise awareness on issues such as use of bednets, nutrition and treatment of child diarrhoea.

In the area of child health, EC support to immunisation has a specific position. Immunisation has been funded by the EC either through contribution to large regional/worldwide vaccination campaigns (GAVI, Polio Eradication Campaign) or targeted country interventions (e.g. *Nigeria*, *Ethiopia*). Through its support, the EC has contributed, to a not negligible extent, to the raising rate of immunised children at a worldwide level.

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

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

The EC's commitment to sexual and reproductive health (SRH) has been continuously strong since the 1990s, as set out in the 1994 International Conference on Population and Development (ICPD) Program of Action,<sup>51</sup> the EC Regulation of 2003 on 'Aid for policies and actions on reproductive and sexual health and rights in developing countries'<sup>52</sup>, the EU Agenda for Action on MDGs (2008), the 'Investing in People' action programme 2007-2013<sup>53</sup> and in the 2010 Council conclusions on the EU Role in Global Health<sup>54</sup>.

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

Looking at the effective EC support to SRH during the evaluation period, the inventory shows that the sector sexual and reproductive health - which includes maternal and child health interventions - has received the smallest share of direct EC support, amounting to only 5% or EUR 219 million of the total

<sup>51</sup> UN (1994): United Nations International Conference on Population and Development (ICPD). <http://www.iisd.ca/cairo.html>

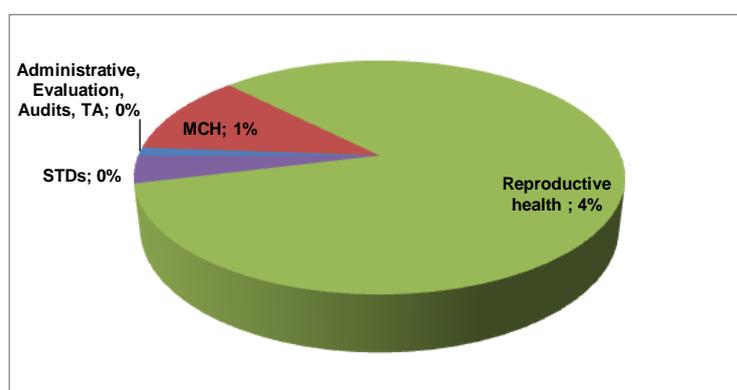
<sup>52</sup> Official Journal of the European Union (2003): Regulation (EC) No 1567/2003 of the European Parliament and of the Council of 15 July 2003 on aid for policies and actions on reproductive and sexual health and rights in developing countries.

<sup>53</sup> European Commission: Investing in People. Strategy Paper for the Thematic Programme 2007-2013

<sup>54</sup> Council of the European Union (2010) Council conclusions on the EU role in Global Health

direct support during the period under evaluation. As can be seen in the figure below, the majority of funds within this subsector (84% of the funds of the SRH-sector) target reproductive health.

Figure 21: Direct EC support to the health sector: Sub-sector reproductive health breakdown, as a proportion of the total direct support to health sector, 2002-2010



Source: CRIS database, analysis Particip

Table 10: Direct EC support to the health sector: Sub-sector reproductive health breakdown, 2002-2010 (in EUR million and %)

Sector categorisation	Contracted amount (EUR million)	% of the sub-sector SRH
Evaluation, Audits, TA	3	1%
MNCH	25	11%
Reproductive health	185	84%
Sexually Transmitted Diseases (STDs)	8	4%
<i>Total SRH</i>	<i>221</i>	
<b>Total EC support during the period</b>	<b>4'118</b>	

Source: CRIS database, Particip GmbH analysis

However, as pointed out in the [Inventory analysis](#), only those SRH interventions are detected which are primarily and solely aiming at reproductive health activities. It would be a mistake to judge the EC's contribution in the area of maternal and child health purely on the amount of direct support clearly labelled in the inventory as MNCH interventions, as they represent only part of actual amounts contracted on reproductive health (RH).<sup>55</sup> MNCH is often integrated in primary health care programmes, funded under big sector interventions (e.g. Provision of Basic Health Care Services or Sector Budget Support) or GBS programmes. Through these sector interventions, aiming at providing basic health care, access or quality of health care, the EC has certainly provided additional support for the improvement of maternal health, resources, although not directly quantifiable that must be added to the direct support to SRH.

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

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

<sup>55</sup> For further explanation see Annex 2 (inventory).

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

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

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

Furthermore, it is interesting to note that 95% of EC support geared towards MNCH is channelled through individual projects, usually with rather small budget (less than EUR 2 million).<sup>56</sup> In most cases, MNCH support is implemented by MNCH-specialised NGOs or multilateral organisations (e.g. UNFPA, IPPF, Marie Stopes International, or UNICEF). (I-411, 412, 413)

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

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

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

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

- Support targeting in priority remote, underserved and conflict area and underprivileged populations: Targeting has been made either through low-budget NGO interventions or through large regional programmes implemented by specialised multi-lateral organisations. Both types

<sup>56</sup> With the exception of the component “Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction” of the Support to the national Health, Nutrition and Population Sector Programme in Bangladesh

of interventions have yielded the expected results related to the improvement of maternal health. While regional support has achieved its targets, it must however be noted that problems related to the co-operation and administrative procedures between implementing partner organisations and the EC were frequent. Individual projects also have contributed to improved maternal health, although, due to their limited scope, the benefit of these projects can mainly be found in the awareness raising of women and communities on health behaviour related specifically to health behaviour during pregnancy and neo-natal care as well as sexual health rights. So the EC contributed locally to reduce the - still huge gap - between rural/poor/badly educated areas and the urban/wealthier and educated areas.

- Support of basic health care and/or health system strengthening programmes, which often included rather substantial targeting of maternal health, e.g. in sector programmes, SBS and, to some extent, also GBS. EC financing of basic health care packages (*Afghanistan, Egypt*) or support to primary health (*Ecuador, South Africa, Philippines*) has been most successful in improving maternal health (supervised deliveries as well as ANC visits) and family planning. Also in countries where the EC provided support via GBS (*Burkina Faso, Ghana*), the situation related to maternal health indicators, especially related to supervised deliveries, has improved. It must however be noted that indicators are again declining towards the end of the evaluation period, which might also be related to an increased population growth and a declining ratio in health facilities and health workers per inhabitant.

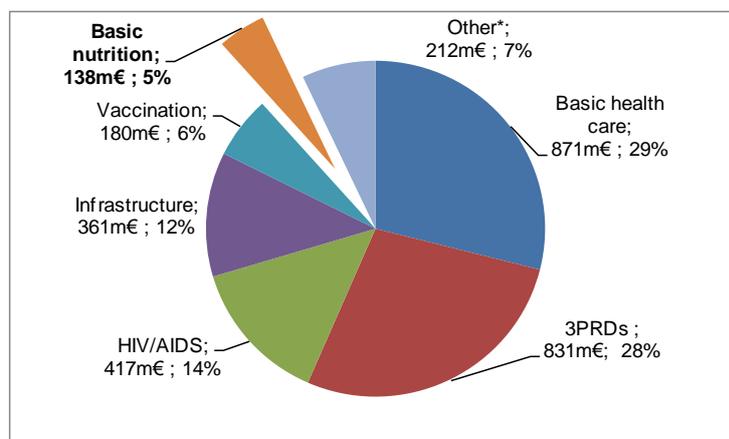
#### 5.4.2 JC 42 Increased use of services and facilities to support health care for children supported by the EC

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

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

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

Figure 22: Breakdown of EC committed funds within the Sector "Basic health" (contracts between 2002-2010)



Source: CRIS database, Particip analysis

With the exception of *Bangladesh*, where the EC supported child nutrition explicitly through the "Support to the national Health, Nutrition and Population Sector Programme," none of the **case study countries** benefited from substantial interventions aimed specifically at child nutrition. Only small projects

related to food security and child nutrition can be found in *DRC, Zimbabwe, Afghanistan, Myanmar, Vietnam and Yemen*.

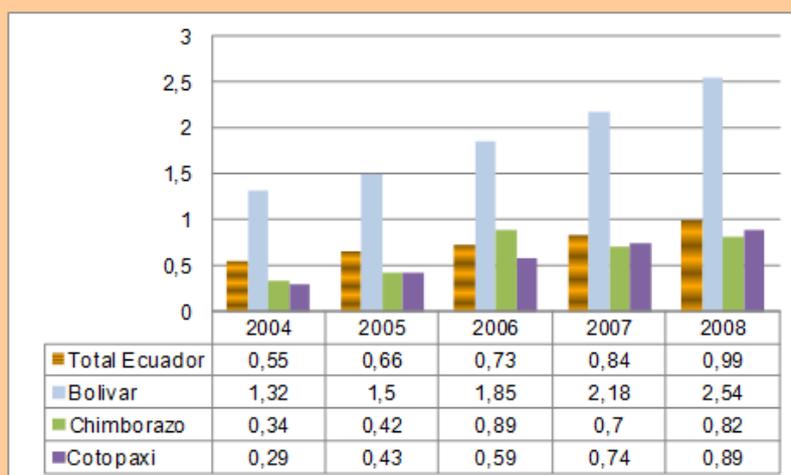
Literature confirms that increased health service utilisation of children under the age of five has positive impacts on children's growth monitoring. The evaluation's analysis reveals encouraging records for *Afghanistan* (increases in child attendance to Basic Package of Health Services (BPHS) centres,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

**Box 4:** Findings from the Country Case Studies: Example of the EC project PASSE in Ecuador

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

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

**Figure 23:** Change in number of annual consultation per region for children aging between 1 and 4 years. (Ecuador)



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

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

According to the *inventory*, the EC has supported vaccination interventions with EUR 180 million, which represents 4% of the total EC support to the health sector during the evaluation period. The majority of funds (EUR 100 million) went to global initiatives, such as GAVI (EUR 39.4 million) and the Polio Eradication Campaign, implemented by the WHO (EUR 60 million). Remaining funds went to large scale country vaccination interventions in *Nigeria* and *Ethiopia*. However, evaluations of both global initiatives show a mitigated picture concerning the results of routine immunisation campaigns (funded by GAVI) or specific campaigns tackling measles (GAVI) or polio (WHO). While some significant progress related to the vaccination coverage of children has been made in a number of countries related to polio and measles vaccination, shortfalls in vaccines, delayed vaccination activities or poor implementation of the immunisation campaigns have led to new outbreaks and failure to reach initial targets. Moreover, large donor-funded vaccination campaign, especially when it comes to routine vaccination, also implies a certain risk to substitute the government's own activity. However and despite some negative points, it can be concluded that EC financed country wide immunisation programmes, helped considerably to raise awareness for the importance of children's immunisation and made a concrete contribution towards higher immunisation rates.

**Box 5:** Findings from the Country Case Studies: EC support to immunisation: The Nigerian EC-PRIME<sup>57</sup> programme as an example

*The EC-PRIME project*

The PRIME project was implemented from 2001 to 2009, starting at a time when immunisation state was very poor in Nigeria, with only 13% of children in the country fully immunised. Its primary aim was to facilitating change and behaviour regarding immunisation. The “Change agent programme” therefore exposed committed individuals to countries that had excelled in their immunisation programmes and Primary Health Care.

*Achievements of the PRIME project*

PRIME supported eight international study tours to Tanzania, Zambia, Egypt and Malaysia. Results of these study tours helped to resolve the polio rejection controversy in the country, as religious and traditional leaders publicly announced their support for Polio immunisation and withdrew previous statements that immunisation would be in conflict with Islamic law.

The identification of targeted change agents or champions within government at all levels has institutionalised the commitment to Routine Immunisation (RI) as opposed to an emphasis on campaigns, national immunisation days (NIDs) or other one-off efforts to raise the level of immunisation coverage.

These important achievements of EU-PRIME have enhanced the potential for sustained government-managed-and-financed RI activities beyond the lifetime of the project. There seems to be a general agreement by all stakeholders that the EC support has contributed to the greater immunisation coverage of the population. PRIME is considered as a success programme of EU assistance in Nigeria.

At regional level within Nigeria, the EC has supported six focal states. Cold chain systems have been in place in 2010 and services continued even after the termination of PRIME in June 2009. However, only a few activities could be supported in the 17 additional States from 2008 onwards. The State-specific routine immunisation project “Support to Routine Immunisation in Kano State” (SRIK) has not yet materialised, although it would be needed, as Kano State is a hotspot for wild polio spread.

*Problematic aspects of the PRIME project*

There is the impression that PRIME was a substitute for the Government of Nigeria rather than a change facilitator. This impression, according to the CSE, is evident both in government circles and also among other donors operating within the immunisation sector.

There is, however, recognition that the project itself has adopted a resource mobilisation approach at level to encourage Government to put into practice mechanisms for supporting RI and also some evidence that certain States are beginning to adopt a resource mobilisation approach at Local government area (LGA) level.

At state level, cost sharing between the Federal level, State and LGA levels remains problematic. As disease prevention is a public good, which benefits to the whole nation (and beyond, as in the case of polio eradication as a global goal), the increased reliance on individual federated states to prioritise routine immunisation cannot be considered a viable approach, so the conclusion of the CSE.

Source: Country Strategy Evaluation (2010)

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

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

<sup>57</sup> Partnership to Reinforce Immunisation Efficiency

good. Furthermore, the EC also contributed, through its immunisation programmes, to an increased awareness on the importance and use of children's immunisation.

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

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

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

**International statistics** indicate that over the evaluation period there has been a substantial increase in the proportion of children sleeping under insecticide-treated bednets (ITNs). Especially in the malaria risk zones of sub-Saharan Africa, data for 2009-2010 show that ITN coverage increased and, further, disparities in the use of bednets among population groups reduced<sup>58</sup>. This is largely due to nationwide campaigns aiming at the distribution of free nets with a specific focus on poor, rural areas as well as pregnant women and children, to which the EC has indirectly contributed through its GBS support, e.g. in *Ghana* and *Burkina Faso*.

The GFATM, of which the EC is one of the largest supporters, is the biggest distributor of bednets in the developing world. Figures show that GFATM activities, financed by the EC, have contributed to considerably increase bednet coverage for children especially in high-risk zones and countries such as West- and Southern Africa (*Ghana, Burkina Faso, Zambia*), where figures increased from almost no use at of bednets for small children at the beginning of the evaluation period to a coverage of around 40% in 2009-2010. Furthermore evidence from the **country case studies** shows that the EC financed small self-standing projects in *Afghanistan, Bangladesh* and *Laos* which have resulted in an increased availability of ITNs as well as awareness raising on its use, especially for children and pregnant women. Two EC initiated projects on bednet distribution in *Afghanistan* and *Laos* (the latter in the context of a regional project which also covered *Vietnam and Cambodia*) have been continued by the GFATM after the project end. These examples, as well as the rather small amounts of EC funds directly targeting child health, highlight that the EC has chosen to channel its main support related to malaria-control activities through other than bilateral support, i.e. mainly through the GFATM, as it has greater expertise and influence in this area. (I-431)

According to UNICEF and WHO, diarrhoea remains the second leading cause of death among children under five globally. Nearly one in five child deaths is due to diarrhoea. Diarrhoea is more prevalent in the developing world, in large parts due to the lack of safe drinking water, sanitation and hygiene, as well as poorer overall health and nutritional status. Diarrhoea deaths are concentrated in two regions (Africa 46% and South Asia 38%).<sup>59</sup> The use of oral rehydration salt (ORS) therapy and continued feeding is an effective way to children to save children from death caused by diarrhoea and can be directly applied by the families.

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

In sum, no direct interventions to both indicators could be found. However, the EC contributed indirectly to increased availability of ITN through GBS and its impressive contribution to the GFATM activities. Concerning the treatment of diarrhoea through ORS, the EC has through its support to primary health

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<sup>58</sup> UN. 2011. The Millennium Development Goals Report 2011. New York: United Nations

<sup>59</sup> UNICEF and WHO. 2009. Diarrhoea: Why children are still dying and what can be done, p.7

care, in some countries, contributed to reducing child mortality due to diarrhoea diseases, e.g. by financing of basic health care packages in *Afghanistan and DRC*. Small projects have helped to spread the knowledge on water-borne diseases and increase the use of ORS, especially in remote and rural areas.

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

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

This question aims to address the management and governance capacity – as well the policy making capacity of the health system. Governance in health is being increasingly regarded as a salient theme on the development agenda. Leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. The need for greater accountability arises both from increased funding and a growing demand to demonstrate results.

Accountability is therefore an intrinsic aspect of governance that concerns the management of relationships between various stakeholders in health, including individuals, households, communities, firms, governments, nongovernmental organisations, private firms and other entities that have the responsibility to finance, monitor, deliver and use health services. Accountability involves, in particular: (i) delegation or an understanding (either implicit or explicit) of how services are supplied; (ii) financing to ensure that adequate resources are available to deliver essential services; (iii) performance around the actual supply of services; (iv) receipt of relevant information to evaluate or monitor performance; (v) enforcement, such as imposition of sanctions or the provision of rewards for performance.

Governance in health is a cross-cutting theme, intimately connected with issues surrounding accountability and transparency. In the context of health systems strengthening, it is an integral part of the health system components. Despite consensus on the importance of leadership and governance in improving health outcomes, they remain inadequately monitored and evaluated.

The question is to consider how EC support has helped the partner government in these areas and the extent to which the EC practices contribute to improved sector governance and transparency. It has been addressed through two JCs:

- JC 51 Improved availability of policy analysis and data for health sector management and governance due to EC support
- JC 52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.

The answer to this question is mainly based on the following sources:

- Country Case Studies
- EUD Survey
- ECA reports
- MoH survey
- Selected further literature on Budget Support
- Interviews
- ECA reports

### **EQ5 on Management and Governance – Summary Answer Box**

There is mixed evidence on the degree to which EC assistance has contributed to strengthening the management and governance of health systems. In some areas there has been a clear contribution such as in strengthening health policy strategy processes. This has been through improving the availability of policy analysis and data, supporting the preparation of national strategic health plans, the co-ordination of performance monitoring, development of health indicators and assisting in the development of sector co-ordination mechanisms. Key issues related to health sector management and governance such as PFM, accountability and capacity have also been incorporated into policy dialogue in most cases.

The EC has also made some contribution to strengthening institutional and procedural systems related to transparency and accountability in the countries in which it has implemented programmes. The majority of the EC's work has been addressing public financial management and this has been the

**EQ5 on Management and Governance**  
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area where there has been most success. There has been some technical and capacity building support provided by the EC to assist Ministries of Health in establishing and monitoring Annual Work Plans and budgets, but this assistance has not been comprehensive as it was only been provided to a limited number of countries.

Most of this support has been in the form of TA to support the drafting of health sector plans, Medium-Term Expenditure Framework (MTEFs) and development of indicators, while EUDs in country have been active in establishing health co-ordination mechanisms. Evidence also indicates that there has been a good level of dialogue in health sector forums related to PFM, accountability and capacity building measures, in the majority of countries, although it is not always clear the extent to which this dialogue has resulted in strengthened capacity in these areas as a result.

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

The EC has undertaken limited work on decentralised capacity building to strengthen health policy capabilities, but not in all countries, which is an issue as capacity at provincial and district levels remains low.

Procurement is the governance area where there had been the least contribution by the EC; there appears to be little focus in EC health programmes on this aspect.

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

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

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

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

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

The EC has undertaken limited work on decentralised capacity building to strengthen health policy capabilities, but not in all countries and often the support undertaken has not been sufficient. This is probably due to the fact that most SBS/SWAs tend to focus more on upstream policy and monitoring processes, rather than the actual delivery of services. It is also notable that in the countries where decentralisation has been addressed, capacity building support was provided through projects. The activities that have been implemented ranged from TA to support and building capacity at local government level developing road maps to guide the decentralisation of health budgets, training in Inte-

grated Financial Management Information Systems (IFMIS) at local level capacity building and supporting planning. It is not clear in all cases from the information analysed, what tier of local government this work was aimed at and the extent to which it was successful. This is an omission as it is pointed out by the European Court of Auditors (ECA) report on health services in Sub-Saharan Africa that low capacity at provincial and district level negatively affects the performance of EDF projects. Examples of where capacity building at local level has been successful include the *Philippines*, *India*, *Ecuador*, *DRC*, *Afghanistan* and *South Africa* (see box below):

**Box 6: Successful examples of support to strengthening health systems at the local level**

*Afghanistan* – Under the ‘Health Management Training to the General Directorate of Provincial Public Health, Ministry of Public Health’ (2006-2009), the EC strengthened the managerial and administrative capacity of the Afghan Ministry of Public Health for providing an efficient, accessible and equitable health services to the Afghan population at large and specifically in rural and remote areas.<sup>60</sup> This was undertaken through a combination of national and international TA supply contracts and training. The programme has a positive impact on the capacity of the provincial public health and as an example, other donors started to replicate the same format late in 2007.

*India* – The Health and Family Welfare Development Programme, 1998-2007 (HFWS) programme’s support to the decentralisation process and to the planning and implementation capacity of State and District health authorities has led to better-defined roles and responsibilities. The initiative also allowed State and District health authorities to develop various initiatives to recruit and retain staff and to increase and maintain their skills and knowledge. These initiatives range from various training programmes to incentive schemes, including renovated staff houses for health workers.<sup>61</sup> The HFWS programme has also played a crucial role in the decentralisation process by providing budgets to participating Districts, based on plans developed by the District authorities in addition to the existing, rigid expenditure-based funding from State and national level.

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

*DRC* – EC support in capacity development have prioritised the decentralised level, especially targeting health facilities. The PS9FED has supported the provincial health departments by creating an expert team at provincial level, which has helped the DPS to better fulfil their new role in the context of devolution of responsibilities.<sup>62</sup>

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

*South Africa* - The Delivery of Primary Health Care including HIV and AIDS Programme (PDPHCP) I and II were successful in supporting decentralised capacity building to strengthen health policy capabilities at provincial, district and local level. The 2009 MTR<sup>63</sup> states that through PDPHCP II 1,264 non-profit organisations were funded to provide the primary health care packages to support the DoH in provide PHC to all communities. By 2009 the programme was operational in 40 of the 52 health districts in the country.

Source: EUD Survey (*Philippines*), Country Case-study *Afghanistan*, *DRC* and *South Africa*

### 5.5.2 JC 52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support

The EC has made some contribution to strengthening institutional and procedural systems related to transparency and accountability in the countries in which it has implemented programmes. The majority of the EC’s work has been addressing public financial management and this has been the area where there has been most success. There has been some technical and capacity building support provided by the EC to assist Ministries of Health in establishing and monitoring Annual Work Plans and budgets, but this assistance has not been comprehensive as it was only been provided to a limited number of countries. The area where there is least evidence of EC support is procurement as there appears to be little focus on this in EC health programmes.

In terms of improving transparency and accountability, much of this work has been aimed at strengthening public financial management, planning, statistical strengthening and auditing, with less evidence

<sup>60</sup> Final Progress Report on Health Management Training to the General Directorate of Provincial Public Health, Ministry of Public Health

<sup>61</sup> India CSE 2007

<sup>62</sup> Country Case-study

<sup>63</sup> Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&Aids Services – PDPHCP II, Mid-Term Review, September 2009

of support aimed at the division of roles and responsibilities between the MoH and MoF. Most of this support was through TA or through actions related to PFM in health sector policy matrices and has included work at both national and sub-national level. This has resulted in improvements in most countries where the EC had provided this support (I-521)

There has also been some technical and capacity building assistance given by the EC to assist Ministries of Health in establishing and monitoring Annual Work Plans and budgets in a limited amount of countries. This has been reasonably successful in supporting Ministries of Health in strengthening their capacity for establishing and monitoring Annual Work Plan and Budgets linked to health sector plans and budgets. This support has not been comprehensive, however and it is notable that there has not been much assistance in this area to Sub-Saharan African countries. It is not clear why this is the case, but could well be due to the fact that and other development partners may be providing support in this area so the EC does not need to fund these activities. (I-522)

EC support to the health sector has not focused very strongly on procurement reform. Where there has been support, it has mainly been in the form of (i) public financial assessments of the current system and (ii) technical assistance to the government and there is little evidence provided of improvements in accountability and transparency from these activities.

## **5.6 EQ 6: To what extent and how has the EC contributed to strengthening government-led co-ordination, complementarity and synergies with Member States and other donors in the health sector, in line with the Paris Declaration? (national, regional and global levels)**

This question focuses on how efforts in support of the health sector were co-ordinated – between the EC and the EU MSs and with other donors and funding agencies – and whether this led to complementary emphasis and approaches. With the increasing acceptance of programme and sector approaches to health sector support, donor co-ordination and complementarity have become increasingly important. This is underpinned by the fact that these are crucial elements in the Paris Declaration. With the advancement of joint approaches of Development Partners and Development Banks towards budget support, donor co-ordination is even more essential.

Policy documents and evaluations suggest that the EC is well placed to take a leading role in co-ordination<sup>64</sup>, by way of the special position with regard to MS and through experience with and major involvement in the health sector worldwide. The EQ seeks to provide answers on EC's leading role in that regard.

Moreover, dialogue and co-ordination should not be confined to programme preparation. On-going dialogue and co-ordination efforts are necessary for monitoring implementation progress and for taking necessary corrective actions.

By looking into all these aspects, the question aims at providing information on the EC's value added in the health sector in relation to the benefits that would have resulted from Member States' interventions only.

Co-ordination and complementarity issues are very much related as well to the issues of alignment and harmonisation as spelled out for instance the Paris Declaration's indicators related to these issues. Grasping some aspects of alignment and harmonisation efforts under this EQ will complement the assessment.

In addition to country co-operation, the EC uses financing channels such as World Bank, GFATM, GAVI, etc. This question will therefore also analyse the complementarity with them and possible synergies between such channels and other EC modes of supporting the health sector.

The evaluation question is addressed through the following two JCs:

- JC 61 Level of health sector-related co-ordination in place with active role/contribution of the EC
- JC 62 Increased complementarity of EC support and between EC support and support of other donors

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<sup>64</sup> See e.g. Midterm Review: "The EU's Contribution to the Millennium Development Goals-Halfway to 2015", report by Alliance 2015. The European Economic and Social Committee and the Committee of the Regions: "Keeping Europe's promise on Financing for Development" Com (2007) 164final. See also: Treaty of Amsterdam, Article 180; and, for instance: Evaluation Services of the European Union (2004): The Treaty of Maastricht and Europe's Development Co-operation. Triple C Evaluations, No. 1.

The answer to this question is mainly based on the following sources:

- Literature analysis
- EUD Survey
- Paris Declaration Evaluation
- CSP analysis
- Thematic case studies: 'Global public goods' and 'GFATM'
- Interviews
- ECA reports

**EQ6 on Co-ordination, complementarity and synergy**  
– Summary Answer Box

Overall donor co-ordination in the health sector has considerably improved over the period under evaluation and can generally be judged as good in 2010. The EC usually participates actively in sector co-ordination and most EUDs have also been involved in one or several formal sector working groups. However, EUDs chaired only few co-ordination mechanisms including donors only. Specifically related to EU MS co-ordination, the EC has played a key role, most of the time chaired these groups and thus provided added value. The tool "Delegated Partnership Agreements" may, in the future, help to further simplify co-ordination among donors, just by reducing the number of players involved in these processes, while at the same time ensuring that EC has adequate access to relevant information.

Co-ordination mechanisms including partner governments have also been an important ingredient of co-ordination during the period under evaluation with an active participation of the EC. EC played a key role in a good number of countries in the health sector, e.g. by being increasingly involved in forms of sector support, including SWAp and channelling funds via common baskets (e.g. *Zambia*). Since 2003, there is a general trend towards more formal co-ordination, involving all donors working in the health sector and engaging the governments in the co-ordination tasks for the health sector. The move towards more sector support also requires closer co-ordination between MoH and Development Partners (DPs). The increasing role of partner governments in donor-government co-ordination mechanisms clearly demonstrates the improving capacity of governments to steer and co-ordinate donor assistance. However, some respondents of the MoH survey indicated that their weak capacity and low government leadership continue to be a major bottleneck. The main problems identified in these co-ordination mechanisms are the difference in priorities, procurement policies and rules among donors. Increased government leadership is often a result of an emerging sector approach (e.g. *Philippines*, *Tanzania*). However, there is little evidence on EC support in the health sector affecting government's capacity to steer and co-ordinate donor assistance.

The use of parallel PIUs has decreased during the evaluation period. There is a clear will to phase out during these parallel units, thus showing progress of EC support to health in achieving Paris Declaration indicators. It appeared that, where parallel PIUs in the framework of EC support in the health sector have existed over the evaluation period, problems such as creating parallel power structures, distortion of salaries and diversion of staff and difficulties in achieving sustainability tend to occur.

Co-ordination can help achieving complementarity. Overall and especially for the second programming period within the evaluation period (i.e. from around 2007 onwards), there is further evidence of co-ordination of the programming process with other donors, thus allowing for complementarity and synergies. In this context, an enhanced Division of Labour among EU MS became clear for this second period, most of the time in the EC programming process but also in implementation. In particular, the EU Code of Conduct and the Nordic Plus Initiative have contributed to limiting overlaps in EU donors' sector support in partner countries. Within this framework, a Joint Action Plan has been agreed and a donor task force has established the comparative advantage of donors, in order to enhance Division of Labour in the implementation among EU donors.

The Paris Declaration of 2005 has certainly further strengthened joint efforts between donors and governments. A number of JAS have been developed during the evaluation period. However, they are not necessarily complete nor applied in all areas of support. Moreover, too many separate strategies and initiatives are a major area of concern. Progress has also been made in increasing the number of joint field missions and shared analytical work. The driving forces to start using joint actions during the evaluation period are the improved capacity of the MoH, taking the lead on the sector approach or the introduction of a new sector-wide intervention.

The EC has provided considerable financial contribution to global trust funds as well as trust funds at country level. While, across the board, complementarity of these funds with other EC support at country level can be assessed as rather good, co-ordination at country level between the participants of the trust funds has shown to be sometimes problematic (e.g. different administrative procedures, different

**EQ6 on Co-ordination, complementarity and synergy  
– Summary Answer Box**

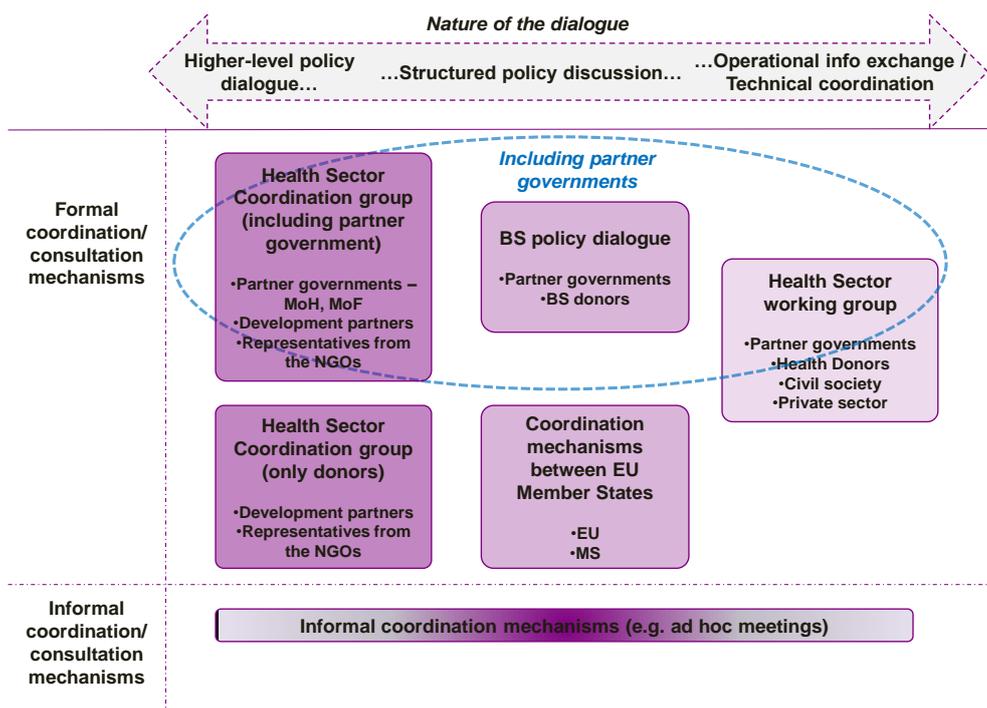
objectives and strategic goals). The main factor of success identified in the implementation phase of multi-donor trust funds are a regular and transparent dialogue between donors and partner governments, as well as an active participation of EUDs in the steering and co-ordination committees. With its support to global trust funds, the EC provides an important contribution to Global Public Goods for Health. In the case of GFATM, the significant role of EC headquarter has found to be in contrast to the limited role played by most EUDs in the partner countries.

**5.6.1 JC 61 Level of health sector-related co-ordination in place with active role/contribution of the EC**

Overall donor co-ordination in the health sector was judged by the EUDs as rather positive in 2010 and communication and co-ordination between the Development Partners has considerably improved between 2002 and 2010. As for co-ordination between donors and related to EC support to the health sector, including the EU MS, findings reveal a rather positive picture. Since 2003, there is a general trend towards more formal co-ordination, specific to the health sector, involving all donors working in the health sector and engaging the governments in the co-ordination tasks for the health sector. Specifically related to EU MS co-ordination, the EC has played a key role, has chaired these groups and thus provided added value.

The following figure depicts the main types of co-ordination mechanisms related to the health sector that the evaluation team could identify, from numerous sources like the [EUD survey](#), the [Paris Declaration evaluation](#), [CSEs](#) and [sector evaluations](#).

Figure 24: Co-ordination mechanisms in the health sector



Source: Particip analysis

According to the [EUD survey](#), most EUDs have been involved in one or several formal sector working groups. The EC participated actively in sector co-ordination and only few EUDs (mostly when GBS was provided) reported no participation at all of the EC in sector-related co-ordination groups. However, EUDs chaired only few co-ordination mechanisms including donors only and thus provided much less value added as compared to EU MS co-ordination. The tool “Delegated Partnership Agreements” may, in the future, help to further simplify co-ordination among donors, just by reducing the number of players involved in these processes, while at the same time ensuring that the EC has adequate ac-

cess to relevant information. However, according to an EC mandated study on *Development Partnership in Action (DPA)* in the health sector<sup>65</sup> of June 2011, the only DPA to date can be found in *Tanzania. (I-611)*

**Box 7: Tanzania: Example of a Delegated Co-operation Partnerships between EUD and EU MS in the health sector**

The German Embassy - through its bilateral co-operation (Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH) – and the European Union Delegation in Tanzania decided to co-operate strategically for development assistance in the health sector of the Republic of Tanzania, in the spirit of greater donor co-operation and harmonisation. In accordance with the *EU Code of Conduct of Complementarity and Division of Labour in Development Policy* and the subsequent Division of Labour agreements in Tanzania, the EC under the 10<sup>th</sup> EDF is no longer involved in the health sector. However, the EC is still following the developments in the sector, notably in the context of the MDG contract which includes a number of health indicators. In consultation with HQ, the Delegation has therefore signed a formal MoU empowering the German Embassy as the co-ordinator of the German Development Co-operation in Tanzania – which is an active partner in the health sector – to engage strategically on health policy related matters on behalf of the EC. This arrangement should ensure to the EC access to health-related information required to inform the preparation of budget support payment files. The documents signed between the two parties - on the 15<sup>th</sup> of December 2009 – detail the: (i) Scope and representation of the agreement; (ii) Responsibilities of the Lead and Silent partners and (iii) Monitoring, evaluation and reporting.

Source: *Study on DPAs in the health sector, 2011, EUD presentation workshop in Brussels 27-29th June 2011*

The move towards more and more sector support requires closer co-ordination between MoH and DPs, especially when programme implementation is not as smooth as hoped for (e.g. *Bangladesh*). EC also played a key role in a good number of countries in the health sector, e.g. by being increasingly involved in forms of sector support, including SWAp and channelling funds via common baskets (e.g. *Zambia*). Health sector working groups (HSWG) in which governments usually participate, are more technical in nature and rather focus on operational (rather than strategic) information sharing. HSWG are sometimes underpinned by Task Forces or specialised sub-groups (e.g. *Bangladesh*), or specialised sub-groups work e.g. on Maternal Health (e.g. *Morocco*), HIV (e.g. *Moldova*), Tuberculosis and vaccination (e.g. *Burkina Faso*).

Co-ordination mechanisms including partner governments have been an important ingredient of co-ordination during both periods under evaluation. Overall, the EC was active in this type of co-ordination mechanism, with almost two thirds of the EUDs participating actively and regularly or at least on specific occasion. Among the EUDs not participating in sector co-ordination groups, were, not surprisingly, GBS-countries (*Ghana*) and SBS-countries (*South Africa*). On the other hand, this pattern cannot be generalised, as EUDs in *Laos*, *Mozambique* and *Vietnam* claim to have participated actively or occasionally in technical health working groups gathering donors and partner governments.

The increasing role of partner governments in donor-government co-ordination mechanisms clearly demonstrates the improving capacity of governments to steer and co-ordinate donor assistance. However, evidence on EC support in the health sector affecting government's capacity to steer and co-ordinate donor assistance has only been found in *Afghanistan* so far. Increased government leadership is often a result of an emerging sector approach, federating donor and government around the same strategy or objectives (e.g. *Philippines*, *Tanzania*). A tool that was made available at the end of the evaluation period is joint assessment of national health strategies (JANS) in the framework of the International Health Partnership Initiative (IHP+). The EC is an active promoter of this initiative and EUDs highlight the positive contribution of the use of JANS in the overall co-ordination process for the health sector. (I-612)

The use of parallel PIUs related to health has decreased during the evaluation period and a clear will to phase out during these parallel units can be seen, thus showing progress of EC support to health in achieving Paris Declaration indicators. According to more general findings of the *survey on monitoring the Paris Declaration*,<sup>1</sup> most countries of the desk phase sample for which data was available even achieved to have no parallel PIU in 2010 (*Afghanistan*, *Bangladesh*, *Ecuador*, *Moldova*, *Morocco*, *Mozambique*, *Philippines*, *Timor-Leste*, *Viet Nam*, *Zambia*). Different interpretation of the concept of PIU leaves some room for interpretation of the actual number of PIU still running today in the desk sample countries. It should be noted that, where parallel PIUs in the framework of EC support in the health sector have existed over the evaluation period, problems such as creating parallel power struc-

<sup>65</sup> Donelli, Eric (2011) Delegated Co-operation Partnerships (DCP) in the Health Sector for Health Sector Performance Monitoring (HSPM) and Health Sector Policy Dialogue (HSPD).

tures, distortion of salaries and diversion of staff and difficulties in achieving sustainability tend to occur. An example of the case of *Afghanistan* is described in the box below. (I-613)

**Box 8:** *Afghanistan: Grants and Contract Management Unit (GCMU) as separate PIU*

One issue of particular significance is the role of the (GCMU) as the central liaison between the MoPH, the three main health donors and the implementing NGOs and its effect on the management and administrative capacity of the MoPH overall.

The central question is if it is **preferable for the EC to work through the GCMU as a separate PIU** or if, in the **long run, it is better to work directly with the MoPH.**

One key concern is that the GCMU is being built up as a “ministry within the ministry” and thereby effectively hinders the build-up of capacity in the wider Ministry. It is feared that this development could eventually limit the sustainability of those interventions that currently are being managed by the GCMU.

The substantial volume of funds managed by the GCMU, the better working conditions and higher salaries in the unit also have created tension within the MoPH and have limited the willingness of other departments to accept GCMU’s input. The Unit has responded to these dynamics by engaging in a capacity building strategy within MoPH and by seconding advisors to other MoPH departments. One challenge is, however, that these advisors receive an income that is many times higher than that of the department heads they are assisting and to whom they are reporting. Both GCMU and MoPH recognise this, but neither side has found a solution yet.

A separate issue is the debate on the best approach for the EC to organise and manage its contracts with the NGOs. In principle, the choice of the EC to work as much as possible through existing institutions is coherent with its intention to build capacity in the MoPH and at the same time to expand the delivery of health services. In practice, however, the EC has yet to follow through with its commitment to decentralisation. At the time of the evaluation, it had not yet decentralised the implementation and contracting of NGOs to the MoPH.

Source: CSE Afghanistan, November 2007, p.465-468

### 5.6.2 JC 62 Increased complementarity of EC support and between EC support and support of other donors

According to the EU toolkit, “*complementarity is a result of an optimal division of labour (DoL) between various actors in order to achieve optimum use of human and financial resources for enhanced aid effectiveness, i.e. to attain country strategy objectives and achieve better results in poverty reduction.*”

Co-ordination can help achieving complementarity. In EC support, one of the steps is ensuring, when drafting the CSPs that complementarity of support with the support of other donors is researched. The fact that donor matrices detailing donor interventions in all sectors, including health, have been produced in most **CSPs reviewed** is a first indication of reflection on the issue. Overall and especially for the second programming period under review, there is further evidence of co-ordination of the programming process with other donors, thus allowing for and, as e.g. in *Bangladesh*, leading to, synergies. In this context, an enhanced Division of Labour, at least in the EC programming process, among EU MS becomes apparent for this second period. (I-621)

The Paris Declaration of 2005 has put significant pressure on both donors and governments to further strengthening their joint efforts, which had already partly started in the first period under evaluation. Evidence of joint efforts has been found ranging from a fully-fledged joint assistance strategies to punctual joint donor efforts (i.e. joint field mission or shared analytical work) has been found. It also appeared that joint efforts have helped enhancing co-ordination over the period under evaluation and improved co-ordination then has helped launching further joint efforts.

A number of JAS have been developed during the evaluation period. However, they are not necessarily complete nor applied in all areas of support, as indicated by several **EUDs**. Moreover, too many separate strategies and initiatives are a major area of concern. The JAS may complement CSP, their aim being to provide a joint response to the partner countries needs and priorities, each donor focusing on specific sectors where it has a comparative advantage. However, these processes may not be synchronised in time.

Progress has also been made in increasing the number of joint field missions and shared analytical work. The driving forces to start using joint actions during the evaluation period are the improved capacity of the MoH, taking the lead on the sector approach (*Ecuador, Philippines*) or the introduction of a new sector-wide intervention (e.g. *Vietnam, Bangladesh*). (I-622)

EC contribution to global trust funds, including global initiatives, amounts to € 900.6 million for the evaluation period. Most of this amount was directed to the GFATM, the Avian Influenza Preparedness and GAVI. With its funds to global trust funds, the EC provides an important contribution to the realisation of Global Public Goods for Health.

Moreover, the EC finances and is actively involved in several (multi-donor) trust funds at country level. Most of them can be found in Asian and ACP countries. They either support the entire health sector in fragile states (*Timor Leste, Philippines-Mindanao province, Occupied Palestinian Territory, Angola*) or

actions related to specific diseases (*Myanmar, Nigeria, Ethiopia*). This hints to the fact that trust funds at national level can take many forms when it comes to the geographical coverage (national level vs. provincial level), thematic focus (entire health sector, or specific areas, like immunisation, PRDs, health workers). In some countries, Task Forces at national level have been used as a pre-step towards a full SWAp and possible SBS (*Afghanistan*); in one occasion they were purely used as a tool to speed up implementation (*DRC*).

The following box shows the case of the Three Diseases Fund in Myanmar, which replaced the GFATM for a certain period in the country and to which the EC contributed substantially. It is a good example of how donors may effectively work together and the support of trust fund being an appropriate way to jointly tackle challenges and reach specific aims. In the words of the EUD Myanmar, the Three Disease Fund in Myanmar is: “*Good quality of partnership, efficiency, effectiveness, impacts, co-ordination.*”

**Box 9: Myanmar - The Three Diseases Fund: A special case**

The Three-Diseases Fund (3DF) is a multi-donor consortium, which raised an initial USD 100 million to assist Myanmar in the control of three diseases over a five year period 2006-2011/12. It was set up with the donations of six countries and organisations -- the EC, the Department for International Development (DFID), the Australian Agency for International Development (AusAID), the Swedish International Development Co-operation Agency (SIDA), the Netherlands and Norway. The United Nations Office for Project Services (UNOPS) is the Fund Manager on behalf of the Donor Consortium. In 2009, Denmark also joined the consortium.

The core aim is to provide a simple and transparent instrument to finance a nationwide programme of activities to reduce the transmission of HIV and AIDS, TB and malaria and enhance care and treatment through access to essential drugs and related services. The target beneficiaries are the most vulnerable and under-served populations, especially those living in remote and inaccessible areas and those most at risk.

By the end of 2010, 3DF had effectively supported 28 HIV projects, nine TB projects, ten malaria projects and four integrated projects. In addition, as part of its identified priorities, the 3DF has provided gap-filling support to the GFATM PRs until their programmes are fully-functioning.

The EC contributed approximately 21% of the overall envelope over the five years period. If EU member states are considered the financial contribution to the fund exceed 80% of the total budget.

The Mid Term Review finalised October 2009 concludes that the fund has performed well and has made significant contribution to the containment of the three diseases epidemics. Major achievements and examples of impact achieved: The 3DF MTR report concluded that the fund has been successful in averting deaths and reducing illness due to the diseases. It notes that fund performance shows that 5-10% of needs met by services provided with Fund support. The Fund has contributed 30-50% of achievement towards the identified national targets and possibility even greater contribution to nationwide outputs. It noted that the level of effect is significant in the Myanmar context, especially given the level of need compared to available resources. The Fund has helped contain but unlikely, on its own, to have contributed to reduced mortality and morbidity nationally. Among the indirect impacts of the 3DF it notes that the Fund has demonstrated that it is possible to successfully provide health services to vulnerable groups in Myanmar.

Longer term plans for 3DF are being reconsidered given the announced return of the GFTAM. It should start operations in 2011. One option would be to widen the scope of the Fund to include mother and child health (MDG 4 and 5). A scoping mission (framework contract (FWC) financed by the EC), to define various options to take place in March 2010. The EC is among the lead donors.

*Source: Thematic case study: The European Commission and the Global Fund, External Assistance Management Report n°17, 04.02.2010; External Assistance Management Report n°19, 31.01.2011*

By their very nature, trust funds can be a vehicle to enhancing complementarity in the health sector, as they bring together different donors and usually have a certain financial impact on the sector. This has been confirmed by the [EUD survey](#) giving clear indication that trust funds increase harmonisation and co-ordination efforts between donors (*Vietnam, Bangladesh*) and can facilitate the implementation of joint actions, such as joint needs assessments (*Vietnam, Philippines*) or a common and aligned donor-government strategy (*Timor Leste, Zimbabwe*). The majority of task force participants ranked them as satisfactory, the main issues of concerns being related to the day-to-day management, especially different donor procedures (*Bangladesh, Philippines, Vietnam*) and the lack of visibility of EC action within the trust funds (*Vietnam, Zimbabwe*). In most cases, the trust fund administrator at country level is the World Bank, with a total amount of € 129 million being trusted during the evaluation period ([inventory](#)). Not surprisingly, the main factor of success in the implementation phase of multi-donor trust funds is a regular and transparent dialogue between the donor partners and the government and the active participation of the EUD in the steering and co-ordination committees. (I-623)

Classified as global goods for health, the following two initiatives are an example of the work towards complementarity between different EC budget lines and between different Directorates General of the EC (mostly DG Research and Health and Consumers).

*Box 10: Global public goods for health: The role of the EC***The Avian and Human Influenza Facility (AHIF)<sup>66</sup>**

The Avian and Human Influenza Facility (AHIF) is a multi-donor financing mechanism administered by the World Bank that helps developing countries to minimize the risk and socio-economic impact of avian influenza (H5N1) and other zoonoses and of possible human pandemic influenza), created following the Beijing conference. AHIF complements the World Bank supported Global Program for Avian Influenza Control and Human Pandemic Preparedness and Response (GPAI) which has as its objective “to minimize the threat posed to humans by HPAI infection and other zoonoses to prepare for, control and respond to influenza pandemics and other infectious disease emergencies in humans”.<sup>67</sup>

The AHIF is currently supported by ten donor agencies, led by the EC, which have collectively pledged more than USD 127 million. The EC is the largest donor to AHIF with total contribution of USD 80.73 million since inception to 2010 (figure below). EC funds are earmarked for East and South Asia, the Mediterranean, Central Asia and Eastern Europe. The other nine donors - Australia, China, Estonia, Iceland, India, Korea, the Russian Federation, Slovenia and the United Kingdom – contributed to AHIF which is not geographically restricted and can be used, notably, to assist countries in Africa and Latin America and the Caribbean regions. The EC played a leading role in responding to the highly pathogenic avian influenza (HPAI) crisis and policy preparations to combat a potential pandemic influenza outbreak.<sup>68</sup>

**EC funds under the Framework Research programmes**

For more than 10 years the EC has been supporting research on influenza in both humans and animals. Already under the 5<sup>th</sup> Framework Programme for Research (1998-2002, FP5) about EUR 6 million was spent in 22 institutions and national reference laboratories across 8 European countries. In FP6 (2002-2006) activities were extended and reinforced with a set of new projects launched with an almost tenfold increase in funding (more than EUR 50 million plus share in several larger projects dedicated to influenza as well as to other viral infections). In the FP7 (2007-2013) the pandemic influenza is addressed in the ‘Co-operation Programme’, Theme 1 ‘Health’ under the sub-heading ‘Emerging (Infectious) Epidemics’ and avian influenza in animals is dealt within the Theme 2 ‘Food, Agriculture and Biotechnology Research’.<sup>69</sup>

Source: *Thematic case study on Global Public Goods for Health, Annex 19*

## **5.7 EQ7: To what extent have the various financing modalities (GBS, SBS, other sector support, projects), funding channels and instruments and their combinations, been appropriate, thus contributing to improving access to, equity of and policy-based resource allocation in health?**

The EC uses various aid modalities, channels and instruments in order to achieve its objectives in the health sector. It is assumed that each of them should serve specific objectives and be selected and used based on specific national context requirements. The question analyses to what extent the respective advantages of the different modalities and channels have been analysed and what specific contribution they had in improving access to, equity of and policy based resource allocation of support in health sector.

The question will build upon an analysis of the modality specific findings of the EQs on access, service delivery and governance. Specific attention is given to SBS, GBS, trust funds and development banks, thematic instruments but also on the mix of these modalities and appropriateness of these channels in a given context.

This question gives complementary insights into the selection of and process towards modality and channel implementation; contribution to policy related objectives, resource allocation and aid efficiency and effectiveness.

This question seeks to address whether the choice of aid modalities has been based on a sound analytical basis, appropriate to the context and has contributed to the health outcomes and objectives as stated both globally and locally. To this end, three Judgement criteria have been established:

- JC71 Aid delivery methods (incl. modalities and channels) adapted to national context

<sup>66</sup> For an evaluation of the Global Response to the Avian Influenza Crisis see: HTSPE (2010): Outcome and Impact Assessment of the Global Response to the Avian Influenza Crisis. Final Report – August 2010

<sup>67</sup> AHI Facility, Avian & Human Influenza: A Partnership for Results.

[http://ec.europa.eu/europeaid/where/asia/regional-cooperation/animal-human-health/documents/ahif\\_results\\_report.pdf](http://ec.europa.eu/europeaid/where/asia/regional-cooperation/animal-human-health/documents/ahif_results_report.pdf)

<sup>68</sup> Ibid.

<sup>69</sup> [http://ec.europa.eu/world/avian\\_influenza/](http://ec.europa.eu/world/avian_influenza/). A catalog of funded projects on avian influenza of the period 2001-2007 is at: [http://ec.europa.eu/research/health/poverty-diseases/doc/influenza-research\\_en.pdf](http://ec.europa.eu/research/health/poverty-diseases/doc/influenza-research_en.pdf); FP7 projects are at [http://ec.europa.eu/research/health/infectious-diseases/emerging-epidemics/fp7projects\\_en.html](http://ec.europa.eu/research/health/infectious-diseases/emerging-epidemics/fp7projects_en.html)

- JC72 Contribution of EC GBS and SBS to policy based resource allocations and inclusive objectives in the health sector
- JC73 Increased cost-effectiveness and internal consistency of EC support

The answer to this question is mainly based on the following sources:

- Analysis of GBS /SBS documentation
- Literature analysis, mainly evaluations, such as country level evaluations, sector evaluations, Paris Declaration evaluation, ...
- EUD survey
- CSP analysis
- Interviews
- ECA report
- Inventory
- MoH Survey

**EQ7 on aid modalities, funding channels and instruments and their combination  
– Summary Answer Box**

The selection by the EC of aid modalities and channels was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities, although this was weaker in the earlier period of the evaluation. EC aid delivery modalities were adapted well to the national context in recipient countries and this trend has improved over the evaluation period and was accompanied by an increasingly thorough analysis of the different dimensions of the health sector in partner countries. In terms of delivery modalities, this evolution has corresponded to more use being made of budget support especially sector budget support, although its use is still at a relatively low level compared to other sectors.

The EC in most countries analysed has had reasonably ambitious health-related indicators for both SBS and GBS programmes, although there are exceptions. Most programmes use outcome indicators focused on improving standards of health, which are linked to the health MDGs. The main problems have been finding sufficient data to assess whether these indicators have been achieved. There are also indicators in most programmes aimed at improving the allocation of resources to health, either through GBS which tends to be focused on improving budgeting and planning at Ministry of Finance level or SBS working on planning and budgeting at the level of the MoH. Evidence tends to suggest that the achievement of indicators used by the EC varies, illustrating that not all have been easily achievable. In particular, the indicators used for the health performance indicators of GBS have tended to be overambitious, leading to low rates of disbursement.

Although the EC, both on its own and in conjunction with other donors, has made a contribution through GBS and SBS to inclusive objectives in the health sector, this does not seem to have been translated into improved policy based resource allocations. There is no strong evidence on a significant positive impact of budget support on national health expenditures and on budget processes at both central and decentralised levels. There is, however, evidence that SBS has resulted in increased levels of capacity building support for health, including all EC financed SBS and in some instances GBS. On the other hand, SBS or health-related GBS lending has not led to comprehensive improvements in budgeting and policy processes, but there have been some notable contributions by the EC. Where there have been achievements, the development of MTEFs and sector strategies is the most common, but there is mixed evidence of consistent results in strengthening of policy processes or enhancing PFM. There was also limited success in improving policy based resource allocations, through SBS or GBS.

There has been a move towards decreasing transaction costs for recipient governments through moving to SBS/GBS, reducing PIUs and increasing joint missions, the move to SBS/GBS has increased transaction costs for some EUDs, particularly as sufficient health PFM expertise was not always available in-house (a lack of health and PFM expertise has been an issue that has restricted the effectiveness of the EC in dialogue related to GBS and SPSP as well). Also as projects still dominate EC portfolios there is still a significant burden in terms of transaction costs for recipient governments. Furthermore, the finding that SBS can reduce transaction costs is in contrast to the fact that it has a low rate of disbursement in comparison to other aid modalities such as projects. Much of EC's health support is also implemented by other agencies and consistent problems are reported in projects run by UN agencies. These tend to suffer from protracted delays and large transaction costs for the EC.

### 5.7.1 JC71: Aid delivery methods (incl. modalities and channels) adapted to national context

The selection of aid modalities and channels was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities. EC aid delivery modalities were adapted well to the national context in recipient countries and this trend has improved over the evaluation period and was accompanied by an increasingly thorough analysis of the different dimensions of the health sector in partner countries. In terms of delivery modalities, this evolution has corresponded to an increasing use of budget support especially sector budget support. (I-7.1.1, I-7.1.2) The growth in SBS is perhaps the most notable increasing trend over the evaluation period. The amounts contracted through SBS increased from about €2 million in 2002 to €200 million in 2009 and €185 million in 2010 (inventory). This progress was quite consistent over the years and accelerated from 2008. This rapid switch to a major use of SBS coincided with the signature of the last CSPs for the period 2008-2013 and resonates with the EC's commitment in the context of aid effectiveness to make increased use of sector approaches. However, compared to other social sectors such as Education, the EC made relatively little use of Sector Budget Support to directly assist the health sector. Only 16% of the total funds contracted to support the health sector were contracted for SBS operations, while for the education sector (basic and secondary education), SBS accounted for 47% during the period 2000 to 2007.<sup>70</sup> This is mainly due to the fact that the health sector in recipient countries is often more fragmented than the education sector, which means that there is not always a coherent sector strategy to support, which is an EC eligibility criteria for SBS, while donor support is not harmonised due to multiple funding channels used, such as vertical funds, which make it difficult to pool health financing. The EC supported also health sector policy programmes of beneficiary countries that are not delivered through SBS. This modality represented 15% of the total amount contracted by the EC. So overall, roughly a third of EC support to health has been given in various forms of support to the sector.

This relatively small and late shift by the EC from a project approach to a sector approach has been in response to the preference stated by the EC for using budget support where possible, in acknowledgement of commitments made by the EC under the Paris Declaration (2005) and Accra Agenda for Action (2008)<sup>71</sup>. This shift can be clearly seen over the evaluation period, with an increase in sector and budget support and the design and choice of these aid modalities benefitting from previous EC as well as other development partners experience in the sector. (I-7.1.1)

This means that most analysis in documentation is focused on the suitability of moving towards a budget support approach or explaining why budget support has not been chosen. In nearly all cases, the discussion regarding alternative aid modalities is extremely limited. For example in financial proposals where there is the most discussion of this issue, the focus is mainly on why a particular aid modality was chosen rather than an assessment of alternatives. (I-7.1.1)

Support provided by the EU has become more aligned with national systems and procedures, given the shift from projects towards sector approaches and GBS, although this is not as large as it could have been, as there is still a considerable amount of EC support to the health sector which is not aligned. Despite this, the EU is still using fewer parallel aid delivery methods and making more use of national systems by channelling funds through national systems and supporting recipient government plans and strategies in the health sector. However, there are still countries where the EC had not been aligned with national systems and procurement is controlled by the EC, but this is due to concerns regarding the strength of government systems and fiduciary risk. (I-7.1.3)

Aid delivery methods were reasonably well tailored to the capacity of implementing partners and the methods selected were generally appropriate to the context. Evidence of the EUD survey, CSPs and programme reviews in desk study countries shows that the capacity of organisations to implement programmes was often assessed with stakeholder institutional capacity assessments to analysis partner readiness, capacity and potential structures for implementing health programmes. (I-7.1.2)

### 5.7.2 JC72: Contribution of EC GBS and SBS to policy based resource allocations and inclusive objectives in the health sector

Findings reveal that, although the EC, both on its own and in conjunction with other donors, has made a contribution through GBS and SBS to inclusive objectives in the health sector, this does not seem to have been translated into improved policy based resource allocations. There is no strong evidence from numerous sources (interviews with EUDs, EC monitoring reports, Commission on Audit (CoA)

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<sup>70</sup> See, Particip GmbH (2010): Evaluation of the EC support to the education sector 2000-2007.

<sup>71</sup> EC (2007) Support to Sector Programmes, p.7

report 2008, on GBS and evaluations of GBS for Ghana and Zambia) on a significant positive impact of budget support on national health expenditures and on budget processes at both central and de-centralised levels.

It is clear that during the period assessed, the EC in nearly all countries analysed have had reasonably ambitious indicators for both SBS and GBS programmes, although there are exceptions. Most programmes have used outcome indicators focused on improving standards of health, which are linked to the health MDGs.

There are also indicators in most programmes, aimed at improving the allocation of resources to health, either through GBS which tends to be focused on improving budgeting and planning at Ministry of Finance level or SBS strengthening public financial management at the level of the Ministry of Health (MoH).

In most cases, the indicators addressed well the core issues in the health sectors in the specific countries where the EC was giving support. Analysis of the [country context in programme and other documents](#) showed that the indicators chosen in nearly all cases were appropriate to the country context, although GBS variable tranche indicators have often proved to be over-ambitious. Another problem was that often there was not sufficient data available to judge progress on these indicators. Evidence from the [Court of Auditors Report, Special Report, No 10, 2008](#) tends to suggest that the achievement of indicators used by the EC varies, showing that not all are achievable. Those related to GBS EC health performance tranches were least successful, with on average 50% achieved, whereas overall GBS indicators were achieved 70% of the time.

**Box 11:** *Sector Budget Support to Zambia: An example of indicators addressing core issues well*

In the Retention of Human Resources for Health Programme (2006- 2008) general conditions for tranche release were that PFM is transparent and effective and there is good macroeconomic and sector strategy. Conditions for the fixed tranche came from the health sector plan and were for 2006:

- formal adoption of the national development Plan (2006-2010),
- creation in the Government of Zambia budget items related to the retention of human resources.

For 2007, they were:

- creation of a human resources(HR) database;
- M & E system for the HR plan
- agreed and formalised mechanisms for providing incentives for Staff to go to underserved areas.

For 2008 they were:

- improvement in the ratio of health professionals to populations and
- progress in the integration of the MoH payroll of staff.

*Source: Financing Agreement between the European Commission and the Republic of Zambia: Retention of Human Resources for Health Programme, 2006.*

There were also increased levels of capacity building support normally being given as a result of health SBS, although support for health capacity building was not normally part of the GBS package. In SBS, capacity building was more frequently included as the aim of sector support programmes and was often focused on strengthening institutional capacity.

Given this, it would be expected that as the design of programmes was appropriate, with indicators focusing on the right issues and significant capacity building components in the case of SBS, that this would result in improved health sector policies, processes and resource allocations.

There is evidence ([interviews, EC programme reviews and EUD survey](#)) that GBS and SBS were able to enhance the framework for dialogue, particularly on PFM and capacity building issues. Also that good policy dialogue on health issues is more likely to result from SBS than GBS, which is logical given that financial support to the health ministry gives a good entry point and incentive for strengthening discussions.

An assessment of the [documentation](#) indicated that neither SBS nor GBS led to comprehensive improvements in budgeting and policy processes, although there has been a contribution from EC and joint donor programmes of support. Where there have been achievements, the development of medium-term expenditure frameworks (MTEFs) and sector strategies are the most common, but there is mixed evidence of consistent results in strengthening of policy processes or enhancing public financial management (PFM). Health sectors by their nature tend to be fragmented which makes it difficult to implement sector wide plans and processes. Additionally, political will to undertake reforms was lacking in some cases.

Another area that was not successfully addressed was improved policy based resource allocations, despite being tackled through both GBS and SBS indicators in many countries. There was only evidence from *Ghana and Zambia* of budget allocations to health improving, while in *Bangladesh* funding

to the sector increased, but not as a percentage of the total budget.<sup>72</sup> This is probably as this is also an issue that needs to be tackled by the Ministry of Finance and as a result is out of the control of health ministries. However, there is the possibility to use GBS to try and enhance budget processes, but this does not appear to have been successful in most of the countries assessed.

### 5.7.3 JC73 Increased cost-effectiveness and internal consistency of EC support

There has been an increase in the cost effectiveness of EC support over the evaluation period, as there has been a clear reduction in transaction costs for recipient governments due to the change in aid modalities used by the EC and implementation of Paris Declaration commitments to harmonise and align support. This resulted in a reduction in the number of parallel project implementation units, a move towards more joint missions and analytical work and the shift towards using SBS and GBS (I-733). This latter trend was highlighted in the results of the *EUD survey* and *interviews with EUDs*, while the reduction in transaction costs for recipient governments was reported to be the case when *external evaluations* were undertaken of GBS in *Egypt, Vietnam, Lao, Ghana* and the *Philippines* and in *interviews with EUDs*.

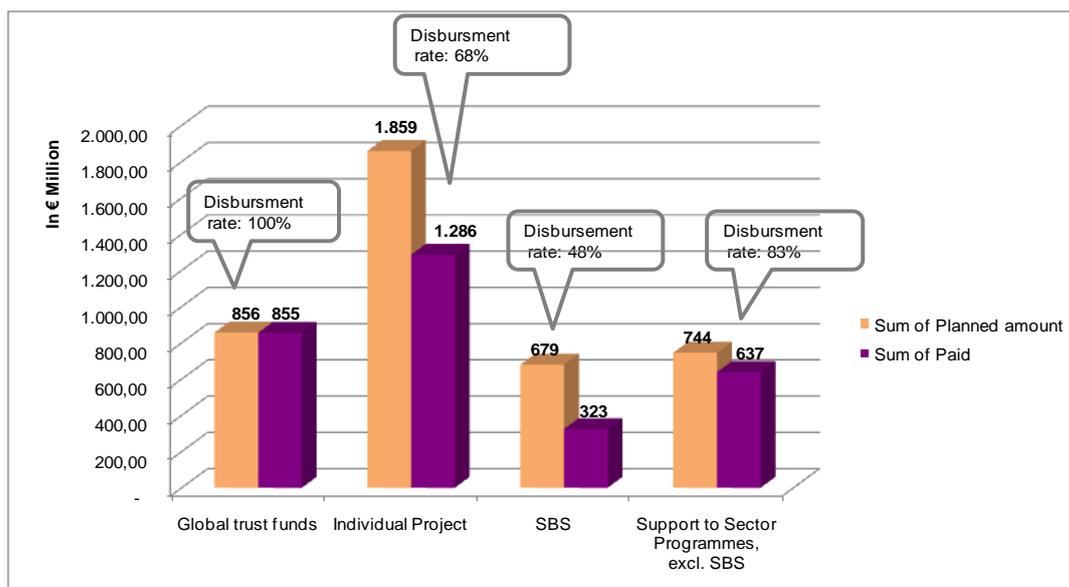
On the other hand, the expected reduction in transaction costs for the EC and development partners has not always occurred, due to the time that has to be devoted to policy dialogue and co-ordination for SBS and GBS programmes and the fact the EC is still implementing projects, so two types of aid modalities need to be managed. This problem has been exacerbated by a lack of health sector and PFM expertise in some EUDs (see *CoA Special Report No. 10, 2008*). Also, as projects remain the dominant aid modality for the EC, transaction costs for both recipient governments and the EC are still higher than need be. This was reported to be the case in Mozambique, Vietnam, Zambia, Bangladesh, India and Barbados. Sources for this information came from *interviews with EUDs, EUD survey and reviews and evaluations*.

There have been significant differences in disbursement rates over the evaluation period suggesting that some EC support is more effective at disbursing than others. The financing of trust funds has had the highest disbursement rate, with 100% disbursement on the amount committed followed by support to sector programmes (excluding SBS) at 86%, while the disbursement rate for individual projects is 68% and SBS 48% (see figure below). In terms of channels for disbursement, multilateral organisations (World Bank and UN bodies, GFATM) have the highest disbursement rate (87%), while the second highest at 77% is “other channels” (private companies and development agencies) and funding for NGOs which also has a disbursement rate of 77%. Private-public partnerships (mainly GAVI) score lower with a disbursement rate of 75% and the public sector, mainly governments, scored the lowest at 63%

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<sup>72</sup> Interview EUD.

Figure 25: Direct EC support to the health sector: Disbursement levels by modality, health sector, 2002-2010



Source: CRIS database; Particip GmbH analysis

This interestingly indicates that, although SBS and GBS reduce transaction costs, SBS has the lowest disbursement rate, with the rate for projects significantly higher. This is due to the fact that indicators have to be achieved prior to disbursement for SBS, which are not always met - which means that not all funds are released. For projects this is not the case as funds are disbursed when project activities are undertaken. Similarly, disbursement through other bodies results in a high rate of disbursement, but there is evidence from [interviews and EC programme reviews](#) of dissatisfaction among EC respondents when using both the World Bank and UN funding channels (I-731).

Analysis of the internal consistency of EC support suggests that although the majority of EUDs thought that EC financial instruments to support the health sector were coherent, there were distinct problems related to thematic programmes, which indicates that they do not always add value to programmes of a geographic nature. This is mainly a result of the way that these programmes are managed and implemented, as thematic programmes are subject to general multi-country guidelines so are not always tailored to a country's needs. There also tends to be little communication or synergies between thematic and geographic programmes as the former are managed from Brussels and the latter at programme level (I-733). Evidence was also found by the ECA of a lack of coherence between EC instruments in health, as projects tend not always to be linked or complementary to SBS or GBS, while there are no links between Global Fund operations and EUD instruments, although this did not come cross strongly in this study.

Standing a bit apart from the Indicator as stated but still relevant is the mixture of bilateral and regional geographical instruments. In a number of areas – human resources for health, sexual and reproductive health and infectious disease control – the EC used regional instruments. Specific examples from Southeast Asia include the regional malaria control programme in *Vietnam, Cambodia and Lao PDR* (antedating the evaluation period but extending into it), the Regional Health Initiative for Health in Asia and work related to cross-border animal health in the context of avian influenza. In Latin America and Africa, regional approaches financed by thematic instruments addressed human resource issues. In general, regional approaches were well supported by the two main aspects which call for a regional approach: either a genuine cross border or regional aspect to a problem, or the potential for sharing of experiences. Most, however, involved international agencies such as WHO, UNFPA and World Bank, with the dilution of effectiveness identified under EQ 4 above.

Overall, the evidence on increased cost-effectiveness and internal consistency of EC support is mixed. Although there has been a move towards decreasing transaction costs for recipient governments through moving to SBS/GBS, reducing PIUs and increasing joint missions, the move to SBS/GBS has increased transaction costs for some EUDs (*Egypt, Vietnam, Lao, Zambia, Ghana and the Philippines*). Also as projects still dominate EC portfolios there is still a significant burden in terms of transaction costs for recipient governments. Furthermore, the finding that SBS can reduce transaction costs is in contrast to the fact that it has a low rate of disbursement in comparison to other aid modalities such as projects, while evidence from [interviews and the EUD survey](#) on the relationship between

thematic and geographic programmes suggests there is not much coherence and consistency between them.

## 5.8 Overall assessment of EC strategy

**Relevance:** In view of the powerful links between health and poverty, EC co-operation in health was highly relevant to needs, as well as coherent with EC development policy. In general, the poverty focus of health co-operation was well maintained over the evaluation period. Also in general, the theme of access to quality health care cut across all EC interventions, as would be expected. Issues of gender, indigenous peoples, remote and disadvantaged regions, etc., were introduced as needed. EC assistance in health was also well in line with the observed fact that many countries are off track on the health MDGs, which have proven among the most difficult to achieve (especially MDG5 on maternal mortality). In covering health care finance, human resources for health, improved governance in health, global public goods for health, the EC has been in line with the pillars of universal health care access stressed in the most recent EC global health policy.

A few caveats are, however, in order. Human resources for health was ranked first by EUDs when asked what constrained progress on improving the quality of care. While the EU has taken a strong policy stance (through its 2006 Communication and has more recently committed itself to taking a global view that includes consultations with Member States on national policies, only few concrete interventions had sought directly to alleviate the human resource crisis. What was accomplished, by contrast, was strengthening of human resources planning, improved data and analysis and the sharing of regional experiences.

While the concentration of projects on rural, as well as geographically remote and disadvantaged areas was appropriate for the poverty focus, the growing trend of urbanisation was little taken into account.

TA and policy dialogue regarding finance were highly relevant and in line with the universal access goal, even if impact was limited. EC support in fragile states, such as provision of basic benefit packages in *Afghanistan* and *DRC*, was relevant but the overall small portion of EC co-operation going to fragile states is not in line with its recent policy commitment. The EC participation in various initiatives related to provision of global public goods for health, some related to pharmaceuticals and implemented under DG Research Framework Programmes, was highly relevant to needs as well as coherent with the EC's role as a supranational organisation.

**Efficiency:** Overall, EC support to the health sector was no more or less efficient than support in comparable sectors such as education. The efficiency of EC interventions providing infrastructure and equipment was often impaired by the inadequate attention paid to maintenance and operating costs, either in the form of allocating budget directly or in assuring that beneficiaries had made adequate provision. As a result, the use-life of EC-financed equipment is lower than could be achieved. In answering EQ4, it was found that in almost all regional interventions (implemented by partner organisations such as UN agencies and international NGOs, co-ordination weaknesses and differences in procedure limited efficiency. Much of EC's health support is implemented by UN agencies and consistent problems of protracted delays and high transaction costs are reported in such projects. Similar problems were encountered with co-ordination of national multi-donor trust funds, where participants had different administrative procedures, different objectives and different strategic goals. In general, the EC has made progress on aligning with national systems and decreasing the use of parallel PIUs, in line with its Paris Declaration commitments. In answering EQ 7, it was found that there has been a move towards decreasing transaction costs for recipient governments through moving to SBS/GBS, reducing PIUs and increasing joint missions. However, the move to SBS/GBS increased transaction costs for some EUDs, particularly as sufficient health PFM expertise was not always available in-house (a lack of health and PFM expertise has been an issue that has restricted the effectiveness of the EC in dialogue related to GBS and SPSP as well). To keep perspective, however, the EC has been slower to move to SBS than in comparable sectors, such as education. Projects still dominate EC health portfolios. The human resource crisis, leading to high turnover and staff shortages, impaired the efficiency of interventions across the board, from capacity building to direct provision of services.

**Effectiveness:** EC co-operation in the health sector has been generally effective. However, in such as health finance reform and human resources, these results have been found to be small compared to the scope of the challenges.

A factor limiting effectiveness throughout has been the chronic shortage of technical expertise in EUDs. This weakens policy dialogue on health and PFM, co-ordination with other donors and participation in multi-donor trust funds and also the translation of EU global policy into country programmes via EU Delegation staff.

**Impact:** Impact is difficult to assess, but there is no doubt that overall, EC health assistance contributed to progress towards health MDGs, not only strictly speaking in the areas of maternal and child health and HIV/AIDS, but more broadly in terms of promoting better health outcomes, especially among the poor. By contrast, EC impact in health care finance and in human resources has been modest. Health care finance is ultimately the responsibility of governments and all the EC can do is to provide technical assistance and, through policy dialogue, encouragement. A disappointing finding of the evaluation is that, with a few exceptions, it is difficult to see hard evidence that EC SBS and GBS resulted in expanded resources for the health sector. Regarding the closely-related area of health sector PFM, there is evidence of EC capacity building, but less evidence of tangible improvements.

In the area of human resources, the basic problem is the gap between salaries and working conditions in the public health sector and those available by emigration or by working in the private sector or a donor-financed project. Under such circumstances a significant share of capacity built is lost due to attrition. Some EC programmes and policies have sought to address this issue, but the scope of the problem has been too large to speak of substantial impact. General support for the health sector, by contributing to better infrastructure, better availability of needed drugs and equipment, etc., should improve the work environment and help to diminish health worker attrition, but the evaluation found no concrete examples of this.

In answering EQ 2, it was found that most governments have in place schemes to improve health care access for the very poor or those with special needs. In some cases (e.g. ARV treatment financed by the EC-supported GFATM or GAVI vaccination campaigns), the EC had a significant impact. In other cases, general EC support may have had some impact. However, problems abound, either with targeting the poor, or with enforcing the exemptions or subsidies that have been mandated at the clinic level.

With a few exceptions, the share of out-of-pocket expenses in total health spending remained high or increased. This reflects a combination of limited impact on health sector finance and, closely related, the continuing low quality of public health service in many countries. EC programme providing direct provision of health services, as in *Afghanistan* and *DRC* have, not surprising, had a major impact, even if their sustainability is to be questioned. In a number of settings, EC support for improved MNCH has contributed to significant progress, even if the related MDGs are proving elusive.

Apart from projects in disadvantaged areas, infrastructure supply is not a main focus of EC assistance, but in interventions that were geographically targeted the EC had significant impact on access via infrastructure and equipment. However, the problem of operations and maintenance has remained unresolved.

There is mixed evidence on the degree to which EC assistance has contributed to strengthening the management and governance of health systems. In some areas there has been a clear contribution such as in strengthening health policy strategy, planning and processes. There is however little evidence as to how successful the EC support was in strengthening health systems themselves, a priority goal of recent EC health strategy. The EC has also made some contribution to strengthening institutional and procedural systems related to transparency and accountability. Evidence also indicates that there has been a good level of dialogue in health sector forums related to PFM, accountability and capacity building measures in the majority of countries, although it is not always clear the extent to which this dialogue has actually resulted in strengthened capacity in these areas. Procurement is the governance area where there had been the least contribution by the EC; there appears to be little focus in EC health programmes on this aspect. The EC has undertaken limited work on decentralised capacity building to strengthen health policy capabilities, but not in all countries, which is an issue as capacity at provincial and district levels remains low.

The selection by the EC of aid modalities and channels was made on the basis of a relatively good analysis of the health sector and of partner country needs and capacities, although this was weaker in the earlier period of the evaluation. On the other hand, the indicators themselves have not always been achieved, while there have been problems experienced with finding sufficient data to assess whether indicators have been met. The EC, in most countries, analysed has had reasonably ambitious health-related indicators for both SBS and GBS programmes. Evidence tends to suggest that the achievement of indicators used by the EC varies, illustrating that not all have been easily achievable. In particular, the indicators used for the health performance indicators of GBS have tended to be over-ambitious, leading to low rates of disbursement. Regional instruments and regional applications of thematic instruments were used when cross-border and regional aspects were prominent.

There is no strong evidence on a significant positive impact of budget support on national health expenditures and on budget processes at both central and decentralised levels. There is however, evidence that SBS has resulted in increased levels of capacity building support for health, including all EC financed SBS and in some instances GBS.

**Sustainability:** Sustainability of EC health impacts has remained limited. A major theme to have emerged in the evaluation is the persistent and continuing under-resourcing of health sectors by beneficiary governments. Related to the under-resourcing is the lack of clear evidence, with a very few exceptions, that SBS and GBS resulted in higher allocations of resource to the health sector. Health, even in very poor countries, represents a substantial proportion of GDP and it is ineluctable that, provided donors are not willing to underwrite the sector indefinitely (and they indeed are not) that resources will need to be generated nationally. If the economic growth, good governance, sound public financial management and stability required for solid fiscal accounts are not present, combined with a policy commitment to provide reasonable health care, then it follows that the current situation will prevail. In too many countries that situation is characterised by low access to quality health care, high out-of-pocket costs and persistent health inequalities. EC assistance, like all donor assistance, can seek to break countries out of this low-level equilibrium trap, but this evaluation has found no clear examples of national health sector-wide success stories. While the evaluation has found some clear evidence of successful impacts, it is not clear that many of these impacts will persist after donor support is withdrawn.

**EU added value:** One way of approaching the valued added question is to ask what the EC was able to provide that other donors would have been incapable of, or worse at, providing. The EC, with its wide range of health policy styles in the Member States and close linguistic and historical ties with some developing regional, has a comparative advantage in TA and it provided a great deal in the health sector. . In part, this is because there are definable “styles” in health policy (the mix between public and private provision and the mix between public and private finance) and all of these (with the exception of the American private finance-private provision model) are to be found in the EU. The EU, through its member states, is effectively a “one-stop shop” for TA in the health policy area, giving the EC a comparative advantage. Adding to this is linguistic diversity (English, French, Spanish, Portuguese) Another area in which the EC clearly added value was in promoting global public goods for health, an area in which, virtually by definition, nation-states under-provide and joint action is required. In most other areas, it is hard to define a unique EC contribution, which is, of course, not to downplay the massive financial resources that it has supplied.

**Co-ordination, complementarity and coherence:** Overall donor co-ordination in the health sector has considerably improved over the period under evaluation and can generally be judged as good in 2010. The Paris Declaration of 2005 as well as health-sector specific initiatives such as the ‘International Health Partnership Initiative (IHP+) and Joint Assessments of National Health Strategies (JANS) have strengthened joint efforts between donors and governments. The EC has played a key role especially in MS co-ordination, most of the time chaired these groups and thus provided added value. The tool “Delegated Partnership Agreements” may, in the future, help to further simplify co-ordination among donors by reducing the number of players involved in these processes, while at the same time ensuring that EC has adequate access to relevant information. Co-ordination mechanisms including partner governments have also been an important ingredient of co-ordination during the period under evaluation with an active participation of the EC. The increasing role of partner governments in donor-government co-ordination mechanisms demonstrates the improved capacity of governments to steer and co-ordinate donor assistance; however, weak capacity and low government leadership continue to be bottlenecks. Moreover, there is little evidence on EC support in the health sector affecting government’s capacity to steer and co-ordinate donor assistance. The persistence of projects is testimony to governments’ continuing tendency, widely reported although not established by any specific findings in this evaluation, to accept whatever interventions are offered.

In general, there could be better co-ordination and complementarity between the multiple interventions that are supported by the EC through multiple instruments, modalities and channels. The strategic relationship between thematic budget line projects (managed from Brussels and not tailored to country strategies), GFATM projects and bilateral geographical programmes was often not clear. While regional projects were deployed effectively, there was no sign of co-ordination between regional and bilateral programmes. Under such circumstances, it is practically inevitable that there was overlap and lack of coherence.

## 6 Conclusions and recommendations

### 6.1 Conclusions

For analytical clarity we have grouped the conclusion into three clusters.

#### 6.1.1 Cluster 1: Strategic focus

##### 6.1.1.1 Despite policy statements from EC headquarters, the EC still lacks a clearly articulated and implemented global strategy for health co-operation with developing countries

**Conclusion 1:** The evaluation has found that the EC was involved in essentially every aspect of health using a wide range of financing instruments, modalities and aid channels. While a strong anti-poverty focus was successfully maintained, it is difficult to identify any single, coherent and focused strategy in health with clearly defined priorities. At field level, CSPs aligned with national health priorities for the most part, but coherence with an overall EC vision was lacking. The absence of sufficient technical expertise in many EUDs worsened the situation.

*This conclusion is based on all the EQ answers*

The EC is a major health donor. In moving towards SBS and GBS, it has tried to align its aid more closely with national strategic priorities and decisions while reducing transaction costs and increasing predictability. CSPs / National Indicative Programmes (NIPs) over the evaluation period were generally linked to national health strategic plans and the alignment with national plans is set to increase significantly under new programming guidelines. However, global health aid continues to be highly fragmented and outside government control. The EC continues to support a multiplicity of interventions with a multiplicity of instruments, each with its own support constituency – bilateral and regional projects, thematic budget line projects, Global Fund, GAVI, SBS, GBS, etc. Focus areas also each have each their own support base and constituency: MNCH, SRH, HIV/AIDS, infectious disease control, health system finance, etc. The result is that, apart from the poverty focus (which was well maintained over the evaluation period, there was no single, clearly articulated overall global EC health support strategy with clearly defined priorities for developing countries. The 2010 Communication *The EU Role in Global Health* and accompanying Staff Working Documents (especially *Contributing to universal coverage of health services through development policy*) made progress towards addressing this issue, but came only at the end of the evaluation period and were themselves very broad. The disarticulation had repercussions in the field, i.e., from the implementation, perspective. The EC sought to support essentially all aspects of health, from encouraging the production of global public goods to addressing the human resource crisis to providing technical advice and capacity building for health sector policy making and management, to concrete provision of clinics, staff, medicine and equipment. The result was an activity-driven approach rather than one that systematically incorporated major thematic or areas of concern such as human resources, operations and maintenance issues, health care finance, sustainability, global public good aspects, etc. Under-staffed EU Delegations, lacking in technical expertise, are trying to cope with a vast range of initiatives, each worthwhile in its own way, but failing to add up to a coherent and manageable whole.

##### 6.1.1.2 EC health strategies have tended to focus on the present, not the longer term over which health sector development takes place

**Conclusion 2:** Because of its development co-operation cycle, the EC is in a weak position to take long-term trends such as urbanisation and the demographic and epidemiological transitions, into account. Some health challenges are clear and present and EC co-operation has effectively addressed many of these (as detailed below in Cluster 2). Yet, others are closely linked to demographic, economic and social development, so they emerge and evolve over the long term. The EC's global health strategy, to the extent that it can be identified, rather focused on near-term problems / solutions, paying insufficient attention to the longer at least one, if not several, decades) time frame over which health sector development occurs.

*This conclusion is based on all the EQ answers*

In part because of the lack of a unifying policy, EC global health strategies in health have taken insufficient account of long-run structural trends affecting health sector needs. Two of these are related to population: the ageing of populations, not evident in some of the poorest beneficiary countries (e.g. most of Africa) but acute in others (e.g. East Asia) and of growing concern in others (e.g. India) and urbanisation (of concern everywhere). Both of these trends are contributing to an epidemiological transition in which, despite continuing problems of poverty-related infectious disease, the burden of disease in poor countries is increasingly shifting towards non-communicable diseases (e.g. cancer), chronic conditions (e.g. diabetes and cardiovascular disease), trauma (especially road accidents) and

mental illness. The needed responses overlap with those traditionally financed by the EC, but not entirely. While the burden of non-communicable disease was recognised in, e.g. the November 2008 *Programming Fiche*, there was little evidence that much attention was paid to it over the evaluation period. More generally, as acknowledged in the Commission staff Working Document *Contributing to universal coverage of health services through development policy* (March 2010), global donors' (and the EC's) support for HIV/AIDS is greatly in excess, proportionally speaking, to the actual burden of that disease.

Another long-term trend is the increased availability of more advanced medical technology, medication and procedures in many countries. These are being imported and made available thanks to rising income (in most developing countries), globalisation and increased expectations. Together with the epidemiological transition, this is accelerating growth in the demand for health care. Public health systems, under-resourced as they are, find themselves unable to meet expectations, as a result of which, even poor families incur large expenses as they seek care in the private sector. This helps to account for our finding (see the conclusion on health sector finance under Cluster 2) that, despite support to reforms, in a number of countries, out-of-pocket payments for health care continue to rise.

The EC's move towards sector budget support and general budget support (see Cluster 3 conclusions) have been appropriate reactions to aligning better with government priorities for health sector development. It is, however, discouraging to report that the evidence found that budget support significantly increases resource allocations for the health sector is thin. The move to sector budget support in health has also been slow relative to in other sectors, such as education.

### 6.1.1.3 While the EC has made contributions to health system strengthening and had impact in the form of better health outcomes, the magnitude and sustainability of these impacts are limited by the chronic under-resourcing of health systems in poor countries

**Conclusion 3:** Despite the clear link with poverty, its prominent role in the MDGs and donor (including EC) pressure to pay more attention to the social sectors, health remains a low budgetary priority sector in most co-operation partner countries. In some of the poorest, the share of total health expenditure that is donor-financed is unsustainably high. Long-term progress towards better health in poor countries, which requires durable health sector reform, is dependent on increasing national resource allocations to the sector. That requires economic growth, better governance, absence of conflict and stability, in addition to shift in policy attitudes and priorities.

*This conclusion is based on all the EQ answers, but especially EQs 2 and 7.*

One of the most important conclusions to emerge is that the EC's move towards SWAp / SBS / GBS cannot be shown to have resulted in a strong increase in allocations to the health sector save in isolated cases (e.g. *Zambia*). Despite policy dialogue, policy matrices and capacity building, Ministries of Health remain in a weak position to assert and enforce claims on budgetary resources. In some settings, aggressive decentralisation has complicated the picture. Health represents a significant proportion of GDP even in very poor countries. Trends described above will increase it further, as will any meaningful attempt to deal with the human resource crisis in health. While donors often favour the health sector, their financial means are and should be, limited: eventually health sectors in development co-operation partner countries will have to stand sustainably on their own.

Health care finance reform is one approach to increasing resource availability. The EC has, as we describe below, made a contribution to designing needed reforms, but the record on outcomes is not very encouraging. Even in *Ghana*, a country where institution of mandatory health insurance went hand in hand with a reduction in out-of-pocket payments, targeted exemptions from fees are commonly not recognised at clinic level and threaten financial sustainability. In *Philippines* and *Moldova*, there is broad popular dissatisfaction with reformed health insurance systems and, in the latter, widespread informal payments for care have been reported. In *China*, pilot rural health insurance schemes have not been widely rolled out, meaning that health coverage is still essentially urban. In *Vietnam*, there remain gaping holes in health insurance coverage, now running about 40% with a putative goal of universality by 2014.

While the EU has committed itself to supporting universal coverage, serious bottom-efforts to quantify the resource gap, based on a prescribed basic care package, unit costs, coverage targets and national revenue estimates, have not been systematically made at country level. The EC's approach to estimating the resource gap, namely the difference between the Abuja target of 15% of national budget resources for health and the Commission on Macroeconomics' estimate of a minimum Euro 20 per capita per year, is top-down, ad hoc and not flexible to different country situations.

## 6.1.2 Cluster 2: EC support to specific thematic issues

### 6.1.2.1 EC direct support to infrastructure / equipment contributed to improved access to health care in focused geographic areas, but failed to pay adequate attention to issues of maintenance and operating costs

**Conclusion 4:** EC direct support to infrastructure and equipment provision has significantly increased access to health care in specific geographical areas (essentially disadvantaged areas and essentially related to PHC) in some countries, but has been limited overall. While policy dialogue through SBS improved policy making, planning and management related to infrastructure / equipment. Issues of maintenance and operating cost were neglected. These are most closely tied to the under-resourcing of public health systems, a problem against which there is little evidence that the EC made progress.

*This conclusion is based mainly on EQ1, EQ2, EQ 3, EQ 5 and EQ7*

The EC has supported improved health infrastructure via projects, often in disadvantaged and under-served areas, often via projects implemented by NGOs (e.g. *Ecuador, Afghanistan*) and typically at the primary health care level. This has been appropriate in light of the EC's poverty orientation as well as the fact that it does not have sufficient resources to finance large, national-level infrastructure projects. The EC has, however, participated in multi-donor trust funds which permitted it to contribute to national infrastructure development.

While there has been some improvement in some countries, the issue of inadequate, broken, or outdated equipment remained serious in many. The issue of maintenance was generally neglected (i.e., there was generally no clear maintenance strategy / plan) resulting in deterioration of EC-supplied vehicles, cold chain equipment, medical technology, etc. While data on operating and maintenance budgets proved hard to find, it is broadly recognised that inadequate maintenance and operations problems such as lack of electricity, are tied to the overall under-resourcing of the public health sector, a theme that emerges repeatedly in these conclusions.

While (see Cluster 3 conclusions) there is little evidence that EC-supported SBS contributed to increased resource allocations to health, it did contribute to better planning, management and policy making, including in the area of infrastructure.

### 6.1.2.2 While the EC has expressed strong policy commitment to addressing the human resource crisis in health, not much concrete impact has been found at country level

**Conclusion 5:** Through its 2006 Communication, the EC has pledged to take actions to tackle the human resource crisis in health and EC project documents and SBS / GBS policy matrices regularly cite the human resource crisis, as called for by policy. However, the shortage and attrition of trained health personnel remains serious in most countries and EC actions have been limited.

*This conclusion is based mainly on EQ1, EQ2, EQ 6 and EQ*

There have been some actions specifically devoted to addressing the human resource crisis in health, for example through the Thematic Budget Line on Migration and Asylum and the SANTE budget line, e.g. the programme "*Strengthening Health Workforce Development and Tackling the Critical Shortage of Health Workers*". The EC's contribution to improved health sector policy making and management capacity covers human resource planning issues and human resource strategic and action plans have been developed with EC support (e.g. *South Africa*). However, in most countries affected by the crisis (particularly English-speaking ACP countries, but others such as in Asia such as *Philippines, India and Bangladesh* and in Latin America such as *Ecuador*, as well, the crisis remains unresolved. Two reasons can be stated. The first is that the conditions that lead health professionals to migrate, whether internationally, to the private sector, or to donor-financed aid projects, are too great for the EC or any other donor to address. The failure of governments to significantly increase the allocation of resources to health despite SWAp / SBS / GBS is one reason for this. Human resource retention schemes and incentive schemes to encourage health professionals to live in rural areas have not succeeded, in large part because they are inadequate. The EC actively participates in health sector donor co-ordination, which addresses human resources, but donors still compete to recruit health professionals. Another reason for human resource shortages is the persistence of vertical programmes financed through, e.g. GAVI and the Global Fund. This is despite the increased orientation of these programmes towards general health sector strengthening (due in large part to criticism over their impact on human resources for health). In some countries (e.g. *Moldova and Egypt*), training or re-certification schemes financed by the EC increased the supply of primary health care family physicians, but these represent special cases and large areas remain under-served. While the EC pledged to consult with Member States in order to increase co-ordination between MS policies and EC policies,

no evidence that this has effectively been done has been found. At least some national schemes, e.g. a proposed scheme in the United Kingdom to encourage circular migration, have foundered on the shoals of domestic politics.

#### 6.1.2.3 The EC's support to health care finance through TA, policy dialogue and support to better policy making has had only mixed success in reducing out of pocket payments as a share of total health care spending

**Conclusion 6:** In a number of countries, EC technical assistance has supported overall health sector financial reform. Unsustainable financing policies have been addressed (e.g. *Moldova*), new strategies have been proposed and piloted (e.g. *Egypt* and *Lao PDR*) and existing health insurance schemes have been reformed e.g. in the *Philippines*). In many cases, despite policy changes, the key indicator of out-of-pocket payments as a share of total health expenditure has remained high or increased. Overall evidence for SBS / GBS contribution to increased public budgetary resources in health is thin; however, some countries that received GBS did experience significant declines in out-of-pocket payments.

*This conclusion is based mainly on EQ1, EQ2 and EQ 7*

In all its interventions, whether projects, or SBS / GBS the EC has sought directly or indirectly to reduce the burden of out-of-pocket payments, with their poverty, equity and access implications. There have been some successes. In *Burkina Faso* and *Ghana*, GBS may have helped to create fiscal space for health care finance reform and large declines in the share of out-of-pocket payments in total health care expenditure were observed in the context of instituting mandatory health insurance. In the latter case, the wide scope of exemptions and subsidies casts some doubt on long-run financial sustainability. In *Egypt*, TA contributed to needed reform of the Health Insurance Organisation, but coverage is still only a bit over 50% and out-of-pocket payments remain at about 70% of total expenditure. In the *Philippines*, out-of-pocket payments continued to rise despite EC support for PhiHealth reform. In *Moldova*, where EC TA helped to address an unsustainable financial situation through mandatory health insurance, there is widespread dissatisfaction with the system, families continue to pay informal fees for health care and doctors' salaries and the quality of care available remain low. *Vietnam* is another country where, despite EC support for health sector reform, out of pocket payments show no sign of declining in absolute or relative terms.

Several reasons for continuing problems in health finance reform have been found. One is the fact that, despite SBS / GBS, overall budgetary resource allocations for health remain low in most countries. Capacity has been built in Ministries of Health, but their ability to make and enforce claims on fiscal resources remains weak. As a result, the large quality differential between private and public facilities leads many families, even though poor, to seek expensive care in the private sector (e.g. *Vietnam*). We have found some countries where there is evidence that the EC contributed to an improvement in public sector care quality (e.g. PHC in *Egypt*). In others (e.g. *Philippines*), this has not happened.

A third reason for the stubbornly high level of out-of-pocket payments is to be found in structural changes that do not reflect a failure of EC support, but rather secular trends. The EC has properly concentrated on essential medicines, Basic Benefit Packages and other hallmarks of the European public health model approach. Yet, higher incomes (in most countries), the availability of new or improved drugs, tests and treatments due to globalisation and structural factors such as population ageing have led to a secular rise in the demand for health care. Much of this is at the secondary care level, or concentrated among middle- and upper income groups which are not the focus of EC assistance but who exercise strong claims on public resources.

#### 6.1.2.4 Geographically targeted interventions improved access to health care for the poorest populations, but innovative approaches to remote regions and interventions to address the increasingly urban face of poverty were not in evidence

**Conclusion 7:** When it was geographically targeted, EC assistance concentrated on rural regions where health is poorest and access to quality health care is lowest. The EC scored some successes against health problems in remote and geographically disadvantaged regions, which are the worst-off of all. However, in concentrating its resources on rural areas – a strategy in line with the broad-urban-rural gap in health – the EC did not take into account the fact that health challenges are gradually shifting from urban to rural areas because of urbanisation.

*This conclusion is based largely on EQ1, EQ3 and EQ4.*

Those EC health interventions that were geographically targeted (e.g. *Philippines*, *Lao PDR*, *Egypt*, *Ecuador*, *South Africa*, *Afghanistan*), were appropriately targeted. However, little evidence was found that the EC has taken into account the fact that, while the rural-urban divide in health is still striking,

the face of poverty is increasingly an urban one. There were many more rural health interventions than urban ones designed to address the health care needs of growing slums with high rates of poverty and poor health.

In rural areas, geographical access to health care is increasingly an issue of remote or isolated regions, often characterised by a large proportion of ethnic minority populations and sometimes affected by conflict. A number of EC projects (e.g. *Philippines, Lao PDR, Ecuador and Afghanistan*) addressed the needs of such regions and achieved significant impacts. NGO-implemented projects were especially effective in such settings. Document review suggests that traditional service provision approaches (financing clinics or supporting community health workers) tended to take precedence over innovative interventions such as non-traditional outreach services (e.g. use of mobile telephone networks for community health workers or putting in place an adequate emergency referral and transport system). However, training of community workers was a key feature of many NGO-implemented projects.

#### 6.1.2.5 EC support to MNCH resulted in significant progress in many settings. In some of these, not only contribution to progress, but concrete impacts can be identified

**Conclusion 8:** The EC has provided significant support to improved MNCH, mostly through its support to primary health care (the number of interventions exclusively devoted to MNCH has been low). In a wide range of settings, there has been progress against maternal mortality and under-five mortality, the two MDGs directly related to MNCH. That progress towards these MDGs has been slower than hoped for is due to the complex nature of the problem and the fact that ambitious goals have been set.

*This conclusion is based mainly on EQ1, EQ3 and EQ4*

The EC has contributed to better MNCH through its PHC interventions in many countries (notably *Egypt, Afghanistan, Burkina Faso and Ecuador*). MNCH has been improving over the long term in most countries, in part due to economic growth, cultural change including gender roles, increased use of family planning and the like. However, the EC's strengthening of PHC systems has made a direct contribution. In particularly adverse circumstance (e.g. *Afghanistan*) concrete EC impacts through direct provision can be identified. That progress towards the related MDGs has been slower than expected is in part due to the high targets that have been set. Also contributing is the fact that MNCH is tied to many other factors, such as water and sanitation, gender, traditional cultural practices, geographical remoteness or isolation, income poverty and nutrition. Country case studies have uncovered many examples of this, particularly in the sharp rural-urban and income-level differences between basic MNCH indicators. Problems of remote and geographically disadvantaged areas have been especially serious. While the traditional provision of PHC as supported by the EC has contributed to improvements, a broader approach involving multiple sectors and innovative approaches would be necessary to accelerate progress. EC support to the Global Fund (to prevent mother-to-child transmission (MTCT)) and GAVI (to promote vaccination) have made significant contributions. In the latter case, these have been quantitatively estimated.

#### 6.1.2.6 In the case of fragile states, only in the case of Afghanistan, can a more than modest contribution to health improvements be established

**Conclusion 9:** One of the largest EC health programmes was that in Afghanistan, with a well-documented impact on health status. Support to other fragile states has remained much more modest. The EC was also more bound by procedural constraints than other donors in such settings and would need to be more innovative to make a significant contribution to progress.

*This conclusion is based mainly on EQs 1-4.*

The EC spent around 15% of the total amount allocated to the health sector in fragile states, which have lagged seriously behind in achieving the health-related MDGs. Thirty-five countries, out of 40 countries identified as fragile states, received support, but half of the total went to only a few countries *Afghanistan, Nigeria, DRC, Zimbabwe and Angola*, with by far the largest share (17%) going to Afghanistan. A large proportion of this support was channelled through projects run by NGOs. The EC contribution to fragile states may have increased somewhat during the second half of the decade, but remained modest when compared to needs and the size of the EC's health programme as a whole. As demonstrated in the inventory, significant amounts of EC assistance went to middle-income countries where overall fiscal reform and improved public financial management could generate significant additional resources for health from national sources.

In an October 2007 Communication from the Commission "Towards an EU response to situations of fragility" and its ensuing "Conclusions of the Council," a range of recommendations to ensure improved EC policy and implementation in case of fragility were formulated, but steps to operationalise these recommendations have not yet been taken. Improved policy development for fragile states is

called for since traditional approaches may not be suitable. The EC's approaches, however, as confirmed by the Afghanistan example, have been traditional, consisting in the main of direct provision of primary health care by NGOs. As documented in the Afghanistan case study, this is, in part, due to the inflexibility of the EC's procedures as compared to other donors, which have generally been more innovative. That said, the substantial EC input in the health sector has definitely had positive impact on the health status of the population covered by EC programmes, including in remote and insecure areas. This resulted from sustained commitment to a programme with a clear focus aligned with government policy and other key donor policies.

#### 6.1.2.7 Through TA, capacity building and SBS / GBS-based policy dialogue, the EC has contributed to improved health sector policy and management, however, impact on resource availability has been modest

**Conclusion 10: In most countries where the EC has been involved in health co-operation, especially SBS, EC support has led to improved health sector policy making capacities and improved management practices. While capacity for better PFM has been built, the ultimate impact on health sector PFM has often not been seen.**

*This conclusion is based mainly on EQ 2, EQ 5 and EQ 7*

The EC, through policy dialogue, TA and capacity building, often in the context of SBS, strengthened health sector policy making and management, although this was been less evident at a decentralised level or in the area of procurement. There was, in a number of countries, improvement in transparency and accountability and, in general, the EC's contribution to improved sector strategies and planning was significant (e.g. *Moldova, Timor-Leste, Lao PDR, Philippines, Bangladesh, Egypt*). The latter may be looked upon as one of the main achievements of budget support, particularly SBS, where TA to Ministries of Health made possible improvements in planning, reporting and monitoring. However, given that SBS only accounted for 16% of total health assistance, the width of impact of such measures, especially TA and capacity building, has remained limited. Moreover, increases in the capacity for better PFM were not always matched by actual improvements.

Limiting the actual impact and sustainability, of improved policies and capacity was the overall shortage of resources in the health sector. The human resource crisis limits the long-run impact of the EC's contribution to capacity building, as persons trained often do not remain in post, leaving tools provided under-utilised.

The human resource crisis is a symptom of financial resource shortages. We have found that there is little evidence that SWAp / SBS / GBS engagements have led to increased resource allocation to health (*Ghana, Zambia and Burkina Faso* being likely exceptions). There is no evidence that Ministries of Health strengthened their claim, or ability to defend it, on Ministries of Finance who typically hold the purse strings. The *Philippines* is a counter-example, but MoF resources support only a limited number of vertical MoH programmes, real health sector finance depends heavily on local budget decision makers. Health remains a low-priority sector in virtually all poor countries.

The chronic under-resourcing of public health systems is a theme that has recurred throughout EQ answers and these conclusions: it slows progress against not only the human resource crisis, but shortages of infrastructure / equipment (including operations and maintenance issues) and, generally, the public-private quality gap in health care.

#### 6.1.2.8 The EC significantly contributed to the production of global and regional public goods for health, a contribution in line with its status as a supranational organisation

**Conclusion 11: Through support to research, infectious disease control (much of it through the Global Fund, GAVI and initiative to eliminate polio, but also in emerging areas such as cross-border veterinary health and pandemic influenza), the EC made a significant contribution to the production of global and regional public goods for health. This is appropriate in view of its status as a supranational organisation. In the case of GFATM and GAVI, the significant role of EC headquarters is in contrast to the limited role played by most EU Delegations, meaning that co-ordination with other EC programmes is lacking.**

*This conclusion is based mainly on EQ2, EQ4 and EQ6*

The EC headquarter has played an important role in setting up the GFATM, with considerable resources allocated to it (the EC is the fourth largest contributor), as well as in agenda setting on HIV/AIDS, tuberculosis and malaria issues. However, EU Delegations are little involved in GFATM activities, which has given rise to overlap and poor co-ordination with other EC support to the health sector. The EC has also been one of the major donors to GAVI since 2003. Again, better co-ordination, for example, between general EC support for health system strengthening (vehicles, cold chain, human resources, etc.) and GAVI immunisations campaigns might have improved results. Bet-

ter co-ordination of both GFATM and GAVI with EC efforts in MNCH would also have been beneficial. However, estimates of the number of lives saved, based on number of immunisations provided, give evidence of a significant impact of EC assistance to GAVI. The EC has played a significant role in responding to the threat of emergent diseases (e.g. avian influenza) and pandemic influenza. Nonetheless, the EC's engagement with other emergent disease threats (Dengue, Chagas, etc.) has been limited. Where appropriate, the EC has been involved in some regional health initiatives, appropriately so when, as in the case of malaria and avian influenza, problems are inherently regional and cross-border in nature. No evidence was found of EC development co-operation involvement in the area of antibiotic resistance (apart from GFATM involvement in work against multiple-drug resistant TB).

### 6.1.3 Cluster 3: EC interaction with donors and partner governments in the health sector

#### 6.1.3.1 EC participation in co-ordination mechanisms has led to increased health aid effectiveness, but has been limited by the lack of technical expertise in EU Delegations

**Conclusion 12:** The EC, through its participation in co-ordination mechanisms, contributed significantly to improved co-ordination and complementarity, in line with the Paris Declaration. It has effectively exploited its role as a supranational organisation and its special relationship with the EU MSs. However, the shortage of technical expertise in EU Delegations placed it at a comparative disadvantage relative to other donors and governments.

*This conclusion is based mainly on EQ1, EQ4 and EQ6*

The health sector has been a lead sector for donor co-ordination, especially in view of the potential for geographic and thematic overlap. The EC has participated in health co-ordination mechanisms in all countries where it is a significant health donor and, in a number, has taken a leading role. Specifically related to EU MS co-ordination, the EC has played a key role, has chaired groups and thus provided added value. The EC's co-ordination role has been strengthened by the fact that in some countries, it is a far larger health donor than the MSs. The EC has supported and respected the division of labour. The tendency of many governments to accept aid offers regardless of co-ordination concerns has been noted at a number of points, but in general the situation has improved over the evaluation period and the EC can claim some of the credit for that.

Limiting the EC's ability to co-ordinate effectively has been the under-capacity of EU Delegations in terms of health technical expertise. The health portfolio has often been found to be handled by generalists who are balancing a number of sectors. Other multi-lateral donors and MS bilateral donors, when they choose to be involved in health, usually have a technically qualified specialist handling the portfolio. Government, it goes without saying, is represented by technically qualified staff. In countries where the EU Delegation is under-resourced, the imbalance of expertise gives rise to a credibility gap and limits the ability of the EC to co-ordinate effectively with other partners.

#### 6.1.3.2 The EC moved in the direction of honouring Paris Declaration commitments, but interaction with MoHs and other partners would have been enhanced by more EUD capacity

**Conclusion 13:** The EC has contributed to reducing health co-operation transaction costs for recipient governments through a reduction in PIUs and, despite the persistence of the project approach, moved towards sector support through SBS and GBS. However, one of the more recent instruments for this, Delegated Co-operation, was little utilised as of the end of the evaluation period. Moreover, EC effectiveness, as well as impact, is weakened by under-staffing in EUDs.

*This conclusion is based mainly on EQ 6 and EQ 7.*

In line with Paris Declaration commitments, the EC contributed to reducing transaction costs for recipient governments in the health sector through a reduction in reliance on Project Implementation Units (PIUs) and, as documented by the EUD survey, moving towards sector support through SBS and GBS. The move towards SBS has been slower than in some sectors such as education and it is fair to say that budget support is still under-utilised relative to the project approach. Transaction costs have often not fallen for EU Delegations (e.g. in *Mozambique, Vietnam and Zambia*). This has been due to a lack of health sector expertise in-country – most EUDs are under-staffed in terms of technical expertise even when there is substantial health involvement – and the fact that EU Delegations must deal with a range of aid modalities. This reduced the quality of the interaction with other health stakeholders, partners and MoHs, all of which are usually better resourced in terms of technical expertise and weakens EUDs' impact in the overall health policy dialogue and health system implementation at the country level.

One of the recently promulgated tools meant to increase aid effectiveness is “Delegated Co-operation for HSPM and HSPD among EU MS and the EC, related to health.” Based on the country case studies, this approach was little utilised as of the end of the evaluation period.

#### **6.1.3.3 While EU Delegations’ participation in policy dialogue in the context of SWAp / SBS / GBS contributed to better health sector policies and management, there is little evidence that it resulted in concrete increases in resources allocated to health**

**Conclusion 14: As reported in Conclusion 10, despite capacity shortages, EU Delegation policy dialogue as part of the wider donor dialogue related to GBS and sector support has contributed to improved capacity. However, we have not found strong evidence that it has resulted in higher budget allocations for health.**

*This conclusion is based largely on EQs 2, 5 and 7.*

The essential long-run challenge in addressing global health gaps is increasing the availability of financial resources in the health sectors of poor countries. Repeatedly, whether in discussing the human resource crisis, problems of inadequate equipment and maintenance, the public-private health care quality gap and the heavy burden of out-of-pocket payments on families, we have cited the under-resourcing of public health systems. Some, albeit not all, sectoral SBS and GBS policy dialogues, including policy matrices, was designed to increase the resources available to the traditionally under-prioritised social sectors such as health. We have looked for evidence that budget support increased resources in health and generally not found it.

The only evidence of budget allocations to health improving due to GBS was found in *Ghana, Burkina Faso* and especially *Zambia*, while in *Bangladesh* funding to the health sector increased, but not as a percentage of the total budget. In Vietnam it was specifically noted that efforts to increase sector funding through GBS, had not been as successful as in the education sector through SBS.

Two reasons can be found in evidence considered. One is that decisions on budget allocations are made at Ministry of Finance. No evidence emerged that Ministries of Health, despite their improved capacity, have strengthened their claim on fiscal resources allocated by MoFs. Another is that dialogue has been constrained by a lack of capacity in EU Delegations to engage effectively, due to a lack of in-house PFM and health expertise and the fact that EU Delegations often do not have dialogue strategies which can help to focus EC efforts on a few key issues. Engaging in policy dialogue is time consuming, often frustrating and can considerably increase the transaction costs for the EUD. The skills required for participating in policy dialogue are very different to those needed for project management. Sufficient staff with the appropriate expertise is essential to ensure the effectiveness of policy dialogue and the management of GBS and sector support.

#### **6.1.3.4 Policy matrices focused on core health sector issues, but health sector progress has often been difficult to measure**

**Conclusion 15: The indicators chosen to form the performance assessment frameworks for SBS and GBS were in most cases reasonably well specified and addressed the core issues in the health sector. In some instances however, a lack of data availability has made it difficult to track progress of indicators chosen.**

*This conclusion is based on all EQ answers.*

SBS/GBS performance assessment has suffered from a lack of baseline data and the fact that statistical data are often not regularly collected and as a consequence can cause difficulties in making disbursement decisions. Vague and inappropriate specification and inclusion of unrealistic indicators in policy matrices made the tracking of health sector progress and EC disbursement decisions hard at country level. In *Laos, Uganda, Mali, Tanzania, South Africa, Burkina Faso* and *Paraguay*, there was found to be a lack of data to assess if indicators had been achieved. Generally speaking, case studies and the ED Delegation survey revealed surprising difficulty in tracking health indicators having to do with infrastructure and equipment and maintenance budgets.

Indicator targets were generally achievable, except in the case of EC health indicators for GBS which have an overall 50% achievement rate. An example of this is in *Zambia* where in 2010 it was noted that the performance in meeting health indicators had deteriorated over time and was not as good as in education. A similar comment was made relating to *Burkina Faso’s* second GBS operation.

This is due to a number of possible reasons such as being over-ambitious as they are linked to achievement of the MDGs, the incentive of the small amount of funds attached to them not being enough, the fact that some are out of the government’s control and are difficult to measure. Non-achievement reduces the amount of resources available to recipient governments and given this, it

would suggest a closer look needs to be taken at the design and incentive structure of these performance targets.

#### **6.1.3.5 EC participation in multi-donor trust funds on country level served as a force magnifier, permitting the EC to leverage its resources for greater impact as well as enhancing complementarity**

**Conclusion 16:** In many settings (e.g. *Philippines, Vietnam*), EC participation in multi-donor trust funds on country level has proven effective. The main factor of success in the implementation phase of multi-donor trust funds was a regular and transparent dialogue between donors and partner governments, as well as active participation of EU Delegations in the steering and co-ordination committees. Once more, however, limited technical capacity of Delegations was been a constraining factor.

Multi-donor trust funds were effective vehicles for reaping economies of scale and scope, thereby increasing impact beyond what could have been achieved by donors acting separately. Some of this was due to enhanced complementarity in the health sector. The main issues of concern are related to daily management, especially with different donor procedures. Trust fund managers and other donors complain of rigid EC financial and reporting procedures, in particular citing the EC's relatively heavy requirements. Also of concern is the lack of visibility of EC action within the trust funds. Greater capacity at EU Delegations would increase the effectiveness of participation in joined-up approaches such as multi-donor trust funds.

#### **6.1.3.6 EC aid modalities are increasingly aligned with recipient government systems, but the mix of aid modalities could be more coherent and strategic**

**Conclusion 17:** The EC uses a wide range of aid modalities, which are increasingly aligned with recipient government systems, in the health sector. However, it is often not clear why alternative aid modalities and funding channels have been chosen and how they are intended to be complementary. This has led to a lack of coherence and consistency between programmes.

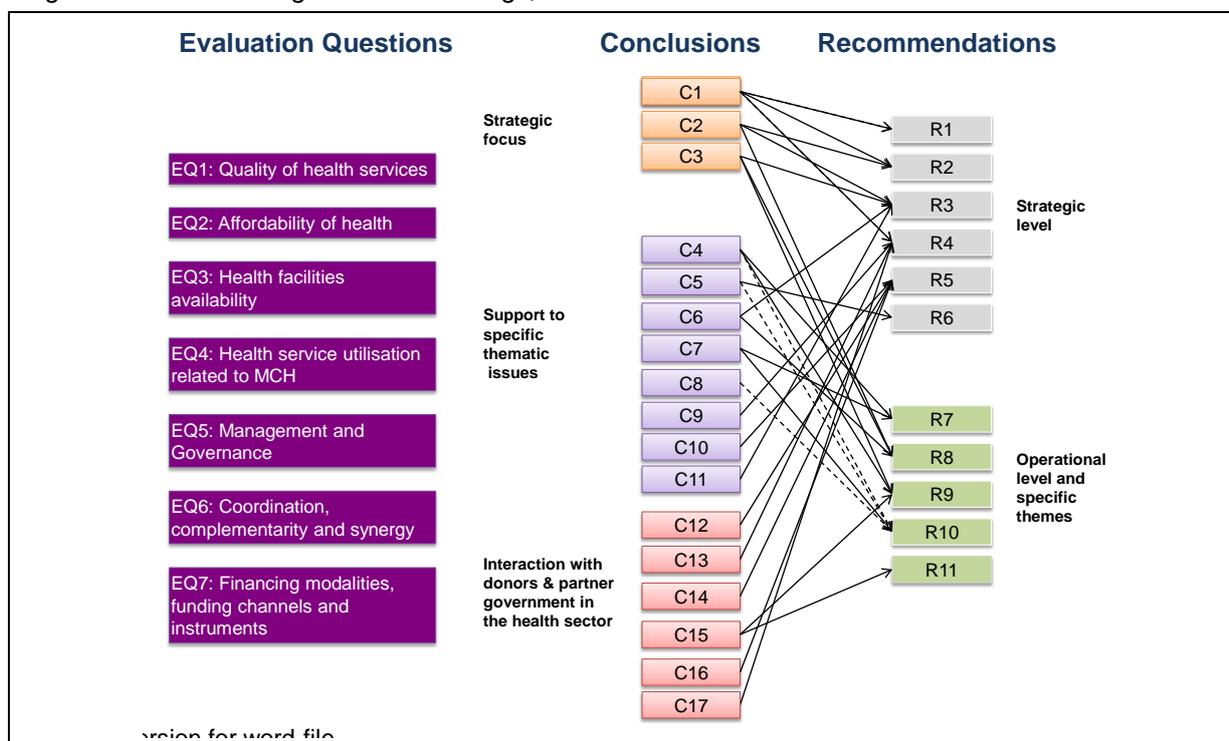
*This conclusion is based mainly on EQ 6 and EQ 7*

For example, co-ordination between thematic and geographic programmes is not as effective as it could be, as the former are run from Brussels and the latter in-country, while attention is not always paid to ensuring that projects are co-ordinated with other interventions (EUD Survey). The Global Fund, of which the EC is a major supporter, HIV/AIDS projects that are parallel to other EC-funded interventions. GBS and SBS on their own are unlikely to leverage results attained via policy matrices unless there are other targeted interventions, which is not always the case.

## 6.2 Recommendations

The linkages between EQs (findings), conclusions and recommendation are illustrated in the following figure.

Figure 26: Linkage between findings, conclusions and recommendations



The table below provides an overview of the level of priority in terms of importance of the recommendations and the urgency (agenda) of their realisation. This information is also provided schematically in the following figure.

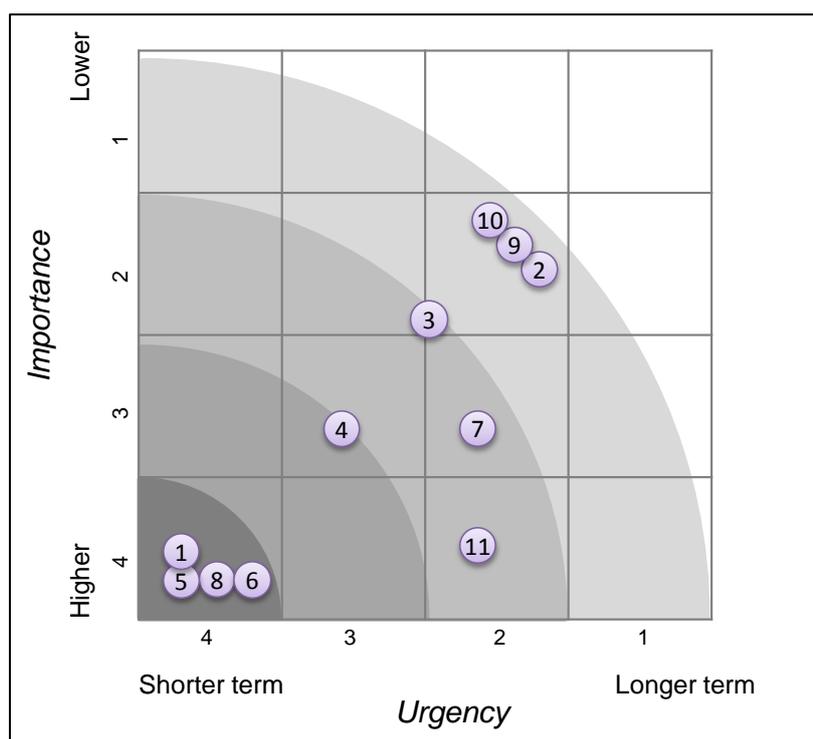
Table 11: Prioritisation of recommendations

	Issue	Importance*	Urgency*
1.	Comprehensive health co-operation strategy and operationalisation at field level	4	4
2.	Shifting burden of diseases and long term structural trends	1	1
3.	Encourage move towards health systems strengthening within global initiatives (GFATM, GAVI)	2	2
4.	Choices of instruments and modalities to improve coherence	3	3
5.	Technical health capacities within EUDs	4	4
6.	Human resources for health	4	4
7.	Complementarities, synergies and inter-sectoral links	3	2
8.	Systematic review of health system finance support	4	4
9.	Health infrastructure and operation and maintenance requirements	1	1
10.	Support to remote, isolated and vulnerable population and minorities	1	1
11.	Needs assessment in designing budget support interventions	4	2

\* 1 = low, 4 = high

The following figure depicts this assessment graphically.

Figure 27: *Prioritisation of recommendations, schematic overview*



The team has attached the highest importance and greatest urgency to consolidating EC health co-operation policy and strategy, strengthening EUD technical capacity where needed and more effectively addressing the key constraining issues of human resources and financing for health. Improving the availability, quality and timeliness of statistical data is also quite important, but can be addressed in the medium term. A number of other recommendations, while we consider them highly relevant and useful, are judged to be lower in importance, urgency, or both.

Addressing these priorities requires interventions by different actors. Therefore, each recommendation includes suggestions for operational steps for putting it into practice and identifies implementation responsibilities.

## 6.2.1 Strategic level recommendations

### 6.2.1.1 Recommendation 1: Consolidate various global policy statements and approaches into a comprehensive health co-operation strategy that can be effectively operationalised at the field level in conformity with national sector development plans

Based on conclusion 1	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU HQ</li> <li>• Selected EUDs</li> </ul>
<p>Conclusion 1 found that the EC's global health strategy, trying to cover all fronts at once, does not result in sound country level strategies, especially since thin-stretched EUDs lack the capacity to absorb everything. In order to rise above the current activity-driven approach, the EU should review, consolidate and synthesise its health co-operation strategies, perhaps in the form of a White Paper. Major dimensions of a comprehensive approach should be identified, including the anti-poverty focus, PHC, health systems strengthening, health care finance, global public goods, human resources, etc. The goal should not be to devise a one-size-fits-all approach, but rather one sufficiently broad and well-articulated that components can be matched to country priorities and other donors' activities to identify priority interventions while ensuring that the major issues are covered. In this way, e.g. capacity building will need to be matched with human resources policy; infrastructure and equipment needs with health care finance via maintenance and operating budgets; support for vertical programmes with health systems strengthening, etc.</p> <p>The persistent fragmentation of health aid and the need for improved co-ordination with national health sector plans and budget cycles argues for a continued strong role for both sector and general budget</p>	

support. In providing sector support of GBS, account needs to be taken of countries' policy commitments and resource allocation decisions related to social sector reform. Governments should be asked to do a credible case for additionally of how budget support has contributed to additional resources being made available for inclusive and equitable health sector development, including health finance and social protection reform where needed. In addition to serving EU accountability, this will result in a stronger sense of country ownership.

The hallmarks of the approach should be (i) identification, prioritisation and choice of interventions while maintaining enough breadth to allow consistency with national programmes and (ii) avoidance of overlap with other agencies such as GFATM, UNFOPA and UNICEF. It would distil overarching policy commitments into a menu of choices into which national strategic priorities could be mapped.

Implementing this recommendation would include the following elements:

- Create a Task Force (EC HQ and selected EUDs) to devise and design a comprehensive approach to health in developing countries. The emphasis should not be on process, already covered in recent documents relating to new programming procedures, but rather on how to prioritise health needs.
- Strengthen EC/WHO collaboration as a means of promoting coherence with MoH objectives and approaches.
- In countries receiving SBS for health, ensure that EUD capacity in health and PFM is adequate to support effective policy dialogue.
- Design a flexible and robust bottom-up methodology through which country needs can be quantified and matched with needs for donor assistance. This could focus on four-pillar approach: primary health care (covering inclusive and equitable coverage), health systems strengthening (particularly resilience to national, regional and global shocks), human resources for health and health system finance.

**6.2.1.2 Recommendation 2: When defining the focus of support, take the shifting burden of disease and structural shifts such as urbanisation more carefully into account**

Based on conclusions 1 and 2	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU HQ</li> <li>• EU Delegations</li> </ul>
<p>The EC should take the shifting burden of disease and emerging problems into account in formulating global and country health strategies. The EC may be fighting yesterday's battles in some settings – for example, HIV/AIDS receives a share of health assistance much greater than its estimated 3.8% contribution to the global burden of disease in 2004 (a share projected by WHO to decline to 2.5% in 2030). –At the same time, little notice has been taken of challenges associated with urbanisation and non-communicable diseases. Health and climate change is another area in need of consideration, less so issues such as heat stress and the shifting range of disease vectors than the problem of how to provide essential medical care in the wake of natural catastrophes, widely agreed to be rising in frequency as a result of climate change (a health system resilience issue). The health-poverty focus has properly led the EC to concentrate on rural areas, but poverty is increasingly an urban phenomenon and the EC's health strategy should be pro-active along this dimension.</p> <p>With its emphasis on primary health care and poverty focus, the EC is perhaps not in a strong position to directly address chronic conditions and non-communicable disease, which often require secondary- and tertiary-level care. However, there are a number of areas where the EC can intervene. One is prevention, including behavioural change, widely agreed to be the most cost-effective response to non-communicable disease. Another is health care finance, which can stand as a cushion between catastrophic health events and poverty. Another is encouraging health planners to address road trauma and mental disease squarely. Integrated PHC programmes, a clear and continuing focus of the EC, can be adapted to play an important role (e.g. health promotion, blood pressure monitoring, routine screening procedures, etc.) Addressing non-communicable disease does not compete with or crowd out primary health care, it leverages it.</p>	

Implementing this recommendation would include the following elements:

- EC HQ should provide clear approach guidelines to the EUDs in order to address and shifting burden of diseases. Basic training on the “burden of disease” concept may be needed and could be done in co-operation with WHO.
- Strengthen EUDs health technical capacity.

- Undertake a systematic study of the relationship between EC health assistance and the burden of disease, taking into account the support of other donors to ensure complementarity and coherence.

**6.2.1.3 Recommendation 3: While continuing to support global initiatives such as GFATM and GAVI, the EC should use its influence to encourage further moves towards the health systems strengthening components of such vertical programmes and in particular address the human resource consequences**

Based on conclusions 1, 5, 8 and 11	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU HQ</li> <li>• Health working Groups</li> <li>• Country Co-ordinating Mechanism (CCM)</li> </ul>
<p>The EC should continue its support to global initiatives such as the Global Fund (which has fallen somewhat outside this evaluation) and GAVI. However, the Health System Strengthening components of the GFATM and GAVI proposals (since Round 8) provide an entry point for HSS support and therefore should be prioritised. The EC's considerable role in financing these initiatives gives it a strong governance voice for pushing them in the direction of systems strengthening. In addition to aligning more closely with country priorities, this will help to address the human resource crisis, which is in significant part due to health professionals having been absorbed by vertical programmes. The HSS approach is crosscutting and horizontal in addressing the weakest aspects of health system including service delivery and more in line with the goal to create a strong PHC framework.</p>	

Implementing this recommendation would include the following elements:

- EC HQ should use its voice in GFATM and GAVI governance to promote the Health Systems Strengthening approach.
- Health Systems Strengthening should, when appropriate (e.g., certainly in the case of vaccination and infectious disease control) be integrated with the EC's work on global public goods for health.

**6.2.1.4 Recommendation 4: In order to improve coherence, the EC should be more strategic regarding the choice of instruments**

Based on Conclusions 1, 9, 13 and 17	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU Delegations</li> <li>• EU HQ</li> <li>• Health working groups</li> </ul>
<p>The EC needs to be more strategic regarding which aid instruments to use in which contexts, to ensure an appropriate mix and greater coherence between them. Thematic programmes need to be coherent with geographic programmes, while consideration needs to be given as to how GBS, SBS/other sector support and projects can be complementary. GBS is most likely to be successful in raising key health sector issues to a higher level of dialogue, with the achievement of objectives supported through a coherent series of interventions through sector support programmes and projects aimed at improving service delivery. SBS and other sector support can support dialogue aimed at better health sector management and strategic interventions related to this. More use of SBS should also be considered, with capacity building support given prior to SBS to ensure that the EC prerequisites are met.</p> <p>Fragile states present a special challenge. Relatively little EC assistance has gone to such countries, yet impacts have been substantial. In fragile states, emphasis should be put on strengthening basic service provision as a means of confidence building and, in situations of conflict or near-conflict, building bridges. Operations in fragile states should be innovative, flexible and adaptable, as situations may change rapidly.</p>	

Implementing this recommendation would include the following elements:

- EU HQ to revise the design of thematic programmes to make them more responsive to individual countries needs and complement geographic programmes more effectively.
- CSPs should outline how different interventions link together and complement each other and the process of developing CSPs should be used to think this process through.
- EUDs and health working groups to ensure that sector objectives/targets are supported through complementary interventions designed to support achievement of these objectives.
- EUDs to develop a strategy to influence key EC health objectives through GBS dialogue and other interventions to ensure a joined up approach.

- EUDs to consider whether additional capacity building support can be provided to lay the groundwork for more SBS in health.

**6.2.1.5 Recommendation 5: The EC should strengthen the technical health capacity of EUDs or, in countries where this is impossible, consider either reducing its direct participation in the health sector, delegating to others by participating in pooled funding, or drawing on expertise in EU MS embassies**

Based on Conclusions 10, 12, 14 and 16	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU Delegations</li> <li>• EU HQ</li> <li>• EU Member States</li> </ul>
<p>A theme that has emerged repeatedly in conclusions is that most EU Delegations, even in countries with significant health engagement, are short of technical capacity. In order for policy dialogue related to sector SPSP and budget support to be effective, EUDs should have sufficient in-house expertise and capacity in health and PFM and there should be a dialogue strategy developed focused on key issues which the EC is interested in influencing. Participation in co-ordination exercises and multi-donor trust funds also requires that the EU Delegation be credibly represented and input into policy dialogue and visibility suffer from a lack of credible expertise. The planned tightening of focus on only three focal areas per country is a golden opportunity for doing an inventory of needs and formulating a staffing plan. Where needed technical expertise cannot be mobilised, delegated co-operation may be employed to use the skilled staff of EU MS embassies.</p>	

Implementing this recommendation would include the following elements:

- This point is crosscutting and it is valid for all recommendations. If the EC wants to play a greater role in health, the capacity of EUDs is a fundamental starting point.
- EU HQ to provide training in key skills for staff engaged in sector dialogue (negotiation, influencing, etc.).
- EUDs to develop a strategy to influence key EC health objectives through GBS.
- EU HQ to recruit health and PFM specialists to EUDs where expertise is lacking.

**6.2.1.6 Recommendation 6: More explicit actions are called for in favour of human resources for health**

Based on conclusion 5	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU</li> <li>• EUDs</li> <li>• Health working groups</li> <li>• CCM of the GFATM</li> </ul>
<p>We have found that, in many developing countries, Ministries of Health struggle to attract and retain sufficient numbers and types of human resources for health to provide quality services, especially in rural and remote areas. The EC should give more attention to this burning issue, e.g. in human resources planning in consultation with key stakeholders to provide a framework and strategic directions to guide the development of an effective workforce that can meet the challenges facing in countries' health systems. The aim is to ensure that the health system has health professionals in the required quantity and quality at leadership, managerial and technical levels, deployed where and when needed and motivated to perform their functions. One of the key pillars of the strategy is to ensure appropriate incentives for health workers based on the national policy and legal frameworks. Guidelines describing various strategies a country can pursue to increase access to health workers in remote and rural areas through a range of retention interventions covering four main categories: education, regulation, financial incentives and personal and professional support mechanisms were released by WHO in 2010.</p> <p>Moreover, the EC should ensure that HRH are taken into account in SBS / GBS policy matrices. Through its participation in co-ordination, it should act in concert with other donors and government to reduce poaching from the public health system.</p> <p>The EC should also explore the links between problems experienced in Third Countries and the burgeoning demand for health worker immigrants in EU MS. In so doing, co-ordination and liaison with the MS and WHO would be especially valuable.</p>	

Implementing this recommendation would include the following elements:

- All national health sector development policies supported should be subjected to a human resources sustainability audit.

- EU HQ should take advantage of its unique role to engage in co-ordinated policy dialogue with MSs on their policies towards immigration of health professions, with the goal of establishing an EU policy / programme to support circular migration as opposed to brain drain.
- Actions/indicators related to HR attrition should be included in SBS/GBS policy matrices to complement and reinforce EC and other donor programmes aimed at directly tackling the problem.

## 6.2.2 Operational and level recommendations - specific themes

### 6.2.2.1 Recommendation 7: Take greater account of complementarities, synergies and inter-sectoral links

Based on conclusion 4 and 7	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EUDs</li> <li>• EC HQ</li> </ul>
<p>The EC's country programmes should take into greater account the synergies, as well as the complementarities and cost-efficiency considerations that exist between different sectors – e.g. health, rural development, food security, water / sanitation, transport, etc. Policies seemingly diverse but in reality closely tied, such as provision of effective community-level health care, a referral system based on mobile telephony and emergency transport availability, deserve consideration in many settings. Particularly in the area of MNCH and in dealing with remote regions, integrated approaches may be especially important in accelerating progress. In addition, EUDs should ensure that, in aligning with national sector development plans, co-operation is aligned with EU policies on climate change, migration and environment.</p> <p>As education, health and social protection are priority sectors and as the new approach is to limit assistance to three priority sectors, if one of these is selected, then aspects of the other two should be mainstreamed into the support package.</p>	

Implementing this recommendation would include the following elements:

- Strengthen EUD technical capacity in the health sector.
- Systematically include linkages with the health sector in the project formulation process in related sectors.

### 6.2.2.2 Recommendation 8: The EC should undertake a systematic review of its health system finance support to identify lessons learned and directions for further action

Based on conclusion 2, 3 and 6	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EC HQ</li> </ul>
<p>In view of the generally weak record of the EC (and other donors) in effectively, sustainably and equitably reforming health system finance and the crucial importance of increasing resources available to the health sector, the EC should conduct a thematic review specifically devoted to this area in order to identify lessons learned and identify new strategic directions. The EU Member States, having succeeded in delivering reasonably affordable health care in a financially sustainable manner using a range of approaches, are in a unique position to serve as a one-stop shop for policy advice in this central area. The role of the private sector – which accounts for more than half of health spending in many developing countries – should be given more attention than in the past. Where out-of-pocket payments remain high despite health system finance reform, reasons should be identified and shared with partners and stakeholders. The actuarial sustainability of mandatory public health insurance should be analysed in a selection of partner countries and income distribution and poverty consequences of health system finance should be explored.</p>	

Implementing this recommendation would include the following elements:

- In aligning with national health sector development plans, the EU should (in co-ordination with MS donors) impose a mandatory financial sustainability audit.
- Regarding the uses of funds, a bottom up “costing” methodology, in which basic interventions are identified, unit intervention costs are estimated, the target population is estimated and coverage rates are assumed, should be used to estimate the cost of attaining reasonable inclusiveness and equity.
- Regarding the sources of funds, the straightforward WHO approach of looking at public resources, insurance, the public sector, donor finance and out-of-pocket should be used.

**6.2.2.3 Recommendation 9: Regardless of the modality chosen, EC support to health infrastructure**

Based on conclusions 3, 4 and 15	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EU Delegations</li> </ul>
<p>While infrastructure and equipment are not and should not be EC priorities, in those cases where the EC does provide these, it should more carefully assess the operations and maintenance requirements that arise. Whenever the EC is involved in support to infrastructure and equipment (cars, medical equipment, cold chain, etc.) an amount of the project/programme budget should be mandatory included and allocated to a simple and hoc maintenance strategy and plan. From the effectiveness, efficiency and sustainability perspectives, the EC needs to tighten the link between facilities and health system finance. The EC clearly cannot itself finance operations and maintenance. However, through sector support and to the extent possible, general budget support, it should provide support to strengthen ad hoc maintenance strategy in the health sector following WHO guidelines on performance inspections, preventive maintenance and corrective maintenance. Monitoring and data collection regarding the state of infrastructure and equipment need to be drastically strengthened, as evidence by the difficulties that the evaluators had in collecting data in this area.</p>	

Implementing this recommendation would include the following elements:

- Clear guidelines are provided from EC HQ to the different EUDs and partners. It will be a conditionality in/of the SBS and GBS.
- The costs of infrastructure and equipment maintenance and operation should be fully reflected in project documents and the sources of such finance made explicit.

**6.2.2.4 Recommendation 10: Pay greater attention to innovative approaches to target remote, isolated and vulnerable population and minorities**

Based on conclusions 7 and, to lesser extent, 4, 5 and 8	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EUDs</li> <li>• Health working groups</li> </ul>
<p>It is clear that the worst health outcomes are increasingly concentrated among remote, geographically isolated, more often than not ethnic minority populations and frequently affected by conflict. These are inherently difficult areas to work in, with typically high costs of operations. Therefore, the EC should help to develop comprehensive strategies at country level that are tailored to local circumstances. Where needed, the EC should support data gathering and mapping exercises in MoHs. In some cases, traditional provision of infrastructure and equipment, typically through NGO projects, will be appropriate. In others, supporting government in putting in place a human resources policy that relieves staff shortages will be more effective. In other cases, innovative approaches involving mobile telephony and community health workers, bush ambulance services, medical evacuation, etc. may be more cost effective. Addressing the human resources issue will, whatever the strategy developed, probably be necessary. Improving health system performance in remote and disadvantaged regions can be added to SBS / GBS policy matrices. Moreover, the EC should consider the role of health in some of its other activities in these areas, such as rural development, roads and water and sanitation. Geographical division of labour may be called for in some countries.</p>	

**6.2.2.5 Recommendation 11: Pay increased attention to data needs, particularly in designing sector and GBS interventions**

Based on all conclusions, especially conclusion 15.	Main implementation responsibility: <ul style="list-style-type: none"> <li>• EUDs,</li> <li>• Health working groups</li> </ul>
<p>There exists almost everywhere a solid core of data availability regarding key indicators such as mortality and vaccination. However, data needed to guide government policy, donor policy dialogue and resource allocation now cover a much wider range: infrastructure, budgets and health outcomes and expenditure data disaggregated by income, poverty status, household structure, sex, age, etc., as well as geographical disaggregation. In the context of its sector support, the EC should continue to strengthen data collection, stressing not only disaggregation, but timeliness, as data five or more years old are of little use. This may require co-operation with statistical agencies as well as the EC's traditional MoH partners.</p>	

Implementing this recommendation would include the following elements:

- Consultation with partner governments to agree on indicators to be used in measuring health interventions.

- Ensure that indicators used are SMART (specific, measurable, attainable, relevant, timely).
- EUDs and health working groups ensure that indicators chosen for SBS/GBS policy matrices are measurable and collected on a timely basis.
- EC support to statistical offices in recipient countries to strengthen capacity to collect data or funding by the EC of key surveys and data collection activities.
- EC support to the MoH to enhance capacity to collect data and monitor results.