

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

Final Report  
Volume IIc

August 2012

*Evaluation for the European Commission*







European Group for  
Evaluation EEIG  
Germany



Particip GmbH  
Germany



Aide à la Décision Economique  
Belgium



Development  
Researchers'...  
Network  
Italy



Deutsches Institut für  
Entwicklungspolitik  
Germany



European Centre for  
Development Policy  
Management  
The Netherlands



Overseas Development Institute  
United Kingdom



South Research  
Belgium

A consortium of  
Particip-ADE-DRN-DIE-ECDPM-ODI  
c/o Particip GmbH, leading company:  
**Headquarters**  
Merzhauser Str. 183  
D - 79100 Freiburg / Germany  
Phone: +49-761-79074-0  
Fax: +49-761-79074-90  
[info@particip.de](mailto:info@particip.de)

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

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

**Ref.: EuropeAid/122888/C/SER/Multi  
Contract n° EVA 2007/social LOT2**

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

**Final Report  
Volume IIc**

**August 2012**

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



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



The evaluation team comprised of: Landis MacKellar (Team leader), Ann Bartholomew, Eric Donelli, Egbert Sondorp. The team has been supported by: Georg Ladj (QA expert); Sarah Seus (evaluation co-ordinator); Veronique Girard, Sara Gari, Regina Husáková, Julia Schwarz (junior consultants).

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

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



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

## Final Report

The report consists two volumes:

**Volume I: Main report**

**Volume II: Annexes**

<b>VOLUME I: MAIN REPORT</b>
1. Introduction
2. Answers to the Evaluation Questions – General level
3. Approach and methodological tools used in the evaluation
<b>VOLUME II: ANNEXES</b>
<b>VOLUME IIa: DETAILED ANSWERS TO THE EVALUATION QUESTIONS</b>
Annex 1: Detailed answers to the Evaluation Questions
<b>VOLUME IIb : Main individual analysis</b>
Annex 2: Inventory
Annex 3: Results of survey to EU Delegations
Annex 4: CSP analysis
<b>Volume IIc: Country case studies and thematic case studies</b>
Country case studies
Annex 5: Burkina Faso
Annex 6: Democratic Republic of Congo
Annex 7: Ghana
Annex 8: South Africa
Annex 9: Zambia
Annex 10: Egypt
Annex 11: Moldova
<b>Volume IId: Country case studies and thematic case studies (continued)</b>
Annex 12: Afghanistan
Annex 13: Bangladesh
Annex 14: Philippines
Annex 15: Lao PDR
Annex 16: Ecuador
Thematic case studies
Annex 17: The European Commission and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
Annex 18: EC support to the health sector in fragile states
Annex 19: The European Commission and Global Public Goods (GPG) for Health
<b>Volume IIe: Terms of References, Definitions and Methodological remarks, References</b>
Annex 20: Terms of References
Annex 21: Evaluation Matrix
Annex 22: Methodology and tools used for the evaluation
Annex 23: Overview of sources used per indicator
Annex 24: Selection criteria and ranking for the 12 country case studies
Annex 25: Overview of selected interventions in the 12 case study countries
Annex 26: Overview of Budget Support operations in the 25 desk study countries
Annex 27: Statistical tables
Annex 28: Specific features of EC support to health in partner country regions
Annex 29: Consideration of cross-cutting issues in EC policies to the health sector
Annex 30: List of People Interviewed
Annex 31: Documents consulted





## Table of content

### Volume IIc

#### ACP countries

1	Annex 5: Country case study Burkina Faso.....	1
2	Annex 6: Country case study Democratic Republic of Congo .....	39
3	Annex 7: Country case study Ghana .....	71
4	Annex 8: Country case study South Africa .....	107
5	Annex 9: Country case study Zambia.....	150

#### Eastern and South European Countries

6	Annex 10: Country case study Egypt .....	183
7	Annex 11: Country case study Moldova.....	223

### Volume IId

#### Asian countries

- Annex 12: Country case study Afghanistan
- Annex 13: Country case study Bangladesh
- Annex 14: Country case study Philippines
- Annex 15: Country case study Lao PDR

#### Latin American countries

- Annex 16: Country case study Ecuador

#### Thematic case studies

- Annex 17: Thematic case study – GFATM
- Annex 18: Thematic case study – Fragile States
- Annex 19: Thematic case study – Global Public Goods

*Note: Each case study includes a detailed table of content.*



## 1 Annex 5: Country case study Burkina Faso

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

## Thematic case study BURKINA FASO



## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>5</b>
1.1.1	Country context of EC support.....	5
1.1.2	EU funds between 2002-2010 .....	5
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>7</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	7
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	8
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	10
1.2.4	JC 14 Increased or maintained quality of service provision .....	12
<b>1.3</b>	<b>EQ2- Affordability of health: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>13</b>
1.3.1	JC 21 The cost of basic health care services are reduced for households due to EC support.....	13
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC .....	14
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC .....	16
1.3.4	JC 24 Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC .....	17
<b>1.4</b>	<b>EQ 3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>18</b>
1.4.1	JC 31 Increase in availability of primary health care facilities .....	18
1.4.2	JC 32 Increase in availability of secondary health care facilities.....	18
<b>1.5</b>	<b>EQ4- Health service utilisation related to MNCH: To what extent has EC support to health contributed to improving health service utilisation related to MNCH? .....</b>	<b>19</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	19
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	24
1.5.3	JC 43 Children better protected from key health threats as a result of EC support.....	26
<b>1.6</b>	<b>EQ 5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?.....</b>	<b>26</b>
1.6.1	JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	26
1.6.2	JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.....	29
<b>1.7</b>	<b>EQ6- Coordination, complementarity and synergy : To what extent and how has the EC contributed to strengthening government-led coordination, 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>	<b>30</b>
<b>1.8</b>	<b>EQ 7 Financing modalities, funding channels and instruments: To what extent have the various financing modalities (GBS, SBS, other sector support, projects), funding channels and instruments and their</b>	

	<b>combinations, been appropriate, thus contributing to improving access to, equity of, and policy-based resource allocation in health? .....</b>	<b>30</b>
1.8.1	JC 73 JC 73 Increased cost-effectiveness and internal consistency of EC support .....	30
<b>1.9</b>	<b>Annex .....</b>	<b>32</b>
1.9.1	Key documentation used for the analysis .....	32
1.9.2	EU funds between 2002-2010 –detailed listing: .....	34
1.9.3	Overview of funds committed to the country’s health sector .....	37

### List of boxes

Box 1:	The essential drugs policy adopted by the Government and the creation of CAMEG .....	7
Box 2:	Health Infrastructures and resources –Health system in Burkina Faso .....	9
Box 3:	Health facilities and the provision of services in health facilities in Burkina Faso .....	9
Box 4:	Health insurance in Burkina Faso.....	14
Box 5:	EC support and the accessibility to health care services for the poor.....	15
Box 6:	The introduction of free ARV in Burkina Faso .....	15
Box 7:	Research supported by the EC in the health sector in Burkina-Faso.....	17
Box 8:	Proportion of deliveries supervised by a skilled attendant .....	20
Box 9:	L’intervention de l’UE a contribué à l’amélioration des services sociaux de base .....	20
Box 10:	Results and impacts of the EC project on “Integrated approach to the fight against HIV / AIDS in two urban districts of Burkina Faso” (C-060794).....	21
Box 11:	EC support regarding reproductive health.....	23
Box 12:	Effectiveness and impact of the “Prevention and treatment of STI / HIV / AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po” (C-78605) .....	24
Box 13:	Vaccination rate in Burkina Faso .....	25
Box 14:	The Trustfund CCIA (Comité de Coordination Inter Agences) / PEV (Programme Elargie de Vaccination) / GAVI – (Global Alliance on Vaccine and Immunization) .....	25
Box 15:	EC sectoral dialogue with the Ministry of Health .....	27
Box 16:	Political of the EUD in the Health sector.....	28
Box 17:	The EC support to the Ministry of Health concerning statistics .....	29
Box 18:	The EC support to PFM in the framework of ABRP 2002-2004 and 2005-2008 .....	29

### List of tables

Table 1:	Direct intervention in the health sector between 2002 and 2010 .....	6
Table 2:	General Budget Support to Burkina Faso between 2002 and 2010.....	6
Table 3:	Evolution of indicators related to Health between 2002 and 2006 and since 2008.....	8
Table 4:	Evolution de quelques indicateurs phares du PNDS, de 2008 à 2010.....	11
Table 5:	Health Infrastructures and resources – Health system in Burkina Faso .....	18
Table 6:	Evolution de quelques indicateurs phares du PNDS, de 2008 à 2010.....	19
Table 7:	Santé sexuelle et de la reproduction .....	20
Table 8:	Evolution of indicators related to Health 2002-2008.....	21
Table 9:	Contraceptive prevalence in Burkina Faso between 2002 and 2007 .....	22
Table 10:	Evolution of immunisation coverage for children from 0 to 11 Months (in %) .....	25
Table 11:	Evolution of indicators related to Health 2002 - 2008.....	26

## 1.1 Introduction

### 1.1.1 Country context of EC support

Burkina Faso is a landlocked country sharing its borders with Benin, Mali, Togo, Ghana, Niger and Ivory Coast. The population exceeds 16 million with the capital Ouagadougou, located in the centre of the country, being home to one and a half million. Ranked 181<sup>st</sup> of 187 countries according to the 2009 Human Development Index (HDI) and with a GDP (nominal) per capita of respectively USD 536 in 2010 (World Bank) and USD 670 in 2011 (International Monetary Fund, 2011 estimate), Burkina Faso is one of the poorest countries in the world. Despite the economic progress made, the population of Burkina Faso has remained extremely poor. The poverty rate has progressively increased from 44.5% in 1994 to 45.3% in 1998, 46.4% in 2003 and 43.9% in 2009 (forecast results of the last survey on living conditions of households - EICVM). Income poverty is primarily located in rural areas with 52.8% of individuals in these areas living below the poverty threshold. In the last years, turmoil have slightly increased, including the riots of February 2008 and 2011, when Burkinabè protests were dubbed by an uprising throughout the country, coupled with a military mutiny and a strike of the magistrates.

According to the Worldbank statistics, annual GDP growth has highly increased between 2002 and 2006 with around 3,5% annual growth, after three years of recession, and the numbers for 2010 reveal promising with 9,2% annual growth. These promising results are due to the implementation of structural reforms and of extensive investments.

The Burkina Faso healthcare system is divided in 13 regions and 63 health districts. Each district covers a population of between 150,000 and 200,000 people. Primary healthcare operates at a community level, providing Burkinabe with general medical needs or referrals to district hospitals; there were 43 district hospitals in the country in 2010. Secondary healthcare is provided in any of nine central hospitals; patients are normally referred to one of these facilities after seeking medical advice from a district healthcare provider. Tertiary healthcare is provided via three central hospitals (university hospitals) based in the main cities of Ouagadougou and Bobo-Dioulasso. There are a handful of private clinics in Burkina Faso, 380 private structures in 2010, mostly found in the cities. The national and regional hospitals have great autonomy in terms of finance and personnel management, meaning hospitals are allowed to retain fees from patients and medications sold.

Despite steady recorded progress over the last years, notably in immunisation of children, access for numbers of Burkina Faso's most vulnerable children to primary health care or basic education is non-existent, very limited, or it comes too late. Many Burkinabe are unable to afford a contribution towards medical treatment costs, limiting their treatment options to government medical facilities. The healthcare system in Burkina Faso came under scrutiny in 2010 by Amnesty International, who highlighted the fact that maternal care was corrupt, lacked adequate medical equipment and qualified medical staff, resulting in a high number of deaths each year linked to child birth.

Many towns and villages are remote. While certain services of public healthcare are subsidised, access is still not possible to all as some payments still need to be made by the patient out-of-pocket (approx. 40%). The cities and large towns are home to the better quality medical care centres, with rural areas having very limited access to facilities. Outside the capital, the quality of medical care declines and is virtually non-existent in rural areas.

There are a number of major infectious diseases that severely affect Burkina Faso; they occur under different circumstances and times of the year, such as the annual meningitis epidemic which spreads quickly from January to May, but the risk declines when the rainy seasons start. However, the threat from water borne and vector borne diseases increases when rainy season arrives (May to September) resulting in growing epidemics.

### 1.1.2 EU funds between 2002-2010

The European Union's Cooperation Strategy in Burkina Faso between 2002 and 2010 covered implementation of the 9th and 10th EDFs. The focal sectors have been: infrastructure including road transport and water and sanitation, macroeconomic support via the MDG contract which includes a focus on health and education, food security and rural development. Outside the focal sectors, the EU supported culture, business, regional integration, environment, gender, HIV and human rights.

The cooperation strategy between the EC and Burkina-Faso defined in the National Indicative Programme (NIP) for the 9th EDF, the NIP (2001-2007) totalled EUR 351 million at the start of programming, divided between: support for the macroeconomic framework by means of budget support; two sectors of concentration (transport and rural development/food security); and actions scheduled outside the focal sectors, in particular institutional support.

Health has never been an EC focal sector in Burkina Faso in the past decade. Direct support to the health sector was minor during the evaluation period. Some support has been provided during the 8th

and 9th EDF in supporting EC-Member State NGOs in the field of HIV/AIDS and reproductive health. A TA was also provided to the Ministry of Health. Most of the funds went to the sub-sector “basic health” and all of them were delivered via a project modality.

The following table gives an overview on the direct health intervention in Burkina Faso.

*Table 1: Direct intervention in the health sector between 2002 and 2010<sup>1</sup>*

<b>Contract Title</b>	<b>Decision number</b>	<b>Contract number</b>	<b>Contract year</b>	<b>Decision year</b>	<b>Contracted amount</b>
AT JURIDIQUE AU MINISTERE DE LA SANTE	FED/2002/01 6-032	188567	2002	2002	48.456€
Appui a la direction regionale sanitaire de Ouahigouya dans la mise œuvrre de son plan de développement sanitaire - Burkina Faso	ONG-PVD/2003/00 4-562	63626	2004	2003	749.791€
Prévention et prise en charge des IST/VIH/SIDA auprès des femmes vulnérables des villes de Ouagadougou, Bobo-Dioulasso et PÔ	SANTE/2004 /006-079	78605	2005	2004	2.002.500€
Projet d'approche solidaire en santé génésique	SANTE/2004 /006-082	100641	2005	2004	1.618.623€
Forum médias et développement : Services de santé et logistique conférence de presse	(blank)	164794	2008	(blank)	2.973€
Appui au développement de stratégies municipales de santé à Bamako et Ouagadougou	(blank)	221876	2009	2009	930.915€

Source: CRIS database, Particip GmbH analysis

The health sector has been addressed by the EC indirectly through general budget support. Especially within the MDG contract (2009-2012) variable tranches are based to health performance indicators. In total, Burkina Faso received EUR 514 million general budget support.

*Table 2: General Budget Support to Burkina Faso between 2002 and 2010*

<b>Name of the intervention</b>	<b>Amount contracted between 2002 and 2010</b>
APPUI BUDGETAIRE REDUCTION PAUVRETE 2001 (ABRP 2001)	€38.323
	(total of GBS contracted : €20.038.323)
Appui budgétaire pour la réduction de la pauvreté ABRP 2002-2004	€2.299.865
APPUI BUDGETAIRE POUR LA REDUCTION DE LA PAUVRETE 2005-2008	€191.762.822
CONTRAT OMD ABCRP 2009-2014 (APPUI BUDGETAIRE POUR LA CROISSANCE ET LA REDUCTION DE LA PAUVRETE)	€320.142.936

Source: CRIS database, Particip GmbH analysis.

<sup>1</sup> The inventory only takes into account funds provided through EDF or thematic budget lines of DG DEVCO which directly target the country. Multi-country projects are difficult to identify in CRIS and are thus only included in an ad-hoc manner. Further, the inventory excludes other EC funds such as ECHO or research grants, e.g. FP7 .



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

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

#### Indicators

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

#### 1.2.1.1 Findings per indicators

**I-111** Under the period of evaluation, the EC funded Budget Support, i.e. ABRP (*Appui budgétaire pour la réduction de la pauvreté*) 2002-2004, ABRP 2005-2008 and ABRP 2009-2014 (MDG contract), have been supporting the national strategies, mainly the implementation of the PRSP (CSLP) but also the PNDS (*Plan National de Développement Sanitaire*).

The PNDS outlines the orientation of the “National Health Policy in Burkina Faso” which was adopted in 2000, covering the period between 2001 and 2010. The second objective of this policy was specifically designed to improve the quality of health services provided in the country. The specific objectives are/were: (i) To develop a national strategy on the health services quality and (ii) to ameliorate the availability and accessibility of essential drugs as per WHO recommendations.

**Box 1:** *The essential drugs policy adopted by the Government and the creation of CAMEG*

*Pour faire face aux difficultés d'approvisionnement du secteur public et à la faveur de la politique des médicaments essentiels adoptée par le gouvernement, une Centrale d'Achat des Médicaments Essentiels Génériques et des consommables médicaux (CAMEG) a été mise en place pour appuyer l'Initiative de Bamako. La dévaluation du franc CFA en janvier 1994 a accéléré la création des dépôts de Médicaments Essentiels Génériques (MEG) dans les formations sanitaires. La réforme pharmaceutique a intéressé, entre autres, les volets suivants : la législation et la réglementation pharmaceutiques, l'approvisionnement, la production locale, la distribution y compris les remèdes traditionnels issus de la pharmacopée traditionnelle, l'assurance qualité des médicaments, l'usage rationnel, l'information et la promotion des médicaments, l'accessibilité financière aux médicaments.*

*Malgré les nombreux acquis dans le secteur pharmaceutique, quelques insuffisances persistent : il n'existe pas un plan de développement des structures de production et de distribution des médicaments, les textes législatifs et réglementaires existants sont inadaptés et ne sont pas toujours appliqués, l'usage des médicaments est souvent inapproprié, favorisant la vente illicite des médicaments et l'automédication, le médicament reste inaccessible financièrement à la majorité de la population.*

It is safe to conclude that EC budget support contributed to the adoption of this policy on access to essential drugs.

**I-112** In Burkina Faso, improving healthcare services and the availability of pharmaceutical products constitute growing concerns for the population.

One of the objectives of the National Health Policy in Burkina Faso included in the PNDS was to “improve the availability of essential medicines quality and accessibility” and the “percentage of districts that have not been out of stock for the ten most commonly used molecules” has been chosen as an indicator to be monitored.

In the framework of the Budget Support funded by the EC over the evaluation period, the accessibility of essential drugs had been selected as one of the indicators related to health for the payment of the variable tranche.

Between 2002 and 2006, there has been a significant improvement of this indicator in Burkina Faso. The availability of essential drugs (*Médicaments Essentiels Génériques*-MEG) in health care facilities (*Centre de Santé et Promotion Social*-CSPS)<sup>2</sup> has considerably improved. As shown by Table 3, the percentage of health care facilities without shortage in essential generic drugs has increased from 74.6% to 91.8% between 2002 and 2010.

The evolution of these indicators since 2008 has been reported in Table 3.

<sup>2</sup> The indicator is: “Pourcentage de CSPS sans rupture en MEG.”

Table 3: Evolution of indicators related to Health between 2002 and 2006 and since 2008

	2002	2003	2004	2005	2006	Base-line	2008 Réalisation (Cible)	2009 Réalisation (Cible)	2010 Réalisation (Cible)
Taux de couverture vaccinale rougeole (%)	64,1	71,1	77,7	84,0	88,0	93,9	97,6 (95)	99,4 (100)	99,3 (100)
Taux de CPS respectant la norme en personnel (%)	76,6	76,8	75,8	77,1	nd	76,0	76,8 (78,0)	83,2 (79,0)	83,1 (85,0)
Taux d'accouchement assisté (%)						54,6	64,0 (57,0)	70,7 (64,0)	76,0 (72,0)
% de dépôt de molécules essentielles au niveau des CPS n'ayant pas connu de rupture sur les 20 médicaments traceurs	74,6	73,3	94,8	91,3	92,92	94,5	95,0 (>=95)	91,5 (>=95)	91,8 (>=95)
Nombre de nouveaux contacts par an						0,43	0,50 (0,45)	0,56 (0,51)	0,64 (0,59)

Source : 2002-2006 : Note de dossier, Convention de financement 9361/BK - ABRP 2005-2008, Décaissement de la tranche fixe macroéconomique 2007, Examen des conditions générales et spécifiques, May 2007, p.3 ; 2008-2010 : Annexe à l'aide mémoire, Rapport technique, Délégation de l'Union Européenne au Burkina Faso, p.10.

These data provide evidence of EC contribution towards improvement in these indicators. It should be noted that there has been a change in the definition of the indicator related to the availability of essential medicines as of 2009, from 10 MEG to 20 "medicaments traceurs".

### 1.2.1.2 Resume of the JC

Between 2002 and 2010, the percentage of health care facilities without shortage in essential generic drugs has increased from 74.6% to 91.8%.

The Accessibility of Essential Drugs has been selected as performance indicator in the framework of the Budget Support funded by the EC over the evaluation period.

Since access to essential drugs was a key component of the national plan that was supported by EC budget support, it is safe to conclude that the EC contributed in some degree to progress.

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

### Indicators

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

### 1.2.2.1 Findings per indicators

**I-121** There has been an increase in the coverage of sanitation infrastructure with 1,429 Health care facilities (*Centre de Santé et Promotion Social* - CSPS) recorded in 2010 compared to 1,072 in 2000. The ratio of CSPS by inhabitant, however, decreased from around one CSPS for 11,000 people to one CSPS for 9,813 inhabitants<sup>3</sup>.

<sup>3</sup> Ministère de la santé (2010) : Annuaire statistique 2010.

**Box 2: Health Infrastructures and resources –Health system in Burkina Faso**

« Le nombre de formations sanitaires publiques a sensiblement augmenté ces dernières années, passant de 975 en 1996 à 1072 en 2000 et 1487 en 2006. Cette augmentation est le fait du secteur primaire, avec les Centre de Santé et Promotion Social (CSPS) passant de 721 en 1996, à 798 en 2000 et 1.211 en 2006. [...]»

Cela s'est traduit par une diminution du rayon moyen d'action qui est passé de 9,4 à 7,8 kms. Le ratio CSPS par nombre d'habitants a en revanche très peu varié (il reste aux alentours d'un CSPS pour 11.000 habitants) car la population augmente à un taux pratiquement aussi rapide que celui du nombre de formations sanitaires. L'augmentation de la dépense globale de santé enregistrée entre 2003 et 2005 par les comptes nationaux de la santé n'est pas seulement le reflet d'une véritable augmentation de la dépense, mais aussi le fait que la méthodologie de collecte de l'information s'est affinée (notamment avec le recours à l'outil ENRDS (ou NASA) d'estimation des dépenses dans le domaine de la lutte contre le VIH/SIDA). Ainsi, ce sont près de 24 milliards de FCFA qui ont été ajoutés à l'estimation initiale pour 2005 (qui était de 178 milliards). »

Source: Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso (May 2008).

Between 2005 and 2008 the EC supported the construction of maternity hospitals in the framework of the project of "Prevention and treatment of STI/HIV/AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po" (C-78605). The construction of two maternity hospitals, maternity homes and rehabilitation of 12 health facilities in 30 districts in the area of Ouagadougou, Banfora and Po had started in 2006.<sup>4</sup> However the ROM report from 2007<sup>5</sup> does not indicate the results achieved regarding this activity, which could be further investigated during the fieldwork.

While there has been an increase in the number of primary health care facilities, this has barely kept pace with population increase which is growing at 3.1% according to the 2006 census. No information has been gathered on whether geographic disparities have been addressed. While the EC provided a few maternity facilities under an NGO project, no major direct contribution has been found. It is possible that budget support created fiscal space that helped Government to expand the number of PHC facilities.

**I-122** In the early 2000s, the basic equipment and medicines were lacking in health facilities and the most qualified staff was mostly concentrated in large urban area. The access to health facilities and the provision of services in health facilities in Burkina Faso has improved. However, it should be noted that these rates remain low and very uneven across regions.

**Box 3: Health facilities and the provision of services in health facilities in Burkina Faso**

« On note une amélioration des indicateurs de fréquentation et de fournitures de services dans les formations sanitaires au Burkina Faso. Cependant, on note également que ces taux restent faibles et très inégaux entre régions. Par ailleurs, on voit, avec la Table 5, que si le rayon d'action des formations sanitaires a eu tendance à diminuer, ce qui indique une plus grande proximité mais les disparités régionales / intra-districts importantes existent. On constate aussi que l'adéquation des ressources en personnel, indicateur de qualité des services, a tendance à stagner, voire reculer, y compris dans les dernières années de l'évaluation [2000-2007].»

La situation est assurément très différente de ce qu'elle était au début des années 2000 lorsque les équipements de base et les médicaments manquaient dans les formations sanitaires tandis que les personnels les plus qualifiés étaient, pour une bonne part, concentrés dans les grands centres urbains (avec un tiers des médecins du secteur public dans les services centraux du ministère). Les ressources de l'Etat (donc avec la contribution de l'ABG) semblent désormais davantage mobilisées pour le financement des activités tendant à confronter spécifiquement les conditions les plus impliquées dans le mauvais état de santé de la population (paludisme, tuberculose, santé génésique, VIH/SIDA notamment).»

Source: Particip (2008), Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso.

Between 2005 and 2008 the EC supported the equipment of maternity hospitals in the framework of the project C-78605, which has achieved the following activities among others:

- Equipment of 17 centers Maternal and Child Health (MCH) of health care facilities in Ouagadougou, Po and Banfora that had been achieved in 2006.
- Equipment for maternity in order to improve the quality of care given to women in health facilities that has been achieved in 2006.

<sup>4</sup> Medicos des Mundo (2006) : Rapport narratif intermédiaire - Projet de prévention et prise en charge des IST/VIH/SIDA auprès des femmes vulnérables de Ouagadougou, Bobo-Dioulasso, Banfora Et Po financé par la Commission Européenne, 01 juillet 2005 – 31 août 2006.

<sup>5</sup> Danish Management (2007) : Monitoring Report n°002093.01, 15/06/2007.

- Purchase and distribution of drugs for treatment of STIs in 26 health facilities that had been achieved from April 2006.<sup>6</sup>

### 1.2.2.2 Resume of the JC

Some EC interventions concerning physical structure of facilities and equipment can be highlighted at project level, as for example the equipment of maternity hospitals in the framework of the project of "Prevention and treatment of STI / HIV / AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po."

At a national level, there has been an overall increase in the number of PHC facilities between 2000 and 2006 with 1,429 CSPS recorded in 2010 compared to 1,072 in 2000. The ratio of CSPS by inhabitant, however, almost remained constant (around one CSPS for 9813 inhabitants) as the population increased almost as fast as the number of health facilities. Geographic distribution remains uneven and inequitable.

The EC contributed indirectly through GBS to the health infrastructure in the country. According to the EUD, it is difficult to define and quantify the equipment availability in primary and secondary health facilities provided through GBS, and therefore the latter's impact. The issue of equipment availability in health facilities is complex and raised the following comments: (i) seen from one side we can definitely say that the quality of health infrastructures (physical structure of facilities, equipment) has been reinforced and ameliorated throughout the country in recent years. (One year ago a study was launched in order to measure what the GBS has done in the health sector; but at the end this became a pure academics exercise with doubtful results). On the other hand (ii) this vertical approach raised concern regarding the maintenance aspect of those infrastructures and equipments.

According to the EUD, the issue of maintenance remains crucial and did not receive the deserved attention because in general it is not seen as "sexy" by donors. Problems also arise due to differences in the purchase approaches between departments inside MoH. Additionally no indicators are available in this area and therefore there is not a proper follow up and the issue of quality control and inspection remains. For sure this is a much neglected area in need of attention.

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

#### Indicators

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

#### 1.2.3.1 Findings per indicators

**I-131** Overall the number of key health workers (doctors; nurse/midwives) per 10.000 inhabitants has increased in Burkina Faso. According to the statistics from the Ministry of Health, the densities of nurses and midwives per 1,000 population increased from 0.54 in 2005 to 0.71 in 2008. The densities of physicians per 1,000 population remained unchanged (0.06 per 1,000) over the same period.<sup>7</sup>

According to the EUD, GBS definitely has contributed to strengthen human resources.

**I-132** At national level, the training of general practitioners is given in the public universities of Ouagadougou and Bobo-Dioulasso and in the private University of Saab. Some specialties and the training of pharmacists are given at the University of Ouagadougou. The training of nurses, technicians and midwives is provided by the National School of Public Health ("Ecole nationale de santé publique", ENSP). Other public training centres that have been created in Koudougou, Fada Tenkodogo and Ouahigouya provide training of paramedical staff. These public facilities are enhanced by the opening of a private structure for the training of midwives.

Between 2005 and 2008, the EC supported the training of health workers in the framework of the project of Prevention and treatment of STI/HIV/AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po with the following activities:

- Completion of three courses of five days on recycling in the syndromic management of STIs in the direction of health workers of the health district of Po and Banfora in April, May and June 2006. In total 59 staff have been trained.

---

<sup>6</sup> Medicos des Mundo (2006).

<sup>7</sup> Source: Worldbank Statistics.

- Conduct a five-days training to medical care for people living with HIV for health workers in the sector of the health district of Ouagadougou and 30 staff of the association AJPO Ouagadougou. In total 28 people were trained.
- Conduct training for community health workers to care for those infected and affected by HIV / AIDS during the second period of the project.

Furthermore, we may infer that the EC budget support had an impact on the availability of qualified human resources, as the percentage of CSPS meeting the standards on health workers (including in terms of qualification), was selected as indicator for the payment of the variable tranche of the BS over the period of evaluation, i.e. the ABRP 2002-2004, ABRP 2005-2008 and the MDG contract for 2009-2014. As shown on Table 4, the objective of 80% set for 2010 had been met with 86.9% of CSPS meeting the minimal standards on health workers.

Table 4: Evolution de quelques indicateurs phares du PNDS, de 2008 à 2010

Indicateurs	02	03	04	05	06	07	08	09	10	Cible du PNDS 2010
Rayon moyen d'action théorique (km)							7,54	7,5	7,3	7,2
Nombre de nouveaux contacts/habitant/an au niveau district							0,50	0,56	0,65	0,53
Pourcentage de CSPS remplissant la norme minimale en personnel							76,8	83,2	86,9	80
Pourcentage de DMEG n'ayant pas connu de rupture des 20 médicaments traceurs							95,0	91,5	90,8	≥95
Taux d'occupation des lits au niveau des hôpitaux (%)							52	49,4	43,7%*	n.a.
Taux d'accouchements assistés (%)							64	70,7	73,4	73
Taux d'accouchements assistés y compris les hôpitaux (%)	39,9*	30,1*	33,5*	37,8*	37,8*	42,9*	64**	70,7**	75 73,4**	73**
Taux d'utilisation des méthodes contraceptives (%)	14,48***	15,85***	16,39***	21,89***	24,34***	26,16***	27,9**	26,6**	30,1**	n.d.
Taux de couverture en CPN 2 (%)							69,9	73,8	72,8	78
Taux de couverture en CPN 4 (%)							16,9	20,5	22,2	n.d.
Proportion des césariennes réalisées								0,8	0,9	n.a.
Létalité palustre chez les enfants de moins de cinq ans							2,5	2,9	2,7	n.a.
Létalité palustre chez les femmes enceintes							0,7	1,1	1,6	n.a.

Source : *Annuaire statistiques 2008, 2009 ; DGISS 2010 ; rapport de progrès 2008, 2009, in Ministère de la Santé (2011): Revue du secteur de la santé au titre de l'année 2010, Burkina Faso, Version provisoire du 24 février 2011; \* Particip (2008); \*\* Ministère de la Santé (2011): Revue du secteur de la santé au titre de l'année 2010, Burkina Faso, Version provisoire du 24 février 2011; \*\*\* Annuaire statistiques DEP/Santé, Mai 2007.*

**I-133** Health worker attrition is high and mainly due to migration: (i) From rural to urban setting because of lack of opportunities for development and difficult conditions of life, and (ii) from public to



private and to international organisations including INGOs because of financial motivation and career development.

The issue of health workers attrition has been partially addressed by the following MoH actions: (i) Policy for HRH development (2002); (ii) MOH study on motivation of HRH (managers in 2003) and (iii) Action plan for the motivation of HRH (2004). There is no evidence so far of such intervention after 2004.

There is no evidence of direct EC support in addressing this problem. However, under its Migration and Asylum budget line, the EC supported a World Bank initiative to better make policy for and manage the migration of health professionals in Africa (MTR of EC assistance to third countries in the areas of migration and asylum, 2010).

The issue of health workers absenteeism has partially been addressed by: (i) MOH study on motivation of HRH (managers in 2003) and (ii) Action plan for the motivation of HRH (2004). A national action plan is under construction at the end of the evaluation period. There is no evidence of direct EC support to these endeavours.

### 1.2.3.2 Resume of the JC

At this stage of the evaluation, it seems that the use of the GBS could have contributed to improve the availability of qualified human resources for health but we may infer that the EC Budget support has an impact on the availability of qualified human resources as the percentage of CSPS meeting the standards regarding health workers (including in terms of qualification) is one of the indicators for the payment of the variable tranche of the BS over the period of evaluation, i.e. the ABRP 2002-2004, ABRP 2005-2008 and the MDG contract.

### 1.2.4 JC 14 Increased or maintained quality of service provision

#### Indicators

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities)
- I-142 Clinical treatment guidelines available, disseminated and applied
- I-143 Percentage of people who are satisfied with the quality of the services (by facility and specific service provider: physician, dentist, nurse, etc.)

#### 1.2.4.1 Findings per indicators

**I-141** Overall, it seems that the quality of health service has been problematic in Burkina Faso: “*Des préoccupations importantes restent et notamment: La problématique de l’amélioration de la qualité des services de santé, qui n’est pas suffisamment abordée. A côté de l’extension de la couverture sanitaire, il faut une amélioration significative de la qualité des prestations, pour garantir un meilleur niveau de santé des populations.*”<sup>8</sup>

One of the highlighted weaknesses of the Burkina Faso Public Health System was actually the lack of an efficient and effective **quality assurance mechanism** at facility level. This was addressed in the 2000-2010 “Plan National de Développement Sanitaire (PNDS)” and resulted in the 2003 “Programme National d’Assurance Qualité en Santé.” However, the implementation of these mechanisms/recommendations is far from optimal.

However, there is no evidence that EC intervention has affected this indicator.

**I-142** In the health sector a vast range of treatment guidelines for health sectoral topics (e.g. PHC, EPI, MNCH, Malaria, TB, HIV/AIDS, etc.) are available in Burkina Faso. They are mainly derived and/or translated by WHO, UNICEF, UNFPA, UNAIDS, guidelines and/or from main multi/bilateral donors as USAID, WB and ADB. In general, these guidelines are disseminated at peripheral level; however, it is not possible to quantify the percentage or rate of dissemination and real implementation of those treatment guidelines in the field.

However, there is no evidence that EC intervention has affected this indicator.

---

<sup>8</sup> EAMR 01/2011

**I-143** A study on the quality of care of modern health services as perceived by users and non-users<sup>9</sup> has been carried out in Burkina Faso because only one-fifth of the population in rural area used modern health services. Both users and non-users were relatively positive about health personnel practices and conduct (77% versus 70% of the maximum attainable score) and about health care delivery (77% versus 74%). They were less positive about the adequacy of resources and services (51% versus 46%) and financial and physical accessibility of care (57% versus 51%). Both groups were very negative regarding the availability of drugs (33% versus 27%). Users were more positive than non-users overall (66% versus 61%) and especially regarding payment arrangements (51% versus 43%) and costs (50% versus 40%). Observed differences were generally significant. Unfortunately, we have only a snapshot view from 2005 and cannot establish a time trend.

Given that "client satisfaction" is the resultant of numerous components of health services, EC support might have contributed to any of the changes observed.

#### 1.2.4.2 Resume of the JC

At this stage of the evaluation, there is no evidence that EC intervention has contributed substantially to improving the quality of service provision, with the exception of HIV/AIDS and reproductive health domain, where projects were active.

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

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

##### Indicators

- I-211 Change in proportion of health spending out of pocket
- I-212 Change in share of health expenditure financed by social security schemes
- I-213 Change in public and private health insurance tax/contribution rates.
- I-214 Change in proportion of the population covered by public health insurance / enrolled in the public health scheme

##### 1.3.1.1 Findings per indicators

**I-211** Due to a significant increase in the share of health expenditure financed by the public sector, the share of out of pocket payments in total health expenditure is reported by WHO to have declined from 52.9% to 35.6% between 2002 and 2009.

In the framework of the budget support funded by the EC over the period of evaluation, in particular the ABRP 2002-2004 and the MDG contract, one of the indicators for the payment of the variable tranche concerns the evolution of medical costs procedures (IB5). The "Reduction of health services and drug costs" is a key component of the National Plan in the Health Sector (PNDS) between 2001 and 2003. The PRSP clearly defines the areas of implementation: (i) pregnancy, reduction of costs related to vaccination, (ii) reduction of costs related to deliveries, and (iii) cost efficiency related to access to care. Whether there was progress on these indicators is not known.

According to the EUD, the GBS had the merit to encourage the expansion of the public sector role in health care finance and therefore reducing/decrease in out-of pocket payment (from 50% in 1999 to an actual 40% in 2012).

**I-212** Overall, the Social Security of health as % of general government expenditure on health has decreased from 0.8% in 2000 to 0.4% in 2008. The change is insignificant.

However, there is no evidence that EC intervention has affected this indicator.

---

<sup>9</sup> Rob Baltussen and Yazoume Ye (2005): Quality of care of modern health services as perceived by users and non-users in Burkina Faso, Institute for Medical Technology Assessment, Erasmus MC, Rotterdam, The Netherlands and Department of Tropical Hygiene and Public Health, Heidelberg University, Heidelberg, Germany. *The study compared the perceived quality of care of 853 pairs of users and non-users of modern health services. (Private and Public) Non-users were matched to users on age, sex, occupation of the head of the household and distance to health post. Questions were structured according to four dimensions of quality of care. Nouna health care district, Burkina Faso.*

**I-213** The EAMR 01/2011 underlined the fact that the share of health costs to be paid by households is very high and that it is urgent to accelerate the implementation of risk-sharing mechanisms (universal health insurance) and to develop the possibility of subsidising care for the poorest and/or vulnerable groups.

**Box 4:** *Health insurance in Burkina Faso*

*« La part des dépenses de santé supportée par les ménages reste très lourde et il est urgent d'accélérer la mise en œuvre des mécanismes de partages de risques (l'assurance maladie universelle) et de continuer la réflexion sur la possibilité de subventionner les soins pour les plus pauvres et/ou les groupes les plus vulnérables.*

*L'efficacité des dépenses reste une préoccupation.*

*La gestion des ressources humaines pour la santé devrait être améliorée avec la prise en compte des dimensions production, recrutement, déploiement, rétention et motivation du personnel, ainsi la mise en place d'une base de données fiables sur ce sujet.*

*La participation communautaire et le rôle du secteur privé devraient occuper une place plus importante dans le développement du système de santé.*

*La nécessité de garantir l'accès universel à des interventions à gain rapide, notamment dans le domaine de la santé maternelle et infantile. »*

Source : EAMR 01/2011

Despite flagging the challenge, the EC does not appear to have contributed to developing universal health insurance (not quite the same as a social security scheme, but close enough to be discussed under this indicator).

Overall, private pre-paid plans as % of private expenditure on health have increased from 1% in 2000 to 3.4% in 2008. This represents a significant development, but private health insurance is exclusively the purview of the international community and the well to do in Burkina Faso.

**I-214** There is no evidence that EC intervention has affected this indicator.

### 1.3.1.2 Resume of the JC

The thrust of EC support has been to fill gaps in the availability of health care and policy related to provision of health care, not issues of financing. There is little evidence that EC support to health contributed to increasing affordability of health care, especially for the poor.

According to the EUD, the GBS had the merit to encourage the expansion of the public sector role in health care finance and therefore reducing the out-of-pocket payment (from 50% in 1999 to an actual 40% in 2012).

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

#### Indicators

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

#### 1.3.2.1 Findings per indicators

**I-221** One of the objectives of the Government of Burkina Faso in the Health sector is to reduce the cost of access especially in the periphery and for the poorest and most vulnerable people.

The MTEF 2007-2010 shows that the cost of care remains a very important factor impeding access to health services, which has been confirmed by most of the persons interviewed during the fieldwork conducted for the previous health evaluation. A subsidy for childbirth has been created since 2007, and has contributed to increase in the proportion of births assisted by trained personnel. This grant was not financed by the sector's common basket Programme for Health Development (*Programme d'Appui au Développement Sanitaire- PADS*), but should be attributed to the increase of resources allocated by the Ministry of Health, so it can be partly attributed to the EC funded budget support. In some projects, EC interventions have taken into account the financial difficulties of access by subsidising inputs or creating financing mechanisms that enable the poor to benefit from the programmes.

However, the EC had no specific or systematic policy to develop funding mechanisms to improve the accessibility to health care services for the poor (through technical assistance or specific study for example).



**Box 5: EC support and the accessibility to health care services for the poor**

« Le CDMT 2007-2010 montre que le coût des soins demeure un facteur très important freinant l'accès aux services de santé, cela est confirmé par la plupart des personnes interviewées dans le cadre de notre travail de terrain. Cependant, dans le cas de l'accouchement, un subventionnement de celui-ci depuis 2007, a contribué à l'augmentation des taux d'accouchements assistés par du personnel qualifié. Ceci est à mettre au crédit de l'augmentation générale des ressources du secteur. Du fait que cette subvention n'était pas inscrite au programme du PADS, il faut donc l'attribuer à l'augmentation des ressources propres de l'Etat allouées au Ministère de la Santé, donc à l'ABG en partie. Dans le cadre de certains projets (comme celui de Médecins du Monde dans le VIH/SIDA ou de l'Institut de Médecine Tropical d'Anvers en santé génésique), les interventions prennent en compte les difficultés d'accès financier en subventionnant des intrants ou créant des mécanismes de financement qui permettent aux indigents de bénéficier des programmes. L'évaluation du programme menée par le FNUAP sur financement de la CE note, de son côté, que les besoins des plus pauvres n'ont pas été particulièrement pris en compte dans les activités menées, ni leur difficulté d'accéder financièrement aux services de santé génésique. Néanmoins, dans le domaine de la lutte contre la malnutrition, les activités menées par les financements communautaires (ECHO, lignes budgétaires) ont, à l'évidence, concerné des populations particulièrement indigentes (enfants en malnutrition aiguë dans plusieurs régions du pays). Les activités du SAMU social se sont portées sur les enfants des rues de Ouagadougou, une population bien entendu très défavorisée. »

Source: Particip (2008)

More specifically, for the persons living with HIV/AIDS, some improvements have been highlighted during the first semester of 2010 as free ARV has been introduced in Burkina Faso.<sup>10</sup> Heavily supported by the GFATM, this is an example of an indirect EC support to improvement in this indicator as the EU (EC + member states) finance over half of the GFATM.

**Box 6: The introduction of free ARV in Burkina Faso**

« Plusieurs progrès ont pu être notés au 1er semestre 2010 : L'organisation des deuxièmes Etats généraux de la santé en février 2010 et de la 1ère Revue Sectorielle santé fin mars 2010, (ii) la prise en compte, des Interventions à haut impact sur les OMD dans la matrice des mesures et actions 2010-12, (iii) l'institution de la gratuité des ARV [Anti retro viro] à partir de janvier 2010, (iv) L'adhésion du Burkina Faso au partenariat international pour la santé et initiatives connexes (IHP+), (v) la validation du cadre stratégique de lutte contre le VIH, le SIDA et les IST 2011-2015. La plupart des indicateurs sont en progrès même si certains, comme le taux de rupture des MEG ont connu une contreperformance et les disparités régionales demeurent importantes. Le taux de séroprévalence VIH en population générale continue de décroître et est actuellement estimé à 1,2% (OMS / ONUSIDA). La politique de gratuité des soins préventifs et promotionnels a probablement eu des effets positifs sur les indicateurs de santé, même si l'information des populations sur ces subventions reste insuffisante et qu'un meilleur suivi de ces interventions et l'évaluation de leur impact doivent être faits. »

Source : EAMR 7/2010

**I-222** No data on household consumption of health care services has been found and there is no evidence that EC intervention has affected this indicator.

**1.3.2.2 Resume of the JC**

One of the objectives of the Government of Burkina Faso in the Health sector is to reduce the cost of access especially in the periphery and for the poorest and most vulnerable people.

Some improvements have been made:

- A **subsidy for childbirth** has been created since 2006, and has contributed to increased rates of births assisted by trained personnel. This grant was not included in the PADS program,<sup>11</sup> but should be attributed to the increase of resources allocated by the Ministry of Health, so it can be partly attributed to the EC funded GBS.
- For the **persons living with HIV/AIDS**, some improvements have been highlighted during the first semester of 2010 as free ARV has been introduced in Burkina Faso. This can be attributed in part to EC support of the GFATM.

In some projects, EC interventions have taken into account the financial difficulties of access by subsidising inputs or creating financing mechanisms that enable the poor to benefit from the programmes. However, the EC had no specific or systematic policy to develop funding mechanisms to improve the accessibility to health care services for the poor (through technical assistance or specific study for example).

<sup>10</sup> Source: EAMR 7/2010.

<sup>11</sup> The PADS, launched in 2005, is a common basket fund supported by donors in which the EU does not contribute aiming at supporting the main interventions of PNDS (National Health Development Plan).

The EAMR 01/2011 underlined the fact that it is urgent to accelerate the implementation of risk-sharing mechanisms (universal health insurance) and to develop the possibility of subsidising care for the poorest and/or vulnerable groups. However, apart from identifying the need, the EC has played no role.

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

#### **Indicators**

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

#### **1.3.3.1 Findings per indicators**

**I-231** According to the EUD, an advantage of the GBS has been its focus on sustainable finance and provisional financing mechanism. However, it has to be mentioned that the EC has been among the few donors that look at PFM, as other donors financing the basket fund.

According to the EUD, the complementarity of the GBS must be highlighted. Through it, there is the need to look at health sector finances as well as to PFM. This makes the added value of the GBS. Allocation for health ministry has been an indicator of the CSPL. Although also the Worldbank provided its support via GBS, the EUD was the only donor looking at the process side.

According to the MoH GBS (including GBS also from other donors than EC) played in general a supportive role in encouraging the expansion of the public role in health care finance. According to the most recent health indicators the overall financial support to the health sector has increased. Specifically the EC support enhances and strengthens four major topics in the health sector: (i) MNCH; (ii) Epidemiology; (iii) Overall health politic and (iv) Pharmaceutical sector. The interviewee also stressed the specific positive, active and very much appreciated technical support of the EUD.

**I-232** The EC has not been involved in the basket fund which has been the main instrument of the sectoral approach in Burkina Faso. The EUD has actively been involved in sector dialogue with the Ministry of Health and with other partners. It has participated in a number of committees and commissions, and monitoring the implementation of PNDS (joint outputs). However, the staff available for this was very small: the person in charge of the health sector follows also the budget support aspects related to health. From 2006 to 2009 1,5 persons are covering the health sector within the delegation, according to the EUD. In 2009, the staff in charge of health has been reduced to one person. This means that the work load of EC staff is rather high.

Moreover, the regularity of meetings and activities of these committees has been variable and the time between them tended to increase. The coordination of the EUD with the Ministry of Health did not appear to be very good at the beginning of the evaluation period, which made the effectiveness of sectoral dialogue more difficult.<sup>12</sup> According to the EUD the reasons for the difficulties to carry out an effective sector dialogue can on one hand be seen in the “newness” of the GBS modality. On the other hand, the EUD does not participate in the big health basket fund, which makes the EUD less visible within the donor landscape.

It is not known to what extent the EC promoted better coordination between the Ministries of Health and Finance. According to the EUD, better coordination has been systematically encouraged by the EUD for a long time, e.g. via EC involvement in the elaboration of the PRSP and the dialogue targeting to link health sector performance with disbursement rates.

#### **1.3.3.2 Resume of the JC**

The EUD has actively been involved in sector dialogue with the Ministry of Health and with other partners but given the primary modality (GBS) the co-ordination of the EUD with the Ministry of Health was at times challenging especially during the first years of the evaluation period. According to the EUD the relation has improved in the last year and the EU is programming support to the health sector via SBS. The involvement of the Ministry of Finance is assured by the role of the health indicators in the GBS disbursement.

According to the EUD, financial resource allocations for the health sector in recent years have increased also thanks to EU GBS and SBS contribution. It can be estimated that 12% of the national financial budget is allocated to the health sector. It has also to be mentioned that indicators followed in

---

<sup>12</sup> Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso (May 2008).

the global review of the country, did put some pressure on MoF to provide an increased support to the sector. Recently a mission attempted to calculate this trend in a more scientifically manner (% amount allocated to the health sector) the figures provided are although unclear and a little bit foggy, nevertheless - an estimated 11.4% of the state budget allocated to the MoH (not including military component). EUD is also not aware of the proper follow up and M&E provided by other donors on the financial aspect.

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

#### Indicators

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

#### 1.3.4.1 Findings per indicators

**I-241** During the evaluation period, the EC has supported research institutes, such as the Muraz Center (see box below), the Centre de Recherche de Santé de Nouna, the Centre National de Recherche et de formation sur le Paludisme (CNRFP), the University of Ouagadougou, the CNRST/IRSS. The support has been given through e.g. global EC research programmes such as FP7 or regional research programmes, such as the European and Developing Countries Clinical Trials Partnership project (EDCTP) or the PASSAGE project of the Institute of Development Research (IRD). The Muraz center, established in 1939 and located in Bobo-Dioulasso, features a hundred employees, many of them seconded from the Ministry of Health as well as expatriate scientists paid by the cooperation of Member States of the European Union (France and Belgium).

This is part of the recommendations included in response to reports of variable tranches for General Budget Support. Nothing had been done three years after the provision of funds for institutional support through the envelope and GBS from the DSP 2001-2007.

#### Box 7: Research supported by the EC in the health sector in Burkina-Faso

*Le Centre Muraz et l'Institut de Recherche sur le Développement (IRD) sont parmi les institutions de recherche les plus proéminentes en santé de la sous-région. Elles ont bénéficié toutes deux d'appuis divers de la Commission Européenne, comme par exemple pour le projet EDCTP (European and Developing Countries Clinical Trials Partnership) ou les contributions de l'Université d'Heidelberg (sous financement CE), tandis que l'IRD a hébergé le projet PASSAGE. Le centre Muraz, créé en 1939, et situé à Bobo-Dioulasso, compte une centaine d'employés, dont de nombreux détachés du Ministère de la Santé ainsi que des scientifiques expatriés payés par les coopérations d'Etats Membres de l'Union Européenne (France et Belgique).*

*Il convient aussi de noter que des doutes ont été exprimés par certains interlocuteurs, sur l'adéquation des programmes de recherche avec les besoins nationaux, comme par exemple dans le cas du paludisme où les recherches menées sont perçues comme répondant davantage aux intérêts des bailleurs ou institutions impliqués qu'à ceux identifiés par le PNLP (certains des programmes de recherche ne sont pas communiqués au Programme selon ce qui nous a été dit au PNLP). Cependant, ceci n'a pas été confirmé par une revue systématique des programmes de recherche, et nécessiterait une observation plus rigoureuse afin d'être confirmé ou infirmé.*

*On peut cependant noter que, parallèlement, la CE a encouragé à plusieurs reprises les autorités nationales à mener une étude sur les raisons pour lesquelles le taux de respect des normes de personnel des CSPS demeure étal depuis plusieurs années (aux alentours de 76% entre 2002 et 2006). Ceci fait partie des recommandations inscrites en réponse aux rapports des tranches variables de l'Appui Budgétaire Général. Rien n'a pourtant été fait trois ans après la mise à disposition des fonds d'appui institutionnel dans le cadre de l'enveloppe A et de l'ABG inscrit au DSP 2001-2007.*

*Globalement, la recherche ne compte que pour une très faible part des dépenses de santé au Burkina Faso : environ 1% de l'ensemble des dépenses de santé estimées pour 2005, ou 1,7% des dépenses publiques.*

*Source: Particip (2008), Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso*

**I-242** There is no evidence that EC intervention has affected this indicator.

#### 1.3.4.2 Resume of the JC

The EC supported the several health research programmes in Burkina Faso and the sub-region.

Furthermore, the EC has repeatedly encouraged the national authorities to conduct a study on the reasons of a rate of compliance of CSPS personnel remaining around 76% between 2002 and 2006. This is part of the recommendations included in response to reports of variable tranches for General

Budget Support. However, nothing had been done three years after the provision of funds for institutional support through the envelope and GBS from the DSP 2001-2007.

## 1.4 EQ 3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?

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

#### Indicators

- I-311 Change in number of primary care facilities per 10,000 population (towards >1 per 10,000 population); disaggregated by rural/urban and income level, where feasible
- I-312 Change in the proportion of rural population living in a radius of 1 hour of a primary health care facility<sup>13</sup>

#### 1.4.1.1 Findings per indicators

**I-311** As noted under JC 12, there has been an increase in the number of PCH facilities, but this has been matched by population growth.

In the framework of ABRP 2002 – 2004, the access to primary health care facilities has been selected as one of the indicators for the release of the variable tranche. However, the findings so far do not indicate whether this performance indicator has been achieved.

**I-312** The data in the following table indicate that the radius of action of health facilities has decreased between 2000 and 2006 of health, indicating closer proximity.

Table 5: Health Infrastructures and resources – Health system in Burkina Faso

Infrastructures / ressources	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Rayon moyen d'action (km) pour les CSPS	9,4	9,2	9,1	8,7	8,3	8,2	7,8	7,7	7,5	7,5	7,3

Source: Particip (2008), Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso and Ministère de la santé (2010) : Annuaire statistique 2010

However, there is no evidence that EC intervention has affected this indicator.

#### 1.4.1.2 Resume of the JC

We assessed this JC on the basis of two indicators, the number of PHC facilities per 10,000 inhabitants and proportion of the population residing within an hour of a PHC facility. As found above, the ratio of population to PHC facilities has improved to about one per 9813 inhabitants. There is some evidence, cited above, that average proximity to PHC facilities may have been improved. The Country Note of the previous health evaluation noted a general improving trend in access to quality PNC services in Burkina Faso; however, it is not possible to confirm this based on the first indicator. The second may point in this direction. Overall, the provision of services in health facilities and their proximity appear to have improved. The role of health in the general budget support policy matrix, the fact that allocations to the social sectors have increased have probably contributed to this, but it would be hard to confirm this based on the two indicators given.

According to the interview with the MoH, the improvements noted in the EUD survey are hereby confirmed: (i) The access to primary health facilities had increased during the period 2002/2010 and (ii) the gap between rural and urban areas reduced. ECD support focused on the “District Sanitaire” and therefore at peripheral level. Nevertheless it is as usual difficult to quantify and measure the specific EC impact in the overall health system.

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

#### Indicators

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

<sup>13</sup> WHO definition: 1 hour by foot



- I-323 Increased number of Caesarean Sections

#### 1.4.2.1 Findings per indicators

**I-321** Overall, there has been a slight improvement in relation to hospital beds in the last decade.

However, EC support has not focused on infrastructure and, to the extent that access to quality health services can be attributed to EC support, this has been at the PHC level. The possibility that the fiscal space created for health created by GBS has helped the Ministry of Health to maintain secondary facilities cannot be disproven.

**I-322** There is no evidence that EC intervention has affected this indicator. Given the fact that no new secondary facilities have been constructed and the extremely skewed geographical distribution of secondary facilities, it is unlikely that this indicator has significantly changed.

**I-323** Overall, the percentage of births delivered by C-section decreased from 1.1% in 1998/99 to 0.7% in 2003. According to Table 6, this proportion then increased from 0.8% to 0.9% between 2008 and 2010; which is far below international good practice norms.

Table 6: Evolution de quelques indicateurs phares du PNDS, de 2008 à 2010

Indicateurs	2008	2009	2010
Proportion des césariennes réalisées		0,8%	0,9%

Source : *Annuaire statistiques 2008, 2009 ; DGISS 2010 ; rapport de progrès 2008, 2009, in Ministère de la Santé (2011) : Revue du secteur de la santé au titre de l'année 2010, Burkina Faso, Version provisoire du 24 février 2011*

However, there is no evidence that EC intervention has affected this indicator.

#### 1.4.2.2 Resume of the JC

No information has been found which would permit an assessment of this JC. EC assistance clearly did not contribute to infrastructure development in the area of secondary-level health care. However, GBS may have created fiscal space which allowed the MoH to expand quality and availability of services.

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

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

##### Indicators

- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving 4 or more ante-natal check-ups
- I-413 Increased proportion of women using modern family planning

##### 1.5.1.1 Findings per indicators

**I-411** A survey from 2003 showed that approximately 38% of births were assisted by skilled birth attendants (SBA). While 90% of births occurred in rural areas, large disparity in access to skilled care was reported between urban and rural area. The proportion of births under skilled supervision increased to 54% in 2010 of all deliveries according to data from the WHO 2011 Statistical Report. Another data source (admittedly inconsistent) speaks of an increase in the proportion from 31% in 2000 to 34% in 2005 and 62% in 2008.<sup>14</sup>

Finally, there are the data presented in Table 7. As noted above, the improvement seems to be tied to the implementation of a subsidy system for delivery (up to 80% in the primary sector and emergencies, 60% elsewhere) launched in 2007.

<sup>14</sup> *ECO Consult (2010): Evaluation de la coopération de l'Union européenne avec le Burkina Faso, Evaluation de niveau national, Rapport Final, Volume 1 (31 mai 2010).*

Table 7: Santé sexuelle et de la reproduction

	2000	2002	2003	2004	2005	2006	2007 (a)	2008 *	2009 *	2010 *	Objetif 2010
Taux d'accouchements assistés par du personnel qualifié	31%	39,9 % (g)	30,1 %	33,5 %		37,8%	42,9%	64%	70,7 %	73,4 %	73%

Source: Particip (2008) and \* Ministère de la Santé (2011); Revue du secteur de la santé au titre de l'année 2010, Burkina Faso, Version provisoire du 24 février 2011.

Box 8: Proportion of deliveries supervised by a skilled attendant

Les indications préliminaires pour 2007 indiquent un taux global d'accouchement assisté de l'ordre de 54% contre 43% en 2006 et 38% en 2005. Début 2007 marque la mise en œuvre d'un système de subventionnement de l'accouchement (à hauteur de 80% en secteur primaire – dans les CMA – et des urgences, à 60% ailleurs).

Néanmoins, les disparités régionales demeurent fortes (voir Table 7: Santé sexuelle et de la reproduction) tant en termes de services (taux d'accouchements assistés par du personnel qualifié) qu'en termes de résultats de santé (la mortalité maternelle enregistrée dans les formations sanitaires dans la région du Sahel (409 / 100.000 parturientes en 2006) est 10 fois plus élevée que dans la région du Centre où se situe Ouagadougou). Pour répondre à ces défis, les autorités sanitaires burkinabés ont réagi en pourvoyant l'ancienne Direction de la Santé de la Mère et de l'Enfant, désormais Direction de la Santé de la Famille, avec des moyens renforcés, grâce au panier commun PADS notamment mais aussi au budget de l'Etat qui a permis d'augmenter le nombre de personnes travaillant à la DSF (aujourd'hui 9 médecins contre 7 en 2004 plus une quinzaine d'attachés de santé et des auxiliaires), tandis qu'une subvention de 1,5 milliard de FCFA a été accordée en 2007 (1,3 milliard dépensés) pour l'acquisition de produits contraceptifs (400 M FCFA) et la gratuité des soins préventifs pour les femmes enceintes et les enfants de moins de 5 ans (400 M FCFA). Le transfert des fonds via les crédits délégués aux districts sanitaires ont permis l'approvisionnement en consommables et le coût de l'accouchement a été divisé par 5 en moyenne. Le transport a été aussi subventionné sur une base forfaitaire.

Source: Particip (2008)

In the framework of the EC funded BS, the EC support seems to have contributed to improve basic public services in the health sector including the rate of births supervised by a skilled attendant.

Box 9: L'intervention de l'UE a contribué à l'amélioration des services sociaux de base

Les tranches fixes ont été décaissées en partie sur la base du bon avancement du CSLP (qui met un accent particulier sur les secteurs sociaux, reprenant pour l'essentiel des programmes préexistants), et l'une des tranches variables avait des indicateurs sociaux comme déclencheurs. En ce domaine, les incitations de l'UE sont une des composantes d'un ensemble de pressions exercées par les PTF (y compris des conditionnalités du FMI) pour améliorer les services publics de base dans les domaines de l'éducation et de la santé – sans parler des engagements internationaux, comme les OMDs, l'initiative 20/20 ou les engagements d'Abuja dans le domaine de la santé.

La part des budgets alloués au ministère de la Santé et de l'éducation de base (MEBA) a progressé. C'est également le cas (d'après le FMI) des dépenses réductrices de pauvreté, dont la part dans le total progresse. Ces affirmations restent toutefois un peu fragiles, car les données semblent peu fiables (en particulier parce que le budget burkinabè comporte une part importante de dépenses non affectées), portent sur les dotations budgétaires et non sur les décaissements. De plus, il n'est pas toujours clair s'il s'agit des dotations budgétaires hors financements extérieurs, hors intérêts sur la dette, etc.

Les activités dans les domaines prioritaires ont progressé, du moins d'après les indicateurs retenus par le CGAB. Par exemple, la proportion d'accouchements assistés par du personnel de santé qualifié est passé de 42% en 1995 à 31% en 2000 avant de remonter à 34% en 2005, pour atteindre 62% en 2008.

Source: ECO Consult (2010): Evaluation de la coopération de l'Union européenne avec le Burkina Faso, Evaluation de niveau national, Rapport Final, Volume 1 (31 mai 2010).

In the framework of the GBS funded by the EC over the evaluation period, in particular ABRP 2005-2008 and OMD contract (2009-2014), performance indicators for the health sector included the "rate of births supervised by a skilled attendant."<sup>15</sup>

Findings indicate that this performance indicator increased between 2008 and 2010 and that the objectives had been achieved in 2008, 2009 and 2010.

<sup>15</sup> Programme d'Appui à l'Ajustement Structurel 1999-2000.

Table 8: Evolution of indicators related to Health 2002-2008

	2002	2003	2004	2005	2006	Base-line	2008 Réalisation (Cible)	2009 Réalisation (Cible)	2010 Réalisation (Cible)
Taux de couverture vaccinale rougeole (%)	64,1	71,1	77,7	84,0	88,0	93,9	97,6 (95)	99,4 (100)	99,3 (100)
Taux de CPS respectant la norme en personnel (%)	76,6	76,8	75,8	77,1	nd	76,0	76,8 (78,0)	83,2 (79,0)	83,1 (85,0)
Taux d'accouchement assisté (%)						54,6	64,0 (57,0)	70,7 (64,0)	76,0 (72,0)
% de dépôt de molécules essentielles au niveau des CPS n'ayant pas connu de rupture sur les 20 médicaments traceurs	74,6	73,3	94,8	91,3	92,92	94,5	95,0 (>=95)	91,5 (>=95)	91,8 (>=95)
Nombre de nouveaux contacts par an						0,43	0,50 (0,45)	0,56 (0,51)	0,64 (0,59)

Source : 2002-2006 : Note de dossier, Convention de financement 9361/BK - ABRP 2005-2008, Décaissement de la tranche fixe macroéconomique 2007, Examen des conditions générales et spécifiques, May 2007, p.3 ; 2008-2010 : Annexe à l'aide mémoire, Rapport technique, Délégation de l'Union Européenne au Burkina Faso.

It is possible that inclusion of the indicator in the GBS policy matrix contributed to the observed improvement.

**I-412** A survey from 2003 showed that approximately 72% of women who gave birth, at least a live birth, received ANC, whereas in 2006 this percentage had risen to 85%.<sup>16</sup> 73% received ANC from a skilled provider. According to the survey in 2003, 9.5% received one antenatal visit; 45.3% between two and three visits and 17.6% the WHO recommended four antenatal visits. The latest WHO data (2011) provide the following information: 85% received one ANC visit and 18% of women received four ANC visits. This suggests substantial improvement in the proportion of pregnant women receiving at least one ANC visit but no change in the proportion receiving the full four check-ups.

The EC funded Project on fight against HIV / AIDS in two urban districts of Burkina Faso implemented between 2002 and 2006 seems to have achieved good results in terms of quality of prenatal consultations. This is concrete evidence of EC contribution at the project level.

**Box 10:** Results and impacts of the EC project on "Integrated approach to the fight against HIV / AIDS in two urban districts of Burkina Faso" (C-060794)

**ROM report from 07/11/2003**

Efficacité actuelle : Il s'agit d'un programme de haute efficacité pour les femmes enceintes et les nourrissons. Malheureusement des contraintes culturelles et la stigmatisation empêchent une adhésion plus efficace des femmes à la CPN [consultations prénatales] et à la PTME [Prévention de la transmission du VIH de mère à enfant] et, encore plus, le dépistage volontaire des conjoints. Les IOV sont de 50% d'acceptabilité du test chez les femmes et de 20% chez les partenaires. Le chiffre national au Burkina où le programme est lancé depuis janvier 2003 est de 20% chez les femmes et de 7% chez les hommes. On peut espérer un bénéfice indirect par la mise en place d'autres CDV (centres de dépistage volontaire du VIH), d'une meilleure éducation des femmes et des adolescents pour la prévention primaire de l'infection, de meilleurs services de CPN et PF, et une meilleure alimentation des nourrissons. En retirant le lait artificiel de son programme, UNICEF a fortement affaibli une des forces de la PTME qui devra davantage s'associer à d'autres bailleurs pour garder son efficacité. Surtout que le coût du lait reste élevé et inabordable pour les pauvres.

<sup>16</sup> Worldbank statistics.

*Impact actuel* : L'impact maître du programme, la prévention même, se fera sentir dans quelques mois seulement quand les premiers enfants seront testés à leurs 15-18 mois de vie. Dans l'immédiat l'impact est important pour le démarrage des PTME et l'amélioration de la qualité des CPN. L'impact de soutien du projet à la DSF existe mais il pourrait être plus conséquent si le coordinateur mettait plus d'un tiers de son temps à disposition du projet (il est pris par les autres activités d'UNICEF dont le co-financement consiste au paiement de ses honoraires). Le ralliement des associations et bailleurs autour du Fond Global n'a pas été exploité à fond et a laissé une faible coordination au niveau de la DSF. Le retard de la mise en œuvre du plan intégré de communication d'UNICEF a également limité l'impact du programme à ce jour.

#### ROM report from 16/06/2006

*Efficacité actuelle* : Sur les secteurs 22 et 30, plus de 22.000 consultations prénatales ont été réalisées en 2005 dont 9.400 sur de nouvelles femmes. 70% d'entre elles ont reçu un conseil de groupe et 55% un conseil pré-test. 38% ont accepté de faire le test et 14% ont reçu un conseil post-test. Seulement 4,27% ont été diagnostiquées positives. Il faut néanmoins noter que certains résultats sont absents du fait de l'inadaptation des solutions proposées: à titre d'exemple, seuls 54 des partenaires de femmes testées ont accepté de faire le test, mais il semble que le partenaire doit apporter la copie du test de sa femme pour être comptabilisé comme « partenaire ayant été testé ». De même, le projet n'a pu obtenir une couverture contraceptive en post-partum de 70% des femmes VIH positif du fait que la contraception étant payante, les femmes doivent en parler à leur mari, risquant d'éveiller les soupçons.

*Impact actuel* : L'impact du projet, la réduction de la séroprévalence et de la mortalité maternelle et infantile due au VIH est certain même si les performances sont inégales selon les sites. Au centre de Farkan du secteur 22 à Bobo, aucun des enfants testés nés de mères séropositives et qui ont accouchées au CSPS n'est positif depuis 2003, cependant sur les deux districts concernés seuls 7% des enfants ont été testés à 18 mois, 21% d'entre eux étaient positifs. La mise en place du plan intégré de communication a permis d'obtenir une bonne sensibilisation jusque dans les communautés. Le projet a mis l'accent sur la prise en charge car il a été observé que les femmes sont plus enclines à faire le test si elles savent qu'elles seront prises en charge si le résultat est positif. Néanmoins il est difficile d'attribuer strictement l'impact au projet dans la mesure où de nombreuses autres actions sont menées dans les communautés par d'autres ONG/bailleurs. Les résultats sont d'ailleurs à mettre au crédit de cette synergie.

Source : *Projet Approche intégrée de lutte contre le VIH/SIDA dans deux districts urbains du Burkina Faso avec "la prévention de la transmission mère-enfant" comme porte d'entrée, Monitoring Report n°01079.01, 07/11/2003 and Monitoring Report n°01079.02, 16/06/2006.*

**I-413** The percentage of women using family planning nearly doubled between 2002 and 2007, as shown in the table below. However the gap between urban and rural areas of the country is still high. The WHO 2011 Statistical Report provides (inconsistent) data indicating that contraceptive prevalence rose from 8.8% in 2003 to 17.4% in 2011. Despite inconsistencies, it appears clear that contraceptive prevalence has risen over the evaluation period.

Table 9: Contraceptive prevalence in Burkina Faso between 2002 and 2007

Années	Prévalence contraceptive (%)
2002	14,48
2003	15,85
2004	16,39
2005	21,89
2006	24,34
2007	26,16
2008	27,9*
2009	26,6*
2010	30,1*

Sources: *Annuaire statistiques DEP/Santé, Mai 2007 and \* Ministère de la Santé (2011) : Revue du secteur de la santé au titre de l'année 2010, Burkina Faso, Version provisoire du 24 février 2011.*

There have been a number of specific actions supported by the EC in the field of maternal and reproductive health in Burkina Faso. They cover support to UNFPA for a regional program covering ten countries, including Burkina Faso (with a budget of around EUR 1.9 million). Two other major projects financed from the envelope and on the thematic budget lines also focused on: i) Reproductive health with PASSAGE (Proposed Approach to Reproductive Health Solidarity - covering Burkina Faso, Mali and Cameroon), a project which started in 2006, and ii) the fight against maternal mortality (with a project which started in March 2006). Other projects with targets for maternal health / reproductive projects have been implemented by the NGOs AIDOS (which started in 2007) and MDM (launched in 2005).



Maternal and reproductive health received special attention from the EC in Burkina Faso, either directly (through projects) or indirectly (through support to UNFPA) and, more modestly, through GBS. It should be noted here that the sexual and reproduction health has long been the priority of the PNDS (National Health Development Plan).<sup>17</sup>

**Box 11: EC support regarding reproductive health**

*D'autres indicateurs importants semblent confirmer l'amélioration de la couverture des services et produits de santé sexuelle et de la reproduction. C'est le cas par exemple de l'utilisation de méthodes contraceptives, qui reste encore faible et dont la progression est modeste mais, apparemment, en croissance plus marquée depuis deux ou trois ans (les données ne sont pas toutes concordantes) : de 4,2 à 8,6% pour les méthodes modernes entre 1990 et 2003 et 7,9 à 13,8% pour tout type de méthode, tandis que les données disponibles pour 2004 à 2006 indiquent des taux de prévalence contraceptive en district passant de 16,4% à 26,1%. ( Annuaire statistique santé. Mai 2007 )*

*[...] Les actions spécifiquement appuyées par la CE dans le domaine de la santé maternelle et de la reproduction au Burkina Faso sont nombreuses et de plusieurs ordres. Elles recouvrent un appui au FNUAP pour un programme régional couvrant 10 pays, dont le Burkina (avec près de 1,9 millions d'Euros de budget). Deux autres importants projets financés sur le budget de l'enveloppe A et sur celui des lignes budgétaires thématiques (gérées à Bruxelles) ont aussi porté sur : la santé génésique (PASSAGE – Projet d'Approche Solidaire en Santé Génésique – couvrant le Burkina, le Mali et le Cameroun), projet démarré en 2006, et la lutte contre la mortalité maternelle (projet démarré en mars 2006). D'autres projets avec des objectifs concernant la santé maternelle/reproductive sont les projets exécutés par les ONG AIDOS (débuté en 2007) et par MDM (débuté en 2005).*

*Au total, la santé maternelle et de la reproduction a reçu une attention particulière au Burkina Faso de la part de la CE, directement (via des projets) ou indirectement (via l'appui au FNUAP et, plus modestement, via l'ABG). Il convient de noter ici que la santé sexuelle et de la reproduction n'a pendant longtemps pas été la priorité du PNDS (Plan National de Développement Sanitaire). Les allocations budgétaires à la Direction de la Santé Familiale ont été très faibles jusqu'en 2007 (comme indiqué plus haut). Il existe un Plan Stratégique pour une Maternité à Moindre Risque 2004-2008, qui fait suite à une Stratégie Nationale de Maternité à Moindre Risque qui n'avait pas été financée.*

Source: Particip (2008)

Between 2005 and 2008, the EC supported the training of health workers on family planning, prevention and treatment of STI/HIV/AIDS among vulnerable women in Ouagadougou, Banfora and Po, which has achieved the following activities:

- Completion of three courses of five days on the prevention of HIV transmission from mother to child for health workers in the districts of Ouagadougou, Po and Banfora. 80 health workers were trained in November 2005, January and February 2006.
- Completion of four courses of five days in the nutritional management of newborns born to HIV positive mothers for 92 health workers in the districts of Ouagadougou, Po and Banfora.
- Completion of three courses of eight days on the quality of obstetric care and neonatal infection for health workers in the districts of Ouagadougou, Po and Banfora. 85 people were trained in July and August 2006.
- Training in family planning provided during the second years of the project.

<sup>17</sup> Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso (May 2008).

Box 12: *Effectiveness and impact of the “Prevention and treatment of STI / HIV / AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po” (C-78605)*

**Effectiveness to date** : Le nombre de bénéficiaires directs visés par le projet, tels qu’estimés dans la convention de financement, est atteint après près de 2 ans d’exécution du projet. La compétence de plus de 1500 agents de santé dans divers domaines du VIH/SIDA et de la santé obstétricale a été renforcée ; 25% des femmes enceintes vivant dans les zones d’intervention ont été testées pour le VIH et 209 d’entre elles, séropositives au VIH, sont suivies (dont 126 avec leurs nouveau-nés) ; près de 2500 TS ont effectué le test de dépistage du VIH ; plus de 100 000 personnes vivant dans les zones d’intervention sont sensibilisées aux IST/VIH/SIDA et environ 30 000 ont fait le test de dépistage du VIH ; 18 000 cas d’IST ont été traités correctement suivant l’approche syndromique. Les 4 associations ciblées (AJPO Ouagadougou, AJPO Pô, REV+ Bobo Dioulasso et AVO/SIDA Banfora) ont effectivement bénéficié de l’appui du projet. Cette grande efficacité du projet est liée : i) aux UM (camions équipés de mini laboratoires) qui ont facilité la réalisation de stratégies avancées de dépistage aussi bien au niveau de la population générale (par les associations) qu’au niveau des structures de santé reculées et ii) à la mise en place de Centre de Dépistage Volontaires dans des formations rurales dont l’accès était plus facile. Par ailleurs, la réalisation des tests de dépistage sur sang total (récemment adopté au BF) a fortement raccourci les délais d’attente des résultats (de 2 jours à 30 minutes) ce qui a contribué à augmenter l’adhésion des bénéficiaires. L’OS sera certainement atteint à la fin du projet

**Impact prospects** : L’impact potentiel du projet est assez important. Outre l’effet direct attendu sur la réduction de la morbidité et de la mortalité liée au VIH/SIDA dans les groupes cibles, le projet a contribué à l’amélioration de la qualité des soins aux PVVIH aussi bien dans les CSPS que dans les structures de référence. Cette amélioration de la qualité est liée au renforcement des compétences du personnel (plus grande estime de soi, amélioration de la relation soignant-soigné), à la plus grande disponibilité des médicaments et des réactifs de laboratoire. Les associations locales, au travers de leur participation au projet voient leurs capacités opérationnelles et leur visibilité accrues. Toutefois, la relative faiblesse de la composante « soutien psychologique » aux PVVIH pourrait amoindrir l’impact positif du projet auprès des populations.

Source: *Projet de Prevention and treatment of STI / HIV / AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po, Monitoring Report n°002093.01, 15/06/2007*

According to the EUD, the role played by the EC regarding policy dialogue related to sexual and reproductive rights have been consistent and important. Partnership between UN agencies as WHO and UNFPA and INGOs (French NGOs with a project focusing on reproductive rights: young girls in domestic work) has put the emphasis on MNCH allowing the increased use and availability of appropriate ante-natal and maternal care throughout the population. Additionally one of the five indicators for health is linked and related to reproductive health (delivery) and respect of human resource norms in strengthening and improved safe pregnancy. The EU in the last decade gave particular attention to this topic both politically and financially. The EC was also co-founder of the Regional conference on Family planning held in Burkina during 2011.

### 1.5.1.2 Resume of the JC

Overall, national data indicate an increase in the proportion of deliveries assisted by skilled personnel between 2000 and 2007. We may infer that the EC support had an impact on the rate of births supervised by a skilled attendant via its BS.

As regards the proportion of prenatal check ups, good results in terms of quality of prenatal consultations seem to have achieved by the EC funded Project on fight against HIV / AIDS implemented between 2002 and 2006 in two urban districts of Burkina Faso.

The use of modern family planning has improved in Burkina Faso. We may infer that the maternal and reproductive health received special attention from the EC in Burkina Faso, either directly (through projects) or indirectly (through support to UNFPA and, more modestly, through GBS). In particular, the EC supported between 2005 and 2008, the training of health workers on family planning, prevention and treatment of STI / HIV / AIDS among vulnerable women in Ouagadougou, Banfora and Po in the framework of the project C-78605.

According to the EUD, the EC support on increased use of appropriate ante-natal and maternal health care has been important. The ante-natal and maternal health care indicators have been constantly increasing in the past decade. However, it is almost impossible to measure the impact of GBS in this domain, considering the fact that other donors and partners have also been involved.

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

#### Indicators

- I-421 Percentage of children under 5 receiving regular growth monitoring
- I-422 EPI immunisation rate

### 1.5.2.1 Findings

**I-421** There is no evidence that EC intervention has affected this indicator. It can be noted, that ECHO is very active in this domaine. ECHO interventions are out of scope of the present evaluation.

**I-422** Immunisation rates in Burkina Faso have considerably increased over the evaluation period, particularly due to the EC funded ARIVA program (which covered 16 countries of Francophone West Africa), but also the support provided by GAVI (to which the EU contributes) to Expanded Program on Immunization (EPI) since 2001. Children and women were particularly targeted in the framework of these interventions financed by the EC. Data presented below indicate substantial increases in immunisation rates over the evaluation period.

Source: *Particip (2008), Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007).Country Note Burkina Faso.*

Table 10 shows the outstanding results achieved mainly due to the EPI through GAVI and the EU supported projects to strengthen the vaccine immunisation in Africa (ARIVA44).

#### Box 13: Vaccination rate in Burkina Faso

*Les taux de vaccination au Burkina Faso ont très nettement progressé au cours des dix dernières années, notamment en relation avec le programme ARIVA (financé par la CE au bénéfice des pays de l'Afrique de l'Ouest francophones), mais aussi de l'appui fourni par GAVI au PEV depuis 2001. Le PEV à travers GAVI et les projets d'appui au renforcement de l'immunisation vaccinale en Afrique (ARIVA44) de l'Union Européenne, a obtenu des résultats remarquables dans l'augmentation de la couverture vaccinale.[...] Les besoins des enfants et des femmes ont été particulièrement visés dans le cadre des actions financées par ou avec le concours de la CE. C'est notamment le cas de la vaccination de routine avec le projet ARIVA (qui a couvert 16 pays de l'Afrique Occidentale), lequel a contribué à l'appropriation des politiques vaccinales et de la mobilisation des ressources dans ce domaine. La couverture vaccinale, a fortement augmenté depuis 2000 et le taux d'abandon entre les DTCP 1 et 3 a chuté très nettement aussi.*

Source: *Particip (2008), Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007).Country Note Burkina Faso.*

Table 10: Evolution of immunisation coverage for children from 0 to 11 Months (in %)

Années	BCG *	DTC P 3 *	OPV 3**	Rougeole **	Fièvre jaune**
2002	81.0	61.0	nd	64.6	61.8
2003	85.0	68.0*	77.4	71.1	66.3
2004	88.0	75.0	82.7	77.8	75.5
2005	92.0	82.0	94.4	84.0	84.1
2006	92.0	82.0*	94.4	88.1	88.1
2007	92.0	82.0			
2008	92.0	82.0		97,6%	
2009	92.0	82.0		99,4%	
2010				99,3%	

\* Il s'agit de la couverture en DTC3.

Sources: \*worldbank statistic; \*\*Annuaire statistiques DEP/Santé

In 2009, the EC has contributed EUR 20.2 million to GAVI funds. Following the epidemics of measles and meningitis (EPI target diseases) in Burkina Faso in 2009, the DCE has continued to monitor the status of the country (including a Mission WHO / UNICEF in June 2009) and attended meetings of the CCIA / EPI (GAVI Funds), which were twice in 2009. In 2009, monitoring activities in Burkina Faso were examined following the outbreaks of measles and meningitis.

#### Box 14: The Trustfund CCIA (Comité de Coordination Inter Agences) / PEV (Programme Elargie de Vaccination) / GAVI – (Global Alliance on Vaccine and Immunization)

*« Suite aux épidémies de la rougeole et de la méningite au Burkina en 2009, la DCE continue de suivre la situation vaccinale du pays et les réunions du CCIA/ PEV (Fonds GAVI) qui s'est réunit deux fois en 2009. En 2009, la CE a contribué 20.2 M € / 28.6 M\$ aux fonds GAVI (total contribution jusqu'au 2009 = 40.9 M€ / 57.9M\$). Au cours de l'année 2009, les activités de surveillance au Burkina Faso ont été examinées suite aux épidémies de la rougeole et la méningite (maladies cibles du PEV) avec une mission OMS / UNICEF en juin 2009. La revue approfondie du PEV prévue en 2008 doit normalement être effectuée début 2010 avec une présentation des résultats lors de la revue du secteur santé en mars 2010. Suite aux épidémies, il y a eu un rappel au renforcement de la surveillance épidémiologique à tous les niveaux du système de santé et un pré positionnement au niveau des DRS et des CHU de réactifs, matériels et consommables de laboratoire pour la confirmation des cas de méningite. »*

Source : EAMR 1/2010

In the framework of the budget support funded by the EC over the period, the vaccination rate against measles has been selected as one of the performance indicators for the release of the variable tranche.

Findings so far indicate that in 2008, this performance indicator had been achieved. The objective of 100% for 2009 and 2010 has almost been achieved as shown in the table below.

Table 11: Evolution of indicators related to Health 2002 - 2008

	2002	2003	2004	2005	2006	Base-line	2008 Réalisation (Cible)	2009 Réalisation (Cible)	2010 Réalisation (Cible)
Taux de couverture vaccinale rougeole (%)	64,1	71,1	77,7	84,0	88,0	93,9	97,6 (95)	99,4 (100)	99,3 (100)

Source : 2002-2006 : Note de dossier, Convention de financement 9361/BK - ABRP 2005-2008, Décaissement de la tranche fixe macroéconomique 2007, Examen des conditions générales et spécifiques, May 2007, p.3 ; 2008-2010 : Annexe à l'aide mémoire, Rapport technique, Délégation de l'Union Européenne au Burkina Faso, p.10.

### 1.5.2.2 Resume of the JC

Immunisation rates in Burkina Faso have considerably increased over the evaluation period, mainly due to the EC funded ARIVA programme (which covered 16 countries of Francophone West Africa), as well as the support provided by GAVI to Expanded Program on Immunization (EPI) since 2001 to which the EC contributed. We may infer that the EC funded budget support has impacted on the "vaccination rate by antigen" as it has been selected as one of the performance indicator for the release of the variable tranche of the budget support funded by the EC over the period.

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

#### Indicators

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

#### 1.5.3.1 Findings per indicators

**I-431** In the framework of the Plan National de Développement Sanitaire (PNDS) 2001-2010, 400,000 insecticide-treated nets were distributed in 2005. In 2006, 2007, 2008 and the first half of 2009, a total of 4,514,405 insecticide-treated nets were distributed for free to pregnant women and children under 5 years during consultations.<sup>18</sup>

**I-432** No data obtained to date.

**I-433** No data obtained to date. There is no evidence that EC intervention has affected this indicator.

#### 1.5.3.2 Resume of the JC

We have obtained no data to date relevant to the Indicators.

## 1.6 EQ 5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

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

#### Indicators

<sup>18</sup> Ministère de la Santé (2010) : Plan National de Développement Sanitaire (PNDS) 2001-2010, « Evaluation finale » Rapport provisoire, Ministère de la Santé, Secrétariat General, Direction des études et de la Planification, Février 2010.



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

### 1.6.1.1 Findings

**I-511** The EC has not been involved in the basket fund which has been the main instrument of the sectoral approach in Burkina Faso. The EUD has actively been involved in sector dialogue with the Ministry of Health and with other partners. It has participated in a number of committees and commissions, and monitoring the implementation of PND (joint outputs).

However, the staff available for this was very small: The person in charge of the health sector follows also the budget support aspects related to health. From 2006 to 2009 1,5 persons are covering the health sector within the delegation, according to the EUD. In 2009, the staff in charge of health has been reduced to one person. This means that the work load of EC staff is rather high.

Moreover, the regularity of meetings and activities of these committees has been variable and the time between them tended to increase. The coordination of the EUD with the Ministry of Health did not appear to be very good at the beginning of the evaluation period, which made the effectiveness of sectoral dialogue more difficult.<sup>19</sup> According to the EUD the reasons for the difficulties to carry out an effective sector dialogue can on one hand be seen in the “newness” of the GBS modality. On the other hand, the EUD does not participate in the big health basket fund, which makes the EUD less visible within the donor landscape.

On a political level, the impact of activities funded by the EC has had limited visibility. Indeed, the political dialogue appeared to be insufficient. According to the EUD the difficulties of the PND (joint outputs) was related to the distribution of resources and the prioritisation of funding e.g. HIV / AIDS received the biggest share of funding while malaria was by far the biggest cause of mortality in Burkina Faso. Furthermore national authorities, which were by almost 40% dependant of external financing, have not been encouraged to ensure the definition of strategies and control of the device.<sup>20</sup>

**Box 15:** *EC sectoral dialogue with the Ministry of Health*

« Le dialogue avec les autorités sectorielles est rendu difficile par le fait que l'UE n'est pas perçue comme un contributeur au financement sectoriel. En effet, l'AB n'est généralement pas pris en considération par les ministères sectoriels (mais cela dépend aussi du rôle et de l'efficacité du chef de file sectoriel). Le dialogue est donc assez difficile avec ces secteurs, surtout si, comme c'est le cas dans le domaine de la santé, il existe un panier commun (dont l'UE n'est pas membre) qui tend à dominer les discussions sur les politiques, notamment pour des raisons financières. Ce problème conduit à s'interroger sur le bien fondé d'une aide budgétaire sectorielle, qui renforcerait le dialogue. Toutefois, ce problème indique aussi une nécessité de mieux populariser les objectifs et les mécanismes de l'AB, qui reste essentielle pour éviter les distorsions des choix budgétaires. »

Source : ECO Consult (2010)

The EC has been actively implicated in several working groups in the health sector, including the technical WG on the national plan in the health sector. However, Box 16 confirms that the sectoral dialogue with the Ministry of health has been more difficult due to the fact that the EC has not been involved in the basket fund which has been the main instrument of the sectoral approach in Burkina Faso. According to the EUD, the situation is now improving. This can be seen as a result of the foreseen investment by the EC under the MDG initiative which is likely to see sector budget support being put in place. In addition there is increasing frustration that funding within the common basket funding is targeted (in terms of domaine and geography) and does not facilitate the sectoral approach as desired.

<sup>19</sup> Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso (May 2008).

<sup>20</sup> Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso (May 2008).

## Box 16: Political of the EUD in the Health sector

« La Délégation contribue activement au dialogue politique autour de la santé, compte tenu de l'importance de ce secteur dans le cadre des tranches OMD du contrat OMD. Elle est membre dans la CST « Santé, VIH et Nutrition » dans le cadre du suivi du CSLP. Elle reste activement engagée dans les commissions techniques du PNDS (Plan National de Développement Sanitaire) mais il n'y a qu'une commission sur sept qui était régulière en 2009. Mais la délégation reste pénalisée en étant le seul bailleur qui suit activement le secteur mais ne participe pas au « panier de financement commun santé » (PADS), ce qui ne lui donne pas accès au Comité de pilotage de sa mise en œuvre. Or, compte tenu des montants en jeu, le PADS a tendance à prendre le pas sur le PNDS. La délégation essaie actuellement de devenir membre du comité de suivi du PNDS pour mieux assurer un suivi du secteur dans sa globalité.

Le Ministère de la santé a aussi récemment exprimé son intention d'adhérer le Burkina à IHP (International Health Partnership) et une volonté de développer un Compact en 2010 parallèlement au nouveau PNDS 2011-2015 qui doit améliorer la coordination du secteur notamment par rapport aux engagements des PTFs concernant la Déclaration de Paris. Fin 2009 il y avait une mission d'évaluation du dernier PNDS 2001-2010 qui doit servir pour l'élaboration de la nouvelle stratégie PNDS 2011-2020.

En outre, la DUE a participé au courant de 2009 aux plusieurs missions dans la santé, notamment une étude de faisabilité d'un appui budgétaire sectoriel (ABS) dans le secteur et une mission sur le potentiel du mécanisme 'financement basé sur les résultats' au Burkina pour accélérer le progrès vers les OMDs (la mise en place de ce mécanisme est maintenant un objectif principal du Ministère de la santé). 2010 risque de voir le Ministère de la santé surchargé au point qu'on sacrifie la qualité pour la quantité des réformes / processus pendant une année critique concernant la mise en place de la nouvelle politique. »

Source : EAMR 1/2010

**I-512** The public financial management in Burkina Faso has improved, and some basic problems have been solved. The donors including the EC have played an important role, through multiple channels including BS, and have contributed to this improvement.

The EC funded GBS has enabled the EC to play a leading role on other donors, promoting reforms undertaken by the government, including the management of public finances. In the health sector, this contribution was more modest due to the existence of a donor basket fund, in place since 2005, but to which the EC does not contribute.

According to the CSE of 2010, EC funded BS has made the budget planning more difficult (because fundamental expenditures cannot be planned when disbursements are not insured), which constituted a major problem in the early 2000. It has gradually been reduced by an increasing predictability of disbursements, and almost eliminated by the MDG Contract, in place since 2009.<sup>21</sup>

**I 513** There is no evidence that EC intervention has affected this indicator.

### 1.6.1.2 Resume of the JC

The EC has been actively implicated in several working groups in the health sector, including the technical WG on the national plan in the health sector. On a general level, the EC visibility in the health sector must be assessed as not so high. This seems to be due to the fact that the EC was not involved in the health basket fund and the links to the Ministry of health and other health stakeholders were thus less tight. This is changing towards the end of the evaluation period as the EC plans to support the health sector more visibly through a SBS. However, the fact that the EC has not been involved in the basket fund which has been the main instrument of the sectoral approach in Burkina Faso, has made the sectoral dialogue with the Ministry of health more difficult.

EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector. The findings indicate that donors including the EC have played an important role, through multiple channels, especially (?) through GBS, and have contributed to the improvement of PFM in Burkina Faso, including in the Health sector.

<sup>21</sup> ECO Consult (2010): Evaluation de la coopération de l'Union européenne avec le Burkina Faso, Evaluation de niveau national, Rapport Final, Volume 1 (31 mai 2010)

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

### Indicators

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

### 1.6.2.1 Findings

**I-521** The EC has contributed to the overall process of accountability and transparency of the health system by supporting the capacity building of the Court of Auditors and the strengthening of the national institute for statistics, including in the health sector, in the framework of ABRP 2002-2004 and 2005-2008 as shown by Box 17 and Box 18.

**Box 17:** *The EC support to the Ministry of Health concerning statistics*

« Le suivi des indicateurs se révèle plus compliqué que prévu car les systèmes d'information sont d'une fiabilité inégale et les données ne sont pas toujours comparables, quand elles ont été établies par différents systèmes. La situation devrait s'améliorer avec la création d'une direction des statistiques au ministère de la Santé. Un projet soutenu par l'UE est en cours, pour améliorer l'information statistique. Toutefois, la révision des données démographiques suite au dernier recensement pose un problème, car les populations cibles devront être révisées, ce qui entraîne une baisse de la plupart des indicateurs.»

Source : ECO Consult (2010)

**Box 18:** *The EC support to PFM in the framework of ABRP 2002-2004 and 2005-2008*

« L'avenant n° 1 à la Convention de Financement, signé le 15 décembre 2006, a permis de réallouer les 4.9 Mio € non déboursés au titre de la tranche variable 2006 et d'augmenter ainsi l'enveloppe réservée à des actions d'appui institutionnel, qui se monte dorénavant à 6.4 Mio €. A titre indicatif, ce montant sera utilisé pour des appuis sectoriels dans les domaines de l'éducation et de la santé, pour des appuis à la statistique, au renforcement des systèmes de gestion des finances publiques, pour un appui à la Cour des Comptes au titre de son renforcement, et le financement d'audits et de missions d'évaluation.

Les activités d'appui institutionnel de ce programme ont démarré au cours du deuxième semestre de 2006, avec l'élaboration d'une étude diagnostic de la Cour des comptes qui donnera lieu durant le premier trimestre 2007 à un projet d'appui à la Cour des comptes, projet s'insérant dans la Stratégie de Renforcement des Finances Publiques dont le premier Plan d'Action doit démarrer en 2007. Le diagnostic PEFA sur les finances publiques a quant à lui été élaboré en étroite collaboration avec les autres bailleurs du Cadre Général d'Appui Budgétaire en soutien au Cadre Stratégique de Lutte contre la Pauvreté au Burkina Faso. Une mission du Siège dans le cadre de la réalisation du PEFA (Public Expenditure Financial Accountability) est souhaitée par la Délégation en premier semestre 2007.

« Pendant 2006, les activités de renforcement des capacités en cours au titre du programme ABRP 2002-2004 se sont poursuivies et achevées à la fin de l'année. La continuation de 2 actions spécifiques a été prévue dans le programme ABRP 2005-2008: »

[...]- Appui au renforcement des statistiques (ARCS) INSD et des secteurs sociaux : une demande de prolongation de cet appui a été formulée par les services bénéficiaires (INSD et DEP santé et éducation) et approuvée par l'ON et la DCE sous réserve qu'une évaluation à mi parcours en confirme la nécessité et établisse des propositions dans ce sens. Cette évaluation s'est déroulée en juillet 2006 et a révélé la pertinence de la poursuite et du renforcement des activités du projet par un avenant au contrat de service GOPA pour 18 mois, qui a été signé en décembre 2006. »

Source : EAMR 1/2007

The main achievements of the Institutional support component of the BS programme for 2005-2008 (9 ACP-BK-06) included in the area of health and education the annual publication of statistical yearbooks as well as thematic quarterly newsletters. Actions in improving the quality of statistics have been pursued, particularly in terms of health statistics and education, which contributed to make the statistical system of Burkina one of the strongest in West Africa.<sup>22</sup>

<sup>22</sup> EAMR 01/2011

**I-522** There is no evidence that EC intervention has affected this indicator.

**I 523** There is no evidence that EC intervention has affected this indicator.

### **1.6.2.2 Resume of the JC**

The EC has contributed to the overall process of accountability and transparency of the health system by supporting the capacity building of the Court of Auditors and the strengthening of the national institute for statistics, including in the health sector, in the framework of ABRP 2002-2004 and 2005-2008 and the MDG contract.

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

The EUD highlighted that complementarity between different kind of EC support is a domain that deserves particular attention and there is still some need to enhance complementarity. This results in a need for better coordination, division of labors and a strongest common vision. Different, vision, modality, and approach between WB, donors, UN agencies and partners jeopardize/limited the common effort in the health sector. There is a feeling in between stakeholders that there is a huge potential to better work together. Particular attention should be given to issue as sustainability, proper M&E of human resources and training. The EC has strengthened relation and partnership with some donors and UN agency in implementing common field visits. The Health Sectoral Review in the past 2 years has been definitely a step forward.

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

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

According to the EUD, financial resource allocation for the health sector in recent years has increased, partly thanks to EU GBS and SBS contribution. It can be estimated that 12% of the national financial budget is allocated to the health sector. It has also to be mentioned that indicators followed in the global review of the country, did put some pressure on MoF to provide an increased support to the sector. Recently a mission attempted to calculate in a more scientifically manner this trend (% amount allocated to the health sector); the figures provided are although unclear and a little bit foggy, nevertheless - an estimated 11.4% of the state budget is allocated to the MoH (not including military component). EUD is also not aware of the proper follow up and M&E provided by other donors on the financial aspect.

### **1.8.1 JC 73 JC 73 Increased cost-effectiveness and internal consistency of EC support**

- I-732 Evidence that the thematic programmes provide distinctive added-value from programmes of geographic nature

According to the EUD, there is a need for better complementarity and interaction between donors. Timeline, approach and calendar of the thematic support provided by donor/stakeholders need to be improved and aligned in order to be more efficient. However, the added value and complementarity of the EUD results in using GBS as well as ground-level projects also connect to other donor/stakeholders support.

Having clearly defined a budget line is felt a positive approach but not sufficient in order to provide a global vision of the sector. Only with GBS the dialogue would be limited as lacking the view on the field which is provided by the thematic programs. A mixed feeling –mainly negative – can also be reported in relation to the experience with UN agency (WHO and UNFPA) as those agencies have a different approach, political agenda and modus operandi. Additionally some internal difference is reported on some important issues between the EUD and the HQ in Brussels. According to the EUD, communication/information mechanisms are not in place, a factor that creates frustrations for the EUD involved (e.g. there is a lack of information on ongoing regional EC supported projects, which are



coordinated by other EUDs in the regions or other EU funding mechanisms, such as research grants of the FP7.

Especially with the research project of the FP7 (Burkina Faso benefits from some of these research funds), coordination with the programme and the EUD is lacking completely, although there is a high degree of complementarity. The EUD feels that there is a missed opportunity to make a link between different EC support/activities and enhance internal complementarity.

## 1.9 Annex

### 1.9.1 Key documentation used for the analysis

#### 1.9.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
C-78605	na	na	1MR	Progress report	na
C-060794	na	na	MR 1 and 2	na	na
<b>GBS</b>					
BF 015886-ABRP2002-04	available				
BF 017744-ABRP2005-08	available			- Revue conjointe du CSLP et du CGAB-CSLP année 2008 - Rapport d'évaluation de la Matrice des critères de Performances et de Décaissements du CGAB-CSLP en 2008 et Matrice de critères De performances et de Décaissements 2009 – 2011 - Note de dossier/ Objet: Programme "Appui Budgetaire pour la Reduction de la Pauvrete 2005-2008" au Burkina Faso Decaissement de la tranche fixe 2007	
BF 020972-OMD-C 2009-2014	Available - Fiche de projet - Fiche d'identification - Action Fiche			Rapport d'analyse de la performance pour le décaissement : Tranche fixe 2010 RMP?	

#### 1.9.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	OK
EAMR extraction BF	OK
C-78605	OK
C-060794	OK
Country note from old health eval	OK
GBS docs	BF 014578-ajustement structurel1999-2001:OK BF 015219-ABRP2001: OK BF 015886-ABRP2002-04: OK BF 017744-ABRP2005-08: OK BF 020972-OMD-C: OK
Paris Declaration on BF	OK

#### 1.9.1.3 Bibliography

Annuaire statistiques DEP/Santé

EAMR 01/2007

EAMR 01/2010

EAMR 07/2010

EAMR 01/2011

ECO Consult (2010): Evaluation de la coopération de l'Union européenne avec le Burkina Faso, Evaluation de niveau national, Rapport Final, Volume 1 (31 mai 2010)

Financing Agreement of « Appui budgétaire pour la réduction de la pauvreté 2002 – 2004 » (ABRP 2002 2004)

Financing Agreement of « Appui budgétaire pour la réduction de la pauvreté 2005 – 2008 » (ABRP 2005 2008)

Financing Agreement of « Appui budgétaire pour la réduction de la pauvreté 2009 – 2014 » (Contrat OMD)

Danish Management (2007): Projet de Prevention and treatment of STI / HIV / AIDS among vulnerable women in Ouagadougou, Bobo-Dioulasso, Banfora and Po, Monitoring Report n°002093.01, 15/06/2007

Medicos des Mundo (2006): Rapport narratif intermédiaire Projet de prévention et prise en charge des IST/VIH/SIDA auprès des femmes vulnérables de Ouagadougou, Bobo-Dioulasso, Banfora Et Po financé par la Commission Européenne, 01 juillet 2005 – 31 août 2006

Note de dossier, Convention de financement 9361/BK ABRP 2005-2008, Décaissement de la tranche fixe macroéconomique 2007, Examen des conditions générales et spécifiques, May 2007

Projet Approche intégrée de lutte contre le VIH/SIDA dans deux districts urbains du Burkina Faso avec "la prévention de la transmission mère-enfant" comme porte d'entrée, Monitoring Report n°01079.01, 07/11/2003

Projet Approche intégrée de lutte contre le VIH/SIDA dans deux districts urbains du Burkina Faso avec "la prévention de la transmission mère-enfant" comme porte d'entrée, Monitoring Report n°01079.02, 16/06/2006

Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note Burkina Faso

Quality of care of modern health services as perceived by users and non-users in Burkina Faso, Institute for Medical Technology Assessment, Erasmus MC, Rotterdam, The Netherlands and Department of Tropical Hygiene and Public Health, Heidelberg University, Heidelberg, Germany

Rapport d'évaluation de la Matrice des critères de Performances et de Décaissements du CGAB-CSLP en 2008 et Matrice de critères de performances et de Décaissements 2009 – 2011 (ABRP 2005 2008)

Revue conjointe du CSLP et du CGAB-CSLP année 2008(ABRP 2005 2008)

Rapport d'évaluation de la Matrice des critères de Performances et de Décaissements du CGAB-CSLP en 2008 et Matrice de critères De performances et de Décaissements 2009 – 2011 (ABRP 2005 2008)

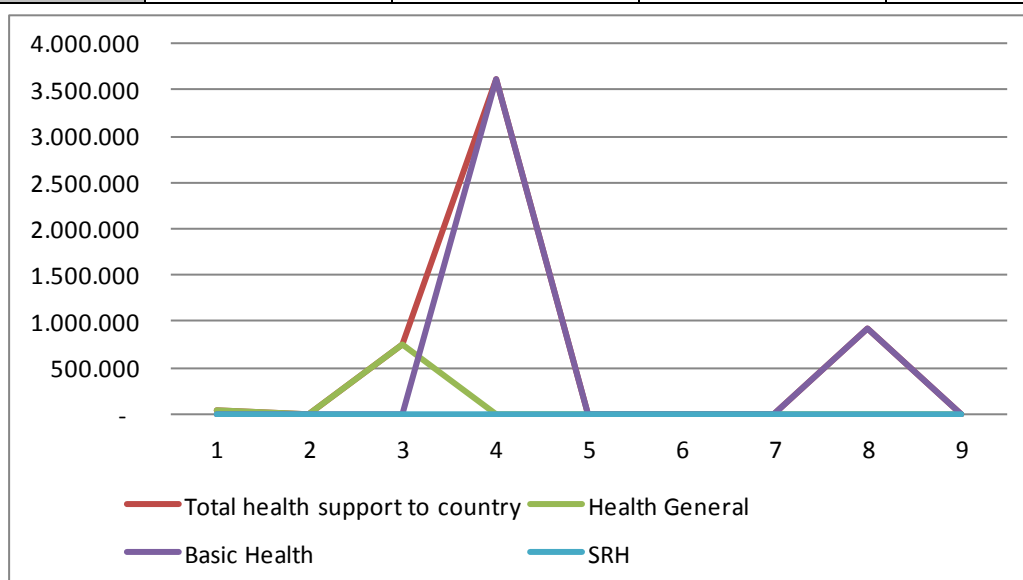
Note de dossier/ Objet: Programme "Appui Budgetaire pour la Reduction de la Pauvrete 2005-2008" au Burkina Faso Decaissement de la tranche fixe 2007 (ABRP 2005 2008)

Rapport d'analyse de la performance pour le décaissement :Tranche fixe 2010 (Contrat OMD)

1.9.2 EU funds between 2002-2010 –detailed listing:

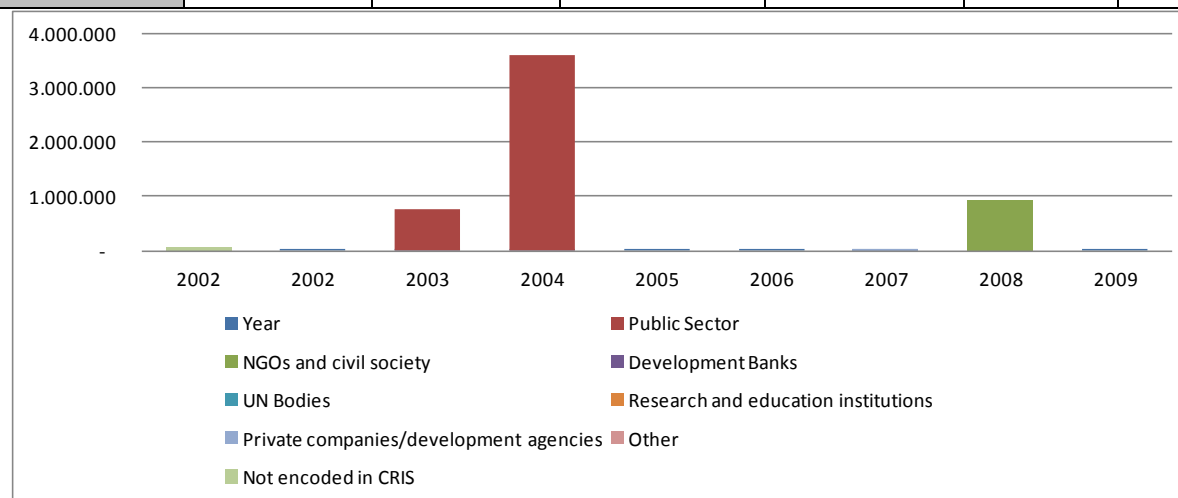
1.9.2.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to country
2002	48.456	-	-	48.456
2003	-	-	-	-
2004	749.791	3.621.123	-	749.791
2005	-	-	-	3.621.123
2006	-	-	-	-
2007	-	2.973	-	-
2008	-	930.915	-	2.973
2009	-	-	-	930.915
2010	-	4.555.011	-	-
<b>Total</b>				



## 1.9.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	-	-	48.456	48.456
2003	-	-	-	-	-	-	-	-	0
2004	749.791	-	-	-	-	-	-	-	749.791
2005	3.621.123	-	-	-	-	-	-	-	3.621.123
2006	-	-	-	-	-	-	-	-	0
2007	-	-	-	-	-	-	-	-	0
2008	-	-	-	-	-	2.973	-	-	2.973
2009	-	930.915	-	-	-	-	-	-	930.915
2010	-	-	-	-	-	-	-	-	0
<b>Total</b>	<b>4.370.914</b>	<b>930.915</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>2.973</b>	<b>0</b>	<b>48.456</b>	<b>5.353.258</b>





## 1.9.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	48.456	-	<b>48.456</b>	30.393
2003	-	-	-	-	-	7.930
2004	-	-	749.791	-	<b>749.791</b>	1.356.940
2005	-	-	3.621.123	-	<b>3.621.123</b>	181.526.258
2006	-	-	-	-	-	1.363.115
2007	-	-	-	-	-	1.251.790
2008	-	-	2.973	-	<b>2.973</b>	3.087.908
2009	-	-	930.915	-	<b>930.915</b>	325.562.936
2010	-	-	-	-	-	56.676
<b>Total</b>	-	-	5.353.258	-	<b>5.353.258</b>	-

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

Contracts Title	Decision No	Contract number	Contract year	Decision year	Contracts contracted amount/
AT JURIDIQUE AU MINISTERE DE LA SANTE	FED/2002/01 6-032	188567	2002	2002	48.456€
Appui a la direction regionale sanitaire de Ouahigouya dans la mise œuvr de son plan de développement sanitaire - Burkina Faso	ONG-PVD/2003/00 4-562	63626	2004	2003	749.791€
Prévention et prise en charge des IST/VIH/SIDA auprès des femmes vulnérables des villes de Ouagadougou, Bobo-Dioulasso et PÔ	SANTE/2004 /006-079	78605	2005	2004	2.002.500€
Projet d'approche solidaire en santé génésique	SANTE/2004 /006-082	100641	2005	2004	1.618.623€
Forum médias et développement : Services de santé et logistique conférence de presse	(blank)	164794	2008	(blank)	2.973€
Appui au développement de stratégies municipales de santé à Bamako et Ouagadougou		221876	2009	2009	930.915€





## 2 Annex 6: Country case study Democratic Republic of Congo

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

Thematic case study  
DEMOCRATIC REPUBLIC OF CONGO



## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>43</b>
1.1.1	Country context of EC support.....	43
1.1.2	EU funds between 2002-2010 .....	43
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>46</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	46
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	48
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	50
1.2.4	JC 14 Increased or maintained quality of service provision .....	51
<b>1.3</b>	<b>EQ2- Affordability of health: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>52</b>
1.3.1	JC 21 The cost of basic health care services are reduced for households due to EC support.....	52
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC .....	53
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC .....	54
1.3.4	JC 24 Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC .....	54
<b>1.4</b>	<b>EQ 3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>55</b>
1.4.1	JC 31 Increase in availability of primary health care facilities .....	55
1.4.2	JC 32 Increase in availability of secondary health care facilities.....	57
<b>1.5</b>	<b>EQ4- Health service utilisation related to MCH: To what extent has EC support to health contributed to improving health service utilisation related to MCH?.....</b>	<b>58</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	58
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	60
1.5.3	JC 43 Children better protected from key health threats as a result of EC support.....	61
<b>1.6</b>	<b>EQ 5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?.....</b>	<b>62</b>
1.6.1	JC 51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	62
1.6.2	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.....	63
<b>1.7</b>	<b>EQ6 Coordination, complementarity and synergy : To what extent and how has the EC contributed to strengthening government-led coordination, 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>	<b>64</b>
1.7.1	JC 61 Level of health sector-related coordination in place with active role/contribution of the EC .....	64
<b>1.8</b>	<b>Annex .....</b>	<b>65</b>

1.8.1	Key documentation used for the analysis .....	65
1.8.2	EC contribution per sector, modality and channel .....	66
1.8.3	Overview of funds committed to the country's health sector .....	69

**List of tables**

Table 1:	Overview of main programmes/funds and sectors .....	44
Table 2:	Small EC financed interventions to the health sector between 2002-2010 .....	44
Table 3:	Concrete results of PS9FED at the end of 2008 .....	47
Table 4:	Results of PS9FED at the end of 2008 .....	49
Table 5:	Percentages of Women with Specific Problems in Accessing Health Care for Themselves: Getting money for treatment .....	52
Table 6:	Concrete results of PS9FED at the end of 2008 .....	53
Table 7:	Results of PS9FED at the end of 2008 .....	55
Table 8:	Percentages of Women with Specific Problems in Accessing Health Care for Themselves: Distance to health facility .....	56
Table 9:	Results of PS9FED at the end of 2008 .....	57
Table 10:	Concrete results of PS9FED at the end of 2008 .....	59
Table 11:	Percentages of currently married women using any modern contraceptive method .....	59
Table 12:	Percentage of children age 12–23 months who received no specified vaccines at any time before the survey .....	60
Table 13:	Vaccination of children age 12–23 months by 12 months of age in DRC .....	60
Table 14:	Diarrhoea prevalence: Number of children .....	61
Table 15:	Diarrhoea treatment in DRC, 2002-2010 .....	62
Table 16:	Major interventions in the health sector during the period 2002-2010 .....	69
Table 17:	Small contracts in the health sector during the period 2002-2010 .....	69

## 2.1 Introduction

### 2.1.1 Country context of EC support

The Democratic Republic of the Congo (DRC) is one of the poorest countries in the world: the proportion of persons living below the poverty line was 80% in 2001 and 70.68% in 2005. Its fragile state is reflected in its poor public social services, healthcare in particular. The development of the social sectors in the DRC is faced with structural difficulties associated with poor governance and the repeated conflicts that have occurred. The precariousness of the social situation is exacerbated by the high prevalence of the HIV/AIDS pandemic, the destruction and lack of maintenance of social infrastructures, the existence of a large number of injured victims of the conflicts, and a significant increase in the number of orphans and street children.

Furthermore, the country is exposed to a resurgence of some epidemics that had formerly been controlled or eradicated (such as measles, whooping cough, plague, poliomyelitis, bacterial dysentery, cholera, and monkey pox), as well as diseases that have emerged more recently, such as HIV/AIDS and the hemorrhagic fever associated with the Ebola virus.

The health system in the DRC is organised in the form of a three-level pyramid, with the levels being: the Health Zone (HZ), the General Referral Hospital (GRH), and the Health Centre (HC). In the 1980s, the DRC was one of the first countries to undertake reforms based on primary health care integrated into HZs. Since 2003, the number of HZs has increased from 306 to 515. According to the PRSP (IMF, 2007), this new HZ map poses a number of problems, in particular: (i) the increased needs for human and infrastructure resources (General Referral Hospitals and HZ Central Offices, Health Centres, etc.); (ii) a decline in the functionality of the Zones resulting from the new distribution; and (iii) the mismatch between the demand for quality health care services and the proliferation of nonviable HZs.

The health sector faces two kinds of weaknesses: (i) the availability and use of quality health services; and (ii) the spatial organisation of services. The inability to go see a physician or obtain care is one of the most telling symptoms of poverty. There is therefore a predominance of self-medication and recourse to traditional medicine. According to the Health and Poverty Status Report (RESP) on the DRC, the average rate of use of health services is approximately 0.15 consultations per person per year. Regarding the use of hospital services, the number of hospital admittances, which was 35 per 1,000 inhabitants in the 1980s, dropped to 15 per 1,000 inhabitants in 2001.

The share of the State budget devoted to health has dropped significantly, reaching a proportion of less than 1%. A tendency to withdraw from the sector has been observed on the part of the development partners. This situation has caused deterioration in the health system and led households to assume almost the entire financial cost of health services in the absence of a well organised health insurance system. Since 2002, there has been an increase in the financing of the health sector, partially attributable to the financing of certain projects in the sector focused on AIDS, malaria, and tuberculosis.<sup>23</sup>

### 2.1.2 EU funds between 2002-2010

The support for the health sector is a component of EC strategy in the DRC since 1994. In response to the deterioration of health services after the discontinuation of most external assistance in 1992, the EC introduced in 1994 the PATS program to support the "transition" of the health sector. This support, focused on the structures and health services, was followed by two other programs 1997-2005 and 2006-2011 (Programme Santé 9ème FED, PS9FED), focusing on rehabilitation of the sector. The continued support of nearly two decades in the health system in the DRC is a strong element of the EC strategy in the DRC. It is among the most constant and continuous axes of the EC strategy in the DRC (together with infrastructure).<sup>24</sup>

Between 2002 and 2010, the total amount of funds provided by the EU to the health sector in the DRC was EUR 92.48 million.

The totality of this amount was provided via the project modality. Table 12 gives an overview of the main programme funded by the EC in the health sector during the period under evaluation:

<sup>23</sup> This section is mainly based on International Monetary Fund (2007): Democratic Republic of the Congo: Poverty Reduction Strategy Paper, IMF Country Report No. 07/330, Washington, D.C., June 2006

<sup>24</sup> SOFRECO (2007): Evaluation de la stratégie de coopération de la Commission européenne avec la République démocratique du Congo, Rapport Final, Juin 2007

Table 12: Overview of main programmes/funds and sectors

Title of the intervention	Decision number	Decision starting year	Committed amount for the intervention
Programme Santé 9ème FED (PS9FED)	FED/2005/017-858	2005	EUR 74.624.577

Source: Particip inventory, 2011

The PS9FED is most important programme funded by the EC in the health sector and had, not only because of the considerable monetary funds, a wide reach within the whole health sector. According to the capitalisation report on the PS9FED<sup>25</sup>, the PS9FED has contributed to the stabilisation of the health sector in the country and is, on a system level, showing positive impacts: «Le PS9FED a été mis en œuvre à la suite du Programme d'appui transitoire au secteur santé, intervenant lui-même dans une situation de désorganisation avancée du système de santé et de désaffectation totale de l'Etat aussi bien sur le plan de la régulation que sur celui du financement des soins de santé. En redonnant durablement aux zones de santé et aux FOSA appuyées la capacité de travailler dans de nouvelles conditions, le PS9FED a incontestablement eu un impact positif auprès des prestataires aussi bien que des patients. (...) De plus, le PS9FED a choisi une voie nouvelle en orientant une grande partie de son financement au niveau des formations sanitaires et en particulier au niveau des prestations médicales effectivement réalisées. Pour ce faire, le PS9FED a mené une approche originale et opté dès le départ pour des mécanismes visant la durabilité en instaurant – plutôt que des agences d'achat appuyées par des ONG – des fondations d'utilité publique congolaises.»<sup>26</sup>

The following table gives an overview over small interventions to the health sector:

Table 13: Small EC financed interventions to the health sector between 2002-2010

Contracts Title	Decision No	Contract no	Contract year	Decision year	Total
APPUI STRUCTUREL AU FONCTIONNEMENT DE LA ZONE DE SANTE DE KATANA, SUD-KIVU, R.D. CONGO	ONG-PVD/2002/01-092	20810	2002	2002	EUR 251.468
MEDAIR-AMELIOR ACCES SOINS POP DEPL ET VULN HAUT ET BAS UELE <i>Décision REHABILITATION DE GOMA ET ASSISTANCE SANITAIRE AUX POPULATIONS DEPLACEES ET VULNERABLE EN PROVINCE ORIENTALE</i>	FED/2002/015-894	187832	2002	2002	EUR 2.785.077
ACTION CONTRE LA FAIM - RENFORCEMENT SECURITE ALIMENTAIRE ET NUTRITIONNELLE - MALEMBA NKULU (KATANGA)	FED/2003/016-469	190883	2004	2003	EUR 213.865
Réhabilitation nutritionnelle et maintien de la santé des enfants mal nourris du réseau nutritionnel BDOM de Kinshasa	FOOD/2004/017-016	106255	2005	2004	EUR 871.515
Appui aux zones de santé urbaines de Matete, Ngaba et Kisenso à Kinshasa, République démocratique du Congo	ONG-PVD/2004/06-239	95333	2005	2004	EUR 691.969
LA PROMOTION DE SANTE PUBLIQUE POUR LA POPULATION LOCALE ET DEPLACEE A NORD-KIVU ET A ITURI, REPUBLIQUE DEMOCRATIQUE DU CONGO	ONG-PVD/2004/06-239	94971	2005	2004	EUR 1.441.776
PROGRAMME D'APPUI A LA REHABILITATION (PAR II)	FED/2002/015-990	188302	2005	2002	EUR 223
MEDAIR ASSISTANCE SECTEUR SANTE EN HAUT ET BAS UELE <i>Décision : REHABILITATION ET REINTEGRATION SOCIO-ECONOMIQUE APRES LA GUERRE, DANS LES REGIONS</i>	FED/2003/016-469	190891	2005	2003	EUR 440.000

<sup>25</sup> De Caluwe, Paul ; Menard, Sylviane (2010) : mission de capitalisation du projet sante 9ème FED et recommandations pour le PA PNDS, 2ème partie. Nov. 2010

<sup>26</sup> De Caluwe, Paul ; Menard, Sylviane (2010) : mission de capitalisation du projet sante 9ème fed et recommandations pour le PA PNDS, 2ème partie. Nov. 2010



<i>Contracts Title</i>	<i>Decision No</i>	<i>Contract no</i>	<i>Contract year</i>	<i>Decision year</i>	<i>Total</i>
<i>DE L'EST DE LA RDC</i>					
MEDAIR SANTE AU HAUT ET BAS-UELE	FED/2003/01 6-469	190894	2005	2003	EUR 500.000
Renforcement de l'offre scolaire maternelle et primaire et de formation professionnelle pour des enfants, adolescents et jeunes adultes en situation de handicap – Congo <i>Décision : REHABILITATION ET REINTEGRATION SOCIO-ECONOMIQUE APRES LA GUERRE, DANS LES REGIONS DE L'EST DE LA RDC</i>	ONG- PVD/2005/0 17-215	119591	2006	2005	EUR 749.100
ASSISTANCE MEDICALE A 13 ZONES DE SANTE DANS LA PROVINCE ORIENTALE	FED/2003/01 6-469	190895	2006	2003	EUR 285.460
MEDECINS DU MONDE FRANCE-APPUI AU SYSTEME DE SANTE ET RENFORCEMENT CAPACITES DISTRICT SANITAIRE DU TANGAYIKA/KATANGA/RDC <i>Décision : REHABILITATION ET REINTEGRATION SOCIO-ECONOMIQUE DANS LES REGIONS DE L'EST DE LA R.D.C. (LRRD)</i>	FED/2006/02 0-696	196135	2006	2006	EUR 3.760.956
PHARMACIENS SANS FRONTIERES-REVITALISATION DE 11 ZS DU TANGANYIKA PAR UN CIRCUIT D'APPRO EN MEDICAMENTS ET CONSOMMABLES	FED/2006/02 0-696	196136	2006	2006	EUR 2.499.938
Amélioration de l'hygiène hospitalière et communautaire de Kinshasa et du Bas Congo par la mise en place d'une Cellule pour la Promotion des Pratiques d'Hygiène (CEPPHY)	ONG- PVD/2006/0 18-227	135022	2007	2006	EUR 339.359
Appui au développement et renforcement des activités en santé de la reproduction dans les zones de santé de Katana et Idjwi, Province du Sud Kivu.	ONG- PVD/2006/0 18-227	135088	2007	2006	EUR 750.000
Appui aux programmes de santé de base dans la zone de santé de Miti Murhesa en province du Sud-Kivu -RD Congo	ONG- PVD/2007/0 19-404	171664	2008	2007	EUR 170.000
Contribuer à l'amélioration de la santé des populations des territoires de Beni, Irumu et Mambasa, au Nord-Est de la République Démocratique du Congo	ONG- PVD/2007/0 19-404	171689	2008	2007	EUR 175.960
Amélioration de l'accès des drépanocytaires aux services de santé	ONG- PVD/2008/0 20-081	228357	2009	2008	EUR 200.000
Prise en charge à base communautaire des personnes infectées et affectées par le VIH/SIDA.	ONG- PVD/2008/0 20-081	228668	2009	2008	EUR 178.815
Appui à l'action du Ministère de la Santé dans la mise en œuvre de la Stratégie de Renforcement du Système de Santé (SRSS) dans les Zones de Santé de Matete, Ngaba et Kisenso à Kinshasa	DCI- NSAPVD/20 09/021-105	237459	2010	2009	EUR 118.725
Programme d'amélioration de la santé des enfants des rues, de lutte contre les IST et le VIH/SIDA, de prise en charge de la santé de la reproduction et de protection des filles des rues dans trois districts de Kinshasa	DCI- NSAPVD/20 09/021-105	233698	2010	2009	EUR 162.758
Amélioration de l'accès aux services de santé sexuelle et génésique et aux services destinés aux victimes de maltraitements et de viols dans le Sud Kivu	DCI- SANTE/2009 /021-136	238129	2010	2009	EUR 1.270.678

Source: Particip inventory, 2011

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

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

#### Indicators

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

#### 2.2.1.1 Findings per indicators

**I-111:** The DRC has a National System of Supply of Essential Drugs (SNAME<sup>27</sup>), coordinated by the National Supply of Essential Drugs (PNAM<sup>28</sup>) to implement the national drug policy (PPN<sup>29</sup>). The SNAME is based on the centralisation of drug purchasing via two purchasing agencies, the BCAF<sup>30</sup> in Kinshasa and ASRAMES<sup>31</sup> in Goma, as well as on the decentralisation of drugs distribution and other health products at the provincial level via a network of 15 regional drug distribution centres (CDR<sup>32</sup>).

The national drug policy is supported by the EC in the framework of the coordination group of major donors and international partners in the sector donor coordination group GIBS<sup>33</sup>. Over the period of evaluation, the EUD has become a reference in the health sector. It has contributed significantly, with the help of Belgian cooperation, to create and to support the GIBS, in which the EUD was a core actor.<sup>34</sup>

The EAMR from July 2006 reported on the dynamism of the thematic group GIBS in the health sector, which has taken significant initiatives involving representatives from the MoH. In particular, a workshop has been organised with the EUD, the coordinator of the GIBS, the Minister of Health, the NAO and other partners. In the framework of the implementation of the SNAME, another workshop has been organised gathering the CDR, in collaboration with the MoH and the PNAM.<sup>35</sup>

Through these activities, the EC has significantly contributed to the definition and implementation of improved drug policies in DRC.

**I-112:** The supply of essential drugs has been improved and stock-outs of drugs decreased with the contracts between FEDECAME<sup>36</sup> and different regional distribution centres (CDRs).<sup>37</sup> Over the period of evaluation, the EC contributed to the implementation of a system for supply and distribution of drugs, which has been considered in the CSE from 2007 as the only way to deliver medicines of appropriate quality at reasonable prices.<sup>38</sup>

In particular the EC funded the Transitional Support Programme to the Health Sector (PATS)<sup>39</sup>, which has been implemented between 1998 and 2005 and contributed to create a national supply of essential generic drugs of good quality at competitive prices. Management teams in areas of health and provinces have been professionalised.<sup>40</sup> During its second phase, PATS II also led to significant results, including the establishment of a functioning health system in North Kivu. However, the launching of the federation of centres supplying essential drugs FEDECAME was difficult mainly due to insufficient financial resources and a weak management team. The review of activities and results of the PATS II established by the programme coordinator (AEDES) in early March 2005 and highlighted the following results concerning the supply of drugs:

<sup>27</sup> *Système National d'Approvisionnement en Médicaments*

<sup>28</sup> *Programme National d'Approvisionnement en Médicaments*

<sup>29</sup> *Politique Pharmaceutique Nationale*

<sup>30</sup> *Bureau de Coordination des Achats de la FEDECAME*

<sup>31</sup> *Association Régionale d'Approvisionnement en Médicaments Essentiels*

<sup>32</sup> *Centrales de Distribution Régionale de médicaments*

<sup>33</sup> *Groupe de coordination Inter Bailleurs Santé*

<sup>34</sup> SOFRECO (2007)

<sup>35</sup> EAMR 7/2006

<sup>36</sup> Acronym for « *Fédération des centrales d'Approvisionnement en Médicaments Essentiels* »

<sup>37</sup> Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note DRC

<sup>38</sup> SOFRECO (2007)

<sup>39</sup> *Programme d'Appui Transitoire au Secteur de la Santé*

<sup>40</sup> SOFRECO (2007)

- Continued support to the regional association of supply of essential drugs ASRAMES<sup>41</sup> (North Kivu, following the ECHO support)
- Installation of three CDRs and supply of Health Zone (HZ)
- Installation of FEDECAME.<sup>42</sup>

During the 9<sup>th</sup> EDF, the Health Program PS9FED, signed in 2005 and focusing on four provinces (North Kivu, the two Kasai Oriental Province), implicitly aimed at establishing an efficient supply of good quality generic drugs before the full deregulation of the private market for drug.

Table 153 highlights the results achieved at the end of 2008 by the PS9FED programme, by province. The total value of provided drugs amounted EUR 3,598,290 in 2008.

Table 14: Concrete results of PS9FED at the end of 2008

	North Kivu	Eastern Province	West Kasai	East Kasai	Total
<b>Target</b>					
Population totale de la Province	5,411,000	7,669,000	6,772,000	8,211,232	<b>28,063,875</b>
<b>Inputs</b>					
<b>Support to access to care</b>					
Valeur totale des médicaments livrés en 2008	EUR 1,358,622	EUR 1,244,199	EUR 647,444	EUR 348,025	<b>EUR 3,598,290</b>

Source: Data from PS9FED, Tableau de bord du PS9FED en fin 2008, available online:

<http://ps9fed.609.be/index.php?page=resultats-2>

According to the Mid-term review of the PS9FED (2009)<sup>43</sup>, the establishment of a supply system shows good results and can be seen as a success in relation to drug supply. The same conclusion can be read in the capitalisation report PS9FED: « Cette évolution a été facilitée par la mise à disposition de médicaments au travers des CDR; de manière concomitante, le PS9FED a grandement renforcé le système d'approvisionnement préconisé par la politique nationale en la matière (FEDECAME-CDR). On a assisté à une augmentation significative des taux d'utilisation des structures de santé; ces augmentations concernant à la fois les prestations curatives et préventives. »<sup>44</sup>

However, when looking at drug prescription the same MTR notes that it is still of very bad quality which also leads to mis-prescription and mis-use of drugs.

In addition, two projects funded by the EDF B envelope launched in 2002 in the health sector supported the installation of a pharmaceutical store to ensure a steady supply of quality essential medicines.<sup>45</sup>

In the framework of LLRD<sup>46</sup>, the project "Revitalisation of 11 Health Zones (HZ) in Tanganyika" has been implemented by the International Committee of Pharmacists without Borders (PSF CI) between 2006 and 2009. It aimed at establishing of a sustainable supply system of Generic Essential Drugs (MEG) in 11 HZ of the District of Tanganyika. The programme aimed at installing a Tanganyika central agency for essential drugs purchasing and distribution (CADMETA<sup>47</sup>) in the capital of the District, Kalemie. Three deposits linked to CADMETA were created to allow the CADMETA deliveries into each Central Bureau of Health Zone (BCZS), in order to address the poor state of transport networks in the District, and the financial difficulty of BCZS and health facilities (*Formations Sanitaires* - FoSa) to centralise their supply in the District. Mid 2009, the availability of drugs in the HZ had already increased, logistics costs had decreased, and there was a better management of the pharmacy. An improved quality health care delivered in health facilities and the opening up of more remote areas are underlined by the increase in attendance rates of FoSa which rose from 19% to 32% in the health

<sup>41</sup> Acronym for « Association Régionale d'Approvisionnement en Médicaments Essentiels »

<sup>42</sup> SOFRECO (2007)

<sup>43</sup> ECO (2009) : Mission d'évaluation à mi-parcours du Programme Santé 9ème FED (PS9FED)- RDC – rapport final, Mai 2009

<sup>44</sup> Caluwe, P. ; Menard, S. (2010)

<sup>45</sup> SOFRECO (2007)

<sup>46</sup> Linking Relief, Rehabilitation and Development

<sup>47</sup> Acronym for « Centrale d'achat et de distribution des médicaments du Tanganyika »

facilities supported by the project<sup>48</sup>. The better availability of quality Generic Essential Drugs potentially contributes to social and economic development of even non-target communities.<sup>49</sup>

### 2.2.1.2 Resume of the JC

The DRC has a National System of supply of essential drugs (SNAME<sup>50</sup>), coordinated by the National Supply of Essential Drugs (PNAM<sup>51</sup>) to implement the national drug policy (PPN<sup>52</sup>). The EC is supporting the national drug policy in the framework of the health thematic group GIBS.

Over the period of evaluation, the EC has implemented several projects and programmes contributing to the implementation of a system for supply and distribution of drugs.

In all, it is safe to conclude that EC support contributed significantly to improved availability of essential drugs in DRC over the evaluation period.

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

### Indicators

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

#### 2.2.2.1 Findings per indicators

**I-121:** The EC intervention has supported the mix of primary and secondary health facilities.

One of the specific objectives of PATS II was to support regionally the coordination and supervision of HZ and support the priority needs of regional hospitals (basic surgery, blood transfusion safety).

In the framework of the 9<sup>th</sup> EDF Health Programme (PS9FED), basic infrastructure has been improved (35% of budget) and there has been a more efficient use of resources compared to the PATS II. Patients have been more encouraged to go to secondary structures, but rural population often did not use the peripheral health centres and went rather directly to hospitals. This problem was lessened during implementation of PS9FED because drugs were then available, staff was more present at work and the cost of services decreased from the equivalent of USD 6 to USD 1 per consultation.<sup>53</sup>

According to the EUD, the EC also supported action research on result based financing in the health sector on a big scale. More than 750 health facilities were contracted in the 9EDF project with performance based payment schedules. Practical conclusions on management plans, performance evaluation and payment modalities have been worked out.

**I-122:** Over the period of evaluation, EC intervention has given a particular attention to guarantee access of the population to well equipped health facilities. Between 2002 and 2006, about a hundred HZs received support funded from the EC. This support improved health care for about 2 to 2.5 million people (calculation based on the attendance rate of health facilities currently observed at national level). This improvement has been particularly significant in some areas such as North Kivu.<sup>54</sup>

Already at the time of PATS I, implemented in the Province of Kinshasa, the two Kasai, North and South Kivu and Maniema, the main objective was to provide health care by maintaining the functioning of remaining functional health facilities in six provinces. Along this line, the overall goal of PATS II was to maintain and enhance the level of access and quality of care obtained at the end of PATS I in selected areas.<sup>55</sup>

PATS II contributed to maintain access to quality health services which is a success during the transitional context of the period of implementation. In addition, blood transfusion has been secured in some hospitals, particularly those supported by MEMISA. In the framework of PATS II many health facilities were equipped. However, there was a gap of 18 months between this project ending in 2005

---

<sup>48</sup> Data from Pharmacists without Borders, Narrative Report 2009

<sup>49</sup> LRRD, C-196136, Pharmaciens Sans Frontières - Revitalisation de 11 ZS du Tanganyika par un circuit d'approvisionnement en médicaments et Consommables, Rapport de Monitoring MR-122265.01, 10/07/2009

<sup>50</sup> *Système National d'Approvisionnement en Médicaments*

<sup>51</sup> *Programme National d'Approvisionnement en Médicaments*

<sup>52</sup> *Politique Pharmaceutique Nationale*

<sup>53</sup> Particip (2008)

<sup>54</sup> SOFRECO (2007)

<sup>55</sup> SOFRECO (2007)

and PS9FED, whose activities started in 2007. During this period, much of the equipment disappeared.<sup>56</sup>

One of the main objectives of the 9th EDF Health Program was to increase the quality and accessibility of health services in the four targeted provinces, with the specific objective of increased performance of the provision of care.<sup>57</sup>

Table 15 highlights the results achieved at the end of 2008 by the PS9FED programme, by province. In total, 41 health centres were being rehabilitated and 160 were being equipped, amounting total estimated investments of respectively EUR 3,729,000 and EUR 3,410,000.

Table 15: Results of PS9FED at the end of 2008

	North Kivu	Eastern Province	West Kasai	East Kasai	Total
<b>Target</b>					
Population totale de la Province	5,411,000	7,669,000	6,772,000	8,211,232	<b>28,063,875</b>
<b>Inputs</b>					
<b>Support to access to care</b>					
Nombre de centres de santé ciblés par le FASS <sup>58</sup> MEG	464	712	159	113	<b>1 448</b>
Nombre d'hôpitaux ciblés par le FASS MEG	25	37	14	17	<b>93</b>
Nombre de CS bénéficiant d'une subvention en numéraire	61	65	117	77	<b>320</b>
Nombre d'Hôpitaux bénéficiant d'une subvention en numéraire	6	9	12	17	<b>44</b>
<b>Investments</b>					
Nombre de CS en cours de réhabilitation ou de reconstruction	12	8	13	8	<b>41</b>
Nombre de CS en cours d'équipement	40	40	40	40	<b>160</b>
montant de l'investissement consenti en réhabilitation dans les provinces (estimations)	EUR 896,000	EUR 762,000	EUR 837,000	EUR 1,234,000	<b>EUR 3,729,000</b>
montant de l'investissement consenti en équipement dans les provinces (estimations)	EUR 910,000	EUR 754,000	EUR 940,000	EUR 806,000	<b>EUR 3,410,000</b>
<b>Support to regulation (intermediate and peripheral level)</b>					
Nombre de zones de santé bénéficiant d'un appui intensif	6 (+8 en préparation)	7	10	9	<b>36</b>
Valeur moyenne mensuelle de l'appui au niveau intermédiaire et périphérique	EUR 110,000	EUR 117,000	EUR 105,000	EUR 100,000	<b>EUR 432,000</b>

Source: Data from PS9FED, Tableau de bord du PS9FED en fin 2008, available online: <http://ps9fed.609.be/index.php?page=resultats-2>

<sup>56</sup> Particip (2008)

<sup>57</sup> SOFRECO (2007)

<sup>58</sup> Fonds pour l'achat des soins de santé



The capitalisation report highlights that the PS9FED did not targeted properly the question of the financing of maintenance of health facilities. That's why parts of the financing for equipment and investment have been taken from the drug credit line.<sup>59</sup>

In addition the two projects funded on the EDF B envelope and implemented between 2002 and 2005, contributed to the improved functioning of 600 health facilities. Both interventions had good results. For example, in the Eastern Province, 341 health facilities were supported, which represented 18% more than the objective set, the number of direct beneficiaries (i.e. the number of patients treated) was 1.5 million over a period of two and a half years, which corresponded to 85% of the target.<sup>60</sup>

The EC contributed to improved health financing in North Kivu. In the framework of the PATS II, a credit line has been set up to fund 80% of the drug purchased by health facilities.<sup>61</sup>

### 2.2.2.2 Resume of the JC

Over the period of evaluation, EC intervention has given a particular attention to guarantee access of the population to well equipped primary and secondary health facilities.

Between 2002 and 2006, about a hundred HZs received support funded from the EC. This support has improved health care for about 2 to 2.5 million people.

The EC also contributed to improved financing of pharmaceuticals in North Kivu. In the framework of the PATS II, a credit line has been set up to fund 80% of the drug purchased by health facilities.

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

#### Indicators

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

#### 2.2.3.1 Findings per indicators

**I-131:** From the documents available so far, there is no evidence of EC support that could have affected this indicator.

**I-132:** The EC intervention contributed to improve the training of health workers.

One of the specific objectives of PATS II was to further support the activities of primary health care of HZs at peripheral level, with emphasis on the quality of care through better training, and strengthening of HZ structures in their core functions. In particular, the PATS II supported the training of nationals at the School of Public Health. In 2005, just before the end of the EC funded PATS II, the programme coordinator (AEDES) undertook a review of activities and results. Positive results in terms of capacity building with training, supervision, coordination of partners, improvement of health information systems, have been highlighted in the Provincial Health Inspection<sup>62</sup> of North Kivu and Kinshasa. However, fewer results have been noted in other provinces as budgets and skills of NGOs have proved inadequate.<sup>63</sup>

The 9th EDF support programme to health sector in DRC included a training component of management teams of health zones, starting with 27 health zones, representing six to seven per targeted province. The management teams of health zones were indeed facing various difficulties in carrying out their missions, including: lack of adequate and appropriate staff, staff turnover, but also the lack of skills or qualifications. Furthermore, staff was not motivated due to inadequate salaries and monitoring as well as the absence of positive or negative sanctions on their work.<sup>64</sup>

In the framework of PS9FED, the contracted NGOs were responsible for initial and continuing education of staff and for the strengthening of local structures of the Ministry. AEDES office staff in each province was responsible for the supervision activities.<sup>65</sup>

**I-133:** From the documents available so far, there is no evidence of EC support that could have affected this indicator.

---

<sup>59</sup> Caluwe, P. ; Menard, S. (2010)

<sup>60</sup> SOFRECO (2007)

<sup>61</sup> SOFRECO (2007)

<sup>62</sup> IPS (*Inspection Provinciales de la Santé*)

<sup>63</sup> SOFRECO (2007)

<sup>64</sup> Particip (2008)

<sup>65</sup> Particip (2008)

Through the TA of the PS 9FED which finances local personnel, the EC has influence on the health workers recruitment and working conditions. The MTR highlights that the TA often recruits personnel in post in state structure for the local health facilities. This personnel is remunerated through a mechanisms of bonus on the consolidated revenues of the health centres (issued through the consultations and purchase within the health facilities), which has been officialised according to the capitalisation report. According to the same report, this system of bonus has helped to motivate the health personnel and has contributed to a certain dignity in their work. In the region North Kivu the median salary has doubled for personnel of health centres and tripled for hospital staff throughout the period of existence of the FASS.<sup>66</sup>

**I-134:** From the documents available so far, there is no evidence of EC support that could have affected this indicator.

### 2.2.3.2 Resume of the JC

The EC funded PATS II and PS9FED have contributed to improve the training of health workers. No evidence was found related to the actual availability per capita of workers, or their attrition or absenteeism rates.

## 2.2.4 JC 14 Increased or maintained quality of service provision

### Indicators

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

### 2.2.4.1 Findings per indicators

**I-141:** From the documents available so far, there is no information on EC support.

**I-142:** From the documents available so far, there is no information on EC support.

The PS9FED aimed at tackling clinical treatment processes in its first component. However, the MTR<sup>67</sup> of 2009 highlights that these processes are not systematically applied in the training of health staff. The component 1 “volet performance - L'organisation de la mise en œuvre et de la gestion des programmes de soins curatifs/prescription rationnelle” must be seen as very little advanced, according to the MTR.

According to the capitalisation report<sup>68</sup>, EC support under the PS9FED has helped to put in place a methodology and techniques to insure quality, especially in the regional clinics (Hôpital Général de Référence, HGB). The following has been implemented:

- « De protocoles médicaux et d'attitudes thérapeutiques adaptées aux circonstances
- Un modèle de dossier médical standard
- Mise en place de « projets médicaux » clarifiant les missions et les besoins conséquents des formations sanitaires
- Une grille d'analyse standard - De la mise en place d'audits cliniques et d'analyse des événements critiques
- La mise en place d'audits cliniques et d'analyse des événements critiques
- La mise en place d'un processus d'analyse par les pairs, destiné à doter les formations sanitaires d'un bonus qualité »

**I-143:** From the documents available so far, there is no evidence of EC support.

### 2.2.4.2 Resume of the JC

The PS9FED has aimed with its component 1 “volet performance” to introduce quality assurance mechanisms, especially in regional hospitals. These mechanisms are: medical protocols, a standard medical dossier as well as a standard analysis grid. Furthermore audit and analysis of critical events are introduced as well as an analysis of processes by pairs.

<sup>66</sup> Caluwe, P. ; Menard, S. (2010)

<sup>67</sup> ECO (2009)

<sup>68</sup> Caluwe, P. ; Menard, S. (2010)



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

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

#### Indicators

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

#### 2.3.1.1 Findings per indicators

**I-211:** Cost is a major barrier to seeking needed health care services. For example, according to the DHS 2007, 75.6% of women had problems in getting money for treatment. This proportion was higher in rural area where it reached 83.2% in the same year.

Due to a significant increase in the share of health expenditure financed by the public sector, the share of out of pocket payments in total health expenditure is reported by WHO (WHO, 2011) to have declined from 80.3% to 58% between 2002 and 2009.

Table 16: Percentages of Women with Specific Problems in Accessing Health Care for Themselves: Getting money for treatment

Total	Residence	
	Urban	Rural
75.6	66.4	83.2

Source: DHS 2007 DRC, ICF Macro 2011. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - November 14 2011

EC intervention contributed to this change, in particular through the 9th EDF Health Program. One of the objectives of the PS9FED was to provide preventive and curative care against a patient's contribution towards cost of medical treatment based on the local average income of the population.<sup>69</sup> In East Kasai, for example, the cost of care delivery decreased from USD 6 to USD 1.<sup>70</sup>

The new system of health financing underlying the PS9FED was based on affordability: consultation fees were modulated according to the average income of the population in the Health Zone and performance in the quality of health care was remunerated. The design of this health system was shared by several external partners and several responsables from the MoH. This system has encouraged improved access to health services of quality.<sup>71</sup>

Table 17 shows the results achieved at the end of 2008 by the PS9FED programme in the four provinces. A total of 5,168,580 consultations have been subsidised in health centres in 2008.

<sup>69</sup> SOFRECO (2007)

<sup>70</sup> Particip (2008)

<sup>71</sup> SOFRECO (2007)

Table 17: Concrete results of PS9FED at the end of 2008

	North Kivu	Eastern province	West Kasai	East Kasai	Total
<b>Target</b>					
Population totale de la Province	5,411,000	7,669,000	6,772,000	8,211,232	<b>28,063,875</b>
<b>Outputs</b>					
Nombre de nouveaux cas de consultation subventionnés dans les CS en 2008	2,743,703	1,681,727	565,260	177,890	<b>5,168,580</b>

Source: Data from PS9FED, Tableau de bord du PS9FED en fin 2008, available online: <http://ps9fed.609.be/index.php?page=resultats-2>

**I-212:** No information obtained.

**I-213:** From the documents available so far, there is no evidence of EC support.

### 2.3.1.2 Resume of the JC

The share of out of pocket payments in total health expenditure is reported by WHO to have declined from 80.3% to 58% between 2002 and 2009. EC intervention seems to have contributed to this change. The new system of health financing underlying the PS9FED was based on affordability, depending on average income of the population in the Health Zone.

However, there is no evidence so far that EC intervention contributed to the changes in the share of health expenditure financed by social security schemes, in health insurances contribution rates and in proportion of the population covered by public health insurance.

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

#### Indicators

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

#### 2.3.2.1 Findings per indicators

**I-221:** The EC intervention contributed to a better financial access of the poor to health care services.

Already the EC funded PATS II contributed to improve financial access to health care services in areas covered and thus contributed to improve social welfare.

Affordability became a key component of PS9FED. One of the objectives of the 9th EDF Health Program was free preventive and curative care against a patient's contribution towards cost of medical treatment based on the local average income of the population.<sup>72</sup> In East Kasai, for example, the cost of care delivery decreased from USD 6 to USD 1. In addition, an equity fund, acting like an insurance for the poor and ensuring a more equitable welfare system for the poor, started in July 2008. However, sustainability of the PS9FED does not seem to be guaranteed without good governance and economic progress in the country.<sup>73</sup>

In the framework of LLRD, the project "Support to Health System and Capacity Building" implemented between 2006 and 2009 in the Health District of Tangayika in Katanga Province, has achieved good results. In particular, in 2009 it has been noted that poor patients were receiving free medical care of good quality. In the following health programme, the implementation of a fixed rate adapted to the purchasing power of the population was expected to further strengthen the impact of the project.<sup>74</sup>

<sup>72</sup> SOFRECO (2007)

<sup>73</sup> Particip (2008)

<sup>74</sup> Médecins Du Monde France, Appui au Système de Santé et Renforcement des Capacités dans le District Sanitaire du Tangayika/Katanga/RDC, Rapport de Monitoring MR-122264.01, 10/07/2009

DRC was a significant beneficiary of GFATM finance aimed at subsidising treatment for the diseases of poverty. The EC contributed indirectly via its financing of GFATM.

**I-222:** From the documents available so far, there is no direct evidence of EC support that could have affected this indicator. However, the number of subsidised new health consultations in 2008 shown in Table 5 suggests strongly that EC support had concrete impact in the form of increased use of health care services.

### **2.3.2.2 Resume of the JC**

The EC intervention contributed to a better financial access of the poor to health care services, in the framework of the PATS II and PS9FED, which achieved good results. In East Kasai, for example, the cost of care delivery decreased from USD 6 to USD 1. In addition, an equity fund, acting like an insurance for the poor and ensuring a more equitable welfare system for the poor, has been created.

The fact that there were many health consultations in provinces benefiting from EC support suggests, but does not prove, that the EC contributed to increased health care service consumption.

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

#### **Indicators**

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

#### **2.3.3.1 Findings per indicators**

**I-231:** The EC funded 9<sup>th</sup> EDF health programme (PS9FED) contributed to capacity building of staff of the MoH in management, finance and administration through informal training of TA and the process of identifying the best current practices in the various programmes.<sup>75</sup>

Furthermore, the EC supported the health sector financing reform since 2009. This reform is creating a public central project management unit called 'cellule d'appui et de gestion' which is in charge of programmatic management and a network of non-state fiduciary agencies in charge of payments to suppliers and beneficiaries. The 9 EDF project has been implemented by the 'fonds d'achat de services de santé' who have become the provincial fiduciary agencies in the framework of this reform.

**I-232:** From the documents available so far, there is no evidence of EC support.

#### **2.3.3.2 Resume of the JC**

The EC funded 9<sup>th</sup> EDF health programme (PS9FED) contributed to capacity building of staff of the MoH in management, finance and administration through informal training of TA. The EC was especially involved in the health sector reform, starting 2009. This reform created public central project management units as well as a network of non-state fiduciary agency in charge of the payments of suppliers and beneficiaries.

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

#### **Indicators**

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

#### **2.3.4.1 Findings per indicators**

**I-241:** From the documents available so far, there is no evidence of EC support.

**I-242:** From the documents available so far, there is no evidence of EC support.

#### **2.3.4.2 Resume of the JC**

From the documents available so far, there is no evidence of EC support affecting global research partnerships to develop new treatments and medicines relevant to poor countries.

---

<sup>75</sup> 9 ACP RPR 011, Programme Santé 9ème FED (PS9FED)-DRC, Rapport de Monitoring MR-002210.02, 10/07/2009

## 2.4 EQ 3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?

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

#### Indicators

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

#### 2.4.1.1 Findings per indicators

**I-311:** EC intervention contributed to rehabilitate primary health care infrastructure, which directly contributed to increase the number of functioning primary care facilities.

In the framework of LLRD, the project “*Support to Health System and Capacity Building*” implemented between 2006 and 2009 in the Health District of Tangayika in Katanga Province, contributed to the increased use of 121 rehabilitated health care infrastructures (health centres, maternity centres and centres for the treatment of cholera).<sup>76</sup>

The 9<sup>th</sup> EDF health programme also contributed to increase the access to Primary Health Care, by the rehabilitation of primary health care infrastructures. At the end 2008, the EC was contributing to rehabilitate 41 Health Centres in the framework of PS9FED, as shown by Table 18.

Table 18: Results of PS9FED at the end of 2008

	North Kivu	Eastern Province	West Kasai	East Kasai	Total
<b>Target</b>					
Population totale de la Province	5,411,000	7,669,000	6,772,000	8,211,232	<b>28,063,875</b>
<b>Outputs</b>					
Taux d'utilisation des services atteint (en nombre de contact par habitant par an) en 2008 dans les zones de santé ciblées	0.5	0.37	0.34	0.17	<b>0.41</b>
<b>Inputs</b>					
<b>Support to access to care</b>					
Nombre de centres de santé ciblés par le FASS MEG	464	712	159	113	<b>1 448</b>
Nombre d'hôpitaux ciblés par le FASS MEG	25	37	14	17	<b>93</b>
Nombre de CS bénéficiant d'une subvention en numéraire	61	65	117	77	<b>320</b>
Nombre d'hôpitaux bénéficiant d'une subvention en numéraire	6	9	12	17	<b>44</b>
<b>Investments</b>					
Nombre de CS en cours de réhabilitation ou de reconstruction	12	8	13	8	<b>41</b>

<sup>76</sup> Médecins Du Monde France, Appui au Système de Santé et Renforcement des Capacités dans le District Sanitaire du Tangayika/Katanga/RDC, Rapport de Monitoring MR-122264.01, 10/07/2009

	North Kivu	Eastern Province	West Kasai	East Kasai	Total
Nombre de CS en cours d'équipement	40	40	40	40	160
Montant de l'investissement consenti en réhabilitation dans les provinces (estimations)	EUR 896,000	EUR 762,000	EUR 837,000	EUR 1,234,000	EUR 3,729,000
Montant de l'investissement consenti en équipement dans les provinces (estimations)	EUR 910,000	EUR 754,000	EUR 940,000	EUR 806,000	EUR 3,410,000
<b>Support to regulation (intermediate and peripheral level)</b>					
Nombre de zones de sante bénéficiant d'un appui intensif	6 (+8 en préparation)	7	10	9	36
Valeur moyenne mensuelle de l'appui au niveau intermédiaire et périphérique	EUR 110,000	EUR 117,000	EUR 105,000	EUR 100,000	EUR 432,000

Source: Data from PS9FED, Tableau de bord du PS9FED en fin 2008, available online:

<http://ps9fed.609.be/index.php?page=resultats-2>

The Mid-term-review of the PS9FED highlights that the rehabilitation of health facilities are delayed 48 months after the beginning of the project.

**I-312:** In 2007, distance to health facility was a problem in accessing health care for 40.4% of women. This proportion was much higher in rural area as shown by Table 19.

Table 19: Percentages of Women with Specific Problems in Accessing Health Care for Themselves: Distance to health facility

Total	Residence	
	Urban	Rural
40.4	24	54.1

Source: DHS 2007 DRC, ICF Macro 2011. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - November 14 2011

Besides increasing the availability of primary care facilities, the EC also contributed to facilitate the access of the population to these infrastructures, by rehabilitation of roads, in particular in rural area.

In early March 2005, the review of activities and results of the PATS II by the programme coordinator (AEDS) highlighted that the EC support to health zones contributed to maintain or increase access rates of health facilities. The following trends have been underlined in the different regions:

- Slight upward trend in the provinces of Kinshasa and the two Kasai provinces (but very low starting level below 20%);
- Maintained rate in North Kivu (but good initial 40-50%);
- Significant improvement in the provinces of Bandundu and Bas Congo.<sup>77</sup>

In the framework of the Support program for Rehabilitation (PAR II) implemented between 2003 and 2007, the EC supported the rehabilitation of roads infrastructures in the DRC, both in urban and rural areas, to facilitate productive activities and contribute to meet the basic needs of populations, particularly in terms of water supply. Two projects have been assigned to two NGOs: the CDI-Bwamanda<sup>78</sup> that implemented the maintenance and rehabilitation of rural roads in the province of Ecuador, and the NGO "Solidarité" that contributed to improve and extend drinking water in the town of Beni. The activities of the CDI-Bwamanda have significantly and very positively contributed to the improvement of living conditions of people of the Ecuador province. The EC funded intervention

<sup>77</sup> SOFRECO (2007)

<sup>78</sup> Centre de Développement Intégré Bwamanda

implemented by “Solidarité” was considered to have a very positive potential impact on the health of the people in Beni.<sup>79</sup>

Thus we can infer that the EC intervention has contributed to reduce the time needed by the rural population to access health care facilities.

#### 2.4.1.2 Resume of the JC

The EC funded PS9FED contributed to rehabilitate primary health care infrastructure, which directly contributed to increase the number of functioning primary care facilities.

Besides increasing the availability of primary care facilities, the EC also contributed to facilitate the access of the population to these infrastructures (as for example with PATS II), in particular by the rehabilitation of rural roads (as for example in the framework of PAR II).

A major problem, noted by the MTR PS9FED is the fact that monitoring indicators related to number of treatments and population are often invalid. This is due to different reasons, mainly imprecise (often under-notification) number of treatments per health facilities and imprecise population figures.

Thus we can infer that the EC intervention has contributed to reduce the time needed by the rural population to access health care facilities.

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

##### Indicators

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

##### 2.4.2.1 Findings per indicators

**I-321:** EC intervention contributed to rehabilitate hospitals, which directly contributed to increase the number of functioning secondary care facilities.

In the framework of PS9FED, hospitalisation rates have increased and rates of intra-hospital mortality as well as postoperative infections decreased.<sup>80</sup>

At the end 2008, 93 hospitals were supported by FASS MEG and 44 hospitals were subsidised in the framework of the EC funded PS9FED, as shown by Table 20.

Table 20: Results of PS9FED at the end of 2008

	North Kivu	Eastern Province	West Kasai	East Kasai	Total
<b>Target</b>					
Population totale de la Province	5,411,000	7,669,000	6,772,000	8,211,232	<b>28,063,875</b>
<b>Outputs</b>					
taux d'utilisation des services atteint (en nombre de contact par habitant par an) en 2008 dans les zones de santé ciblées	0.5	0.37	0.34	0.17	0.41
<b>Inputs</b>					
<b>Support to access to care</b>					
Nombre de centres de santé ciblés par le FASS MEG	464	712	159	113	<b>1 448</b>
Nombre d'hôpitaux ciblés	25	37	14	17	<b>93</b>

<sup>79</sup> Programme D'appui à la Rehabilitation – PAR II, Rapport de Monitoring MR-01279.01 – 03/12/04

<sup>80</sup> 9 ACP RPR 011, Programme Santé 9ème FED (PS9FED)-DRC, Rapport de Monitoring MR-002210.02, 10/07/2009

	<i>North Kivu</i>	<i>Eastern Province</i>	<i>West Kasai</i>	<i>East Kasai</i>	<i>Total</i>
par le FASS MEG					
Nombre de CS bénéficiant d'une subvention en numéraire	61	65	117	77	<b>320</b>
Nombre d'Hôpitaux bénéficiant d'une subvention en numéraire	6	9	12	17	<b>44</b>
<b>Investments</b>					
Nombre de CS en cours de réhabilitation ou de reconstruction	12	8	13	8	<b>41</b>
Nombre de CS en cours d'équipement	40	40	40	40	<b>160</b>
montant de l'investissement consenti en réhabilitation dans les provinces (estimations)	EUR 896,000	EUR 762,000	EUR 837,000	EUR 1,234,000	<b>EUR 3,729,000</b>
montant de l'investissement consenti en équipement dans les provinces (estimations)	EUR 910,000	EUR 754,000	EUR 940,000	EUR 806,000	<b>EUR 3,410,000</b>
<b>Support to regulation (intermediate and peripheral level)</b>					
Nombre de zones de santé bénéficiant d'un appui intensif	6 (+8 en préparation)	7	10	9	<b>36</b>
Valeur moyenne mensuelle de l'appui au niveau intermédiaire et périphérique	EUR 110,000	EUR 117,000	EUR 105,000	EUR 100,000	<b>EUR 432,000</b>

Source: Data from PS9FED, Tableau de bord du PS9FED en fin 2008, available online : <http://ps9fed.609.be/index.php?page=resultats-2>

**I-322:** From the documents available so far, there is no evidence of EC support.

**I-323:** From the documents available so far, there is no evidence of EC support.

#### 2.4.2.2 Resume of the JC

EC intervention contributed to rehabilitate hospitals, which directly contributed to increase the number of functioning secondary care facilities.

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

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

##### Indicators

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

##### 2.5.1.1 Findings per indicators

**I-411:** In 2001, the proportion of pregnant women for whom childbirth was attended by trained medical personnel was 23.7%. In the same year, the proportion of pregnant women assisted in childbirth by



relatives, friends, or without assistance, was still close to 40%. The percentage of mothers excluded for financial reasons was ranging from 7% to 30%.<sup>81</sup>

The proportion of deliveries supervised by a skilled attendant has almost tripled between 2001 and 2007. According to the DHS 2007, 63% of deliveries have been assisted by qualified personnel carry out 58% institutional deliveries.<sup>82</sup>

Monitoring of IOV from the Logical Framework of PS9FED has shown improved birth rates in a protected environment (with an increase from 70% to 73% at the end of 2008) in the areas covered by the programme.<sup>83</sup>

Table 21: Concrete results of PS9FED at the end of 2008

	North Kivu	Eastern Province	West Kasai	East Kasai	North Kivu
<b>Target</b>					
Population totale de la Province	5,411,000	7,669,000	6,772,000	8,211,232	<b>28,063,875</b>
<b>Outputs</b>					
Nombre d'accouchements financés dans les CS (sur un an)	179,079	111,090	51,910	26,655	<b>368,734</b>
Taux d'accouchement en milieu protégé dans les zones de santé ciblées	83%	62%	78%	63%	<b>73%</b>

Source: Data from PS9FED, Tableau de bord du PS9FED en fin 2008, available online :

<http://ps9fed.609.be/index.php?page=resultats-2>

**I-412:** According to the DHS 2007, 80% of pregnant women were attending prenatal control.<sup>84</sup>

In the framework of the EC funded LIRD, there has been a good overall performance of the project "Support to Health System and Capacity Building" implemented between 2006 and 2009 in the Health District of Tangayika in Katanga Province. At the end of the project, pregnant women were attending operational maternity health facilities and received quality care. Furthermore, the project contributed to an improved quality of care for pregnant women diagnosed with high-risk pregnancies, in particular the adequate treatment of 100% of dystocia diagnosed in the five supported hospitals.<sup>85</sup>

**I-413:** At the beginning of the evaluation period, women's access to family planning services was still limited. In 2001, the prevalence of contraceptive use was 4.4% (MICS 2, UNICEF 2001).<sup>86</sup>

The prevalence of contraceptive increased over the period of evaluation and 5.8% of married women were using any modern contraceptive method in 2007. This proportion even reached 9.5% in urban areas as shown by Table 22.

However there is no evidence of EC support.

Table 22: Percentages of currently married women using any modern contraceptive method

Total	Residence	
	Urban	Rural
5.8	9.5	3.3

<sup>81</sup> International Monetary Fund (2007): Democratic Republic of the Congo: Poverty Reduction Strategy Paper, IMF Country Report No. 07/330, Washington, D.C., June 2006

<sup>82</sup> Particip (2008)

<sup>83</sup> 9 ACP RPR 011, Programme Santé 9ème FED (PS9FED)-DRC, Rapport de Monitoring MR-002210.02, 10/07/2009

<sup>84</sup> Particip (2008)

<sup>85</sup> Médecins Du Monde France, Appui au Système de Santé et Renforcement des Capacités dans le District Sanitaire du Tangayika/Katanga/RDC, Rapport de Monitoring MR-122264.01, 10/07/2009

<sup>86</sup> International Monetary Fund (2007): Democratic Republic of the Congo: Poverty Reduction Strategy Paper, IMF Country Report No. 07/330, Washington, D.C., June 2006

Source: DHS 2007 DRC, ICF Macro 2011. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - November 14 2011

### 2.5.1.2 Resume of the JC

The proportion of deliveries supervised by a skilled attendant has almost tripled between 2001 and 2007. With PS9FED, the EC contributed to improved birth rates in a protected environment in the areas covered by the programme.<sup>87</sup>

As concerns prenatal control, the EC funded LLRD contributed to improve the access of pregnant women to operational maternity health facilities and quality care.

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

#### Indicators

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

#### 2.5.2.1 Findings

**I-421:** In 2001<sup>88</sup>, 4.2 million children under age five suffered from malnutrition in the DRC. Approximately 10% of children were underweight at birth. Malnutrition and mortality rates among children under age five were higher among the poor. Acute malnutrition had increased among children under five, rising from 12% to 16%.<sup>89</sup>

From the documents available so far, there is no evidence of EC support affecting the percentage of children under five receiving regular growth monitoring.

**I-422:** In 2001, the proportion of children aged 12-23 months who had received all their vaccinations was only 29% (MICS 2, UNICEF 2001). A proportion of 41% of children who received the first dose of DTC vaccine did not receive the third.<sup>90</sup>

The vaccination rate did not increase much over the period of evaluation in DRC. In 2007, only 30.6% of children aged 12-23 months had received a vaccination. This proportion is even lower in rural area as shown by Table 23. In the same year, the vaccinations against Polio, DTP, BCG and measles were the most current in the first year of life.

Table 23: Percentage of children age 12–23 months who received no specified vaccines at any time before the survey

Total	Residence	
	Urban	Rural
30.6	38.7	25.4

Source: DHS 2007 DRC, ICF Macro 2011. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - November 14 2011

Table 24: Vaccination of children age 12–23 months by 12 months of age in DRC

Number of children	% showed vaccination card	None	Meas-les	Polio 3	Polio 2	Polio 1	Polio 0 (at birth)	DPT 3	DPT 2	DPT 1	BCG
1,585.00	24.3	17.6	62.9	45.7	67.5	77.7	44.4	45	59.1	70.6	71.7

Source: DHS 2007 DRC, ICF Macro 2011. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - November 14 2011

There is few evidence of EC support affecting immunisation rates from the documents available so far. In the framework of LLRD, there has been a good overall performance of the project “Support to Health System and Capacity Building” in the Health District of Tangayika. At the end of the project,

<sup>87</sup> 9 ACP RPR 011, Programme Santé 9ème FED (PS9FED)-DRC, Rapport de Monitoring MR-002210.02, 10/07/2009

<sup>88</sup> According to the MICS 2 survey (UNICEF 2001), cited in IMF (2007)

<sup>89</sup> International Monetary Fund (2007)

<sup>90</sup> International Monetary Fund (2007)

children were benefitting from preventive services, i.e. Expanded Programme on Immunisation (EPI) and advanced strategies of immunisation, in the area covered by the project.<sup>91</sup>

### 2.5.2.2 Resume of the JC

The vaccination rate did not increase much over the period of evaluation in DRC.

There is few evidence of EC support affecting immunisation rates from the documents available so far. In the framework of LLRD, the EC contributed to implement Expanded Programme on Immunisation and advanced strategies of immunisation for children in the area covered by the project.<sup>92</sup>

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

#### Indicators

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

#### 2.5.3.1 Findings per indicators

**I-431:** According to MICS 2 (2001)<sup>93</sup>, the prevalence of fever among children under five was 42%, which corresponds to a number of episodes, ranging from 6 to 10 per child per year. In the same year, it was estimated that 150,000 to 250,000 children under five years of age were dying from malaria each year.<sup>94</sup>

However, there is no evidence so far of EC support affecting the proportion of children sleeping under bednets.

**I-432:** In 2007, 8,009 children under five years had been ill with diarrhoea during the two weeks preceding the interview. However, there is no evidence of EC support from the documents available so far.

Table 25: Diarrhoea prevalence: Number of children

Births in three years preceding the survey			Births in five years preceding the survey		
Total	Residence		Total	Residence	
	Urban	Rural		Urban	Rural
5,003	1,984	3,019	8,009	3,186	4,823

Source: DHS 2007 DRC, ICF Macro 2011. MEASURE DHS STATcompiler - <http://www.statcompiler.com> - November 14 2011

**I-433:** In 2007, 42.3% of children under five were receiving oral rehydration and continued feeding to treat diarrhoea and 42% of household management of diarrhoea was based on oral rehydration salts (ORS). However, there is no evidence of EC support from the documents available so far.

<sup>91</sup> Médecins Du Monde France, Appui au Système de Santé et Renforcement des Capacités dans le District Sanitaire du Tangayika/Katanga/RDC, Rapport de Monitoring MR-122264.01, 10/07/2009

<sup>92</sup> Médecins Du Monde France, Appui au Système de Santé et Renforcement des Capacités dans le District Sanitaire du Tangayika/Katanga/RDC, Rapport de Monitoring MR-122264.01, 10/07/2009

<sup>93</sup> Cited in the PRSP : UNICEF (2001): Enquête nationale sur la situation des enfants et des femmes, DRC- Multiple Indicators Cluster Survey (MICS 2), UNICEF Statistics and Monitoring Section, 2001 Available at <http://www.childinfo.org/>

<sup>94</sup> This section is mainly based on International Monetary Fund (2007): Democratic Republic of the Congo: Poverty Reduction Strategy Paper, IMF Country Report No. 07/330, Washington, D.C., June 2006

Table 26: Diarrhoea treatment in DRC, 2002-2010

Indicator	2002	2003	2004	2005	2006	2007	2008	2009	2010
Diarrhoea treatment (% of children under five receiving oral rehydration and continued feeding)	n.a.	n.a.	n.a.	n.a.	n.a.	42.3	n.a.	n.a.	n.a.
Household management of diarrhoea based on oral rehydration salts (ORS)	n.a.	n.a.	n.a.	n.a.	n.a.	42.0	n.a.	n.a.	n.a.

Source: [http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST\\_TYPE=802&DIMENSION\\_AXIS=](http://databank.worldbank.org/ddp/viewSourceNotes?REQUEST_TYPE=802&DIMENSION_AXIS=)

Source: CHILINFO [http://www.childinfo.org/diarrhoea\\_statable.php](http://www.childinfo.org/diarrhoea_statable.php)

UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys by Macro International.

### 2.5.3.2 Resume of the JC

From the documents available so far, there is no evidence of EC support contributing to better protection of children from key health threats, such as malaria and diarrhoea.

## 2.6 EQ 5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

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

#### Indicators

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

#### 2.6.1.1 Findings per indicators

**I-511:** EC supported the institutional strengthening of the MoH, covering the elaboration of health policy related documents. In the framework of the PATS II one of the objectives at national level, was to support the coordination of national programmes, as well as the elaboration of legal texts completing the sanitary code and defining the role of the state in the health sector, in order to strengthen the democratic process.

In 2005, support cells to the Ministry of Health have being implemented and the creation of a support unit to the NAO was finalised.<sup>95</sup> At the beginning of 2006, the External Assistance Management Reports to Commission Headquarters reported that the EUD had set as a priority to strengthen the Country coordination System (CCM) of the Global Fund, so that the body could actually become a platform for joint decision to the Ministry of Health, donors and civil society.<sup>96</sup>

The institutional strengthening of the Ministry of Health became an area of EC support in the framework of the 9th EDF Health Program. It was noted that in 2008, the Ministry was not independent in its ability to design or management policies, but significant efforts started to be devoted. However, support in this area was still required as Directorates of the Ministry was only implementing projects designed by others.<sup>97</sup>

The PS9FED has significantly contributed to national capacity development. However, ownership has more been developed in the provinces compared to the central level. Projects with significant external technical assistance have always had problems to create real ownership. Nearly 38% of the PS9FED have been devoted to technical assistance and therefore there were only 62% of the funds which were planned for field activities.

<sup>95</sup> EAMR 7/2005

<sup>96</sup> EAMR 1/2006

<sup>97</sup> Particip (2008)

The PS9FED MTR notes that the EUD played an important role as designer in the health sector and as such the EUD can facilitate discussions on questions related to the future strategy of donors especially Member States in the health sector.<sup>98</sup>

**I-512:** In the framework of GAVI, the EUD was a member of the ad hoc project to strengthen the health system (USD 54 million) and has led the promotion of improved financial governance and institutional reform in 2010.<sup>99</sup>

**I-513:**

EC efforts in the field of capacity development have clearly prioritised the decentralised level, especially targeting directly health facilities. The PS9FED has supported the provincial health departments (DPS) by creating an expert team on provincial level, which helped the DPS to better fulfil their new role in the context of devolution of responsibilities.

### 2.6.1.2 Resume of the JC

EC supported the institutional strengthening of the MoH, covering the elaboration of health policy related documents, and has led the promotion of improved financial governance.

Further, EC support targeted also health departments on provincial level, in the context of devolution of power in the health sector.

## 2.6.2 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

### Indicators

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

### 2.6.2.1 Findings per indicators

**I-521:** The EC contributed to the overall process of accountability and transparency of the health system, in particular by supporting the national system for collecting and analysing health data.

The EC funded programme PATS II supported the creation of a national system for collecting and analysing health data SNIS.<sup>100</sup> This system has received the full support of the Ministry of Health and has been gradually extended to the whole country.<sup>101</sup> In 2005, good results have been highlighted concerning institutional support of the PATS II. Concerning the National Health Information System, good results have been highlighted in terms of publication of statistical yearbooks, but it has been noted that the quality of data could still be improved. It has also been underlined that the methodology had been defined for the establishment of the contractual approach.<sup>102</sup>

In the framework of the 9th EDF Health Program, an additional technical assistance has been provided to AEDES to strengthen the National Health Information System (SNIS), (up to EUR 200,000). In 2008, the progress made was significant, especially in the four provinces where the PS9FED was implemented where reports were produced regularly. North Kivu was already using the data from the SNIS for local planning. At the central level, progress with the SNIS has been slower.<sup>103</sup>

**I-522:** From the documents available so far, there is no evidence of EC support.

**I-523:** From the documents available so far, there is no evidence of EC support.

<sup>98</sup> ECO (2009)

<sup>99</sup> EAMR 1/2010

<sup>100</sup> *Système National d'Information Sanitaire*

<sup>101</sup> EAMR 7/2005

<sup>102</sup> SOFRECO (2007)

<sup>103</sup> Particip (2008)

### **2.6.2.2 Resume of the JC**

The EC intervention (PATS II and PS9FED) contributed to the overall process of accountability and transparency of the health system, in particular by supporting the national system for collecting and analysing health data.

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

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

- I-611 Evidence of EC participation and value added in functioning coordination mechanisms between donors

**I-611** The PS9FED MTR notes that the EUD played an important role as designer in the health sector and as such the EUD can facilitate discussions on questions related to the future strategy of donors especially Member States in the health sector.<sup>104</sup>

---

<sup>104</sup> ECO (2009)

## 2.8 Annex

### 2.8.1 Key documentation used for the analysis

#### 2.8.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
C-006239	x	n.a.	1 report	n.a.	n.a.
C-015990	n.a.	n.a.	1 report	n.a.	n.a.
D-017858	x	n.a.	1 report	1 audit. 1 MTR	Capitalisation report
C-020696	n.a.	n.a.	1 report	n.a.	n.a.

#### 2.8.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	OK
EAMR extraction BF	OK
Project docs	C-006239: OK C-015990: OK C-017858: OK C-020696
Country note from old health evaluation	OK
Paris Declaration evaluation, case study DRC	OK

#### 2.8.1.3 Bibliography

9 ACP RPR 011, Programme Santé 9ème FED (PS9FED)-DRC, Rapport de Monitoring MR-002210.02, 10/07/2009

De Caluwe, Paul ; Menard, Sylviane (2010) : mission de capitalisation du projet santé 9ème fed et recommandations pour le PA PNDS,, 2ème partie. Nov. 2010

EAMR 7/2005

EAMR 1/2006

EAMR 7/2006

EAMR 1/2010

ECO (2009) : Mission d'évaluation à mi-parcours du Programme Santé 9ème FED (PS9FED)- RDC – rapport final, Mai 2009

International Monetary Fund (2007): Democratic Republic of the Congo: Poverty Reduction Strategy Paper, IMF Country Report No. 07/330, Washington, D.C., June 2006

LRRD, C-196136, Pharmaciens Sans Frontières - Révitalisation de 11 ZS du Tanganyika par un circuit d'approvisionnement en médicaments et Consommables, Rapport de Monitoring MR-122265.01, 10/07/2009

Medecins Du Monde France, Appui au Système de Santé et Renforcement des Capacités dans le District Sanitaire du Tangayika/Katanga/RDC, Rapport de Monitoring MR-122264.01, 10/07/2009

Particip (2008): Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007). Country Note DRC

SOFRECO (2007) : Evaluation de la stratégie de coopération de la Commission européenne avec la République démocratique du Congo, Rapport Final, Juin 2007

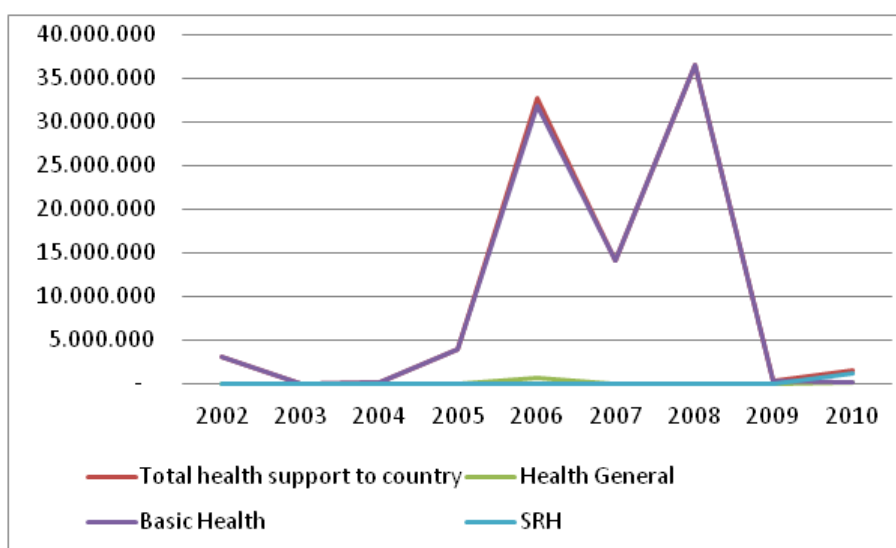
UNICEF (2001): Enquête nationale sur la situation des enfants et des femmes, DRC-Multiple Indicators Cluster Survey (MICS 2), UNICEF Statistics and Monitoring Section, 2001, Available at <http://www.childinfo.org/>



## 2.8.2 EC contribution per sector, modality and channel

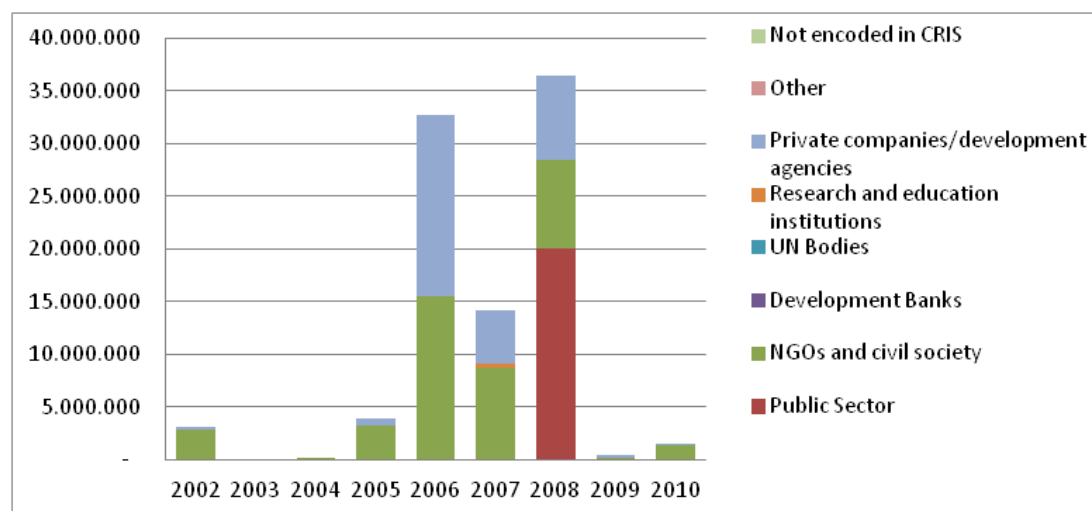
### 2.8.2.1 Per Subsector

Year	Total health support to country	Health General	Basic Health	SRH
2002	3,036,545	-	3,036,545	-
2003	-	-	-	-
2004	213,865	-	213,865	-
2005	3,945,483	-	3,945,483	-
2006	32,707,355	749,100	31,958,255	-
2007	14,134,868	-	14,134,868	-
2008	36,513,127	-	36,513,127	-
2009	378,815	-	378,815	-
2010	1,552,161	118,725	162,758	1,270,678
<b>Total</b>	<b>92,482,220</b>	<b>867,825</b>	<b>90,343,717</b>	<b>1,270,678</b>



## 2.8.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	2,785,077	-	-	-	251,468	-	-	3,036,545
2003	-	-	-	-	-	-	-	-	0
2004	-	213,865	-	-	-	-	-	-	213,865
2005	-	3,253,291	-	-	-	692,192	-	-	3,945,483
2006	-	15,518,558	-	-	-	17,188,797	-	-	32,707,355
2007	-	8,709,085	-	-	424,129	5,001,654	-	-	14,134,868
2008	20,110,982	8,288,729	-	-	-	8,113,416	-	-	36,513,127
2009	-	178,815	-	-	-	200,000	-	-	378,815
2010	-	1,433,436	-	-	-	118,725	-	-	1,552,161
<b>Total</b>	<b>20,110,982</b>	<b>40,380,857</b>	<b>0</b>	<b>0</b>	<b>424,129</b>	<b>31,566,251</b>	<b>0</b>	<b>0</b>	<b>92,482,220</b>



**2.8.2.3 Per Modality**

<b>Year</b>	<b>SBS</b>	<b>Support to sector programmes</b>	<b>Projects</b>	<b>Potential pool funding (funds already included in SSP)</b>	<b>Total health support</b>	<b>GBS related to health</b>
2002	-	-	3,036,545	-	3,036,545	-
2003	-	-	-	-	-	-
2004	-	-	213,865	-	213,865	-
2005	-	-	3,945,483	-	3,945,483	-
2006	-	-	32,707,355	-	32,707,355	-
2007	-	-	14,134,868	-	14,134,868	-
2008	-	-	36,513,127	-	36,513,127	-
2009	-	-	378,815	-	378,815	-
2010	-	-	1,552,161	-	1,552,161	-
<b>Total</b>	-	-	<b>92,482,220</b>	-	<b>92,482,220</b>	-

### 2.8.3 Overview of funds committed to the country's health sector

Table 27 Major interventions in the health sector during the period 2002-2010

Title of the intervention	Decision number	Decision starting year	Committed amount for the intervention
Programme Santé 9ème FED (PS9FED)	FED/2005/017-858	2005	EUR 74.624.577

Table 28 Small contracts in the health sector during the period 2002-2010

Contracts Title	Decision No	Contract no	Contract year	Decision year	Total
APPUI STRUCTUREL AU FONCTIONNEMENT DE LA ZONE DE SANTE DE KATANA, SUD-KIVU, R.D. CONGO	ONG-PVD/2002/01-092	20810	2002	2002	EUR 251.468
MEDAIR-AMELIOR ACCES SOINS POP DEPL ET VULN HAUT ET BAS UELE <i>Décision REHABILITATION DE GOMA ET ASSISTANCE SANITAIRE AUX POPULATIONS DEPLACEES ET VULNERABLE EN PROVINCE ORIENTALE</i>	FED/2002/015-894	187832	2002	2002	EUR 2.785.077
ACTION CONTRE LA FAIM - RENFORCEMENT SECURITE ALIMENTAIRE ET NUTRITIONNELLE - MALEMBA NKULU (KATANGA)	FED/2003/016-469	190883	2004	2003	EUR 213.865
Réhabilitation nutritionnelle et maintien de la santé des enfants mal nourris du réseau nutritionnel BDOM de Kinshasa	FOOD/2004/017-016	106255	2005	2004	EUR 871.515
Appui aux zones de santé urbaines de Matete, Ngaba et Kisenso à Kinshasa, République démocratique du Congo	ONG-PVD/2004/006-239	95333	2005	2004	EUR 691.969
LA PROMOTION DE SANTE PUBLIQUE POUR LA POPULATION LOCALE ET DEPLACEE A NORD-KIVU ET A ITURI, REPUBLIQUE DEMOCRATIQUE DU CONGO	ONG-PVD/2004/006-239	94971	2005	2004	EUR 1.441.776
PROGRAMME D'APPUI A LA REHABILITATION (PAR II)	FED/2002/015-990	188302	2005	2002	EUR 223
MEDAIR ASSISTANCE SECTEUR SANTE EN HAUT ET BAS UELE <i>Décision : REHABILITATION ET REINTEGRATION SOCIO-ECONOMIQUE APRES LA GUERRE, DANS LES REGIONS DE L'EST DE LA RDC</i>	FED/2003/016-469	190891	2005	2003	EUR 440.000
MEDAIR SANTE AU HAUT ET BAS-UELE	FED/2003/016-469	190894	2005	2003	EUR 500.000
Renforcement de l'offre scolaire maternelle et primaire et de formation professionnelle pour des enfants, adolescents et jeunes adultes en situation de handicap – Congo <i>Décision : REHABILITATION ET REINTEGRATION SOCIO-ECONOMIQUE APRES LA GUERRE, DANS LES REGIONS DE L'EST DE LA RDC</i>	ONG-PVD/2005/017-215	119591	2006	2005	EUR 749.100
ASSISTANCE MEDICALE A 13 ZONES DE SANTE DANS LA PROVINCE ORIENTALE	FED/2003/016-469	190895	2006	2003	EUR 285.460
MEDECINS DU MONDE FRANCE-APPUI AU SYSTEME DE SANTE ET RENFORCEMENT CAPACITES DISTRICT SANITAIRE DU TANGAYIKA/KATANGA/RDC <i>Décision : REHABILITATION ET REINTEGRATION SOCIO-ECONOMIQUE DANS LES REGIONS DE L'EST DE LA</i>	FED/2006/020-696	196135	2006	2006	EUR 3.760.956

<i>Contracts Title</i>	<i>Decision No</i>	<i>Contract no</i>	<i>Contract year</i>	<i>Decision year</i>	<i>Total</i>
<i>R.D.C. (LRRD)</i>					
PHARMACIENS SANS FRONTIERES-REVITALISATION DE 11 ZS DU TANGANYIKA PAR UN CIRCUIT D'APPRO EN MEDICAMENTS ET CONSOMMABLES	FED/2006/02 0-696	196136	2006	2006	EUR 2.499.938
Amélioration de l'hygiène hospitalière et communautaire de Kinshasa et du Bas Congo par la mise en place d'une Cellule pour la Promotion des Pratiques d'Hygiène (CEPPHY)	ONG-PVD/2006/0 18-227	135022	2007	2006	EUR 339.359
Appui au développement et renforcement des activités en santé de la reproduction dans les zones de santé de Katana et Idjwi, Province du Sud Kivu.	ONG-PVD/2006/0 18-227	135088	2007	2006	EUR 750.000
Appui aux programmes de santé de base dans la zone de santé de Miti Murhesa en province du Sud-Kivu -RD Congo	ONG-PVD/2007/0 19-404	171664	2008	2007	EUR 170.000
Contribuer à l'amélioration de la santé des populations des territoires de Beni, Irumu et Mambasa, au Nord-Est de la République Démocratique du Congo	ONG-PVD/2007/0 19-404	171689	2008	2007	EUR 175.960
Amélioration de l'accès des drépanocytaires aux services de santé	ONG-PVD/2008/0 20-081	228357	2009	2008	EUR 200.000
Prise en charge à base communautaire des personnes infectées et affectées par le VIH/SIDA.	ONG-PVD/2008/0 20-081	228668	2009	2008	EUR 178.815
Appui à l'action du Ministère de la Santé dans la mise en œuvre de la Stratégie de Renforcement du Système de Santé (SRSS) dans les Zones de Santé de Matete, Ngaba et Kisenso à Kinshasa	DCI-NSAPVD/20 09/021-105	237459	2010	2009	EUR 118.725
Programme d'amélioration de la santé des enfants des rues, de lutte contre les IST et le VIH/SIDA, de prise en charge de la santé de la reproduction et de protection des filles des rues dans trois districts de Kinshasa	DCI-NSAPVD/20 09/021-105	233698	2010	2009	EUR 162.758
Amélioration de l'accès aux services de santé sexuelle et génésique et aux services destinés aux victimes de maltraitances et de viols dans le Sud Kivu	DCI-SANTE/2009 /021-136	238129	2010	2009	EUR 1.270.678
<b>Total EC funds (incl FS9FED)</b>					<b>EUR 92.482.219</b>

### 3 Annex 7: Country case study Ghana

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

Country case study

GHANA





## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>75</b>
1.1.1	Country context of EC support.....	75
1.1.2	EU funds between 2002-2010 .....	75
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>76</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	76
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	77
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	79
1.2.4	JC 14 Increased or maintained quality of service provision due to EC support .....	82
<b>1.3</b>	<b>EQ2- Affordability of health: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>83</b>
1.3.1	JC 21 The cost of basic health care services are reduced for households due to EC support .....	83
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to the poor and persons with special health care needs supported by the EC .....	85
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC .....	87
<b>1.4</b>	<b>EQ3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>88</b>
1.4.1	JC 31 Increase in availability of primary health care facilities due to EC support.....	88
1.4.2	JC 32 Increase in availability of secondary health care facilities due to EC support .....	89
<b>1.5</b>	<b>EQ4- Health service utilisation related to MNCH: To what extent has EC support to health contributed to improving health service utilisation related to MNCH? .....</b>	<b>90</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	90
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	92
1.5.3	JC 43 Children better protected from key health threats as a result of EC support .....	93
<b>1.6</b>	<b>EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system? .....</b>	<b>95</b>
1.6.1	JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	95
1.6.2	JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.....	95
<b>1.7</b>	<b>Annex .....</b>	<b>97</b>
1.7.1	Key documentation used for the analysis .....	97
1.7.2	EU funds between 2002-2010 –detailed listing: .....	99
1.7.3	Overview of funds committed to the health sectors .....	103
1.7.4	Details of programmes.....	104

**List of tables**

Table 1:	Distribution of health professionals and government facilities in 2003 and 2008 .....	88
Table 2:	Immunisation coverage, Ghana: 1980-2009 .....	92
Table 3:	Cause of death in children, under five .....	94

**List of figures**

Figure 1:	Health financing gap (per capita USD, 2008) .....	79
Figure 2:	Key indicators of health care coverage 2001-2005 .....	80
Figure 3:	Health Programmes in Universities .....	82
Figure 4:	Health sector spending by source, 2003-2005 .....	84
Figure 5:	NHIS Active Membership.....	84
Figure 6:	Outpatient Utilisation Trend .....	86
Figure 7:	Inpatient Utilisation Trend .....	87
Figure 8:	Ghana, hospital beds per 1,000 people, 1971-2007 .....	89
Figure 9:	Assistance by skilled provider during childbirth, by residence, mother's education and wealth quintile .....	90

## 3.1 Introduction

### 3.1.1 Country context of EC support

In 1957, Ghana became the first country in sub-Saharan Africa to gain independence. Ghana has achieved progress in democracy and the conduct of electoral processes. The December 2008 elections saw the victory of the former opposition party (NDC) in Parliament and the NDC flag-bearer, Professor John Evans Atta Mills was elected President. This was the second peaceful transfer of power between the major political parties (in 2000 and 2008) and marked another step forward in consolidating multi-party democracy in Ghana. Ghana is deepening even further its democratic process, with a new decentralisation policy framework adopted in June 2010 and an on-going constitutional review.

In line with the Paris Declaration and the Accra Agenda for Development, other platforms for dialogue and coordination among Development Partners (DPs) have been established in Ghana: the Heads of Mission (HoM) and the Heads of Cooperation (HoC) Groups.

Foreign Direct Investment (FDI) in Ghana has increased significantly in recent years. New investment in Ghana has been predominantly in the service, manufacturing and building and construction sectors. FDI for the 2010 is expected to be boosted by investments in the offshore oil sector. Ghana is currently ranked 67th out of 183 countries in the 2011 World Bank's Doing Business (DB) Report and identified among the ten economies that made the greatest progresses in making their regulatory environment more favourable to business.

The European Commission and Ghana have a long standing relationship, dating back to 1976 when the EU delegation was established in Ghana. Since the establishment of delegation, Ghana has benefitted from a total of EUR 1.1 billion of the EU development cooperation.

In terms on health issues, Ghana faces all major diseases common in sub-Saharan Africa, a weak health system and a burden of disease structure characterised by continuing high prevalence of infectious diseases while chronic and non-communicable diseases gain ground. In 2008, malaria continued to be the disease claiming the highest number of victims, followed by HIV/AIDS, diarrhoeal diseases, lower respiratory infections and perinatal conditions. These five diseases account for 50% of all deaths in Ghana and 68% of deaths among children under 14 years old.<sup>105</sup> On a brighter note, after the introduction of the National Health Insurance Scheme (NHIS) in 2003-2005, out of pocket payments for health care have been significantly reduced.

### 3.1.2 EU funds between 2002-2010

Full details of EC support are given in Annex.

EU support for health in Ghana has been mostly of the budget support type, either sectoral (early in the evaluation period) or general (in recent years). The implication is that is often difficult to attribute progress to specific EC-financed interventions, since EC funds are mingled with the health sector budget or, in the GBS case, with the overall budget. While the EC and other donors can exert promote some priorities over others, ultimately, resource allocation decisions are up to Government.

The last "Health Sector Support" programme in Ghana was financed under the 8th EDF, covering a period from 1998 to 2004 for an amount of EUR 11 million to the Health Fund. Since 2006 the European Union to Ghana has changed its funding modality and its contributions to the health sector are now incorporated into the general budget support (GBS) under the Multi-Donors Budget Support (MDBS) mechanism. While in previous years, certain allocations for earmarked funding under health related programmes (in the area of water and sanitation and through micro projects) continued to provide some resources to the health sector, these programmes have now come to an end. No new resources were foreseen for the period 2010 – 2013 as the health sector is not a focal area under the 10th EDF country strategy paper.

Moreover, following the principles of division of labour, it was decided to not participate in the health strategic dialogue which is instead under responsibility of other development partners involved in specific project/programmes and SBS directly related to the health sector.

However, the EU Delegation is still following core activities and debates in the health sector - particularly in relation to the upcoming support to the decentralisation reform aimed at improved service delivery at local level and the more recent MDG Initiative (proposal submitted, waiting for HQ

---

<sup>105</sup> WRI – World Resource Institute: Improving access to essential drugs through conversion Franchising, March 2008, [http://pdf.wri.org/whatworks\\_careshop\\_ghana.pdf](http://pdf.wri.org/whatworks_careshop_ghana.pdf), p.2.

reply) focusing on health-related interventions aimed at boosting Government's efforts in meeting MDG 5.

While finding that general budget support had been a generally efficient aid modality, the evaluators of the multi-donor budget support programme found in June 2007 that increases in the level of health funding had not translated into improvements in the scale and quality of health services provided. The evaluators cited the problem of health user fees for the poor. This differs, in significant degree, from the generally positive picture that emerges from the Indicators and JCs below.

General budget support is one of the three focal areas of the cooperation between Ghana and the European Commission. The EC offers this form of financial assistance to the Government of Ghana (GoG) with the ultimate aim of supporting efforts towards the implementation of the country's National Medium-Term Development Plan (previously the Ghana Poverty Reduction Strategy - GPRS I & II - and now the Ghana Shared Growth and Development Agenda - GSGDA). The goals set out in this plan are expected to bring improvements in the quality of life and social well-being of all Ghanaians with a particular focus on the poorest and most vulnerable groups. Budget support provides additional resources to Government in support of these investments.

The main component of the EC's budget support programme in Ghana currently is the Millennium Development Goals Contract (MDG-Contract), providing a total of EUR 210 million over the period 2009-2014. The overall objective of the MDG-Contract is to contribute to sustainable growth and poverty reduction in Ghana so that the country can consolidate its recent middle income status and attain the MDGs.

Prior to the MDG-Contract, three Budget Support Programmes were signed between the EU and the Government of Ghana and were implemented:

- Poverty Reduction Budget Support (PRSBS) 1: 2002 – 2004 (EUR 42.8 million)
- Poverty Reduction Budget Support (PRSBS) 2: 2004 – 2006 (EUR 62 million)
- Poverty Reduction Budget Support (PRSBS) 3: 2006 – 2008 (EUR 55,02 million)

Currently, more than 50% of EC assistance to Ghana (under the existing cooperation between the EC and Ghana) is channelled through budget support and this percentage is expected to grow in the years to come.

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

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

#### **Indicators**

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

#### **3.2.1.1 Findings per indicators**

**I-111** Drug Policy is defined in the Ghana National Drug Policy (second edition from 2004)<sup>106</sup>, which is an element of the overall Ghana National Health Policy. A more recent document that sets specific goals for health and also drug policy is the Five Year Programme of Work 2007-2011, issued by the MoH in February 2008 - under the Theme "Creating Wealth Through Health". The program sets clear goals and timelines for achievement. For the pharmaceutical sector, the main program focus areas are access to medicines, improved supply management systems, quality assurance and rational use of drugs (including traditional medicines).<sup>107</sup> The Ghana National Drugs Program is an entity within the MoH; its role is to define medicines policy and coordinate policy implementations within the pharmaceutical sector both public and private.

As a guidance document for the use of drugs by healthcare professionals, Standard Treatment Guidelines (STG) are issued by the Ghana National Drug Program (under MoH) based on a work process that involves the Ghanaian medical and pharmaceutical professionals as well as WHO. The last issue was in 2004 and a review is currently underway. Based on the STG, the Essential Medicines List (EML, last version from 2004) is issued. The EML serves as basis for public procurement and was also used in defining the Medicines List of the National Health Insurance Authority (NHIA, last version

---

<sup>106</sup> <http://collections.infocollections.org/whocountry/en/d/Js6860e/>.

<sup>107</sup> [http://www.moh-ghana.org/UploadFiles/Policies\\_Programs/Nationalhealthpolicy090817040222.pdf](http://www.moh-ghana.org/UploadFiles/Policies_Programs/Nationalhealthpolicy090817040222.pdf).

January 2008), although the latter is broader than the EML. The overall legal framework for the pharmaceutical sector is set by the Food and Drugs Law from 1992, amended by Act 523 in 1996. It defines the role of the Food and Drugs Board as a separate entity under control of the MoH, responsible for regulating the sector.<sup>108</sup> Laws and regulations have been difficult to enforce due to lack of capacity and limited logistics.

In summary, while EC support through “Health Sector Support” Programme” (HSP) covering a period from 1998 to 2004 enhanced drug availability (see Indicator below), it is less clear that it contributed to national health policies regarding pharmaceuticals as described by the Indicator.

**I-112** According to the Ghana Ministry of Health Annual Health Survey 2010, since the introduction of National Health Insurance in 2003, there has been a decline in the number of public facilities experiencing essential drug shortages. However, some rural clinics were observed to be without TB drugs, family planning supplies and bed nets. The World Bank Working Paper 210 assessing the private health sector pointed to “persistent” problems in the public pharmaceutical supply chain, but also pointed out that public facilities may purchase from private providers.<sup>109</sup>

As part of this study, a survey was done of public and private health facilities. It was found that, in rural regions, private facilities were all adequately stocked with six basic medicines and ORT packets, whereas most public facilities were missing one or more. The situation was reversed in urban areas.

In early 2008, availability rates at public facilities were between 80% in urban areas and 40% in rural areas for a number of tracer drugs (on average), which is an improvement over 2004 when the last survey was done. In 2004, availability rates in public pharmacies for a subset of essential drugs including for example ampicillin, hydrochlorothiazide, atenolol and glibenclamide were only between 15 and 40%. A stock-out in a public facility does not necessarily mean that the patient does not get the prescribed drugs; in urban areas patients may have the option to get drugs from private pharmacies that have better inventory management and not necessarily higher prices than the public sector. The situation is different in the rural areas, where the public facility may be the only potential source for medicines in reach of the patient.<sup>110</sup>

The 2<sup>nd</sup> HSP ROM Report of 2006 emphasised the efficient implementation of the Common Donor Health Account (CDHA) and procurement elements of the project, even though the ROM was critical about management of the TA and expressed that in elements such as training, provision of manuals, development of management information systems and publications, little was achieved. Under the impact section the ROM noted that increasing tracer drug availability belongs to the major impacts of the programme.

In summary, HSP helped to increase availability of drugs, which certainly would have translated into lower incidence of stock outages.

### 3.2.1.2 Resume of the JC

The situation is mixed, with the MoH reporting improvements in basic drug availability since the introduction of health insurance while the World Bank, citing the complicated nature of the Ghanaian pharmaceutical supply chain, cites persistent problems. It is the MoH trend data that are, however, most pertinent to the JC as stated.

No specific policies regarding drug policies and essential medicine availability improvements and in particular in underserved regions, had been formulated in the EC funded programmes. However, HSP has contributed to improved availability of essential medicines.

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

#### Indicators

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

<sup>108</sup> Andreas Seiter, and Martha Gyansa-Lutterodt. 2009. Policy Note: The Pharmaceutical Sector in Ghana.

<sup>109</sup> Makinen, M. S. Sealy, R. Bitrán, S. Adjei, and R. Muñoz 2011. Private sector health assessment in Ghana. World Bank Working Paper 210.

<sup>110</sup> Ibid.

### 3.2.2.1 Findings per indicators

**I-121** No time series data have been found. For a population of just under 25 million people (UN 2010), there are only 1,439 health care facilities and about 70% of medical officials are based in the capital Accra and the second largest city, Kumasi (IRIN, 5 August 2008)<sup>111</sup>.

The Ghana Country Strategy Evaluation (CSE) of 2005<sup>112</sup> stated that through the Common Donor Health Account, the EC contributed to increasing access to health services by supporting investment in the country's most deprived regions (construction of regional hospitals, health centres, renovation and re-equipment of health facilities, CHPS initiative).

Further indication for an EC contribution could be found in some documents reviewed related to the Health Support Programme (HSP). The financial agreement (FA) in 1998<sup>113</sup> noted that the purpose of the 5-year plan of work (PoW) and of the EC support was to improve the performance of the health sector in terms of quality, efficiency and access with specific attention to the affordability of services and with increasing service availability for the poor, for women and for vulnerable groups. The expected results of the 5-year Programme of Work (PoW) and therefore of the EC assistance relevant for this indicator are: a) The primary health services are strengthened, b) The secondary and tertiary services are re-oriented to support primary services; c) Private sector involvement in health care provision is increased; and d) Inter-sectoral collaboration is strengthened.

The available ROM reports do not assess the associated indicators per se, but the MR-00005.02 – 08/12/06<sup>114</sup> Report states that problems identified by the 2006 Review and by donors and specific studies include: the lack of measurement of quality; there is little evidence of service improvement; there exist still variations between regions, districts and rural and urban areas; and non-state actor participation is limited.

Regarding the documents reviewed (especially the MDBS evaluation, 2007) it can be assumed that additional fiscal space provided by BS (PRSBS 2004-2006) could also have contributed to an increased proportion of health facilities with appropriate equipment. Fiscal space for health can be defined as additional budgetary resources for health without prejudice to a country's financial sustainability. Governments can create fiscal space in many different ways – e.g. tax measures, external grants, efficiency gains, internal and external borrowing and reprioritization.<sup>115</sup> Even though this is not directly mentioned in the MDBS evaluation, it can be assumed that it could have positively affected the indicator. In this context, the MDBS evaluation states that during the MDBS period, health and education have received significant increases in budget allocations (see health sector spending under I-212), growing substantially in real terms and attracting increased shares of discretionary expenditure. However, the MDBS also adds that increases in the level of health funding have yet to translate into commensurate improvements in the scale and quality of health services provided, despite active dialogue and close monitoring at sector and MDBS levels. Allocative efficiency has been hampered by the fragmentation of sector budgets, the lack of control over the wage bill and the rising administrative costs of health service provision. Similarly the figure below is in accordance with the findings of the MDBS. Consequently in 2008 there was still evidence of a significant health financing gap.

---

<sup>111</sup> [www.irinnews.org](http://www.irinnews.org)

<sup>112</sup> European Commission (2005), Ghana Country Strategy Evaluation, Final Report Volume1.

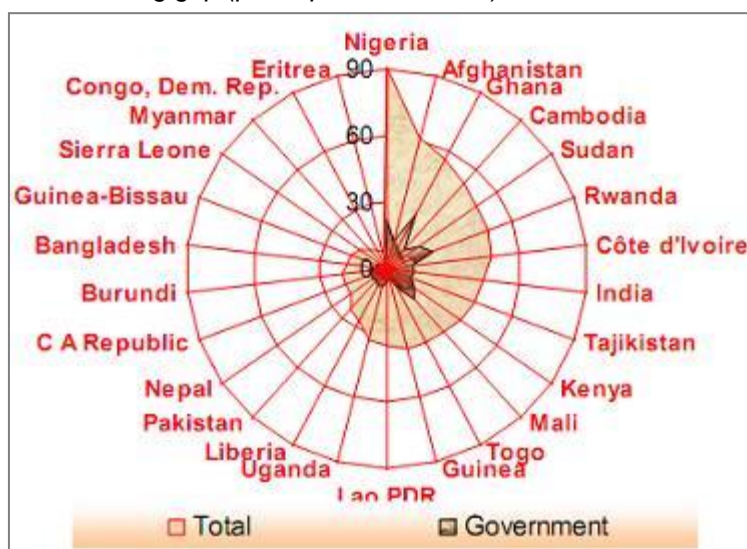
<sup>113</sup> European Commission and the Republic of Ghana (1998) Financing agreement between the Commission of the European Communities and the Republic of Ghana.

<sup>114</sup> European Commission (2000), Monitoring Report Ghana – GHA – Health Sector Policy Support Programme, MR 00005.02 – 08/12/06.

<sup>115</sup> WHO/Durairaj and Evans (2010) Fiscal space for health in resource-poor countries, World Health Report (2010), Background Paper, 41.



Figure 1: Health financing gap (per capita USD, 2008)



Source: WHO (2010) *Fiscal space for health in resource-poor countries*

Consequently improvements in the level of funds to the health sector have yet to translate into significant improvements in the scale and quality of health services provided. As a result the health sector has been unable to achieve most of the targets for improvements in access and coverage which it set for itself.

Because of the lack of time series data, no strong judgment on EC contribution to change in this Indicator can be made. It is likely that there was some contribution through the Common Donor Health Account at the beginning of the evaluation period, an account to which the EC contributed with an amount of EUR 4.2 million. This amount put the EC in a prominent position among the external donors to the CDHA.

**I-122** No time series data have been found. According to a 2007 Service Availability Mapping, of hospitals providing data, 90% had functioning oxygen tank. 95% had an autoclave, 63% had a hemocytometer, 61% had an X-ray machine and 13% had a functioning cytoflowmeter.<sup>116</sup>

According to the facility mapping in the World Bank private health sector assessment cited above (p. 68), over 80% of all public and private hospitals surveyed had all the “basic amenities” such as electricity and running water; 60% of private clinics had them but only 40% of public clinics.

The first report MR 00005.01 -06/04/00 of the Health Sector Support Programme indicated that EC might have contributed to a certain but not measurable extent to provision of equipment through HSP as, in discussions with various donors to the common health fund including the World Bank and Member States, all expressed cautious optimism concerning the level of efficiency of implementation so far.

### 3.2.2.2 Resume of the JC

It is likely that EC support contributed to availability of primary health care facilities and better equipment. However, lack of time series data makes it impossible to make a strong statement in this regard. A significant proportion of public health facilities continue to lack basic equipment and amenities. In general, the situation is better in private clinics. Yet, as seen below, client satisfaction with both types of facilities is found to be high. GBS may have created fiscal space to improve the operating and maintenance budgets of facilities, however, based on documents consulted, this assertion must remain speculation. However, the MDBS evaluation mentions in this context that improvements in the level of funds to the health sector have yet to translate into significant improvements in the scale and quality of health services provided. As a result the health sector has been unable to achieve most of the targets for improvements in access and coverage which it set for itself:

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

<sup>116</sup> [http://www.moh-ghana.org/UploadFiles/Publications/SAM\\_REPORT\\_Ghana090814053653.pdf](http://www.moh-ghana.org/UploadFiles/Publications/SAM_REPORT_Ghana090814053653.pdf)



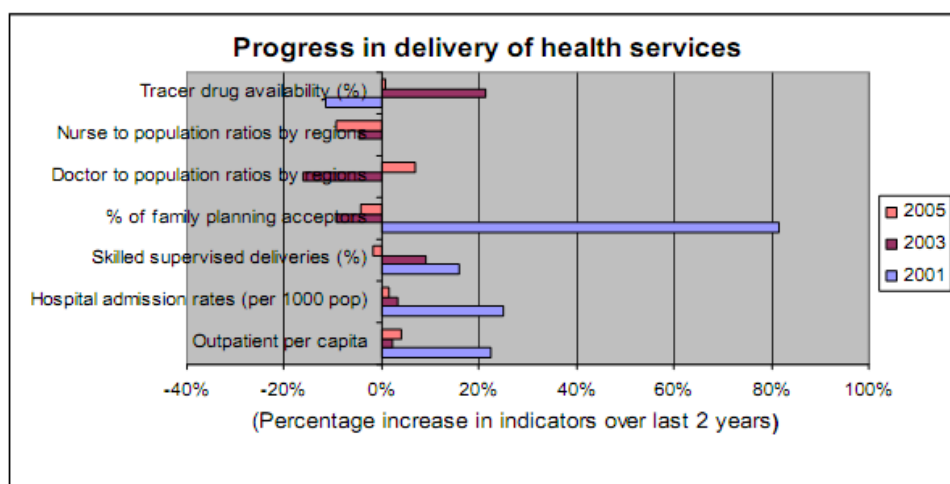
- I-131 Increased number of key health workers (doctors; nurse/midwives) per 10,000 population
- I-132 Improved availability and standards of health worker training
- I-133 High health worker attrition and absenteeism rate addressed

### 3.2.3.1 Findings per indicators

**I-131** A major issue in health is the maldistribution of human resources in the country. External brain drain is a major issue (see the 2004 study “The Health of the Nation and the Brain Drain in the health sector”, by the GHS). Internal brain drain (i.e. from Ghanaian rural areas to urban areas) also negatively affects the distribution of health workers across the regions in the early period of evaluation (CSE Ghana, 2005).

The WHO Global Atlas of the Health Workforce estimates that, in 2009, there were 0.9 physicians per 10,000 population (unchanged from 2002, if World Bank statistics from that year are comparable) and 1.1 nurses. It is not possible to reconcile these estimates with data presented by the Ministry of Health. The MoH reports that there were 22,811 persons per physician in 2001 (0.4 physicians per 10,000 population); 15,423 in 2006 (0.6); and 11,981 in 2009 (0.8). The comparable figures for nurses were 2,043 (4.9 nurses per 10,000 population); 2,125 (4.7); and 1,537 (6.5).<sup>117</sup> See also I-311. The figures presented below point to the same trend. Consequently, the MoH statistics suggest that the number of doctors and nurses per capita increased between 2001 and 2009. However, data inconsistencies make it impossible to reach a firm conclusion.

Figure 2: Key indicators of health care coverage 2001-2005



Source: MoH 2006 cited in MDDBS evaluation

The geographical distribution of health care workers in Ghana is grossly distorted. The World Bank Private Health Sector Assessment provides data indicating that, whereas there is one doctor per 8,000 population in Ghana as a whole and one per 2,000 population in Accra, the ratio in the Northern region of the country is one per 86,000 population. According to a MoH study, over 70% of highly trained health professionals are located in urban areas. This implies that health service delivery in the rural areas is left in the hands of semi-skilled and in some instances unskilled health workers.<sup>118</sup>

There are about 52,258 individuals currently formally working in the health sector in public, private, religious, quasi-government and other organizations in Ghana. The MOH employs 42,299 staff. This number represents about 81.5% of the total health sector workforce. Non-clinical support staff, including administrators, accountants, drivers and technicians; and clinical support staff including health aides and ward assistants constitute about 38% of the total workforce officially employed.<sup>119</sup>

<sup>117</sup> Figures for 2006 and 2009 from MoH Health Sector Review 2010, and for 2001 from MoH Health Sector review 2004, (<http://www.moh-ghana.org/UploadFiles/Publications/Review%20of%20Ghana%20Health%20Sector%202004%20Programme%20of%20Work090717145220.pdf>).

<sup>118</sup> Ibid, p.33.

<sup>119</sup> Africa Health Workforce Observatory (2010) Human Resources for Health – Country Profile Template, Ghana

The Poverty Reduction Support 2 (PRS 2) aimed to address the uneven distribution of health care workers in Ghana in order to bridge the equity gaps in access to quality health care. According to a note for the file (2005)<sup>120</sup>, the EU Delegation has observed progress in the form of the assessment of the Deprived Area Incentive Allowance (DAIA) and completion of the review of the options for decentralising HR management.

The Financial Agreement (p.4) of the Health Support Programme to Ghana<sup>121</sup> focused on capacity building through technical assistance. One of the priority areas was human resources planning. No information has been found on progress in meeting this goal.

Likewise, the Poverty Reduction Support 3 (PRS 3)<sup>122</sup> called in its performance assessment framework 2007-2009 for further human resource development in the health sector (increase by 3% the total number of health staff that are posted to and working in the four deprived regions). However no ROM report is available so far to assess whether this has been achieved.

Ghana developed a human resources strategic plan to guide scale-up from 2007 to 2011. Prior to this plan the Community-based Health Planning and Services (CHPS) programme was initiated in 1999 to place community health officers in rural and deprived communities to work with health aides from the community. The project was viewed as successful by the CSE for Ghana.

However, the joint evaluation of the MDDBS to Ghana<sup>123</sup> in 2007 pointed out that progress for completing the CHPS compounds has been slow, with only 186 out of intended 250 CHPS functional with a Community Health Officer in place. Given that the aim to serve every district had not yet been met, the new human resources plan included strengthening this programme.<sup>124</sup>

In summary, data inconsistencies make it difficult to judge the trend in health workers per capita. The geographical distribution remains skewed. EC support through the MDDBS sought to address human resource issues but targets were not met.

**I-132** The Health Worker Study of 2007<sup>125</sup> reported that health workers generally are of the opinion that the public training institutions in the South of the country are better than those in the North, mainly because they are better equipped. Not all health workers, however, agreed with this statement.

The "Prevention of Mother – to – Child HIV Transmission" projects included a health worker training component. The ROM Report MR-01274.01<sup>126</sup> stated that the project's main activity consisted of trainings. Instead of workshops for counsellors at the selected sites, regionalised trainings were held, co-financed by the EC, WHO and GHS (supported by the Global Fund) for a wide group of healthcare professionals. Additional training was given in infant feeding counselling and kits for HIV testing were also distributed to the sites. However, a significant number of the medical staff trained has left the facilities and midwives capable of voluntary counselling and testing (VCT) during antenatal health care are few.

Further information has been found in the 2<sup>nd</sup> ROM MR-00005.02 for the Ghana Health Sector Support Programme (HSP) in 2006.<sup>127</sup> There it is stated that for elements such as training little was achieved through the HSP.

<sup>120</sup> European Commission (2005): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 2 (PRBS2) Partial payment of the variable tranche 2005.

<sup>121</sup> HSP to Ghana, FA Agreement, p.4.

<sup>122</sup> Poverty Reduction Support 3 (PRS 3) FA Agreement, p.35.

<sup>123</sup> Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report Volume One: Evaluation Results and Recommendations on Future Design & Management of Ghana MDDBS, 2007, p.84.

<sup>124</sup> [http://www.who.int/workforcealliance/documents/Ghana%20Case%20Study\\_Final.pdf](http://www.who.int/workforcealliance/documents/Ghana%20Case%20Study_Final.pdf).

<sup>125</sup> <http://www.moh-ghana.org/UploadFiles/Publications/HealthWorkerStudy090825084556.pdf>.

<sup>126</sup> European Commission (2004), Monitoring Report Ghana – GHA – Prevention of Mother- to-Child HIV Transmission in Ghana, MR 01274.01 – 30/11/04.

<sup>127</sup> European Commission (2000), Monitoring Report Ghana – GHA – Health Sector Policy Support Programme, MR 00005.02 – 08/12/06.

Figure 3: Health Programmes in Universities

Cadre	Number of entrants				Number of graduates
	2003	2004	2005	2006	2003
Physicians	-	207	214	260	-
Nurses	1019	1450	2003	2069	1013
Midwives	-	140	317	385	-
Pharmacists	-	120	110	110	-
Laboratory workers	-	40	100	100	100

Source: Africa Health Workforce Observatory<sup>128</sup>

**I-133** Given observed high attrition rates, it is difficult to characterise retention schemes as effective. However, for those who do decide to stay, there is some evidence that higher wages in the public health service have increased job satisfaction and working hours, while attracting some criticism from other civil servants.<sup>129</sup>

While there is no information on trend, a series of focus group discussions with health personnel undertaken by ODI in 2007 suggested that absenteeism is not seen as a major problem.<sup>130</sup> According to Health Worker Study, informal monitoring mechanisms work adequately.

### 3.2.3.2 Resume of the JC

Despite retention schemes and attempts to increase the production of health workers, Ghana health worker attrition, essentially to work abroad in the English-speaking world, remains a major problem. Data inconsistencies make it hard to offer a firm judgment on trends, however, MoH data suggest that the ratio of population per physician declined between 2002 and 2009. Rural areas, especially in the North, are grossly underserved despite salary enhancement schemes. Absenteeism is not identified as a major problem.

The PRS 3 addressed the human resource problem in four deprived regions and aimed to increase the number of health workforce in the four regions. The HSP included in the 5-year programme of work that the central support systems for human resources, logistics and supplies, financial and health information management gets strengthened. No further EC policies and targets could be identified addressing the brain drain, human resource management, absenteeism and attrition and work satisfaction. MDS targets related to human resources for health were not achieved.

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

#### Indicators

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

#### 3.2.4.1 Findings per indicators

**I-141** The National Health Insurance Authority, (NHIA) issues accreditation marks to facilities based on a range of quality indicators. Health insurance reimbursement rates are adjusted to reflect the mark, providing an incentive to improve quality. Quality assurance was included in the Ghana Health Sector Strategic Plan 2007-11.

The EC indirectly addressed this issue by supporting the Centre of Health Information Management under 8 ACP GH 03 & 8 ACP GH 24. However the information provided in the EAMR 07/2007 was very pessimistic regarding an actual contribution as the main findings highlight an underperformance in each of the three main project areas (strengthening the Centre for Health Information Management - CHIM, development of human resources for health information management and development of systems for data analysis, reporting and information dissemination) and are hence rather negative.

<sup>128</sup> Africa Health Workforce Observatory (2010) Human Resources for Health – Country Profile Template, Ghana.

<sup>129</sup> Witter, S., A. Kusi, and A. Moses: Working practices and incomes of health workers: evidence from an evaluation of a delivery fee exemption scheme in Ghana. In: HRH - Human Resource for Health 5.2, 2007, 22 January 2007 <http://www.human-resources-health.com/content/5/1/2>.

<sup>130</sup> <http://www.moh-ghana.org/UploadFiles/Publications/HealthWorkerStudy090825084556.pdf>.

**I-142** No information available.

**I-143** The Ghana Living Standards surveys 2000 and 2005 both found high levels of customer satisfaction with both public and private health facilities; the private providing slightly better service but the public having a cost advantage.<sup>131</sup>

The Ghana Demographic and Health Survey (DHS) 2008 asked for client satisfaction. The results show that overall, 82% of women and 77% of men with NHIS coverage said that the services were good the last time they were treated at a health facility. Women in the Greater Accra region and men in the Northern region were less likely to say that the services received the last time they were treated at a clinic or hospital were good (67% each), compared with over 90% of insured respondents in the Western region. Further, about 50% of men and women insured with the NHIS think that the NHIS card holders get better service than other clients. About one in ten insured respondents think that the NHIS card holders get worse service than other clients.<sup>132</sup> The Danida Evaluation of 2007<sup>133</sup> noted in this context that patient satisfaction surveys have been instituted at the facility level by MoH and GHS, conducted twice a year to gauge the quality of care of clients. Unfortunately, these surveys have not been implemented regularly because of the heavy load on the service providers and also of lack of capacity. Discussions with community members and health staff revealed that people are more satisfied with the quality of care now (2007) than before.

### 3.2.4.2 Resume of the JC

There has been some attempt to impose quality assurance through the national health system. While clinical protocols are available, they have not been disseminated. Exit surveys indicate that client satisfaction is high at both public and private health facilities.

The purpose of the EC funded HSP was to improve the performance of the health sector in terms of quality, efficiency and access with specific attention to the affordability of services and with increasing service availability for the poor, for women and for vulnerable groups. This included the improvement of: performance monitoring and evaluation and professional regulation and financial and health information management. How far these goals were reached could not be assessed.

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

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

#### Indicators

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

#### 3.3.1.1 Findings per indicators

**I-211** According to the WHO World Health Statistics 2011, out of pocket spending dropped from 50.7% of total health spending in 2002 to 36.8% in 2009. This is broadly attributed to the introduction of health insurance in 2005.

The DHS 2008 asked for out of pocket expenditures and the result shows that the vast majority of the respondents insured with the N/DHIS did have to pay out of pocket for drugs and services at some time before the survey. Only 6% of respondents said they did not pay out of pocket. Differences across subgroups by background characteristics are small. Women in the Eastern region, men in the Western region and those in the highest wealth quintiles are the least likely to pay out of pocket.<sup>134</sup>

No entities could be found for EC policies of reducing out of pocket expenditures in relevant documents.

<sup>131</sup> Makinen, M. S. Sealy, R. Bitrán, S. Adjei, and R. Muñoz 2011. Private sector health assessment in Ghana. World Bank Working Paper 210, pp. 66-67.

<sup>132</sup> DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>, pp.55-56.

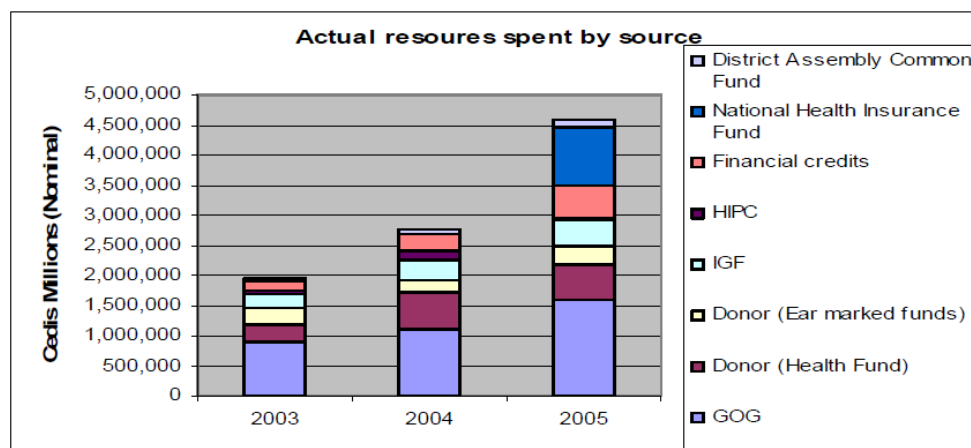
<sup>133</sup> Particip(2008) Joint Evaluation of the Ghana – Denmark Development Co-operation from 1990 to 2006.

<sup>134</sup> DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>, p.53.

**I-212** Since the introduction of the National Health Insurance System (NHIS) in 2005, it is estimated that 40% of all health expenditure is covered. According to the 2011 WHO World Health Statistics, between 2000 and 2008, the share of social security-financed health expenditure in general government health expenditure rose from zero to 37.5% while the share of general government in total health care expenditure rose from 41.4 to 50%. These percentages imply that the share of social security financed health expenditures in total health expenditures rose from zero to 18.8%.

Note that the term “insurance” is a bit of a misnomer, since the NHIS is financed by a range of sources, including tax revenue and an earmarked share of social security contributions from the organised sector.<sup>135</sup>

Figure 4: Health sector spending by source, 2003-2005<sup>136</sup>



Source: MOH, 2006; MOFEP, 2007; DACF 2004

Source: MoH, 2006; MOFEP, 2007 and DACF 2004

**I-213** All Ghanaians, from both the formal and informal sectors, are in principle required to enrol. The NHIA undertook a methodology and data validation exercise during the first quarter of 2011 to ascertain the accuracy of the 2010 membership database. During the exercise, it was realised that the old methodology of calculating active membership was riddled with problems, leading to an inaccurate number of active members reported over the years. In order to address this, a new methodology was used to determine the 2010 active membership. The new approach is based on the sum of the number of new members registered for a given year and the number of renewals made for that year. The new active membership figure of 8.16 million for 2010 does not necessarily represent a drop, as there is no comparative historic data based on the new methodology. The total active membership of 8,163,714 as at December 2010 represented 34% of the total population in 2010.

Figure 5: NHIS Active Membership

Table 1: Active Membership

Methodology	2005	2006	2007	2008	2009	2010
Old	1,348,160	2,521,372	6,643,371	9,914,256	10,638,119	N/A
New	N/A	N/A	N/A	N/A	N/A	8,163,714

Source: NHIS 2010 <http://www.nhis.gov.gh/Uploads/dbsAttachedFiles/8%281%29.pdf>

While the introduction of health insurance is generally regarded as a success, the Joint Evaluation of the MDBS Ghana<sup>137</sup> points to a long-running failure to find a sustainable and satisfactory resolution of

<sup>135</sup> For a detailed discussion of funding sources and distributional consequences, see [http://www.ecoi.net/file\\_upload/90\\_1236873017\\_accord-health-care-in-ghana-20090312.pdf](http://www.ecoi.net/file_upload/90_1236873017_accord-health-care-in-ghana-20090312.pdf).

<sup>136</sup> Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report. ODI & Ghana Centre for Democratic Development; June 2007, p.82.

<sup>137</sup> Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report Volume One: Evaluation Results and Recommendations on Future Design & Management of Ghana MDBS, 2007, p.10.



the problem of meeting health user fees for the poor, either from an improvement in the operation of the exemption scheme or from successful introduction of the National Health Insurance Scheme. This is despite intense donor-Government policy dialogue on this subject.

According to the Note to the file (2006) regarding the release of the 2006 Performance Tranche for the PRS 2, the health finance-related indicators have been fulfilled. 123 District-wide Mutual Health Insurance Schemes (DHMIS) were set up, registering indigents and the National Health Insurance Council (NHIC) transferred subsidies to district schemes.<sup>138</sup> This positive trend has also been observed in the 2007 note to the file<sup>139</sup>, in which it is stated that the newly-established National Health Insurance Scheme (NHIS) was increasing its coverage. In contrary, the PRBS 3/MDG-C note to the file<sup>140</sup> stated that the membership of the NHIS remained skewed due to economic, geographic and cultural balances. Moreover, despite the significant increase in the coverage of the NHIS, a large part of the population was still not covered.

### 3.3.1.2 Resume of the JC

The introduction of national health insurance in 2005 significantly improved the health care finance situation from the patients' point of view (not necessarily from the providers' point of view, since despite the enlarged market, reimbursements are slow in coming). 34% of the population and 40% of all health care spending are estimated to be covered and the share of out-of-pocket spending in total health expenditure has fallen. However, a recent assessment of the viability of the scheme performed by the ILO was cautious:

*"A lesson learnt from Ghana is that instituting insurance by itself is not adequate to remove fully the out-of-pocket payment for health care. Insured patients are still required to pay for items that should be covered by insurance and for informal care. Without proper regulation and incentives for the supply side to improve quality and availability of services, insurance cannot be an attractive product. This in turn will be a hindering factor in coverage expansion and ultimately will affect the prospect of achieving universal coverage."*<sup>141</sup>

Concerning EC funded programmes, GBS and MDBS some information concerning insurance coverage, reduction of out of pocket spending, change in the share of health expenditure financed by social security schemes and change in proportion of the population covered by public health insurance/enrolled in the public health scheme has been found in relevant documents. Based on the documents reviewed, under PRBS 2 and PRBS 3, the EC provided support to I-213 through setting up 123 DHMIS. Moreover, GBS would be consistent with contributing to the fiscal space that enable Government to institute and expand the NHIS.

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

Indicators

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

#### 3.3.2.1 Findings per indicators

**I-221** A wide range of groups are exempt from paying NHIS fees. These include children, the elderly, pregnant women, current social security system participants, pensioners and the indigent. Exempt groups amount to some 70% of the population. However, it is reported that in some districts, authorities are not following the directive to include the indigent population.

Additionally, there are a range of official exemptions in Ghana, including specific services (those for major communicable diseases, immunisations, antenatal and post-natal care). Most importantly, the Ghanaian government has an explicit mechanism for funding exemptions in that facilities can submit a

<sup>138</sup> European Commission (2006): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 2 (PRBS2) Release of the 2006 Performance Tranche.

<sup>139</sup> European Commission (2007): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2007.

<sup>140</sup> European Commission (2009): Note for the File; 9ACP GH28 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2008, Performance Tranche 2009, MDG-C Base Tranche 2009.

<sup>141</sup> Ibid, p. 10.

statement of fee revenue “lost” through exemptions and request reimbursement. This is a major innovation as exemptions are “unfunded” in most countries, leaving health care providers with strong incentives to refuse patients fee exemptions to which they are entitled by law.

There is evidence that the exemption policy is poorly implemented. For example, one study (admittedly antedating the evaluation period) in the Volta region of Ghana found that 84% of patients who were eligible for exemptions did not receive them (Nyonator and Kutzin, 1999). A national study early in the evaluation period found that almost half of the clients interviewed who were eligible for exemptions had in fact paid for services (Garshong et al., 2002). Research has also highlighted that the poor very seldom receive exemptions while the demographic categories (under-fives, elderly and pregnant women) are more frequently exempted (Adams et al., 2002).<sup>142</sup>

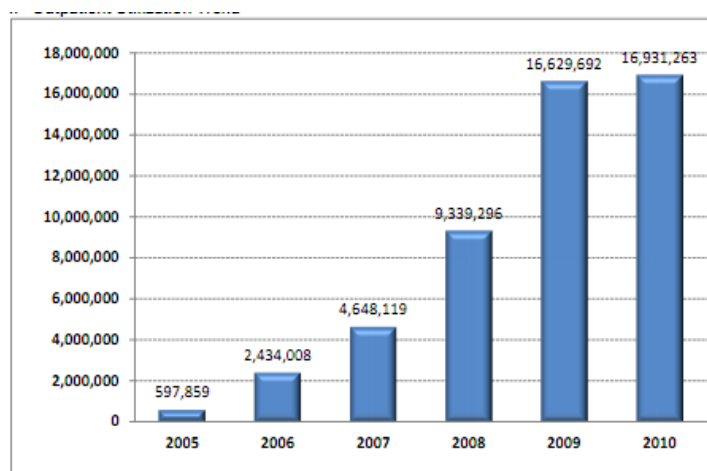
Information from the Joint Evaluation of MDDBS to Ghana<sup>143</sup> further emphasised the poor implementation of exemptions. As a result of significant delays between the utilisation of exemption services and receipt of compensation funds these “free services” were withheld. For example in 2006, GHS reported that GHS 150 billion had been budgeted for exemptions and up to the end of November (the financial year runs from January to December) but only GHS 86 billion (57%) had been disbursed. Regional and district health officials in the Central Region judged inadequate and fluctuating exemption funds to be responsible for the rise in maternal mortality rates. These officials have noted a drop in the number of women choosing ante-natal care and supervised deliveries with the withdrawal of “free services,” with consequent effects on maternal mortality rates.

**I-222** It is universally agreed that consumption of health care, especially by the poor, has increased as a result of the health insurance reform. Between 2000 and 2005, as measured by the Ghana Living Standards Survey, all income groups experienced an increase in the proportion of self-perceived health episodes resulting in the seeking of care. In 2000, members of the highest income quintile were 29% more likely to seek care than members of the lowest; in 2005, they were only 13% more likely to do so.

The introduction of NIHS in 2003, fully implemented in 2005, has been a major advance in increasing access of the poor to health care. It has, ironically, led to increased pressures on health care providers as reimbursements from the insurance fund have proven slow and unreliable. Opinions on the sustainability of the fund vary. The ILO has reported that it is sustainable given strong economic growth and slow expansion to cover currently excluded groups, while the World Bank has expressed greater concerns over its viability.

According to the National Health Insurance Authority Annual Report 2010, outpatient service utilisation increased from 597,859 in 2005 to 16,931,263 in 2010 showing a 2.8-fold increase over this period. This appears inconsistent, however, with the Joint Evaluation of MDDBS to Ghana, 2007, which concluded, “*Out-patients’ department visits have increased only marginally in the last five years*”.

Figure 6: Outpatient Utilisation Trend



Source: NHIS 2010 <http://www.nhis.gov.gh/Uploads/dbsAttachedFiles/8%281%29.pdf>

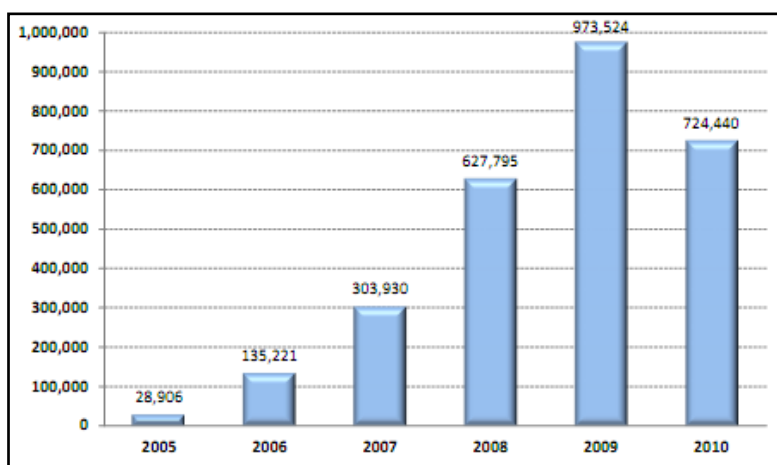
<sup>142</sup> Di McIntyre, Lucy Gilson, and Vimbayi Mutyambizi. 2005. Promoting equitable health care financing in the African context: Current challenges and future prospects, <http://www.equinet africa.org/bibl/docs/DIS27fin.pdf>.

<sup>143</sup> Joint Evaluation of Multi-Donor Budget Support to Ghana, Based on OECD-DAC methodology. Final Report Volume Two: Annexes, Box 6.1.



Inpatient utilisation increased from 28,906 in 2005 to 135,221 in 2006 showing an increase of 368%. It increased further from 303,930 in 2007 to 627,795 in 2008 depicting an increase of 107%. In 2010, utilisation had reached 724,440.<sup>144</sup>

Figure 7: Inpatient Utilisation Trend



Source: NHIS 2010 <http://www.nhis.gov.gh/Uploads/dbsAttachedFiles/8%281%29.pdf>

Regarding EC contribution under the MDBS, the Progress Assessment Framework in the Technical Annex 2006-2008<sup>145</sup> highlighted ten indicators that would be linked to decisions on disbursement in 2006 and 2007. For the MDBS group these indicators would be used to recommend disbursement of the performance component for 2006 and 2007. The health related subset 5 “Improving service delivery for human development” with the policy objective “Bridge Equity gaps in access to quality health care” was defined through the trigger “Increase utilization of health services”.

### 3.3.2.2 Resume of the JC

Despite some data inconsistencies, it appears that the introduction of health insurance has significantly increased household consumption of health care services. The increase has been most marked among the poorest segment of the population which is, in addition, officially exempt from NHIS fees. However, exemptions have been poorly administered, in addition to which, they weaken the financial sustainability of the scheme. Based on the findings for indicator I-221 and I-222 there is no clear evidence that EC contribution under MDBS improved the number of cost waiver and subsidies schemes in place for marginalised groups. However, it is possible that GBS helped to create fiscal space which has enabled government to institute and expand health insurance.

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

#### Indicators

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

#### 3.3.3.1 Findings per indicators

**I-231** No information available.

**I-232** No information available.

#### 3.3.3.2 Resume of the JC

No information has been found regarding studies undertaken and policy-making exercises carried out. However, the introduction of the NHIS in 2003-2005 was a major step forward. Policy dialogue under GBS has contributed to improved policies: “*The most significant immediate effects of MDBS have been in relation to policy dialogue and conditionality. Here, important improvements have been identified in terms of ownership and responsibility for the policy process, as well as in the quality of*

<sup>144</sup> NHIS 2010 <http://www.nhis.gov.gh/Uploads/dbsAttachedFiles/8%281%29.pdf>.

<sup>145</sup> MDBS Technical Annex 2006 - 2008 to the Framework Memorandum on the Multi-Donor Budgetary Support Programme

*prioritisation, target setting and monitoring. New government wide structures for policy dialogue have been created through the sector working groups' framework."*

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

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

##### Indicators

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

##### 3.4.1.1 Findings per indicators

**I-311** The table below gives some insight into size of population a health facility has to serve by administrative region in 2004 and 2007. With exemption of Upper West and Upper East the situation worsened in all regions.

Table 29: *Distribution of health professionals and government facilities in 2003 and 2008*<sup>146</sup>

Region	Population per doctor		Population per nurse		Population per health facility	
	2003	2008	2003	2008	2004	2007
Ashanti	13,494	9,537	2,243	1,336	24,011	26,856
Brong Ahafo	40,729	21,475	2,879	1,140	14,521	14,883
Central	36,877	26,140	1,713	895	15,745	15,235
Eastern	33,279	16,132	1,331	959	9,726	10,413
Greater Accra	5,604	5,103	917	881	47,942	59,508
Northern	73,262	50,751	2,380	1,534	15,175	15,893
Upper East	32,786	35,010	2,027	956	9,243	8,713
Upper West	50,541	47,932	1,860	870	8,567	6,299
Volta	33,930	26,538	1,440	892	6,366	8,329
Western	35,255	33,187	2,309	1,413	16,052	14,542
National	16,759	12,713	1,649	1,079	14,614	15,600

Sources: Ghana Health Service (2009), "2009 GHS Annual Report", Ghana Health Service (2008), "The Health Sector in Ghana: Facts and Figures"; Ghana Health Service (2005), "Facts and Figures".

Sources: Ghana Health Service (2009) GHS Annual Report

The Country Strategy Paper for the period 2002-2007<sup>147</sup> stated that under the EC/GoG microprojects primary health care and education facilities were particularly eligible for funding. The new phase of the EC/GoG micro-project programme aimed to focus on the Northern part of Ghana (Northern Region; Upper West Region; Upper East Region), which is by far the poorest geographical area in the country and in the Central and Eastern Regions which are those (apart from the north of Ghana) where poverty proved to be most stubbornly entrenched according to the poverty studies.

The CSE 2005 for Ghana speaks of a good performance of the EC in terms of promoting increased access to and utilisation of basic health services by the rural and deprived population. Several investments had been implemented over the past decade to improve physical access to health facilities. They include the construction of three new regional hospitals. Fifty-six new health centres had been built and eleven upgraded. A programme targeting renovation and re-equipment of health facilities had been implemented. Thus, the EC contributed to an increased number of primary health care facilities during the earlier years of the evaluation period.

**I-312** A study by van den Boom et al. compiled in 2004 reported that access to health care facilities remained a problem: Medical facilities were not evenly distributed across the country, with most rural areas lacking basic facilities such as hospitals and clinics as well as doctors and nurses. The study

<sup>146</sup> Contribution to the European Report on Development 2010, Extending Health Insurance: Effects of the National Health Insurance Scheme in Ghana by Agar Brugiavini and Noemi Pace, preliminary draft, [http://erd.eui.eu/media/2010/Brugiavini\\_Pace\\_ERD2010\\_final.pdf](http://erd.eui.eu/media/2010/Brugiavini_Pace_ERD2010_final.pdf), p.8.

<sup>147</sup> Republic of Ghana/ European Community (2002) Country Strategy Paper and Indicative Programme for the period 2002-2007.

stated “Ghanaians on average live about 16 km from a healthcare facility where they can consult a doctor, but half of the population lives within a five km radius. By the same token, the other half cannot consult a doctor within five km, which corresponds to a one hour walking distance and one quarter even lives more than 15 km from a facility where a doctor can be consulted.” The Government of Ghana embarked on a health sector reform in the early 1990s to improve the accessibility and quality of services. However, “the health situation in Ghana is still far from satisfactory.” Many people in the country still rely on self-medication.<sup>148</sup>

No information on time trend available.

### 3.4.1.2 Resume of the JC

The differences among the administrative regions for number of population per doctor, nurse and facility are significant. In regard to accessibility to health services, Ghanaians face regional disparities, too. The one-hour radius (or five km radius) of accessibility to health services is available for only about half of the population.

Based on documents reviewed, the EC contributed to an increase in primary health care facilities to some extent at the beginning of the evaluation period; however it is very difficult to measure the contribution as the statements of the CSE have been very vague. No information was available on EC contribution in the second half of the evaluation period.

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

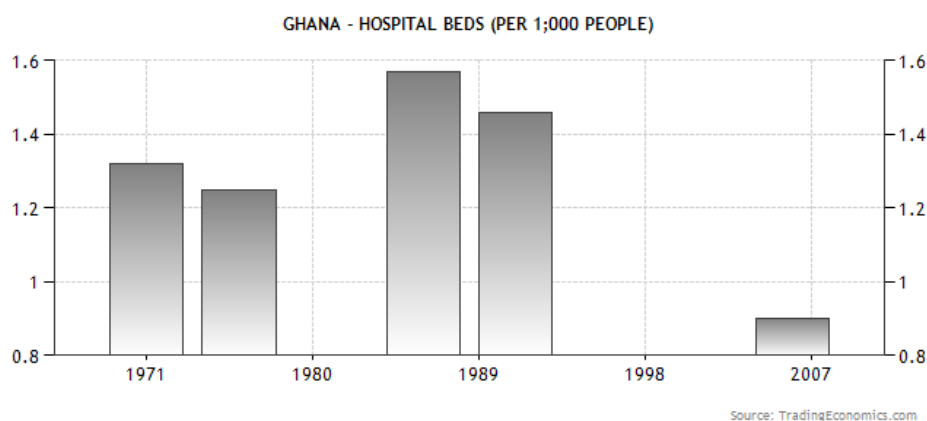
#### Indicators

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

#### 3.4.2.1 Findings per indicators

**I-321** Hospital beds per capita averaged 91 per 10,000 in 2000-2009 according to WHO World Health Statistics.

Figure 8: Ghana, hospital beds per 1,000 people, 1971-2007



Source: [www.Tradingeconomics.com](http://www.Tradingeconomics.com)

The number of hospital beds per 10,000 was higher in the last 40 years than in 2009 according to available data.

**I-322** No information available, see I-312.

**I-323** The proportion of deliveries by caesarean section increased from 4% to 7% between 2003 and 2008.<sup>149</sup> The figures for 1993 were 4.4 (2.9 in rural areas and 8.4 in urban areas) and for 1998 4.1 (2.8

<sup>148</sup> Van den Boom, G.J.M; Nsowah-Nuamah, N.N. N; Overbosch, G. B. Curative Health Care Utilization in Ghana: A multinomial analysis of equitable access opportunities, undated <http://www.agricta.org/partners/sadaoc/Francais/N%B052.pdf>, p. 1, 4, 20, 21.

<sup>149</sup> <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>, pp. 157-58.

for rural areas and 8.0 for urban areas), respectively.<sup>150</sup> A figure of 5-15% is generally viewed as good medical practice.

### 3.4.2.2 Resume of the JC

Not enough information on health facilities has been gathered to permit a meaningful assessment of this JC. No EC interventions seemed to have addressed this JC, apart from the possible contribution to new regional hospitals described under Indicator I-312.

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

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

#### Indicators

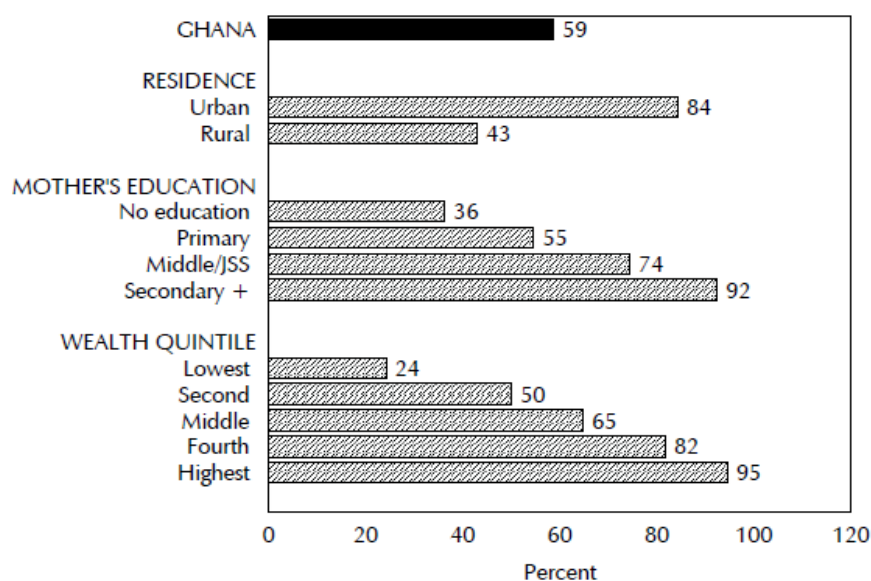
- I-411 Increase in proportion of deliveries supervised by a skilled attendant
- I-412 Increased percentage of women receiving four or more ante-natal check-ups
- I-413 Increased proportion of women using modern family planning

#### 3.5.1.1 Findings per indicators

**I-411** Between 2003 and 2008, the proportion of births attended by a skilled medical professional rose from 42 to 59% (80 to 84% urban, 31 to 43% rural), according to the 2003 and 2008 DHSs.<sup>151</sup> As we can see from the figure below geographical, educational and economic differentials are large.

Figure 9: Assistance by skilled provider during childbirth, by residence, mother's education and wealth quintile<sup>152</sup>

Figure 9.3 Assistance by Skilled Provider during Childbirth



Source: DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>

The EC formulated triggers and indicators for evaluations in the Poverty Reduction Budget Support relevant for the first two indicators. For instance PRBS 2 – 2004-2006<sup>153</sup> emphasised maternal health

<sup>150</sup> GDHSs, cited in: Pierre Buekens, Siân Curtis, and Silvia Alayón. 2003. Demographic and Health Surveys: caesarean section rates in sub-Saharan Africa. *BMJ* Vol. 326, 18 Jan 2003.

<sup>151</sup> [http://www.measuredhs.com/pubs/pdf/GF1/ghana\\_fact\\_sheet.pdf](http://www.measuredhs.com/pubs/pdf/GF1/ghana_fact_sheet.pdf) and <http://www.measuredhs.com/pubs/pdf/GF14/GF14.pdf>, respectively.

<sup>152</sup> DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>.

<sup>153</sup> Poverty Reduction Budget Support 2 (PRBS 2) - 2004-2006, Agreement N° 9199/GH, p.59.

targets, in particular “increasing the proportion of supervised deliveries for the underserved regions (Upper-East, Upper-West, Northern and Central Region).”

According to the documentation on the tranche release, PBRs 2 funds were fully released for 2004. For 2005 the indicators related to the social sectors have been fulfilled. Accordingly it is stated that the increase of supervised deliveries in the three most deprived regions is sufficient to consider the indicator as fulfilled.<sup>154</sup> In addition, in the note for the file regarding the release of the performance tranche 2006<sup>155</sup>, supervised deliveries were described as having increased again, compared to the baseline of 2004 (53.4%). However, there was only a very minor increase, as 54.1% of deliveries had been supervised in 2006. Contradicting the information from 2005 and 2006, the 2009 note to the file<sup>156</sup> only saw an increase from a base of 35.1% in 2007 to 39.3% in 2008. An explanation for these discrepancies or alternatively, drop from the 2006 to 2007 data could not be found.

**I-412** Information for four or more ante natal check-ups is unavailable. It is only mentioned in the PRBS 2001 that performance indicators in the health sector included increases of antenatal health care and the proportion of assisted deliveries. However, no evaluation reports for this are available. Between 2003 and 2008, the proportion of pregnant women receiving antenatal care rose from 92 to 95% (98 to 98% urban, 89 to 94% rural), according to the DHS (see citation above). According to the 2010 Ghana Health Sector Independent Assessment, the proportion of pregnant women making at least one antenatal care visit rose from 88.1% in 2006 to 92.1% in 2009.

The average number of ante-natal visits per client increased from 2.8 to 3.4 between 2001 and 2005, hence below the indicator level.<sup>157</sup> The 2009 note to the file<sup>158</sup> commented that there was an increase in antenatal coverage from 89.5% in 2007 to 97.4% in 2008.

**I-413** Overall, contraceptive use among married women in Ghana nearly doubled in the past 20 years. The results indicate there was a large increase in contraceptive use in the late 1980s and 1990s, from 13 to 22% among married women. The contraceptive prevalence rate increased from 22 % among currently married women in 1998 to 25% in 2003 and has declined in the past five years—24% in 2008—a reversal in the trend. Similarly, use of modern methods nearly doubled over the past 15 years from 10% in 1993 to 19% in 2003, before declining slightly to 17% in 2008 (24 to 19% urban, 15 to 15% rural). Over the past 20 years, there has been a slight decrease in the use of traditional methods. While initially there was a small increase in the use of traditional methods from eight to 10% between 1988 and 1993, use of these methods decreased to 9% in 1998 and to 7% in 2003 and 2008.<sup>159</sup>

### 3.5.1.2 Resume of the JC

Maternal health, as indexed by antenatal care and the proportion of deliveries attended by a skilled health worker, has improved in Ghana. For reasons not known, the proportion of women using modern family planning has declined somewhat in urban areas. Of consideration are the regional and socio-economic differentials for skilled birth attendant in Ghana.

The second CSP<sup>160</sup> mentioned that priorities in the health sector are focused on achieving significant declines in the rates of maternal and child mortality (in particular neo-natal mortality) by improving equitable access to quality basic health and nutrition services.

The EC funded Poverty Reduction Budget Support programmes indicators included the improvement of maternal health in Ghana, particularly for the underserved poor regions. How far the programmes were successful could not be assessed due to missing evaluation reports. However, the 2007 note to the file regarding the PRBS 3 Base Tranche 2007<sup>161</sup> stated that maternal and infant mortality have not experienced a real improvement. Likewise, the ROMs do not explicitly mention developments of maternal health indicators. Anyhow, the overall positive developments in the country and the overall

<sup>154</sup> European Commission (2005): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 2 (PRBS2) Partial payment of the variable tranche 2005.

<sup>155</sup> European Commission (2006): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 2 (PRBS2) Release of the 2006 Performance Tranche.

<sup>156</sup> European Commission (2009): Note for the File; 9ACP GH28 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2008, Performance Tranche 2009, MDG-C Base Tranche 2009.

<sup>157</sup> Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report. ODI & Ghana Centre for Democratic Development; June 2007, p.84.

<sup>158</sup> European Commission (2009): Note for the File; 9ACP GH28 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2008, Performance Tranche 2009, MDG-C Base Tranche 2009.

<sup>159</sup> Ibid.

<sup>160</sup> Government of Ghana/ European Community (2007) Country Strategy Paper and National Indicative Programme for the period 2008-2013.

<sup>161</sup> European Commission (2007): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2007.



aim improving the quality of primary health care facilities and increase in the utilisation rate, one can conclude that EC contributions may have contributed to the enhancements taking place.

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

#### Indicators

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

#### 3.5.2.1 Findings

**I-421** No information available. Between the 2003 and 2008 DHSs, rates of stunting (chronic malnutrition), wasting (acute malnutrition) and underweight changed from 35% to 28%, 8% to 9% and 18% to 14%, respectively.<sup>162</sup>

Contrary figures were described for the earlier period 2001 to 2005: child malnutrition rates are reported to have risen from 25% in 2001 to 33% in 2004.<sup>163</sup>

**I-422** According to the DHS, between 2003 and 2008, the immunization rate for all WHO-recommended vaccinations (BCG, DTP3+polio, measles) rose from 69% to 79%.<sup>164</sup> The WHO database, provides information for vaccines separately and there was a constant increase of immunisation coverage in Ghana (see Table below).

Table 30: Immunisation coverage, Ghana: 1980-2009

	2009	2005	2000	1995	1990	1985	1980
Measles (MCV)	93	83	90	70	61	21	16
Diphtheria tetanus toxoid and pertussis (DTP3)	94	84	88	70	58	22	7
Hepatitis B (HepB3)	94	84					
Hib (Hib3)	94	84					
BCG	99	99	99	87	71	41	
Polio (Pol3)	94	85	88	71	57	18	7

Source: Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

The coverage levels for various vaccines have improved and the proportion of children who received no vaccinations has declined from 5 to 1%. The greatest improvements in vaccination coverage are in the Upper West region (from 60% fully immunised in 2003 to 89 % in 2008), the Western region (from 60% in 2003 to 82% in 2008) and among children in the poorest households (from 54% in 2003 to 75 % in 2008). Immunisation coverage has also improved among children of mothers with no education (27% increase) and children of mothers with primary education (23% increase). The regional differences in vaccination coverage should be interpreted with caution because of the small number of cases.<sup>165</sup>

#### 3.5.2.2 Resume of the JC

While the prevalence of growth monitoring is unknown, childhood nutrition improved in Ghana between 2003 and 2008, as did the basic immunisation rate.

The second CSP<sup>166</sup> reported that priorities in the health sector are focused on achieving significant declines in the rates of maternal and child mortality (in particular neo-natal mortality) by improving equitable access to quality basic health and nutrition services.

EC contributions such as the HSP and the PRBS aimed to improve health service delivery which includes basic immunisation and preparing for epidemic diseases and growth monitoring. The overall positive developments in this area can lead to the conclusion that the EC contributions had positive impacts. Particularly the focus of the PRBSs on disadvantaged regions is of importance to close the regional gaps.

<sup>162</sup> <http://www.measuredhs.com/pubs/pdf/DM17/DM17.pdf>.

<sup>163</sup> Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report. ODI & Ghana Centre for Democratic Development; June 2007, p.87.

<sup>164</sup> <http://www.measuredhs.com/pubs/pdf/DM17/DM17.pdf>.

<sup>165</sup> DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>.

<sup>166</sup> Government of Ghana/ European Community (2007) Country Strategy Paper and National Indicative Programme for the period 2008-2013.

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

#### Indicators

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

#### 3.5.3.1 Findings per indicators

**I-431** According to DHS, the proportion of children sleeping under an insecticide-treated net (ITN) the night before the survey rose from 4% in 2003 to 28% in 2008.<sup>167</sup> This mirrored a dramatic increase in the number of households owning at least one ITN, from 3% to 33%.

In Ghana, children less than five years of age and pregnant women are targeted for the distribution of ITNs. Ghana adopted a multiple approach for the distribution of the ITNs. A voucher scheme with Global Fund support within the framework of public-private partnership was implemented initially in four of the ten regions. The Ghana Health Service (GHS) distributes subsidised ITNs through the child welfare and antenatal clinics of the public health facilities. Occasionally, the Ministry of Health distributes free bednets to pregnant women and children under five as part of immunisation campaigns and other health programmes.

Children in rural areas are more likely than those in urban areas to have slept under any net, an ever-treated net, or an ITN. The proportion of children who slept under any type of mosquito net is highest in the Upper West region (66%) and lowest in the Central and Greater Accra regions (31% each). The proportion of children who slept under a mosquito net generally decreases with increasing wealth quintile, thus while 47% of children in the lowest wealth quintile slept under a net the night before the survey, only 36% of children in the highest wealth quintile slept under a net. The proportion of children who slept under an ITN was highest in the Brong Ahafo region (50%) and lowest in the Northern region (11%).<sup>168</sup>

There is no evidence that EC contributions contribute to bednets distribution (apart from support to the Global Fund, not covered in this country case study but described in a separate thematic case study). The general budget improvements of the MoH and MoH's program to sell and distribute ITNs, for instance to mothers who gave birth, contributes to an overall improvement of the situation.

**I-432** Between the 2003 and 2008 Ghana Demographic and Health Surveys, under-five mortality dropped from 111 per thousand to 80 per thousand and infant mortality from 64 to 50 per thousand. The proportion of these deaths due to diarrhoeal disease has not been estimated based on data obtained to date.

According to WHO country fact sheet of 2008<sup>169</sup>, diarrhoea was the ranked third among the causes of death after neonatal causes (which includes also diarrhoea), pneumonia and malaria (see Tables below)

<sup>167</sup> <http://www.measuredhs.com/pubs/pdf/DM17/DM17.pdf>.

<sup>168</sup> DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>.

<sup>169</sup> [http://www.who.int/whosis/mort/profiles/mort\\_afro\\_gha\\_ghana.pdf](http://www.who.int/whosis/mort/profiles/mort_afro_gha_ghana.pdf).



Table 31: Cause of death in children, under five

Distribution of causes of death among children under 5 years of age Ghana, 2000-2003			Annual estimated proportions of death by cause for neonates Ghana, 2000		
Causes	Deaths <sup>b</sup> (%)	Regional average (%)	Causes	Deaths <sup>c</sup> (%)	Regional average <sup>c</sup> (%)
Total neonatal deaths	100	100	Total neonatal deaths	100	100
Neonatal causes <sup>a</sup>	28	26	Neonatal tetanus	2	9
HIV/AIDS	6	7	Severe infection <sup>a</sup>	29	27
Diarrhoeal diseases	12	17	Birth asphyxia	26	24
Measles	3	4	Diarrhoeal diseases	2	3
Malaria	33	17	Congenital anomalies	8	6
Pneumonia	15	21	Preterm birth <sup>b</sup>	25	23
Injuries	3	2	Others	8	7
Others	0	6			

a. Includes diarrhoea during neonatal period  
b. Sum of individual proportions may not add up to 100% due to rounding.  
c. Sum of individual proportions may not equal 100% due to rounding.

Source: WHO (2008) country fact sheet, [http://www.who.int/whosis/mort/profiles/mort\\_afro\\_gha\\_ghana.pdf](http://www.who.int/whosis/mort/profiles/mort_afro_gha_ghana.pdf)

Diarrhoea, a food-borne and water-borne disease, is a preventable cause of death of neonatals and children. EC programmes and the BGS and the MDBS did not address this topic per se. Inter-sectoral approaches are asked for improvements. Water and sanitation is a policy objective in the PRS 3 (p.36) agenda: 55% access to safe water in rural communities and small towns.

**I-433** During the 2008 DHS, 20% of children of mothers surveyed had experienced an episode of diarrhoea in the two weeks preceding and half had received oral rehydration therapy, 50% of them using ORS. In the 2003 DHS, 15.2% of under-fives had experienced a bout of diarrhoea during the preceding two weeks and 63% had received some form of ORT, 39% of them via ORS.

Overall, 41% of children with diarrhoea were taken to a health provider for treatment of diarrhoea. Children aged 6-23 months were more likely to be taken to a health facility for treatment (44-49%) than children age over two years (32-38%). Differences in treatment-seeking behaviour by gender of child, urban-rural residence and mother's education were small. Children in the highest wealth quintile were more likely than other children to be taken to a health provider for treatment when they have diarrhoea.

Oral rehydration therapy (ORT), which involves giving children with diarrhoea a solution prepared from oral rehydration salts (ORS) or recommended home fluids (RHF) is a simple and effective response to diarrhoeal illness. In the 2008 DHS, more than half (52%) of children with diarrhoea were treated with either ORS (45%) or RHF (13%). 38% of children were given increased fluids. Overall, 67% of children under five with diarrhoea were treated with ORS, RHF, or increased fluids. Children under 12 months of age and children age 48-59 months are less likely to receive ORT than other children. Children in rural areas, children whose mothers have no education and children in the lowest wealth quintile are also less likely to receive ORT.<sup>170</sup>

No specific targets and triggers are formulated in any of the available EC funding documents relating to the health sector. The former formulated improvements in health care utilisation may lead to improvements in ORT prevalence.

### 3.5.3.2 Resume of the JC

Trends in the indicators identified have been generally positive, with more children benefitting from ITNs, a reduction in under-five mortality and a rising proportion of children experiencing diarrhoea being treated with ORSs.

The EC programmes did not formulate policies directly related to ITNs distribution, ORT and to the reduction of child mortality due to diarrhoea. Anyhow, the PRS 3 policy, relating to an intersectoral approach, to address one of the sources of diarrhoea by improving access to safe water and sanitation, EC contributed in reducing child mortality. In addition, child mortality, as well as maternal and neonatal mortality, is strongly tied to overall health sector strength. EC budget support, by helping the Ghanaian government engage in sector strengthening policies and programmes, can safely be assumed to have contributed to the overall improvements described above.

<sup>170</sup> DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>.

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

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

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

##### 3.6.1.1 Findings

**I-511** According to the CSE 2005 for Ghana in the health sector, budget support programmes and the SWAp complemented each other to address this issue in the early phase of the evaluation. A concrete result of this complementary approach is illustrated by the contribution of the SWAp to further decentralisation of management responsibility of Budget Management Centres (BMCs) during the period of programme of work with respect to the Ministry of Health Guidelines for preparation of the 2005-2007 plans and budget.

**I-512** The joint evaluation of MDBS<sup>171</sup> reported that there were several complementary TA projects which have provided support to PFM strengthening – notably to the implementation of the budget and public expenditure management system (BPEMS), to the strengthening of the Ghana Audit Service (EC), to procurement (DFID), to the implementation of the MTEF (CIDA), to debt management (USAID) and to revenue generation (GTZ). Even though the EC contributed to overall PFM strengthening, it is difficult to say if this also happened in the health sector. These guidelines conform to the national Medium Term Expenditure Framework (MTEF) developed within the budget support policy dialogue.

**I 513** For this indicator the second CSP provide some information regarding decentralized capacity building. Increasing local capacities seemed to be the result of micro-projects to complete the construction of schools and clinics, but no data are available on changes in clinic attendance. However, the CSP also pointed that their impact was limited on sustainability, replicability and building capacity for operations and maintenance, because of the parallel institutional architecture and the programme's excessive focus on urban and peri-urban areas. The CSE 2005 found that the involvement of District Assemblies, particularly in setting priorities, was critical to project success. Micro-projects were particularly successful when replacing existing infrastructure and reducing nonutilisation rates, also when focused on community-centre support.

##### 3.6.1.2 Resume of the JC

This JC was assessed by three indicators. (1) EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators), (2) EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector and (3) EC contributed to decentralized capacity building to strengthen health policy capabilities at provincial, district and local levels. The documents reviewed showed some evidence for EC contribution related to these indicators, however particularly for I-512 it is difficult to see if the EC contribution also incorporated PFM in the health sector.

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

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

<sup>171</sup> ODI (2007) Joint Evaluation of Multi-Donor Budget Support to Ghana, Volume One: Evaluation Results and Recommendations on Future Design and Management of Ghana MDBS.

- I-523 EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement

### 3.6.2.1 Findings

**I-521** The evidence found for this indicator in the MR-0005.02-08&/12/06 of the Health support programme is very critical about the EC's contribution to increasing accountability and transparency of the health system. There was general agreement, confirmed by the Final Evaluation of the TA arrangement, that the TA was badly managed by all concerned. Part of the TA adviser's work was admittedly incorporated into the ongoing definition and development of indicators but there was confusion over his role in relation to the MoH and the NAO and over his role as a TA as such. The logistic element went well but, in all other elements, such as training, provision of manuals, development of management information systems and publications, little was achieved.

**I-522** The documents reviewed illustrate a more positive picture of how EC contributed to the indicator. Accordingly the CSE 2005 Ghana mentioned that Technical Assistance provided to the Centre for Health Information Management was particularly relevant to strengthening the MOH's capacity to assess and monitor its interventions and so to enable the EC to assess the sector performance on the basis of sound data. This assistance was particularly well perceived by the sector's national authorities. It also contributed to concretely introduce crosscutting aspects supported by the EC in data collection and analysis (e.g.: information is now systematically broken up by gender).

The CSE also explicitly focused on major improvements which had been observed in the health and education sectors over the two programming periods. Until 2005, the M&E capacity of the MOH and the Ministry of Education, Youth and Sports (MOEYS) had substantially increased, in part due to the support provided by the EC under the form of TA to the Centre for health information management (CHIM) and to the planning, budgeting, monitoring and evaluation (PBME) Division of the MOEYS.

The Joint Evaluation of MDDBS 2007 emphasised significant effects in relation to policy dialogue and conditionality. Here, important improvements have been identified in terms of ownership and responsibility for the policy process, as well as in the quality of prioritisation, target setting and monitoring. New government-wide structures for policy dialogue have been created through the sector working groups' framework. Admittedly, as with the other information extracted from the MDDBS evaluation, it is difficult in what terms this can be related to the health sector and the EC.

**I 523** No information available.

### 3.6.2.2 Resume of the JC

This JC has been assessed by three indicators. For I-523 no information was available. I-521 provided very critical information of EC contribution in the first half of the evaluation period. According to the documents reviewed, EC contribution under the Health support programme did not increase transparency; it may even have contributed to reduced transparency and added confusion over distribution of roles. No information could be obtained for the second half of the evaluation period. I-522 provided more optimistic information, thus it can be assumed that EC has contributed to some extent to increased competencies in MoH for establishing and monitoring Annual Work Plans.

### 3.7 Annex

#### 3.7.1 Key documentation used for the analysis

##### 3.7.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
014061 Health Support Programme			ROM Nr.2 08/12/06 ROM Nr. 1 2000		
Prevention of Mother – to.- Child HIV Transmission in Ghana			ROM MR- 01274.01 – 30/11/04		

##### 3.7.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	Ghana Country Strategy Evaluation, Final Report Volume I, April 2005
EAMR	
Country note from old health eval	No extraction available
Other Evaluations	MDBS Final Report 2007
ODI Briefing Paper Nr. 24 - Budget Support to Ghana: A risk worth taking/2007	
Ministry of Health Ghana, Independent Review of Health Sector Programme of Work 2010, Ghana	The information in this review is not related to EC assistance, thus has not been included into the case study report
Ghana JAS 2007	The information on health in this review is not related to EC assistance, thus has not been included into the case study report
World Bank Working Paper No. 210, Private Health Sector Assessment in Ghana	The information on health in this assessment is not related to EC assistance, thus has not been included into the case study report
Republic of Ghana and European Community, Country Strategy Paper and Indicative Programme for the period 2002-2007	
Republic of Ghana and European Community, Country Strategy Paper and National Indicative Programme for the period 2008-2013	
Paris Declaration Evaluation OECD DAC – PDE Thematic Study on Untied Aid: Ghana country study, October 2009	No relevant information for EQ 1-5 available
EAMR extractions	
Assessment for disbursement requests PRSB 3 and 2 and MDG-C	2005, 2006, 2007 and 2009

##### 3.7.1.3 Other sources

Andreas Seiter and Martha Gyansa-Lutterodt. 2009. Policy Note: The Pharmaceutical Sector in Ghana.

ANNEX Technical and administrative provisions for implementation. The Republic of Ghana. Health Sector Support, FINANCING AGREEMENT No 6069/GH, p.3

Contribution to the European Report on Development 2010, Extending Health Insurance: Effects of the National Health Insurance Scheme in Ghana by Agar Brugiavini and Noemi Pace, preliminary draft, 2010, p.12, [http://erd.eui.eu/media/2010/Brugiavini\\_Pace\\_ERD2010\\_final.pdf](http://erd.eui.eu/media/2010/Brugiavini_Pace_ERD2010_final.pdf)

DHS 2008, <http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>

Di McIntyre, Lucy Gilson and Vimbayi Mutyambizi. 2005. Promoting equitable health care financing in the African context: Current challenges and future prospects, <http://www.equinet africa.org/bibl/docs/DIS27fin.pdf>

European Commission (2000), Monitoring Report Ghana – GHA – Health Sector Policy Support Programme, MR 00005.01 – 06/04/00

European Commission (2000), Monitoring Report Ghana – GHA – Health Sector Policy Support Programme, MR 00005.02 – 08/12/06

European Commission (2004), Monitoring Report Ghana – GHA – Prevention of Mother- to-Child HIV Transmission in Ghana, MR 01274.01 – 30/11/04

European Commission (2005): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 2 (PRBS2) Partial payment of the variable tranche 2005.

European Commission (2006): Note for the File; 9ACP GH7 – Poverty reduction Budget Support 2 (PRBS2) Release of the 2006 Performance Tranche

European Commission (2007): Note for the File; 9ACP GH28 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2007

European Commission (2009): Note for the File; 9ACP GH28 – Poverty reduction Budget Support 3 (PRBS3) Base Tranche 2008, Performance Tranche 2009, MDG-C Base Tranche 2009

European Commission (2005), Ghana Country Strategy Evaluation, Final Report Volume1

Figures for 2006 and 2009 from MoH Health Sector Review 2010 and for 2001 from MoH Health Sector review 2004, (<http://www.moh-ghana.org/UploadFiles/Publications/Review%20of%20Ghana%20Health%20Sector%202004%20Programme%20of%20Work090717145220.pdf>).

[http://www.ecoi.net/file\\_upload/90\\_1236873017\\_accord-health-care-in-ghana-20090312.pdf](http://www.ecoi.net/file_upload/90_1236873017_accord-health-care-in-ghana-20090312.pdf)

GDHSSs, cited in: Pierre Buekens, Siân Curtis and Silvia Alayón. 2003. Demographic and Health Surveys: caesarean section rates in sub-Saharan Africa. *BMJ* Vol. 326, 18 Jan 2003

Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

Government of Ghana/ European Community (2007) Country Strategy Paper and National Indicative Programme for the period 2008-2013

HSP to Ghana, FA Agreement

Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report

Makinen, M. S. Sealy, R. Bitrán, S. Adjei and R. Muñoz 2011. Private sector health assessment in Ghana. World Bank Working Paper 210

MDBS Technical Annex 2006 - 2008 to the Framework Memorandum on the Multi-Donor Budgetary Support Programme

MoH Ghana. Human Resources for Health. Country Profile: Ghana, Edition 2011, [http://www.hrh-observatory.afro.who.int/images/Document\\_Centre/ghana\\_hrh\\_country\\_profile.pdf](http://www.hrh-observatory.afro.who.int/images/Document_Centre/ghana_hrh_country_profile.pdf), p.27

National Health Insurance Authority (2010): National Health Insurance Scheme Annual Report [http://www.nhis.gov.gh/\\_Uploads/dbsAttachedFiles/8%281%29.pdf](http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/8%281%29.pdf)

Nguyen et al. International Journal for Equity in Health 2011, 10:4, <http://www.equityhealthj.com/content/10/1/4>

ODI (2007) Joint Evaluation of Multi-Donor Budget Support to Ghana, Volume One: Evaluation Results and Recommendations on Future Design and Management of Ghana MDBS

Poverty Reduction Budget Support 2 (PRBS 2) - 2004-2006, Agreement N° 9199/GH, p.59 Joint Evaluation of Multi-Donor Budget Support to Ghana Based on OECD-DAC methodology. Final Report. ODI & Ghana Centre for Democratic Development; June 2007

Poverty Reduction Support 3 (PRS 3) FA Agreement

Republic of Ghana/ European Community (2002) Country Strategy Paper and Indicative Programme for the period 2002-2007

Turkson, P.K. 2009. Perceived quality of healthcare delivery in a rural district of Ghana. *Ghana Medical Journal* 43(2).

Van den Boom, G.J.M; Nsowah-Nuamah, N.N. N; Overbosch, G. B. Curative Health Care Utilization in Ghana: A multinomial analysis of equitable access opportunities, undated <http://www.agricta.org/partners/sadaoc/Francais/N%B052.pdf>

Volume One: Evaluation Results and Recommendations on Future Design & Management of Ghana MDBS, 2007

Witter, S., A. Kusi and A. Moses: Working practices and incomes of health workers: evidence from an evaluation of a delivery fee exemption scheme in Ghana. In: HRH - Human Resource for Health 5.2, 2007, 22 January 2007 <http://www.human-resources-health.com/content/5/1/2>

WRI – World Resource Institute: Improving access to essential drugs through conversion Franchising, March 2008, [http://pdf.wri.org/whatworks\\_careshop\\_ghana.pdf](http://pdf.wri.org/whatworks_careshop_ghana.pdf), p.2

#### 3.7.1.4 Weblinks

[http://www.moh-ghana.org/UploadFiles/Policies\\_Programs/Nationalhealthpolicy090817040222.pdf](http://www.moh-ghana.org/UploadFiles/Policies_Programs/Nationalhealthpolicy090817040222.pdf)

<http://www.moh-ghana.org/UploadFiles/Publications/HealthWorkerStudy090825084556.pdf>

[http://www.moh-ghana.org/UploadFiles/Publications/SAM\\_REPORT\\_Ghana090814053653.pdf](http://www.moh-ghana.org/UploadFiles/Publications/SAM_REPORT_Ghana090814053653.pdf)

<http://www.nhis.gov.gh/?CategoryID=158&ArticleID=1110>

[http://www.nhis.gov.gh/\\_Uploads/dbsAttachedFiles/1\(1\).pdf](http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/1(1).pdf)

[http://www.nhis.gov.gh/\\_Uploads/dbsAttachedFiles/8%281%29.pdf](http://www.nhis.gov.gh/_Uploads/dbsAttachedFiles/8%281%29.pdf)

[http://www.who.int/whosis/mort/profiles/mort\\_afro\\_gha\\_ghana.pdf](http://www.who.int/whosis/mort/profiles/mort_afro_gha_ghana.pdf)

[http://www.who.int/workforcealliance/documents/Ghana%20Case%20Study\\_Final.pdf](http://www.who.int/workforcealliance/documents/Ghana%20Case%20Study_Final.pdf)

<http://collections.infocollections.org/whocountry/en/d/Js6860e/>

[http://www.healthgap.org/hcw/documents/HealthcareWorkerShortageFact\\_Sheet\\_UCGH.pdf](http://www.healthgap.org/hcw/documents/HealthcareWorkerShortageFact_Sheet_UCGH.pdf)

<http://www.measuredhs.com/pubs/pdf/DM17/DM17.pdf>

<http://www.measuredhs.com/pubs/pdf/FR221/FR221.pdf>,

[http://www.measuredhs.com/pubs/pdf/GF1/ghana\\_fact\\_sheet.pdf](http://www.measuredhs.com/pubs/pdf/GF1/ghana_fact_sheet.pdf)

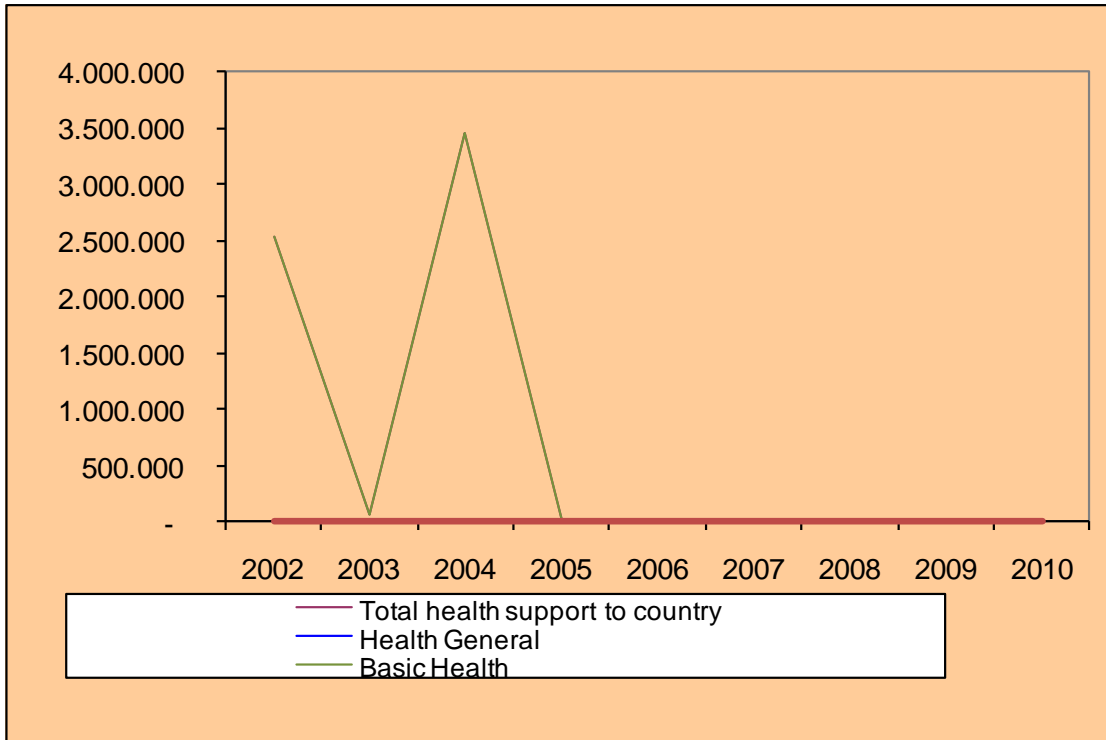
<http://www.measuredhs.com/pubs/pdf/GF14/GF14.pdf>,

[http://www.microhealthinsurance-africa.org/fileadmin/user\\_upload/Afutu-Kotey\\_etal\\_MHI-in-Ghana.pdf](http://www.microhealthinsurance-africa.org/fileadmin/user_upload/Afutu-Kotey_etal_MHI-in-Ghana.pdf)

#### 3.7.2 EU funds between 2002-2010 –detailed listing:

##### 3.7.2.1 Per Subsector

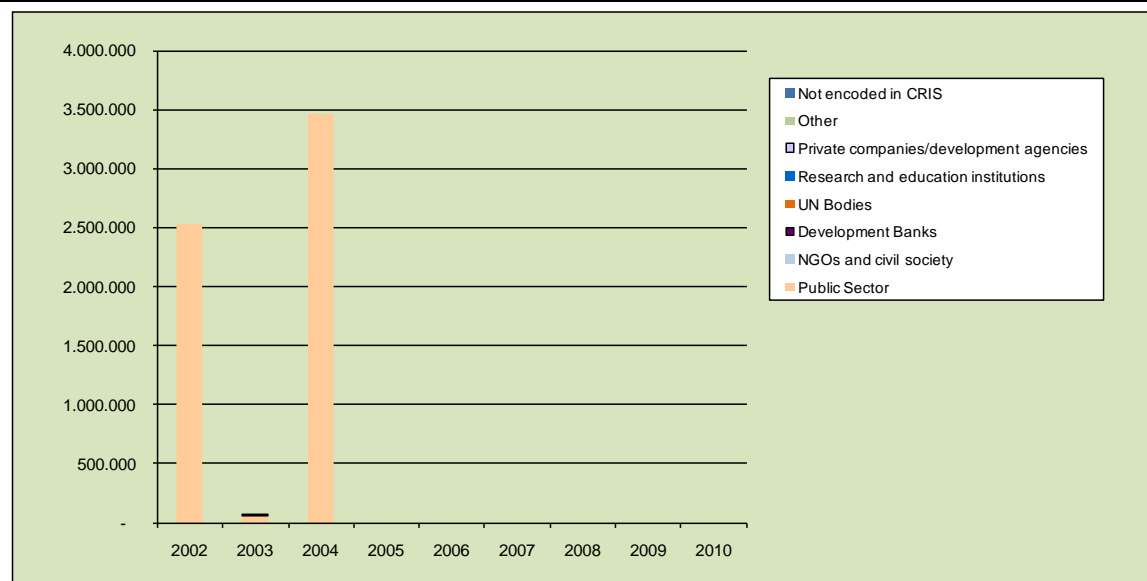
Year	Total health support to country	Health General	Basic Health	SRH
2002	2,526,187	-	2,526,187	-
2003	71,220	-	71,220	-
2004	3,460,593	-	3,460,593	-
2005	-	-	-	-
2006	-	-	-	-
2007	-	-	-	-
2008	-	-	-	-
2009	-	-	-	-
2010	-	-	-	-
<b>Total</b>	<b>6,058,001</b>	-	<b>6,058,001</b>	-





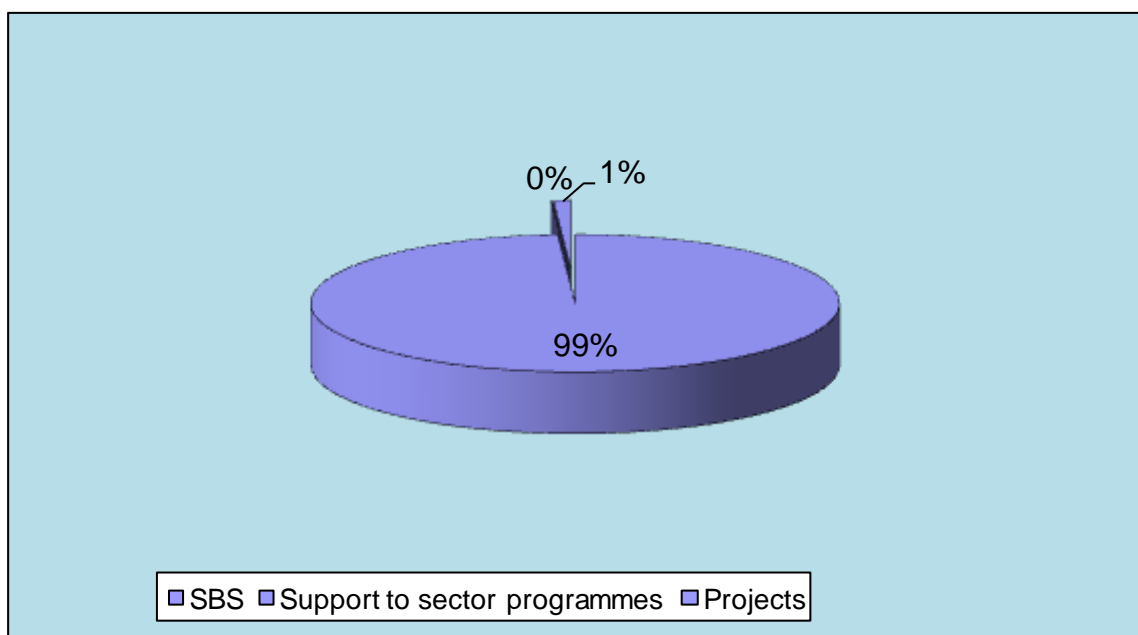
3.7.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	2,526,187	-	-	-	-	-	-	-	2,526,187
2003	64,162	-	-	-	-	7,058	-	-	71,220
2004	3,460,593	-	-	-	-	-	-	-	3,460,593
2005	-	-	-	-	-	-	-	-	0
2006	-	-	-	-	-	-	-	-	0
2007	-	-	-	-	-	-	-	-	0
2008	-	-	-	-	-	-	-	-	0
2009	-	-	-	-	-	-	-	-	0
2010	-	-	-	-	-	-	-	-	0
<b>Total</b>	<b>6,050,943</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,058</b>	<b>0</b>	<b>0</b>	<b>6,058,001</b>



3.7.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	2,526,187	-	-	-	2,526,187	-
2003	7,058	-	64,162	-	71,220	20,652,523
2004	3,460,593	-	-	-	3,460,593	55,205,108
2005	-	-	-	-	-	-
2006	-	-	-	-	-	-
2007	-	-	-	-	-	-
2008	-	-	-	-	-	-
2009	-	-	-	-	-	215,020,000
2010	-	-	-	-	-	16,910,500
<b>Total</b>	<b>5,993,839</b>	<b>-</b>	<b>64,162</b>	<b>-</b>	<b>6,058,001</b>	<b>-</b>



## 3.7.3 Overview of funds committed to the health sectors

Decisions title	Decision No	Decisi on year	Contracts Title	Contract number	Contract year	Implementation starting date	Closing Date	Contracting party	Total
<b>HEALTH SECTOR SUPPORT</b>	FED/1998/014-061	1998	(CLOTURE/CF.019) PE SUPP. TO MED. STORES (09/10/01-08/06/02)	175988	2002	09.10.2001	02.12.2008	REPUBLIC OF GHANA	EUR
			(EX-003) TO MED. STORES (09/10/01-08/06/02); 713,000,000 GHC	175994	2002	09.10.2001	05.05.2009	REPUBLIC OF GHANA	EUR 55,280
			A-BAS (CANCELLED; TRANSFER TO 9 GH 3)	175992	2004	01.02.2004	26.05.2004	(blank)	EUR
			KPMG - AUDIT OF CHIM	175991	2003	17.03.2003	20.01.2004	KPMG	EUR 7,058
			LUMP SUM EU SUPP. GHANA HEALTH SECTOR PROG; 3,460,593.25 EURO	175993	2004	30.05.2004	24.03.2006	REPUBLIC OF GHANA	EUR 3,460,593
			PE3 (01/07/02-31/03/03); 776,655,000 GHC	175990	2002	01.07.2002	15.05.2008	REPUBLIC OF GHANA	EUR 70,907
			THIRD TRANCHE	175989	2002	(blank)	(blank)	REPUBLIC OF GHANA	EUR 2,400,000
<b>Economic reform programme erp 2001</b>	FED/2001/ 015-677	2001	PE4 HEALTH SECTOR (01/09/03-31/12/04); 1,218,360,000 GHC	187053	2003	01.09.2003	15.05.2008	REPUBLIC OF GHANA	EUR 64,162
<b>Grand Total</b>									<b>EUR 6,058,001</b>

### **3.7.4 Details of programmes**

#### **3.7.4.1 Intervention no 1**

<b>Title: HEALTH SECTOR SUPPORT</b>
-------------------------------------

**Budget:** EUR 5,993,839 (only contracts from 2002 on)

**Start and end date:** 1998

**Objectives and expected results:** (Source: FED/1998/014-061)

**Overall objective:**

The overall objective of the national health policy and of the EC support is to improve the health status of all Ghanaians.

**Specific objective:**

The purpose of the 5-year PoW and of the EC support is to improve the performance of the health sector in terms of quality, efficiency and access with specific attention to the affordability of services and with increasing service availability for the poor, for women and for vulnerable groups.

**Expected results:**

The expected results of the 5-year PoW and therefore of the EC assistance are the achievement of the objectives of the seven strategies:

- The primary health services are strengthened.
- The secondary and tertiary services are re-oriented to support primary services.
- A programme to train adequate numbers of staff is implemented.
- The capacity of the MoH for policy analysis, performance monitoring and evaluation and professional regulation is improved.
- The central support systems for human resources, logistics and supplies, financial and health information management IS strengthened.
- Private sector involvement in health care provision is increased.
- Inter-sectoral collaboration is strengthened.

**Activities:**

The proposed EC intervention has three main groups of activities within the framework of the 5-year PoW, which is planned, executed and monitored in an annual cycle.

**I. Participation in the common donor health account**

The participation in the joint financing mechanism has its own set of activities determined by specific events within the same annual cycle. The annual activities that directly and actively involve the external financing partners are:

- February: Joint GoG/partner missions to prepare April monitoring reports
- April: GoG/partner meeting to review annual performance, agree on planned priorities, funding, budget ceiling and guidelines
- September: GoG/partner meeting to agree on next year's plan, budget and procurement schedule

The EC contribution to the common donor health account is going to be approximately 10% of the expected contributions to the same account of all Donors. As the overall support from all Donors to the common donor health account is expected to increase on an annual base, the proposed EC contribution will increase accordingly.

**2. Procurement of equipment and supplies within the 1999 procurement plan**

To assist the implementation of the 1999 PoW and the transition to a full sector-wide approach, the EC will provide earmarked financial support to the MoH to contribute to the execution of its procurement plan for 1999. The items to be procured will be part of the plan adopted by the MoH and sector donors in September 1998.

**3. Capacity building through technical assistance**

The following priority areas for technical assistance were outlined by the MoH:

- Health information: For strategic planning and development of the health information function at all levels of the health system.
- Quality control and quality assurance: For the establishment of policies and procedures for QC/QA at health institutions and for monitoring quality of services on a service-wide scale.
- Human resources: For planning the staff mix and the deployment of staff for the Ghana Health Service.
- Equipment and transport management: To fully implement and maintain the policies and systems, which have been developed.
- Private sector relationships: To establish policies and procedures for private sector regulation and contracting.
- Inter-sectoral relationships: To develop functional links of the future GHS to sectors which have major impacts on health such as water and sanitation and basic education.

The EC will provide one long-term international TA with expertise in health sector administration and health policy to assist in the institutional development of the national health information system. Furthermore, there is budgetary provision for the mobilisation of national and international short-term TA in priority areas. The TA will be mobilised according to the MoH TA procurement plan under terms of reference drafted by the MoH. Consultant selection and contracting will follow EDF regulations.

### 3.7.4.2 Interventions since 2003: Extraction from the Email exchange with the EUD in Ghana following the survey

Information provided by the EUD per mail 12/07/2011: *“For your information, the last “Health Sector Support” programme in Ghana was financed under the 8<sup>th</sup> EDF, covering a period from 1998 to 2004 for an amount of 11Mio Euro to the Health Fund. Since 2006 the European Union to Ghana has changed its funding modality and its contributions to the health sector are now incorporated into the general budget support (GBS) under the Multi-Donors Budget Support (MDBS) mechanism. While in previous years, certain allocations for earmarked funding under health related programmes (in the area of water and sanitation and through Microprojects) continued to provide some resources to the health sector, these programmes have now come to an end. No new resources were foreseen for the period 2010 – 2013 as the health sector is not a focal area under the 10<sup>th</sup> EDF country strategy paper.*

*Thus, following the principles of division of labour, it was decided to not get participate in the health strategic dialogue which is instead under responsibility of other development partners (DPs) involved in specific project/programmes and SBS directly related to the health sector (this resulted in a silent partnership with DANIDA since 2007).*

*Even though the Delegation is still following core activities and debates in the health sector - particularly in relation to the upcoming support to the decentralisation reform in Ghana (improved service delivery at local level) and the more recent MDG Initiative (proposal submitted, waiting for HQ reply) focusing on health-related interventions aimed at boosting Government’s efforts in meeting MDG 5 – the analysis of our GBS impact on MDG’s and on the health sector focuses more on the connection between budget allocation-budget execution-output/outcome.*

*Precisely, what is collectively (Government-DPs) considered as core output/outcome is presented in the sector Progress Assessment Framework (PAF) and assessed annually during the joint annual review of the MDBS. This review mechanism entailed an overall or “holistic” assessment of progress on the implementation of the national development strategy against jointly agreed performance targets/triggers (the result of the assessment informs the financial commitment decisions of DPs engaged in the MDBS).*

*For more in depth strategic discussions regarding the main topics covered by your survey (implementation of strategies/ strengthening national health systems/ quality and affordability of health care services/ health governance /aid modalities and financing channels, etc), we have to refer to the Health Working Group and to other forums like Health Summit, Health Annual Reviews and Health Holistic Assessment.”*



## 4 Annex 8: Country case study South Africa

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

Country case study

SOUTH AFRICA





## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>111</b>
1.1.1	Country context of EC support.....	111
1.1.2	EU funds between 2002-2010 .....	112
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>116</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	116
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	117
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	118
1.2.4	JC 14 Increased or maintained quality of service provision .....	120
<b>1.3</b>	<b>EQ2- Affordability of health: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>122</b>
1.3.1	JC 21 The cost of basic health care services are reduced for households due to EC support.....	122
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC .....	123
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC .....	124
<b>1.4</b>	<b>EQ 3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>125</b>
1.4.1	JC 31 Increase in availability of primary health care facilities .....	125
1.4.2	JC 32 Increase in availability of secondary health care facilities.....	126
<b>1.5</b>	<b>EQ4- Health service utilisation related to MNCH: To what extent has EC support to health contributed to improving health service utilisation related to MNCH? .....</b>	<b>126</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	126
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	127
1.5.3	JC 43 Children better protected from key health threats as a result of EC support.....	128
<b>1.6</b>	<b>EQ 5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?.....</b>	<b>128</b>
1.6.1	JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	128
1.6.2	JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.....	130
<b>1.7</b>	<b>Annex .....</b>	<b>133</b>
1.7.1	Key documentation used for the analysis .....	133
1.7.2	Project documentation of main interventions.....	133
1.7.3	EC documentation on the health sector in the country.....	133
1.7.4	Bibliography .....	133
1.7.5	EU funds between 2002-2010 –detailed listing: .....	135
1.7.6	Overview of funds committed to the country’s health sector during 2002 and 2010 (decisions) .....	138
1.7.7	Overview of main programmes/funds and sectors .....	139

1.7.8	Overview of all health related contracts 2002-2010 .....	139
1.7.9	Details of programmes.....	143

**List of Tables**

Table 1:	Overview of major interventions in the health sector, South Africa 2002-2010 .....	112
Table 2:	Overview of funds committed to the health sector, South Africa 2002-2010 .....	114
Table 3:	Percentage increase in selected public sector health professionals, absolute & per population, 2002-2010.....	118

**List of Boxes**

Box 1:	South Africa Health Sector in a nutshell .....	112
--------	--	-----

## 4.1 Introduction

### 4.1.1 Country context of EC support

Healthcare in South Africa reflects the country's position as a blend of the first and third worlds: some public healthcare facilities in rural areas are very basic indeed, while some private facilities (and medical research) are cutting-edge, placing South Africa at the forefront of medical advances. The public sector is under-resourced and over-used, while the rapidly growing private sector, run largely on commercial lines, caters to middle- and high-income earners who tend to be members of private medical schemes (18% of the population) and to foreigners looking for top-quality surgical procedures at relatively affordable prices via "medical tourism". The private sector also attracts most of the country's health professionals.

Generally, public facilities are underfunded, bureaucratic, inefficient and over-subscribed, whereas many private facilities are excellent. The high level of attrition of health professionals from South Africa is creating a shortage of health professionals in the country, despite the number being trained. Patients must often pay for treatment. Although the state contributes around 40% of all healthcare expenditure, the public health system has to serve over 80% of the population. Public health accounts for around 11% of the government's budget, which is allocated to the nine provinces. The amount of funds they receive and the efficiency of their use vary considerably. Poorer provinces, such as the Eastern Cape, offer a much lower standard of health care than richer provinces like Gauteng and the Western Cape.

The South African public sector health system is attempting to improve service. It is now split into 42 health regions and 52 health districts and a new administrative structure is being developed. Since 1994, over 700 clinics have been built or upgraded, almost 2,300 clinics given new equipment and 125 mobile clinics introduced. There are now over 4,000 clinics in the public sector, offering free healthcare to children under six and to pregnant and breastfeeding women.

To alleviate a long-standing shortage of doctors, 3,004 foreign doctors have been employed in South Africa (approximately 10% of the medical workforce)<sup>172</sup>. Priority has been given to recruitment of Cuban doctors and training of South African medical students in Cuba. The government has also made it easier for other foreign doctors to practise in South Africa and newly-qualified South African doctors and pharmacists now undertake a year of compulsory community service in understaffed hospitals and clinics. Unfortunately, the country still suffers from a medical brain drain, with countries like the UK and Canada keen to recruit South African doctors.

The Department of Health's 10-Point Plan for the health sector includes the following priorities: (i) providing strategic leadership and creating a social contract for better health outcomes; (ii) implementing the National Health Insurance (NHI) system; (iii) improving quality of health services; (iv) overhauling the healthcare system and improving its management; (v) improving human-resource (HR) management, planning and development; (vi) revitalising infrastructure; (vii) accelerating implementation of the HIV/AIDS and Sexually Transmitted Infections Strategic Plan 2007-2011 and increasing focus on tuberculosis (TB) and other communicable diseases; (viii) reviewing the drug policy; (ix) improving the effectiveness of the health system and (x) strengthening research and development.

HIV prevalence in South Africa appears to be stabilising after peaking in the 1990s and early 2000s. South Africa has the largest Antiretroviral (ARV) therapy programme in the world. Since April 2010, government had also begun to expand the Prevention of Mother-to-Child Transmission (PMTCT) Programme. A characteristic of AIDS in South Africa is the interlinkage with the prevalence of TB. The government has decided to put a huge effort into addressing HIV/AIDS and TB in an integrated manner. The most important strategy to combat these diseases is the HIV/AIDS Counselling and Testing (HCT) Campaign. The HIV/TB co-infection rates exceed 70%, with TB being the most common opportunistic infection among AIDS sufferers in 2010. Drug-resistant forms of TB, MDR-TB (multi-drug-resistant) and extensively drug-resistant (XDR-TB) have increased significantly, with about 5,000 and 500 cases diagnosed respectively in 2009. The number of deaths due to malaria decreased from 360 per year in 1999 to 54 in 2008, which represents a decrease of 85% over the period. An increase of 12.4% in the number of houses or structures sprayed with insecticide was witnessed during the 2004 to 2009 period.

---

<sup>172</sup> Department of Health South Africa (2010): HRH Strategy for the Health Sector: 2012/13 – 2016/17.

Box 19: South Africa Health Sector in a nutshell

**In a nutshell**

- South Africa has considered a series of proposals for the institution of variants of NHI since the 1940s and none of these have been implemented to date.
- Lack of political support, the obstructive role of some stakeholders and the lack of general buy in have contributed to the non-implementation.
- A commitment is that which followed the ANC national policy conference in Polokwane in late 2007. The SA government has released a green paper on NHI in August 2011. The EU has provided funding for an international conference on NHI in December 2011.
- The country, though faced with rising poverty, income inequality and unemployment, is among the few countries in Africa with a relatively high per capita health care spending level.
- Such high spending levels are however benefiting largely those who contribute to private medical schemes.
- Specifically, private health care financing dominates the flow of health care funds in South Africa.
- These funds are not pooled adequately and cover a minority of the wealthier population.
- Medical schemes are fragmented with little income or risk cross-subsidisation across schemes and often members still end up making co-payments and out-of-pocket payments for services not covered by their scheme.
- Even though South Africa has relatively high per capita spending on health, it is only if the funds available are pooled that access to quality health services for all South Africans can be guaranteed.

Source: WHO website, EUD comments

**4.1.2 EU funds between 2002-2010**

During the evaluation period, most EC funds were concentrated on five large interventions and complemented by some of individual (regional) projects financed through EC thematic budget lines.

The following table provides the financial overview of these five main EC funded programmes.

Table 32: Overview of major interventions in the health sector, South Africa 2002-2010

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention between 2002-2004</i>
1999/23 2000 Public Health Sector Support Programme (PHSSP)	AFS/1999/000-697	1999	EUR 342,783 <sup>173</sup>
Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II"; EPDPH)	AFS/2006/018-368	2006	EUR 44,183,648
SuCoP for HIV/AIDS - Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme	AFS/2004/016-827	2004	EUR 18,638,057
Higher Education HIV & AIDS (HEAIDS)	Contract no: 146639, 146698, 113413 etc	2004	EUR 19,125,397
SA/1001/000 - Partnership for the Delivery of Primary Health Care including HIV/AIDS (PDPHC)	AFS/2001/000-706	2001	EUR 24,962,887

Source: CRIS database analysis, Particip GmbH

The following paragraphs give a short overview of each of the main programmes' objectives.

**Public Health Sector Support Programme (PHSSP)**

In 2000 the EC commenced a programme of support to the Health Sector in South Africa: the "Public Sector Support Programme" (PHSSP). The main idea behind the 2000-2004 programme was to support the many fundamental changes that were occurring in the health sector in South Africa post 1994. An important feature of the 2000 programme was targeted support to six NGOs. Most funds were allocated in 1999, so impacts of this programme should be understood to apply mostly in the very early years of the evaluation period.

<sup>173</sup> For the PHSSP 36 million Euros were contracted in 1999.

The programme focused on health systems strengthening (often at PHC level) and applied a horizontal and integrated approach to health care which included also actions aiming at major diseases (HIV, TB, non-communicable diseases) but also MCH. This reflected the overall EC policy on health that coalesced over the evaluation period and culminated with the Communication on Global Health in 2010.

The 2000-2002 European Commission (EC) South Africa Country Strategy Paper (CSP) and Multi-Annual Indicative Programme (MIP) foresaw a component related to the development of public-private partnerships (PPP) in relation to health. Furthermore, the role of Non-State Actors (NSA) in the delivery of social services and in the broader development agenda was highlighted.

### **Partnership for the Delivery of Primary Health Care including HIV/AIDS (PDPHC)**

This gave rise in 2001 to the introduction of the EC funded programme “Partnerships for the Delivery of Primary Health Care including HIV and AIDS” (PDPHC) where NSAs with a non profit objective (Non Profit Organisations – “NPOs”) were engaged in a partnership with Government. The programme was approved as a six year programme with funding in two instalments, each of EUR 25 m, in 2001 and 2004. The first phase of the programme supported five of South Africa’s nine provinces (Western Cape, Eastern Cape, Limpopo, Gauteng and KwaZulu Natal).

PDPHC initially supported five of South Africa's nine provinces (Western Cape, Eastern Cape, Limpopo, Gauteng and KwaZulu Natal). Following requests from the four provinces not included in the initial PDPHC (Mpumalanga, Free State, North West and Northern Cape) it was determined that the programme should be expanded to the four remaining provinces. The Expanded Partnerships for the “Delivery of Primary Health Care Programme” (EPDPHC) started in 2007 to include all nine provinces. EPDPHC therefore combines both the second commitment of PDPHC and the expansion to other provinces and operated as a single integrated new programme (see below).

### **SuCoP for HIV/AIDS**

The Support for the Comprehensive Plan for the Care, Management and Treatment of HIV and AIDS Programme (“SuCoP”) was designed as a direct response to the South African Government’s adoption in November 2003 of the National Comprehensive Plan for HIV and AIDS Care, Management and Treatment (“the Comprehensive Plan”), seen within the context of its Health Sector Strategic Framework (1999).

Although SuCoP was primarily an HIV/AIDS support programme, a particular characteristic of SuCoP was the attention given to strengthening health systems underpinning the services and activities of the Comprehensive Plan. This took into account the decentralised nature of public health care provision in South Africa, with activities focused on policy and capacity development on the national level, as well as the improvement of service delivery at provincial and sub-district levels.

However, the original programme design has been assessed as poor, overly complex and seriously deficient in its assumptions and assessment of risk. Although the programme was a response to clear and highly relevant priorities identified by the National Department of Health (NDoH), it lacked coherence and the proper means for ongoing evaluation. There are no baseline data or measurable OVs in the Log Frame and this was not corrected as the programme started to be implemented. There was no mid-term review.

### **Higher Education HIV & AIDS (HEAIDS)**

The objective of this project launched in 2004 was to reduce the spread of HIV/AIDS in the higher education sub-sector. The Programme supported South Africa’s Department of Education to implement a national education and training system, including capacity development especially related to HIV/AIDS.

### **Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services (“Partnerships for Health II”; EPDPHC)**

In the last decade the EC contribution to the health sector switched from the project approach to Sector Budget Support, with a first health SBS, the EPDPHC II, launched in 2007. After assessing the suitability for and the capacity of the government and the ministry of health for a budget support modality and after extensive consultations, including the MoH and the National Treasury, the green light was given for the introduction of a sector budget support in 2007. The Partnership for Health II programme, initially planned as a project modality, was transformed into a non-targeted SBS modality to the health sector and the only tranche was disbursed in its totality in 2007.

With the switch to budget support as the preferred aid modality after 2007, the assignment of EU support to specific interventions becomes difficult and in some ways impossible. As EU funding is mingled with government funding. Supporting the overall health programme, it is often difficult or even impossible to state which part of the EC budget support funding has gone to support, for example, infrastructure development or vaccination. In policy dialogue with Government, of course, the EU is able to communicate its priorities, but the decision is ultimately that of national authorities. Under the budget support modality, the impact of certain interventions cannot be assigned to EU support, but EU support can safely be said to have contributed.

In 2010 the EC has launched a EUR 126 million Health Care Sector Policy Support Programme which aims to contribute to increased life expectancy, reduced maternal and child mortality and the fight against HIV/AIDS and tuberculosis. For this purpose it will support the South African government and notably the Minister of Health, to improve access to healthcare services for patients and to raise the quality and management of the health system at district level. According to the PrimCare SPSP project information sheet<sup>174</sup>, first payments are most likely to be made in 2012. Thus, the project is not in the temporal scope of this evaluation, but is worth keeping in mind as an indicator of evolving priorities at the end of the evaluation period.

This case study concentrates on the analysis of these five programmes in order to provide an overview on the health sector in South Africa between 2002 and 2010. Several small NGO-programmes have complemented these main interventions. If available and relevant, information related to this small project will be taken into account in this case study. During the evaluation period South Africa also benefitted from EU research funding, such as FP7 and EDCTP project for clinical trials. These funding are not provided by DG DEVCO and are as such not taken into account in this evaluation. In addition, since EU support to the Global Fund is dealt with in a separate thematic case study, Global Fund projects will not be dealt with in this case study.<sup>175</sup>

The table below provides an overview of all EU's financial support to health to the country between 2002 and 2010.

*Table 33: Overview of funds committed to the health sector, South Africa 2002-2010*

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention</i>
Theme II/Increasing equitable access to HIV/AIDS information and services within a comprehensive sexual and reproductive health and rights programme serving the poorest and most at risk groups and those living with or affected by HIV/AIDS	(blank)	2006 (contract starting year)	EUR 3,736,770
1999/23 2000 Public Health Sector Support Programme	AFS/1999/000-697	1999	EUR 342,783
1999/22 – Consolidating the Trauma Sector SA	AFS/1999/000-696	1999	EUR 209,744
SA/1001/000 – Partnership for the Delivery of Primary Health Care including HIV/AIDS (PDPHC)	AFS/2001/000-706	2001	EUR 24,962,887
SA/1010/00 Regional HIV/AIDS Awareness and Education Programme	AFS/2002/002-497	2002	EUR 9,968,140
Consolidation and expansion of HIV vaccine preparedness in South Africa - with knowledge translation	SANTE/2002/004-753	2002	EUR 1,350,000
SA/1009/00 Local Economic DVP Support Programme KwaZulu Natal; <i>contract HIV/AIDS "Best Practice" in the workplace in KZN</i>	AFS/2002/004-557 (c88203)	2002	EUR 92,835

<sup>174</sup> PrimCareSPSP (2011): Project Info Sheet.

<sup>175</sup> Also not dealt with are 7th research framework (FP7) projects financed by DG Research and some research projects financed by DG Devco (e.g. the European and Developing Partners Clinical Trial Partnerships and thematic budget line research projects such as the MRC project on HIV-1 Drug Resistance).



<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention</i>
SA/1005/00 EPRD Support Facility (EPRD SF) contract Design & Feasibility Study: Pipeline 2004 (Health)	AFS/2002/002-492 (c83717)	2002	EUR 67,011
Rider n°2 to Financing Agreement "2000 Public health sector sup programme" South Africa" (1999/23 2000 PUBLIC HEALTH SECTOR SUPPORT PROGRAMME)	AFS/2003/005-895 (AFS/1999/000-697)	2003	EUR 5,000,000
SuCoP for HIV/AIDS - Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme	AFS/2004/016-827	2004	EUR 18,638,057
Higher Education HIV & AIDS (HEAIDS)	(blank)	2004	EUR 19,125,397
Pré-engagement dont dépendront les contrats PVD projets; contract Capacity Building Initiative for Organisations engaged in HIV/AIDS Treatment, Care & Support and Holistic Support to Aids Orphans and Vulnerable Children (OVC) through community based programmes - South Africa	ONG-PVD/2004/006-239 (c114076 and c114035)	2004	EUR 1,448,000
pré-engagement dont dépendront les contrats pour les projets PVD Psychosocial support for orphans and community based caregivers working with PLWHA in South Africa	ONG-PVD/2005/017-215 (c119182)	2005	EUR 691,203
Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II")	AFS/2006/018-368	2006	EUR 44,183,648
Programme for Science and Technology Innovations and Capacity building (PSTICB) contract Réseau S&T Afrique Caraïbe de soutien à la lutte contre les maladies infectieuses	AFS/2006/018-197 (c 219014)	2006	EUR 967,742
<b>Grand Total</b>			<b>EUR 130,784,217</b>

Source: CRIS database analysis, Particip GmbH

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

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

#### Indicators

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

#### 4.2.1.1 Findings per indicators

**I-111** South Africa had no essential medicines policy when the post apartheid government came to power in 1994. At that time, the public sector purchased more than 2,600 pharmaceutical products and there was a strong bias toward tertiary-level medicines.<sup>176</sup> In 1995, the Minister of Health appointed an essential medicines list committee and the country's first attempt at such a list was completed and distributed to institutions carrying out public sector procurement the following year. The principal objective of the current South African "Drug National Policy" is to ensure the availability and accessibility of essential drugs to all citizens. For purposes of the drug national policy, essential drugs are drugs that are required to treat the majority of conditions that are prevalent in a cost-effective and efficient manner. The concept does not imply that no other drugs are useful, but that these drugs are the most needed for the health care of the majority of the population. They should therefore be available at all times, in adequate amounts and in the proper dosage forms. A "Standard treatment guidelines and essential drug list for South Africa" was revised and approved in 2006. The EC did not contribute directly to this policy move.

**I-112** Soon after the first attempt to define a list of essential medicines in 1995, an impact study by the South African Drug Action Program assessed the usefulness of the list at primary health care centres. The study selected 30 key medicines to measure the availability of essential drugs and found that health centres had 85% of these key drugs available. Of medicines prescribed by health care providers, 70% were on the essential drugs list, even though there were still medicines not on the essential medicines list in the system. This suggests that the major progress in pharmaceutical availability had been made prior to the evaluation period.

Under the SuCop, the EC has directly supported the improvement of financial access to drugs through a research study conducted on the "National Health Reference Price List" by the University of KwaZulu-Natal (UKZN) together with the Health Financing and Economics (HFE) cluster of the Department of Health. Indirectly, the EC has contributed to enhance the availability of essential drugs through four of the five main programmes supported by the EC: (i) the Public Health Sector Support Programme (PHSSP); (ii) the Support to the Comprehensive Plan on HIV and AIDS (SuCoP); (iii) the Partnerships for the Delivery of Primary Health Care including HIV&AIDS Programme (PDPHC); and (iv) the "Expanded Programme for the Partnerships for the Delivery of Primary Health Care including HIV&AIDS services." As stated above, the sector budget support modality does not permit EC support to be assigned to specific changes, but does allow an overall contribution to be deduced. The strengthening of the management of health and NGO systems and the capacity building at all levels of the health sector have been the key components of these programmes. In terms of quality, all projects have been designed to improve the quality of health services to patients through the improvement of the management of public health systems as well as of NGOs. The focus of these interventions has been made through the training and development of tools on health management and quality assurance.

---

<sup>176</sup> WHO, South Africa: getting essential medicines to the people, *Essential Drugs Monitor*, Geneva: WHO, 1999, No. 027, <<http://apps.who.int/medicinedocs/en/d/Jh1467e/2.3.html>>, accessed Nov. 18, 2010. Chaudhury RR et al., Quality medicines for the poor: experience of the Delhi programme on rational use of drugs, *Health Policy and Planning*, 2005, 20(2):124–136.

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

### Indicators

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

#### 4.2.2.1 Findings per indicators

**I-121** There has been constant improvement in the mix of primary and secondary health facilities during the last decade, both in the private and the public health sector. Support in this sector – mainly for infrastructures rehabilitation and basic equipment - has been provided mostly by government funds with the support of development partners. The major EU players in health are presently: The Commission, UK, Germany, Italy, France, Netherlands, Sweden, Ireland and Belgium. All provide support to community service organisations (CSOs). The Commission, the UK and Belgium provide direct support to the Department of Health (DoH). Italy, Germany, Sweden and UK provide support to the South African National AIDS Council (SANAC). Specific data are available in relation to those projects implementation (selected provinces and districts). No specific information on EC contribution to infrastructure has been found, but the overall contribution through sector budget support is not in doubt and a major government priority has been correcting the legacy of the apartheid-era imbalance in favour of tertiary health facilities.

At the very early beginning of the evaluation period (2002-2004, before the advent of budget support) support to this indicator has been provided through the PHSSP. A number of outcomes have resulted from this support, such as (i) Planning approaches and tools now allow a much more integrated approach to hospital rehabilitation and revitalization strategy. This is linked to overall health strategy, budgets and long-term perspectives and has prompted major revisions of previous plans; (ii) More effective, integrated planning and management of rehabilitation projects has emerged; (iii) The sector has enhanced ability to negotiate resources from Treasury; (iv) New facility design and planning systems, tools and information are now available for use at national and provincial level.<sup>177</sup> Nothing suggests, however, that the EC directly financed infrastructure.

According to the MTR of 2009<sup>178</sup> the EC's programme on Primary Health Care HIV and AIDS Service (EPDPHC) contributed to improvement in the infrastructure mix by linking non-profit organisations (NPOs) to PHC facilities in order to increase harmonisation and improve the continuum of care by providing care at a household level.

**I-122** Since 1994, over 700 clinics have been built or upgraded, almost 2,300 clinics given new equipment and 125 mobile clinics introduced. There are now over 4,000 clinics in the public sector, offering free healthcare to children under six and to pregnant and breastfeeding women. According to the EU Delegation, under EPDPHC construction of accommodation for clinical associates at district hospitals was funded. Furthermore, the support included procurement of vehicles for student transport, supply of laboratory skills equipment and procurement of books. This leads to the conclusion that the EC supported increased proportion of health facilities with appropriate equipment directly to some extent<sup>179</sup>. Indirectly, EU budget support assisted the MOH in its efforts to upgrade facilities and ensure that they are properly equipped.

#### 4.2.2.2 Resume of the JC

Only limited information on direct EC contribution to better infrastructure and equipment has been gathered. It appears that the EC contribution was not directly involved in improving the physical infrastructure of health facilities through the PHSSP, although there was substantial support for planning and policy processes related to infrastructure. The EC contribution has been designed to improve the quality of health services to patients through the improvement of the management of public health systems as well as of NGOs. The focus of these interventions has been made through the training and development of tools on health management and quality assurance. The main support of the EC has been through sector budget support that has helped the MOH to realise its infrastructure and equipment plans, which have, in turn also been supported by the EC.

177 Public Health Sector Support Programme (PHSSP) South Africa (2004): Final Evaluation of the 2000 Public Health Sector Support Programme South Africa.

<sup>178</sup> Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&AIDS Services – PDPHC II, Mid-Term Review, September 2009.

<sup>179</sup> EPDPHC (date not known).

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

#### Indicators

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

#### 4.2.3.1 Findings per indicators<sup>180</sup>

**I-131** South Africa suffers a shortage of health workers for at least four reasons: the demands associated with the HIV/AIDS epidemic, HIV/AIDS mortality and morbidity of health sector workers, brain drain and the attrition of public-sector health workers into donor projects.<sup>181</sup>

According to the Human Resources for Health Strategy (2011), the core team of practising medical practitioners in South Africa consisted of: (i) 11,664 registered practicing physicians; (ii) 4,513 medical specialists; (iii) 55,309 professional nurses; (iv) 828 dental practitioners and (v) 3,285 pharmacists. Over the eight-year period 2002 to 2010, there was an increase in the number of public sector health professionals in all categories (see table below).

Table 34: Percentage increase in selected public sector health professionals, absolute & per population, 2002-2010

Occupational classification	Absolute numbers				Per 10,000 uninsured population			
	2002	2010	% increase	Average annual increase	2002	2010	% increase	Average annual increase
Medical Practitioners	7291	11664	60.0%	6.1%	1.89	2.85	50.6%	5.3%
Medical specialists	3585	4513	25.9%	3.0%	0.93	1.10	18.5%	2.3%
Professional Nurses	40786	55309	35.6%	3.9%	10.57	13.49	27.6%	3.1%
Dental practitioners	527	828	57.1%	6.3%	0.14	0.20	47.9%	5.5%
Pharmacists	1234	3285	166.2%	13.8%	0.32	0.80	150.6%	13.0%

Source: DoH South Africa, *Human Resources for Health*

The response to the human resource crisis has been supported by the EC in collaboration with WHO by assisting in the creation of a new category of health workers in South Africa – “Clinical Associates” – starting in 2008. This initiative should contribute to strengthening the health system, but no information has been found that would make it possible to assess concrete results. The final report of PDPHC<sup>182</sup> reported in this context, that in 2007, the programme put the first 2,700 enrolment of CCW on training.

The move from the project modality to sector support was motivated, in part, by the desire to reduce the human resource distortions caused by projects and the EC coordinates with other donors to attempt to reduce human resource distortions. The EU has in place a policy on international migration of medical professionals, however, most of the countries competing for South African medical professionals (apart from the UK) are outside the EU.

**I-132** The overall increase in the number of medical professionals in the table above hides some less optimistic trends at a more disaggregated level. From 1996 to 2008 there was a decline in key categories such as specialists and specialist nurses. There was a moderate increase after 2006. The slow growth is linked to poor retention of graduates, unplanned and unfunded public sector posts and inefficient management and recruitment processes, in addition to the four factors mentioned above. As a result, South Africa has a shortage of certain health professionals such as physiotherapists, dieticians and radiographers. Education output of most professions has been stagnant for the past fifteen years. Faculty output of MBChB graduates is not a full capacity for all faculties and varies in quality for all professions. Budget cuts in the 1990s led to a reduction in academic clinicians and the freezing of academic clinician posts has been sustained. Specialist training in nursing has declined

<sup>180</sup> Human Resource for Health South Africa 2030 Draft HR Strategy for the Health Sector 2012/13 – 2016/17; August 2011.

<sup>181</sup> WHO Country Cooperation Strategy, [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_zaf\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf), 2009, p.8.

<sup>182</sup> Department of Health Republic of South Africa (2007): Partnership for health I (PDPHC) Final Report 2007.

significantly and affects hospital service capacity. Registrar and sub-specialist training posts are 30% and 75% unfilled respectively due largely to lack of funding.

Adding to the above the WHO mentions the importance of availability of a well-trained, motivated and appropriately-sized cadre of health professionals in South Africa's health system.<sup>183</sup> Also the EC recognised these challenges in EAMR 2008. The EC responded to the need to further strengthen the policies and interventions in place for staff training, recruitment and retention through various programmes (PDPHC and EPDPHC, SuCOP).

According to the Partnerships for Health I ROM Report 2005<sup>184</sup>, a significant impact, although not fully realised at the point when the ROM Report had been published, was the creation of a career path for Community Health Workers (CHWs) which aimed to create a constant pool of well qualified CHWs, ensuring primary health care service of high quality. In the 2006 MTR it was reported that, due the late arrival of the Health and Welfare Sector Education and Training Authority (HWSETA) accredited training curriculum, training had been delayed in most provinces. However the 2006 MTR<sup>185</sup> also reported the substantial contribution of the Programme in providing home based care (HBC) in the provinces of Western Cape and Limpopo, where a large proportion of the population suffering from HIV has been reached by the HBC component. In 2007, the final report<sup>186</sup> stated that the programme developed unit standard for CHW, curriculum materials, initiated training using the new CHW curriculum in Limpopo and Western Cape.

EPDPHC contributed to the availability and standards of key health workers. As examples of major achievements, the EAMR 2011<sup>187</sup> stated that training of personnel of NPOs, DoH and the Programme itself, addressing mainly managerial, leadership and organisational competencies, systems and tools took place. Furthermore the EC supported a 3-year bachelor programme for mid-level medical workers, thus addressing the need for well-trained health professionals (EAMR 2009)<sup>188</sup>. Further documents emphasised the strong link of programme contributions to indicator achievements. The MTR 2009<sup>189</sup> explicitly drew attention to the extent of performance and efficiency of the programme by developing skills and enhancing career opportunities of NPO staff and CCGs. The programme was also collaborating with the Human Resource Planning Development cluster within the National Department of Health (NDoH) to implement the Clinical Associate Programme. The SuCOP programme has also contributed to the availability and standards of health worker trainings to some extent. According to the EAMR 2011 SuCOP supported the development of tools and policies to improve training courses on quality and promoted the involvement of hospital CEOs into a hospital management leadership network, which resulted in a Hospital Management Masters in Public Health (MPH) with first graduates in 2010.

In addition, the Higher Education HIV&AIDS (HEAIDS) Programme in South Africa provided support to this indicator, as the programme was designed to support learning and knowledge development across six result areas, such as for example (i) Specific roles to be played by teacher education faculties in addressing the pandemic are identified and clarified; (ii) Best-practice with respect to, inter alia, prevention, behavioural change, care & support, gender (including masculinities), curriculum integration etc. is identified, investigated, tested and replicated; (iii) Knowledge generation, assimilation and dissemination with respect to the Higher Education sub-sector, the Education sector and the population as a whole are supported; (iv) HEIs' Human Resource capacities and systems development with respect to the challenges posed by HIV&AIDS are supported. The 2007 ROM report<sup>190</sup> and the final evaluation report (2010) noted that the HEAIDS programme had made significant contributions to the way in which HIV/AIDS was regarded in HEIs in the areas of policy development, curriculum mainstreaming, changing behaviour, research, information

<sup>183</sup> WHO Country Cooperation Strategy, [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_zaf\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf), 2009, p.10.

<sup>184</sup> EC, Re-Monitoring Report, South Africa – ZAF – Partnerships for the Delivery of Primary Health Care including HIV/AIDS (PDPHC), 17/05/2005.

<sup>185</sup> EC, Mid-Term Review of the European Commission funded Partnerships for the Delivery of Primary Health Care including HIV&AIDS Programme (PDPHC), Final Report, 2006.

<sup>186</sup> Department of Health Republic of South Africa (2007): Partnership for health I (PDPHC) Final Report 2007.

<sup>187</sup> European Union Delegation to Republic of South Africa, External Assistance Management Report (EAMR), January 2011.

<sup>188</sup> European Union Delegation to Republic of South Africa, External Assistance Management Report (EAMR), January 2009.

<sup>189</sup> DoH South Africa, Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&AIDS Services – EPDPHC, EC Sector Budget Support, Mid-Term Review, September 2009.

<sup>190</sup> EC, Re-Monitoring Report, South Africa – ZAF – Higher Education HIV/AIDS (HEAIDS) MR-01756.02 – 26/06/07.

dissemination/sharing, workplace interventions and service delivery. Regarding curriculum integration, the degree of HIV/AIDS curriculum integration varied, some pockets of success were evident in some institutions reporting (a) the introduction of pilot modules, (b) the use of innovative IT and (c) partnerships being fostered with academic forums, while the majority of institutions indicated that this aspect was a major challenge and that academic staff were very reluctant to incorporate HIV in their curricula because of a) already overloaded curricula; (b) reluctance to forfeit credits, (c) the relative unimportance of this objective; as well as (d) a prevailing negative attitude held by academics with regards to HIV curricula infusion.

**I-133** Attrition from the health professions in South Africa is estimated to be about 25% per annum, with further attrition of about 6% due to death, retirement and change of profession. The attrition of Community Service professionals is notable with about 23% annually not remaining to work professionally in South Africa. The primary reason given for this choice is poor working conditions in the public sector. The high level of attrition is contributing to the shortage of health professionals. Tracking of health professional migration and the reasons for it is necessary.

The EC recognised in the EAMR 2008<sup>191</sup> chronic shortages of health care personnel, for which attrition is partly to blame, as one of the major challenges in the health sector. Evidence for EC contribution to this indicator can be found in the interim report no.3 of 2008, of the “Capacity building Initiative for organisations engaged in HIV/AIDS treatment, care and support”. The EC supported MSSA facilities where a high degree of work environment satisfaction was reported irrespectively of salaries. However it is important to express a reservation regarding the extent to which this can be attributed to EC contribution, as the clinics are under NPO management and only receive funding from the EC.

Attrition has been addressed in the new HR Strategy for the Health Sector 2012/13 – 2016/17; August 2011. No direct EC contribution can be proven, but it is safe to assume that by supporting better working conditions indirectly, the EC has contributed to containing the problem.

#### **4.2.3.2 Resume of the JC**

The EC contributed in improving availability of qualified human resources for health throughout the implementation of its four main programmes support and HEAIDS. Increased numbers of trained health workers in the nine selected provinces as well as a continuum of training has reinforced the Departmental Department of Health were those programmes have been and are implemented. No hard numbers can be cited, but it is safe to assume that, by strengthening the health sector generally, the EC has reduced the problems of attrition and absenteeism. However, low salaries and poor working conditions continue to keep the attrition rate at very high levels.

#### **4.2.4 JC 14 Increased or maintained quality of service provision**

##### **Indicators**

- I-141 Quality assurance mechanisms in place at facility level (hospital, health centre, health posts in private and public health facilities).
- I-142 Clinical treatment guidelines available, disseminated and applied.
- I-143 Percentage of people who are satisfied with the quality of the services (by facility and specific service provider: physician, dentist, nurse, etc.)?

##### **4.2.4.1 Findings per indicators**

**I-141** Several quality assurance mechanisms are in place among the different layers of the South African health system especially for vertical programmes. In the very beginning of the evaluation period, the improvement of the Districts Health Information System (under the PHSSP) which developed new systems and tools in health economics and financial planning, the development of a “twinning” programme between hospitals in South Africa and Europe (UK and France) and the implementation of a cost accounting centre have contributed to quality of care.

With reference to SuCop the EAMR 1/2011 explicitly focused on the project’s achievements in terms of quality improvement. Accordingly quality assurance took place in form of a quality improvement monitoring tool and a PHC facility supervision policy.

Another example is under the PDPHC programme with the strengthening of NGOs’ capacities through the development of tools and guidelines and training including (but not exclusively) the following: (i) “The NPO Supervision Manual: A Quality Tool for NPOs Delivery Health Services in South Africa”

---

<sup>191</sup> European Union Delegation to Republic of South Africa, External Assistance Management Report (EAMR), 2008.



(July 2007) (ii) “The NPO Manual: A Practical Tool to Assist and Guide NPOs Entering into Partnerships with Government” (February 2006); (iii) “The NPO Mentorship Guideline: A tool to assist NPO’s effectiveness for improved quality services with communities” (October 2006); (iv) “The Guideline for Technical Assistants for the Coordination and Management of Partnership Agreements between Provincial Government and NPOs: A Guide for Staff Coordinating and Managing NPOs’ Services” (November 2007) and (v) “The Monitoring and Evaluation Framework for NPOs Delivering Primary Health Care” (June 2007). In this instance the MTR 2006 reported the impressive progress the programme had made in developing health management systems and tools, integrating them in district health management and establishing mechanisms for engaging with the non-profit making private sector and expansion in PHC service delivery. However, despite these various quality monitoring tools developed under the PDPHC, it is difficult to evaluate effectiveness or impact based on these tools since these were developed towards the end of the evaluation period of the MTR (2007).

The MTR 2009 for EPDPHC does not explicitly point out the existence of quality assurance mechanisms; however it confirmed the success of the programme by referring to the high degree of alignment of the 52 health districts to PDPHC processes and procedures. As adherence to uniform processes and procedures are closely related to quality assurance mechanisms, these aspects can be judged to be a contribution to the extent to which quality assurance mechanisms are in place at facility level.

The EAMR 1/2011 and the SuCoP Project information sheet<sup>192</sup> stated that the SuCoP for HIV AIDS project had some major achievements which could have also contributed towards an increase of quality assurance mechanisms in place. These major achievements are:

- The District Hospital Referral Systems Project established patient referral steering committees, patient referral software training and the finalisation of the Patient Referral Policy;
- The Quality Improvement project revised the Clinic Supervision Manual, developed a quality improvement monitoring tool and a PHC facility supervision policy and facilitated the organisation of quality improvement training courses;
- The Hospital Management Training Project (started before SUCOP) – 145 of 400 hospital CEOs involved in hospital management leadership network which resulted in a Hospital Management Masters in Public Health (MPH) with first graduates in 2010, a study tour to France and placements at four French hospitals;
- In a Fellowship project (started before SuCoP), eight fellows were enrolled in Master degree courses, focusing on data capture. These fellows were expected to work for a certain period in the public health sector after their graduation (bursary system);
- The Excellence in Health Care Awards Project (started before SUCOP) is a major event in annual health sector calendar, combined with a Quality Summit.

**I-142** A range of treatment guidelines (e.g. PHC, EPI, MNCH, Malaria, TB, HIV/AIDS, etc.) are available in South Africa. They are mainly derived and/or translated by WHO, UNICEF, UNFPA, UNAIDS, guidelines and/or from main multi/bilateral donors as DFID, USAID, WB and ADB. In general, these guidelines are disseminated at peripheral level; however it is not possible to quantify the rate of dissemination and real implementation of the treatment guidelines in the field. The EC did not contribute to the elaboration or adoption of guidelines; however, through overall health sector strengthening, it may have contributed to their implementation. However, according to the MTR 2009 of the EPDPHC, the EC contributed significantly to the development of guidelines for contracting and monitoring of non-profit organisations (NPOs). Following these procedures and the developed guidelines and in collaboration with the DoH, most provinces undertake joint call for proposals to invite NPOs to participate in delivery of PHC. This has largely contributed towards development of the NPO sector into more formal and professional structures with the ability to deliver quality PHC services.

**I-143** The last South Africa Demographic and Health Survey (DHS) of 2003 (related to the evaluation period) showed in general that adult patients are not happy with the services rendered, both in the private and public sector. Dissatisfaction with public hospitals and community health centres is highest in the provinces of Gauteng and Eastern Cape. It is more frequently expressed by people living in urban areas than those in non-urban areas. The major reason for dissatisfaction in the public sector hospitals and community health centres are long waiting times, staff attitudes, prescription medication shortages and staff shortages. Long waiting times, staff attitude and doctors and pharmacists being too expensive were the main reasons for dissatisfaction with private sector facilities and short

<sup>192</sup> SuCoP (no date provided) Project Information Sheet.



consultations and cost were the most common reasons cited in the case of private doctors. Women aged 15-49 years living in non-urban areas experienced more problems with costs, distance and transport in reaching health services than those in urban settings. This was reported most frequently in Limpopo. No time trend data on client satisfaction has been found to date. However, it is noteworthy that beyond the temporal scope of this evaluation (2002-2010) the DoH has started its fast-track initiative to improve quality of health care facilities, including to address waiting times, staff attitudes, cleanliness, infection control and drug supply.<sup>193</sup>

#### 4.2.4.2 Resume of the JC

In general the quality of service provision had deteriorated at the beginning of the millennium; however signs of amelioration are reported through various reviews and survey in the last few years. However, that the country has a high degree of discrepancy among provinces and districts, which makes it difficult to pronounce an overall judgement. The richer provinces have a far better standard of services provision compared to the poorer ones. The EC contribution for this JC was linked to the specific supported programmes in the nine provinces of the country. In this context the field visit report for the former health evaluation explicitly referred to the extent to which EC support contributed to increase or maintain quality of service provision. In terms of quality, all projects have been designed to improve the quality of health services to patients through the improvement of the management of public health systems as well as of NGOs. The focus of these interventions has been made through the training and development of tools on health management and quality assurance, especially on the central ministry (NDoH) level. Examples for this statement can be found in the Final Evaluation of the SuCoP<sup>194</sup> project in 2009, which reported the contribution of successful projects such as the Electronic Document Management System, the Hospital Management Training Programme and the Incidence Benefit Analysis towards achieving improvement in health status. However it is also stated that these projects made progress in spite of rather than because of SuCoP. They benefitted from pre-existing project proposals, meaningful contributions from other donors and astute and determined leadership which was able to triumph against some of the odds that damaged many of the other projects. Thus, we have to be careful when attributing increased or maintained quality of service provision to EC support, as the reasons may also be found elsewhere.

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

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

##### Indicators

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

##### 4.3.1.1 Findings per indicators<sup>195</sup>

**I-211** According to WHO 2011 data, out of pocket spending increased from 14.2% to 17.7% of total health care expenditure between 2002 and 2009.

The EC's support to improving financial access to health services has been done through the PHSSP via a TA whose function was the development of health financing models – including the cost of the provision of ARVs. Further, under PHSSP and SuCoP there are finance interns. These steps may have contributed to improved health finance policy generally, but cannot be said to have had any direct impact on out of pocket spending.

---

<sup>193</sup> Comment EU Delegation South Africa.

<sup>194</sup> European Commission and National Department of Health South Africa, Support for the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme (SuCoP) 2005-2009, Final Evaluation Report, 2009.

<sup>195</sup> Health care financing in South Africa: moving towards universal coverage. The World Health Organization (WHO) has encouraged this. Resources and risks are the basic principles. JOHN ELE-OJO ATAGUBA, BSc (Hons) Economics, MPH (Health Economics) and JAMES AKAZILI, BA (Hons) Economics, MA Health Economics.

**I-212** Social security expenditure on health as a share of general government expenditure on health remained stable: from 3.3% in 2000 to 3% in 2008.

**I-213** National Health Insurance: In 2007 in Polokwane, the African National Congress (ANC) – the South African ruling party – committed itself to the establishment of a national health insurance (NHI) system, largely due to concerns about the challenges of the South African health system (within both the public and private sectors). This reflects growing concerns for the poor who sometimes cannot utilise health services due to high costs (not only of health services but transport to access services), employees complaining about the escalating contributions to medical schemes and failed attempts in the past to establish such similar schemes.

According to the comments provided by the EU delegation South Africa, “at the moment there is no health insurance in South Africa. However, this will change in the future with the implementation of the NHI.” The EC financed, under SuCoP, a major study and a household survey, with the aim to create a baseline for a potential development of a health insurance system. The final evaluation report of SuCoP (2009)<sup>196</sup> judged that the project was well-designed and executed with a significant and successful impact. The dataset produced by the survey was the only comprehensive dataset containing utilisation rates and forms the basis of modelling the future resource requirements of a national health insurance system.

#### 4.3.1.2 Resume of the JC

The EC supported the health finances to a small extent only, by providing technical assistance (e.g. within the PDPHC to develop a health financing model) or by supporting technical studies, such as the development of a dataset and a model for the design of a future national insurance system. This specific impact was nevertheless evaluated very positively and of use to the South African Government, as pointed out by the final evaluation of the SuCoP project.

Out of pocket spending rose over the evaluation period (roughly defined) while the share of government expenditure financed through social security remained the same. It would be impossible to conclude, based on these Indicators and evidence found to date, the EC support increased the affordability of health care by reforming health care finance. However, it has helped to lay the foundation for such reform.

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

##### Indicators

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

##### 4.3.2.1 Findings per indicators

**I-221** Cost waiver and subsidies schemes in place for the poor and persons with special health care needs are confined per law to (i) pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes; and (ii) all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases.<sup>197</sup> Moreover free subsidies schemes are limited to regional initiatives and/or through faith based organisations. HIV/AIDS patient receive free of charge ARV treatment. There are now over 4,000 clinics in the public sector, offering free healthcare to children under six and to pregnant and breastfeeding women.

At the beginning of the evaluation period, the EC provided support to this indicator under the PHSSP<sup>198</sup> supported project AIDS Foundation South Africa (AFSA). The majority of the 25 NGOs selected under this project were providing either home based care for people with AIDS, support for orphans & vulnerable children and /or undertaking preventative activities such as the distribution of IEC material and condoms. The program had an impact by providing services to people who otherwise

<sup>196</sup> Support for the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme (SuCoP) 2005-2009, 2009.

<sup>197</sup> Government Gazette (2004) Republic of South Africa, National health Act, 2004; No. 61 of 2003.

<sup>198</sup> Public Health Sector Support Programme (PHSSP) South Africa (2004): Final Evaluation of the 2000 Public Health Sector Support Programme South Africa.

had no access to services such as home visits to people dying of AIDS and visits to orphans. In addition, through the AIDS Law Project, funded under PHSSP, provision of free legal assistance, advice and sometimes instituting legal action on behalf of people living with HIV has been achieved.

**I-222** Multi and bilateral donors – including EC - supported health finance of basic health services which have resulted in increased uptake of out-patient services. No data to back up this assertion have been found. However, the EU Delegation noted that there are free PHC services for people infected with HIV and TB.

#### **4.3.2.2 Resume of the JC**

The main sources of finance for the public primary care services come from the government itself; however consistent contributions came also from multi and bilateral donors. The major EU players in health are presently: EC, UK, Germany, Italy, France, Netherlands, Sweden, Ireland and Belgium. All provide support to CSOs, The Commission, UK, Belgium provide direct support to the DOH. EC and EC-MS contribution to the health sector increased development and sustainability of special scheme and ensure availability of health care to groups with special health care needs. For indicator I-221 there is strong evidence that EC provided support to cost waiver and subsidies schemes under PHHSP.

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

##### **Indicators**

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

##### **4.3.3.1 Findings per indicators**

***I-231: Some support along these lines has already been cited in considering Indicators I-221 and I-223.***

Support to this indicator was provided under PHSSP, achieving substantial result through support to the Government in advancing health finance reform. More specifically, the final evaluation (2004)<sup>199</sup> of PHSSP reported several outcomes of activities undertaken under component 1) Establish capacity in financial planning, management in DOH at national and provincial levels. This included for example: (i) Improved use of existing information and budgeting systems, system refinements and development of new systems and tools. These resulted from work on studies, model development, budgeting and planning and have ongoing influences on sector planning. (ii) Studies provided key information, methodologies and tools for evidence based planning and were part of a coherent programme of research. (iii) Improved understanding and monitoring of financing and improved budget systems and capacity through work in areas such as the NHA, expenditure reviews and MTEF. (iv) More systematic approaches to funding of key strategic areas through refined budgeting for conditional grants. This facilitated substantial budget allocations to improve HIV and AIDS services and hospital revitalization in particular. (v) Capacity development at provincial level by the finance trainee programme. During their training trainees also provided critical capacity to address financial administration backlogs. (vi) Successful skills transfer, in particular by the international TA but also by local contractors on studies and model development. The MTR emphasised in this regard that the PHSSP has created awareness on the importance of health care planning and the need for restructuring and rationalisation.

In addition, EC support was provided under SuCOP through Financial and Supply Chain Management Training (continuation of project funded under the previous EU funded Public Health Sector Support Programme) – students from Technicon and universities with accounting background were placed within supply chain and financial management units at provincial level (8 provinces, not Gauteng). Most people were kept after SuCOP was ended.<sup>200</sup>

**I-232** The EC enhances communication and cooperation between MoH and MoF/planning through its TA, financed under the PDPHC.

##### **4.3.3.2 Resume of the JC**

The EC contributed in improvements in health finance policies and enhanced affordability of service through its TA, mainly at the very beginning of the evaluation period through PHSSP. After 2004, TA

---

<sup>199</sup> Public Health Sector Support Programme (PHSSP) South Africa (2004): Final Evaluation of the 2000 Public Health Sector Support Programme South Africa.

<sup>200</sup> SuCOP (no date provided) Project Information Sheet.

was provided through SuCOP. Specific examples are given above as well as under Indicators I-221 and I-223.

#### 4.4 EQ 3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?

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

###### Indicators

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

###### 4.4.1.1 Findings per indicators

**I-311** Before the evaluation period, Primary Health Care was formally introduced to South Africa from April 1994 as the driving principle for health care provision in South Africa with the implementation of two policies, “Free Health for pregnant mothers and children under the age of six years” as well the “Universal Access to Primary Health Care for All South Africans”. The latest available information – dating from the beginning of the millennium report a total of 4,392 Primary Health Facilities in the nine provinces divided in clinics, community health centres and mobile units. It has been reported that over 400 clinics in South Africa have been constructed and upgraded in the recent years.

According to the old health field visit report,<sup>201</sup> the EC’s investment has been mainly targeted towards accessing quality services as opposed to the traditional support to rehabilitation. The only EC contribution to better geographical access to health services is based on supporting the concept of home based care, i.e. bringing services to the people and communities and strengthening the District Health System. This will be discussed under the next indicator, dealing with geographical access.

**I-312** The specific indicator is not available, however recent a study reports that distance to a facility was reported to be associated with increasing maternal and infant mortality, decreased vaccination coverage and decreased contraceptive use. According to Tlebere et al.<sup>202</sup> transportation and distance from a PHC facility were the biggest hindrances to the utilisation of health services, particularly in rural areas in South Africa. A lack of financial resources for transport was the barrier most often cited by women who did not attend antenatal clinics. Some other barriers include limited financial resources, the influence of family members, family responsibilities and women not realising they are pregnant and experiencing difficulty in obtaining time off from work to attend a clinic. It is possible that the EC contributed to an improvement in this Indicator, especially in the second half of the evaluation period through its sector budget support

The EC’s main contribution to geographical access, however, has been through its support for home-based community-based care. The home based care (HBC) concept is implemented through the PDPHC, which had a major role in planning of the rehabilitation of health services but did not finance capital projects, construction and provision of equipment to health infrastructure. Through the PDPHC programme, which was launched in 2001, geographical access has initially been provided to the five poorest provinces (Western Cape, Eastern Cape, Limpopo, Gauteng and KwaZulu Natal). Following requests from the four provinces not included in the initial PDPHC (i.e. Mpumalanga, Free State, North West and Northern Cape) the Expanded Programme of Partnerships for the Delivery of PHC, HIV and AIDS Services was initiated and was launched in 2007 to include all nine provinces. The MTR of the EPDPHC in 2009 reported that 40 out of 52 districts in all nine provinces were implementing the programme, consequently emphasising the extent to which EC could have potentially contributed to better geographical access. In this context, the project information sheet for the EPDPHC stated that there are 1,165 NPOs contracted across all nine provinces (and 37 districts) which in turn engage 19,173 caregivers who received a small stipend with approximately 1,000,000 patients receiving care

<sup>201</sup> Particip GmbH (2008) Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007), Field mission report, August 2008.

<sup>202</sup> Tlebere P, Jackson D, Loveday M, Mafizirofa L, Mbombo N, et al. (2007) Community-based situation analysis of maternal and neonatal care in South Africa to explore factors that impact utilization of maternal health services. *Midwifery Women Health* 52: 342–350.

as a result of the programme. 60% of the patients receiving care are estimated to be HIV+<sup>203</sup>. As EPDPHC was provided via budget support, it is safe to assume that the EC contributed to a better geographical access.

#### 4.4.1.2 Resume of the JC

EC's investment has been mainly targeted towards accessing quality services as opposed to the traditional support to rehabilitation. EC's contribution to better geographical access to health services is based on supporting the concept of home based care, i.e. bringing services to the people and communities and to strengthening the District Health System. This has been done through the PDPHC and continued through the SBS EPDPHC which had a major role in planning of the rehabilitation of health services (but did not finance capital projects), construction and provision of equipment to health infrastructure.

The EPDPHC did support all provinces of South Africa. No data are available specifically on rural population.

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

##### Indicators

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

##### 4.4.2.1 Findings per indicators

**I-321** From the WHO Statistical 2011 Report the number of hospital beds per 10,000 populations was in 2009 28. No information on trend has been gathered.

**I-322** Not available.

**I-323** 20.6% of South African deliveries are via caesarean section. No information on time trend has been found.

##### 4.4.2.2 Resume of the JC

No useful information addressing the Indicators has been gathered and, based on document review, the EC did not finance interventions tackling this JC.

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

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

##### Indicators

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

##### 4.5.1.1 Findings per indicators

**I-411** The WHO Statistical 2011 Report provides the following data: The proportion of births attended by skilled health personnel was 91% for the year 2003 (no more recent data available). Therefore, essentially no data relevant to this Indicator over the evaluation period have been gathered.

**I-412** In 2003, 92% of women received at least one antenatal visit but only 56% received the WHO recommended four. Furthermore, deficiencies in the quality of ANC have been documented, although no source for this observation can be given. No data after 2003 have been gathered, meaning that we have essentially no basis on which to assess this Indicator or EC contribution. However the EC could have potentially contributed to the percentage of women receiving four or more ante-natal check-ups

---

<sup>203</sup> Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II") (no date available): Project information sheet.



through the PDPHC. There it is reported that the EC has provided support to address the needs of maternal and child care through HBC focusing mainly on ante-natal care, which could also include ante-natal check-ups, adequate postpartum care for mothers and babies and STI/HIV/AIDS services including preventing mother-to-child transmission (PMTCT) of HIV.

**I-413** The contraceptive prevalence rate is almost 60% in 2010 and the unmet needs for family planning is estimated to be almost 14%. As no data have been found on earlier contraceptive prevalence rates, we have essentially no basis on which to assess this Indicator. However, it can be assumed that having access to information about Sexual and Reproductive Health (SRH) could positively impact on the proportion of women using modern family planning. The old health evaluation field visit report mentioned in this regard that SRH was not a specific area of focus of the EC, however through the support to Soul City (under PDPHC), SRH has been addressed as part of the country wide campaign which has had notable results (reaching 61% of the population in South Africa) in “improving the understanding and behaviour around all aspects of HIV and AIDS and sexuality through information and communication interventions at the level of communities and the general public.” The project Soul City had had a very good success and has been extended to other countries in Southern Africa, namely, Lesotho, Swaziland and Botswana.<sup>204</sup>

In addition, three thematic projects have been implemented to support SRH:

- (i) “Increasing equitable access to HIV/AIDS information and services within a comprehensive sexual and reproductive health and rights (SRHR) programme serving the poorest and most at risk groups and those living with or affected by HIV/AIDS” – Marie Stopes International (EUR 3,736,770);
- (ii) “Brothel Based Male Involvement Peer Education Programme” - Wits Health Consortium (Reproductive Health Unit (Information on amount not provided to the experts during the mission));
- (iii) “HIV/AIDS Prevention & Adolescent SRH Outreach for Young People in Soweto”.

The Marie Stopes International (MSI) project, which targeted primarily poor women of reproductive age, seemed to be particularly successful in this context. The project design by MSI is based on good evidence and practices for integrating HIV/AIDS with sexual and reproductive health rights (SRHR) service interventions in HIV epidemic settings.

With regard to the thematic project “Increasing equitable access to HIV/AIDS information and services” the monitoring report no. three<sup>205</sup> explicitly pointed out the success of the project in terms of providing support to men and women of reproductive age. More precisely six new MS clinics have been established, are fully functional and are providing the planned range of services. All 40 MS clinics in South Africa are providing Voluntary Counselling and Testing (VCT) services that are supported by the project. Additional SRH services are now being provided at the EC supported clinics which were not in the original project design and these greatly increase the SRH choices available to men and women of reproductive age. The provision of services for Termination of Pregnancy (TOP) ensures that such procedures are affordable, timely and undertaken in an appropriate clinical environment by trained staff.

To summarise, it is likely that EC support led to an improvement in this Indicator, but data consulted do not provide hard evidence that such an improvement actually occurred.

#### 4.5.1.2 Resume of the JC

The EC was involved in this JC; through the implementation of NGO support (e.g. support to Marie Stopes International) in the nine selected provinces especially in relation to HIV/AIDS. As already mentioned above in I-412 and I-413 some achievements under the SBS EPDPHC as well as the thematic projects could have potentially impacted on the percentage of women receiving ante-natal check-ups as the EPDPHC programme targeted through its support to home-based-care mainly ante-natal care. Furthermore there could be a potential impact on the proportion using modern family planning through PDPHC and the three thematic projects regarding their SRH component.

Since no data on time trend have been found, this conclusion must be considered speculative.

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

##### Indicators

- I-421 Percentage of children under five receiving regular growth monitoring.
- I-422 EPI immunisation rate.

<sup>204</sup> Swaziland – SZ – Regional HIV/AIDS Awareness and Education Programme. Implemented by Soul City.

<sup>205</sup> European Commission, (2010), MR 3, MR-109521.03 “Increasing equitable access to HIV/AIDS information and services”, 12/11/2010.

#### 4.5.2.1 Findings

**I-421** No information available.

**I-422** Immunisation rates have generally worsened over the evaluation period in South Africa. EC support, in whatever form, did not contribute to an improvement in this Indicator, although it might have contributed to containing the declines. Sector budget support will have strengthened the MOH's efforts in the area of immunisation.

#### 4.5.2.2 Resume of the JC

No information on growth monitoring or nutrition has been found. Immunisation rates have worsened over the evaluation period. EC support may have prevented a worse deterioration.

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

##### Indicators

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

#### 4.5.3.1 Findings per indicators

**I-431** No information available.

**I-432** The WHO Statistical 2011 Report states that the proportion of children aged <5 years with diarrhoea receiving ORT (ORS and/or RFH) is 63%. No information on time trend available.

**I-433** No information available.

#### 4.5.3.2 Resume of the JC

No data relevant to these Indicators has been found.

### 4.6 EQ 5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?

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

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

#### 4.6.1.1 Findings

**I-511** The EC provided support to this indicator in the very early evaluation period, under PHSSP. The final evaluation of PHSSP (2004)<sup>206</sup> highlights that substantial results were achieved through support to the Government in advancing sector reform. Specifics are given above under Indicator I-231. The contribution of SuCOP is also described there.

In the second half of the evaluation period, the EC may have contributed to the improvement on this indicator through preparatory actions, especially policy dialogue to the SBS "preparation of the Primary Health Care SPSP" (PrimCare SPSP), for which the Financial Agreement was signed in 2011. In the EAMR 2011 (p.10) it is mentioned that as part of the policy dialogue that has accompanied the preparation of this programme the Delegation has been involved in a number of activities including (i) Participation in a small DOH led health working group with a few key health development partners; (ii) Support to the DOH in organising a high-technical meeting on 25 October 2010, chaired by the DG; (iii) Support to the DOH in the development of a new Aid Effectiveness Framework for the health sector; (iv) Preparation of the Annual donor meeting (from now on the ODA Coordination Forum).

---

<sup>206</sup> Public Health Sector Support Programme (PHSSP) South Africa (2004): Final Evaluation of the 2000 Public Health Sector Support Programme South Africa.



As this the financing agreement of the SBS was signed in early 2011 and the implementation only started in 2011, no conclusion on outcomes can yet be drawn.

**I-512** Finding evidence for this indicator was difficult. The First Phase of the Evaluation of the Implementation of the Paris Declaration Country Level Evaluations, Final Report, South Africa, April 2008<sup>207</sup> provided evidence which to some extent relates to this indicator. Accordingly a senior EC official reported that in terms of alignment, the DP was “110% aligned as they have strong support in sector budget support and that the EC demonstrates 100% use of Public Finance Management systems (PFM)”. Particularly the last aspect could potentially indicate that EC policy dialogue incorporated PFM, even though this was mentioned in a rather general context and not specifically relating to health. In addition, the EU Delegation commented that “dialogue on PFM is always a part of the formulation of new programmes and always one of the three conditions for payment of budget support tranches. Therefore, this was part of the EPDPHC and of the PrimCare SPSP. PFM was also supported through different components of the SUCOP project.” Moreover, “DPs also assess the NDOHs annual report.”

**I 513** In the early period of evaluation, EC supported this indicator through the PHSSP and its first component “Establish capacity in financial planning, management in DOH at national and provincial levels.” Capacity development at provincial level was specifically supported by financing trainee programme. During their training trainees also provided critical capacity to address financial administration backlogs.” In continuation of the PHSSP, the SuCOP financed the ‘Financial and Supply Chain Management Training’. In this training, students from Technicon and universities with accounting background were placed within supply chain and financial management units at provincial level (8 provinces, not Gauteng). Most people were kept after SuCOP was ended.<sup>208</sup>

The PDPHC and EPDPHC were particularly successful in supporting the improvement of this indicator, as various sources pointed to an EC contribution to decentralised capacity building to strengthen health policy capabilities at provincial, district and local level.

The PDPHC final report 2007<sup>209</sup> noted that the programme has piloted an accredited NPO training programme for 32 NPOs in Limpopo where 320 NPO staff members were put in training to ensure quality service delivery and compliance to PFMA. The training included aspects such as Governance, management, administration, financial management, bookkeeping etc. After evaluation it was found to be very useful as communities became more professional in managing state funds.

The MTR 2009<sup>210</sup> stated that through EPDPHC 1264 NPOs had been funded to provide the PHC packages ensuring that they support the DoH in its effort to strengthen IDHS and provide PHC to all communities. At the time of the MTR in 2009 the programme was operational in 40 of the 52 health districts in the country, thus contributing to decentralised capacity building at least to some extent.

Similarly, this was emphasised by the old health field visit report by stating that partnerships between the government and non-profit organisations (NPOs) are being strengthened and formalised. These are increasingly aligning their interventions with government policies and strategies (PCPHCP) and in this way accessibility to primary health care for communities and particularly for the poorest and more remote population groups is increased.

The second ROM report of PDPHC, likewise, showed some evidence. This project is establishing a framework for collaborative partnerships between Government and NPOs to render primary health care services by contracting and capacitating NPOs to deliver these services and through institutional strengthening of Government to manage and coordinate these services.

However the Paris Declaration Evaluation “Thematic Study, The Developmental Effectiveness of untied Aid: Evaluation of the Implementation of the Paris Declaration and of the 2001 DAC Recommendations on untying ODA to the LDCs, South Africa Country Study, November 2009” expressed a reservation. On the one hand it indicated that PDPHC is likely to have had a beneficial impact in terms of the availability of technical assistance within South Africa, as there is some evidence of this within the national and provincial departments, where South African individuals are beginning to create and implement policies related to the programme. On the other hand the report pointed out that rather EC support contributing to a transfer of skills and knowledge, there has been a developmental impact through increased experience and learning by doing.

<sup>207</sup> First Phase of the Evaluation of the Implementation of the Paris Declaration Country Level Evaluations, Final Report, South Africa, April 2008.

<sup>208</sup> SuCOP (no date provided) Project Information Sheet.

<sup>209</sup> Department of Health Republic of South Africa (2007): Partnership for health I (PDPHC) Final Report 2007.

<sup>210</sup> Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&Aids Services – EPDPHC, Mid-Term Review, September 2009.

#### 4.6.1.2 Resume of the JC

The JC is assessed by three indicators: (1) EC contributed to overall health policy strategy process and related documents (such as budget documents, annual performance reviews and health indicators), (2) EC policy dialogue incorporated PFM, accountability and capacity building measures in the health sector and (3) EC contributed to decentralised capacity building to strengthen health policy capabilities at provincial, district and local levels.

The EC provided support to this indicator at the very beginning of the evaluation period through the PHSS and again at the very end with the SBS of 2011.

Regarding the second indicator it was difficult to relate the information particularly to health as it has to be seen more generally. Only with the development of a health SBS, it can be assumed that PFM was more strongly related also to health issues. The third indicator provided more concrete information about potential contribution in terms of funded NPOs and number of health districts in which the programme is operational. However the Paris Declaration also pointed out that EC support should be rather seen in terms of increasing experience and learning by doing instead of contributing to a transfer of skills and knowledge.

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

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

##### 4.6.2.1 Findings

**I-521** No information available.

**I-522** Regarding the extent to which the EC supported increased competencies in MoH for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF, the old health field visit report provided some evidence. There it is mentioned that the EC's support to international and local technical assistance (TA) in the DoH has been a key factor in strengthening the institutional management capacity. For example, in the PDPHC, the TA has largely contributed to a better use of resources (human, technical and financial) and to the revitalisation and decentralisation of the management of hospital systems at national and provincial levels. Another example, in the PDPHC, is the provision of TA which was critical in supporting the development of several quality assessment tools.

However it is important to add, that the old health evaluation field reports also expressed a reservation in this context. It pointed out that there is a gap, which was mentioned in most reports and by most persons interviewed, relating to the absence of sound monitoring and evaluation frameworks in order to ensure a better understanding of the efficiency and impact of the activities and to consolidate all the inputs so that they are not lost and that they are sustainable.

In addition, the final evaluation (2004)<sup>211</sup> of PHSSP reported several outcomes of activities undertaken under component 1) Establish capacity in financial planning, management in DOH at national and provincial levels. This included for example (i) Improved use of existing information and budgeting systems, system refinements and development of new systems and tools. These resulted from work on studies, model development, budgeting and planning and have ongoing influences on sector planning. (ii) Studies provided key information, methodologies and tools for evidence based planning and were part of a coherent programme of research. (iii) Improved understanding and monitoring of financing and improved budget systems and capacity through work in areas such as the NHA, expenditure reviews and MTEF. (iv) More systematic approaches to funding of key strategic areas through refined budgeting for conditional grants. This facilitated substantial budget allocations to improve HIV and AIDS services and hospital revitalization in particular. (v) Capacity development at

---

<sup>211</sup> Public Health Sector Support Programme (PHSSP) South Africa (2004): Final Evaluation of the 2000 Public Health Sector Support Programme South Africa.

provincial level by the finance trainee programme. During their training trainees also provided critical capacity to address financial administration backlogs. (vi) Successful skills transfer, in particular by the international TA but also by local contractors on studies and model development.

**I 523** No information available.

#### **4.6.2.2 Resume of the JC**

This JC is assessed by three indicators: (1) EC contribution to the overall process of accountability and transparency of the health system, (2) EC supported increased competencies in MoH and (3) EC supported procurement reform to enhance accountability and transparency. According to the old health field visit report the EC Delegation in South Africa has effectively and significantly contributed to institutional strengthening at all levels and in this way is meeting the health needs of the poorest populations through the two main programs, namely PDPHC and EPDPHC: In addition, PHSSP provided support through component (1) Establish capacity in financial planning, management in DOH at national and provincial levels in the early period of the evaluation.



## 4.7 Annex

### 4.7.1 Key documentation used for the analysis

### 4.7.2 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
Partnership for health I (PDPHC)			2 Rom reports	MTR 2006	Final Report 2007
Partnership for health II (EPDPHC)	Formulation report			MTR 2009: done DOH annual report Macroeconomic assessment 2009	
SuCoP			3 Rom reports		Final evaluation, 2009
Capacity building Initiative for organisations engaged in HIV AIDS treatment, care and support		2 Interim reports 2007 and 2008 done	1 ROM report		
Holistic Support To Aids Orphans And Vulnerable Children (Ovc) Through Community Based Programmes.			2 ROM reports		
Higher Education HIV&AIDS (HEAIDS) Programme in South Africa		Final Evaluation of the HEAIDS Programme in South Africa 2010	2 ROM reports		
Public Health Sector Support Programme (PHSSP) South Africa		Final Evaluation of the 2000 Public Health Sector Support Programme South Africa			

### 4.7.3 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	No up to date CSE existing
EAMR	ok
Country note from old health evaluation	ok
Paris declaration evaluation-country report Phase 1 South Africa – sample prioritised health and environment sectors.	ok
Paris declaration evaluation-country report Phase 2	ok

### 4.7.4 Bibliography

Chaudhury RR et al., Quality medicines for the poor: experience of the Delhi programme on rational use of drugs, *Health Policy and Planning*, 2005, 20(2):124–136.

Department of Health Republic of South Africa (2007): Partnership for health I (PDPHC) Final Report 2007.

DoH South Africa, Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&AIDS Services – EPDPHC, EC Sector Budget Support, Mid-Term Review, September 2009

DoH South Africa (2011) Human Resources for Health South Africa  
[http://www.doh.gov.za/docs/stratdocs/2011/hrh\\_strategy.pdf](http://www.doh.gov.za/docs/stratdocs/2011/hrh_strategy.pdf)

EC, Mid-Term Review of the European Commission funded Partnerships for the Delivery of Primary Health Care including HIV&AIDS Programme (PDPHC), Final Report, 2006

EC, Re-Monitoring Report, South Africa – ZAF – Partnerships for the Delivery of Primary Health Care including HIV/AIDS (PDOHC), 17/05/2005

EC, Re-Monitoring Report, South Africa – ZAF – Higher Education HIV/AIDS (HEAIDS) MR-01756.02 – 26/06/07

European Commission, (2010), MR 3 , MR-109521.03 “Increasing equitable access to HIV/AIDS information and services”, 12/11/2010

European Commission and National Department of Health South Africa, Support for the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme (SuCop) 2005-2009, Final Evaluation Report, 2009

European Union Delegation to Republic of South Africa, External Assistance Management Report (EAMR), January 2011

European Union Delegation to Republic of South Africa, External Assistance Management Report (EAMR), January 2009

European Union Delegation to Republic of South Africa, External Assistance Management Report (EAMR), 2008

Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV&Aids Services – PDPHC II, Mid-Term Review, September 2009

First Phase of the Evaluation of the Implementation of the Paris Declaration Country Level Evaluations, Final Report, South Africa, April 2008

Higher Education HIV&AIDS (HEAIDS) Programme in South Africa (2010): Final Evaluation of the HEAIDS Programme in South Africa 2010

Human Resource for Health South Africa 2030 Draft HR Strategy for the Health Sector 2012/13 – 2016/17 ; August 2011

Department of Health Republic of South Africa (2007): Partnership for health I (PDPHC) Final Report 2007.

Particip GmbH (2008) Evaluation of EC Support to Health Sector Policy Development and the Fight against Poverty Related Diseases (2000-2007), Field mission report, August 2008

Public Health Sector Support Programme (PHSSP) South Africa (2004): Final Evaluation of the 2000 Public Health Sector Support Programme South Africa

Support for the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme (SuCoP) 2005-2009, 2009.

Swaziland – SZ – Regional HIV/AIDS Awareness and Education Programme. Implemented by Soul City

Tlebere P, Jackson D, Loveday M, Mafizirofa L, Mbombo N, et al. (2007) Community-based situation analysis of maternal and neonatal care in South Africa to explore factors that impact utilization of maternal health services. *Midwifery Women Health* 52: 342–350. WHO Country Cooperation Strategy, [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_zaf\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf), 2009, p.8

WHO Country Cooperation Strategy, [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_zaf\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf), 2009, p.10

WHO, South Africa: getting essential medicines to the people, *Essential Drugs Monitor*, Geneva: WHO, 1999, No. 027, <<http://apps.who.int/medicinedocs/en/d/Jh1467e/2.3.html>>, accessed Nov. 18, 2010.

## Weblinks

[http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_zaf\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf)

<http://apps.who.int/medicinedocs/en/d/Jh1467e/2.3.html>

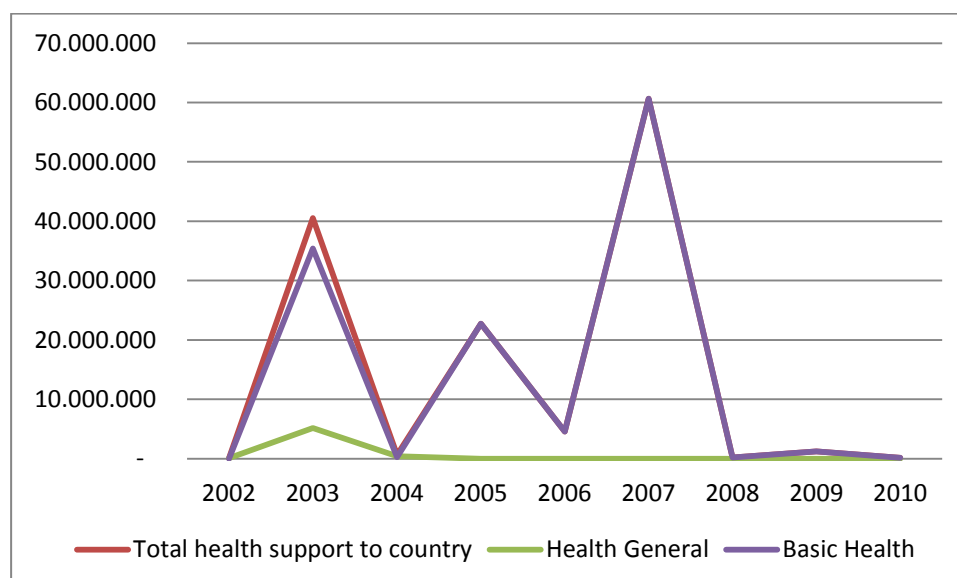
[http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_zaf\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_zaf_en.pdf)

### 4.7.5 EU funds between 2002-2010 –detailed listing:

#### 4.7.5.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to country
2002	80,318	35,406,578	-	80,318
2003	5,140,744	242,485	-	40,547,322
2004	398,477	22,746,698	-	640,962
2005	-	4,576,775	-	22,746,698
2006	-	60,649,851	-	4,576,775
2007	-	178,980	-	60,649,851
2008	-	1,230,322	-	178,980
2009	-	132,990	-	1,230,322
2010	-	-	-	132,990
<b>Total</b>	<b>5,619,538</b>	<b>125,164,679</b>	-	<b>130,784,218</b>

Source: CRIS database, Particip GmbH analysis

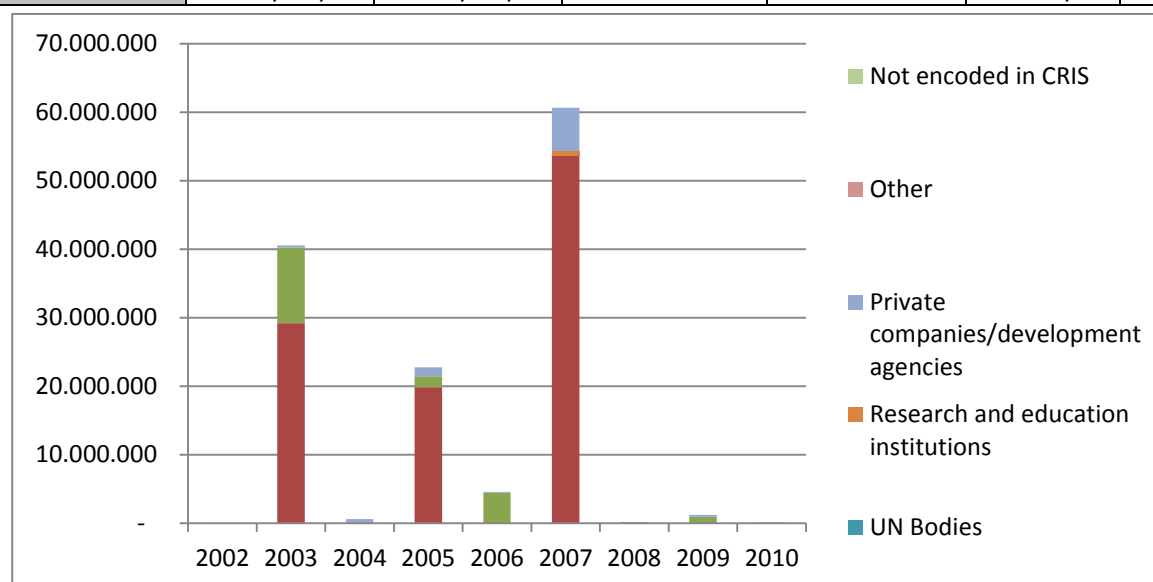


Source: CRIS database, Particip GmbH analysis



**4.7.5.2 Per Channel**

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	80,318	-	-	80,318
2003	29,180,230	11,050,000	-	-	-	317,092	-	-	40,547,322
2004	-	-	-	-	-	640,962	-	-	640,962
2005	19,840,108	1,616,750	-	-	-	1,289,840	-	-	22,746,698
2006	-	4,427,973	-	-	-	148,802	-	-	4,576,775
2007	53,703,989	-	-	-	646,065	6,299,797	-	-	60,649,851
2008	-	-	-	-	-	178,980	-	-	178,980
2009	-	967,742	-	-	-	262,580	-	-	1,230,322
2010	-	-	-	-	-	132,990	-	-	132,990
<b>Total</b>	<b>102,724,327</b>	<b>18,062,465</b>	<b>0</b>	<b>0</b>	<b>646,065</b>	<b>9,351,360</b>	<b>-</b>	<b>0</b>	<b>130,784,218</b>

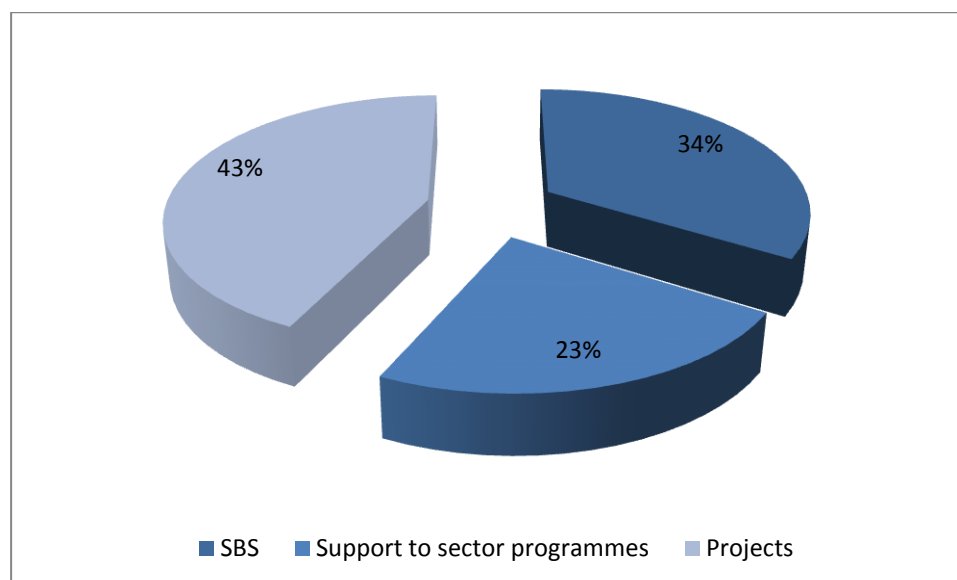


Source: CRIS database, Particip GmbH analysis

## 4.7.5.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	80,318	-	-	80,318	-
2003	-	29,356,578	11,190,744	-	40,547,322	-
2004	-	412,115	228,846	-	640,962	-
2005	-	307,857	22,438,841	-	22,746,698	-
2006	-	148,802	4,427,973	-	4,576,775	-
2007	44,000,000	-	16,649,851	-	60,649,851	-
2008	-	-	178,980	-	178,980	-
2009	183,648	-	1,046,674	-	1,230,322	-
2010	-	-	132,990	-	132,990	-
<b>Total</b>	<b>44,183,648</b>	<b>30,305,670</b>	<b>56,294,899</b>	-	<b>130,784,218</b>	-

Source: CRIS database, Particip GmbH analysis



Source: CRIS database, Particip GmbH analysis

#### 4.7.6 Overview of funds committed to the country's health sector during 2002 and 2010 (decisions)

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention</i>
Theme II/Increasing equitable access to HIV/AIDS information and services within a comprehensive sexual and reproductive health and rights programme serving the poorest and most at risk groups and those living with or affected by HIV/AIDS	(blank)	2006 (contract starting year)	EUR 3,736,770
1999/23 2000 Public Health Sector Support Programme	AFS/1999/000-697	1999	EUR 342,783
1999/22 – Consolidating the Trauma Sector in SA	AFS/1999/000-696	1999	EUR 209,744
SA/1001/000 – Partnership for the Delivery of Primary Health Care including HIV/AIDS (PDPHC)	AFS/2001/000-706	2001	EUR 24,962,887
SA/1010/00 Regional HIV/AIDS Awareness and Education Programme	AFS/2002/002-497	2002	EUR 9,968,140
Consolidation and expansion of HIV vaccine preparedness in South Africa - with knowledge translation	SANTE/2002/004-753	2002	EUR 1,350,000
SA/1009/00 Local Economic DVP Support Programme in KwaZulu Natal <i>contract HIV/AIDS "Best Practice" in the workplace in KZN</i>	AFS/2002/004-557 (c88203)	2002	EUR 92,835
SA/1005/00 EPRD Support Facility (EPRD SF) <i>contract Design &amp; Feasibility Study: Pipeline 2004 (Health)</i>	AFS/2002/002-492 (c83717)	2002	EUR 67,011
Rider n°2 to Financing Agreement "2000 Public health sector sup programme" South Africa"	AFS/2003/005-895	2003	EUR 5,000,000
SuCoP for HIV/AIDS - Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme	AFS/2004/016-827	2004	EUR 18,638,057
Higher Education HIV & AIDS (HEAIDS)	(blank)	2004	EUR 19,125,397
Pré-engagement dont dépendront les contrats PVD projets <i>contracts Capacity Building Initiative for Organisations engaged in HIV/AIDS Treatment, Care &amp; Support and Holistic Support to Aids Orphans and Vulnerable Children (OVC) through community based programmes - South Africa</i>	ONG-PVD/2004/006-239 (c114076 and c114035)	2004	EUR 1,448,000
Pré-engagement dont dépendront les contrats pour les projets PVD <i>contract Psychosocial support for orphans and community based caregivers working with PLWHA in South Africa</i>	ONG-PVD/2005/017-215 (c119182)	2005	EUR 691,203
Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II")	AFS/2006/018-368	2006	EUR 44,183,648
Programme for Science and Technology Innovations and Capacity building (PSTICB) <i>contract Réseau S&amp;T Afrique Caraïbe de soutien à la lutte contre les maladies infectieuses</i>	AFS/2006/018-197 (c 219014)	2006	EUR 967,742
<b>Grand Total</b>			<b>EUR 130,784,217</b>

Source: CRIS database, Particip GmbH analysis

## 4.7.7 Overview of main programmes/funds and sectors

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention</i>
Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II")	AFS/2006/018-368	2006	EUR 44,183,648
SuCoP for HIV/AIDS - Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme	AFS/2004/016-827	2004	EUR 18,638,057
SA/1001/000 – Partnership for the Delivery of Primary Health Care including HIV/AIDS (PDPHC)	AFS/2001/000-706	2001	EUR 24,962,887
Higher Education HIV & AIDS (HEAIDS)	Contract no: 146639, 146698, 113413 etc	2004	EUR 19,125,397
1999/23 2000 Public Health Sector Support Programme (PHSSP)	AFS/1999/000-697	1999	EUR 342,783 <sup>212</sup>

## 4.7.8 Overview of all health related contracts 2002-2010

<b>Decisions Title</b>	<b>Contracts Title</b>	<b>Decision No</b>	<b>Contract number</b>	<b>Contract year</b>	<b>Total</b>
1999/22 – Consolidating the Trauma Sector in SA	EI DRONNET Afrique du Sud	AFS/1999/000-696	<b>66040</b>	2003	EUR 105,404
	MTR for Consolidating the Trauma Sector in south Africa	AFS/1999/000-696	<b>56067</b>	2003	EUR 35,340
	Provision for Final Audit 99/22 Consolidating the Trauma Sector in SA	AFS/1999/000-696	<b>89505</b>	2004	EUR 69,000
1999/23 2000 Public Health Sector Support Programme	99/023: Mid Term Review	AFS/1999/000-697	<b>48140</b>	2002	EUR 80,318
	Final Evaluation PHSSP 99/23	AFS/1999/000-697	<b>87576</b>	2004	EUR 69,542
	Forensic/Financial and Compliance audit of the Aids Consortium	AFS/1999/000-697	<b>86047</b>	2004	EUR 39,000
	Provision for annual and final audits of the PHSSP	AFS/1999/000-697	<b>84588</b>	2004	EUR 145,000

<sup>212</sup> For the PHSSP 36 million Euros were contracted in 1999.

Decisions Title	Contracts Title	Decision No	Contract number	Contract year	Total
	Robert Esposito - Local Costs	AFS/1999/000-697	<b>97504</b>	2004	EUR 8,924
Consolidation and expansion of HIV vaccine preparedness in South Africa - with knowledge translation	Consolidation and expansion of HIV vaccine preparedness in South Africa	SANTE/2002/004-753	<b>61301</b>	2003	EUR 1,350,000
Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II")	Expanded Partnerships for Health	AFS/2006/018-368	<b>147757</b>	2007	EUR 44,000,000
	Support Services for the Identification and Formulation of a Health Sector Support Programme for South Africa	AFS/2006/018-368	<b>214004</b>	2009	EUR 183,648
Higher Education HIV & AIDS (HEAIDS)	Annual and Final Audit of the Higher Education HIV&AIDS Programme	(blank)	<b>156683</b>	2008	EUR 53,000
	Development and implementation of communications and PR strategy for the South African Higher Education HIV/AIDS Programme (HEAIDS)	(blank)	<b>145873</b>	2007	EUR 145,550
	Development and Implementation support for HIV/AIDS Workplace Programmes at 23 public Higher Education Institutions in South Africa	(blank)	<b>145937</b>	2007	EUR 449,875
	Development of Higher Education Sub-Sectoral and Institutional HIV/AIDS Policies in South Africa	(blank)	<b>146698</b>	2007	EUR 479,380
	Development of sustainable funding model(s) and mechanism(s) with respect to a comprehensive HIV/AIDS programme in the Higher Education sub-sector	(blank)	<b>146851</b>	2007	EUR 325,000
	Final Evaluation of the Higher Education HIV & AIDS (HEAIDS) Programme in South Africa	(blank)	<b>244327</b>	2010	EUR 132,990
	Good Practice HIV/AIDS Prevention Strategies for public Higher Education Institutions (HEIs) in South Africa	(blank)	<b>145729</b>	2007	EUR 134,939
	HEAIDS Programme AWP1	(blank)	<b>113413</b>	2005	EUR 12,001,761
	Investigation of graduate competency with regards to HIV/AIDS in the place of work	(blank)	<b>145887</b>	2007	EUR 189,470
	Mid-Term Review of the Higher Education HIV & AIDS (HEAIDS) Programme in South Africa	(blank)	<b>161850</b>	2008	EUR 76,480
	Piloting of HIV module in teacher education faculties in the higher education institutions in South Africa	(blank)	<b>144733</b>	2007	EUR 1,193,300
	Research and establish the role of educators in mitigating the impact of the HIV/AIDS epidemic on the educational system in	(blank)	<b>146639</b>	2007	EUR 321,065

Decisions Title	Contracts Title	Decision No	Contract number	Contract year	Total
	South Africa				
	Sero-Prevalence Study, KAPB Study and Risk Assessment with respect to HIV/AIDS in the Higher Education sub-sector	(blank)	<b>146306</b>	2007	EUR 2,739,99
	Technical Assistance to the Higher Education HIV&AIDS (HEAIDS) Programme	(blank)	<b>109578</b>	2005	EUR 882,593
N/A	Theme II/Increasing equitable access to HIV/AIDS information and services within a comprehensive sexual and reproductive health and rights programme serving the poorest and most at risk groups and those living with or affected by HIV/AIDS.	(blank)	<b>104975</b>	2006	EUR 3,736,770
pré-engagement dont dépendront les contrats pour les projets PVD	Psychosocial support for orphans and community based caregivers working with PLWHA in South Africa	ONG-PVD/2005/017-215	<b>119182</b>	2006	EUR 691,203
pré-engagement dont dépendront les contrats PVD projets	Capacity Building Initiative for Organisations engaged in HIV/AIDS Treatment, Care & Support	ONG-PVD/2004/006-239	<b>114076</b>	2005	EUR 750,000
	Holistic Support to Aids Orphans and Vulnerable Children (OVC) through community based programmes - South Africa	ONG-PVD/2004/006-239	<b>114035</b>	2005	EUR 698,000
Programme for Science and Technology Innovations and Capacity building (PSTICB)	Réseau S&T Afrique Caraïbe de soutien à la lutte contre les maladies infectieuses	AFS/2006/018-197	<b>219014</b>	2009	EUR 967,742
Rider n°2 to Financing Agreement "2000 Public health sector sup programme" South Africa"	Implementation of final AWP DOH 99/23	AFS/2003/005-895	<b>77479</b>	2003	EUR 5,000,000
SA/1001/000 – Partnership for the delivery of Primary Health Care including HIV/AIDS(PDPHC)	2001/73200/001 - FA Partnerships for the Delivery of Primary Health Care	AFS/2001/000-706	<b>63725</b>	2003	EUR 24,180,230
	Annual Audit and Systems Appraisals for the PDPHC Programme (01/01)	AFS/2001/000-706	<b>103244</b>	2005	EUR 45,000
	International TA: Monitoring and Evaluation Specialist	AFS/2001/000-706	<b>101268</b>	2005	EUR 262,857
	Mid-Term Review - Partnerships for the Delivery of PHC	AFS/2001/000-706	<b>119421</b>	2006	EUR 148,802
	TA Support to PMU	AFS/2001/000-706	<b>73439</b>	2003	EUR 176,348
	TA: Compliance Specialist	AFS/2001/000-706	<b>95235</b>	2004	EUR 149,650
SA/1005/00 EPRD Support Facility (EPRD SF)	Design & Feasibility Study: Pipeline 2004 (Health)	AFS/2002/002-492	<b>83717</b>	2004	EUR 67,011
SA/1009/00 Local Economic DVP Support Programme in KwaZulu Natal	HIV/AIDS "Best Practice" in the workplace in KZN	AFS/2002/004-557	<b>88203</b>	2004	EUR 92,835
SA/1010/00 Regional HIV/AIDS Awareness and Education Programme	REGIONAL HIV/AIDS AWARENESS AND EDUCATION	AFS/2002/002-497	<b>57549</b>	2003	EUR 9,700,000

**Particip GmbH**

Thematic evaluation of the European Commission support to the health sector

Decisions Title	Contracts Title	Decision No	Contract number	Contract year	Total
	REGIONAL HIV/AIDS SOUL CITY Mid-Term Review	AFS/2002/002-497	<b>105255</b>	2005	EUR 99,390
	SOUL CITY REGIONAL - ANNUAL COMPLIANCE AUDITS	AFS/2002/002-497	<b>107041</b>	2005	EUR 168,750
SuCoP for HIV/AIDS - Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme	Closure Programme Estimate	AFS/2004/016-827	<b>146702</b>	2007	EUR 105,263
	DoH Workplans	AFS/2004/016-827	<b>111056</b>	2005	EUR 7,838,347
	Electronic Document and Information Management System (EDMS) for MRA	AFS/2004/016-827	<b>146810</b>	2007	EUR 967,289
	Programme Estimate 1	AFS/2004/016-827	<b>146955</b>	2007	EUR 9,598,726
	SuCoP Audit Contract	AFS/2004/016-827	<b>158960</b>	2008	EUR 49,500
	SUCOP Final Evaluation: Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS, Treatment Care and Support Programme	AFS/2004/016-827	<b>217447</b>	2009	EUR 78,932
<b>Total EC support to South Africa</b>					<b>EUR 130,784,217</b>

Source: CRIS database



## 4.7.9 Details of programmes

### 4.7.9.1 Intervention no 1

**Title:** Expanded Programme of Partnerships for the Delivery of Primary Health Care, HIV and AIDS Services ("Partnerships for Health II")

**Budget:** EUR 44,183,648

**Start and end date:** 2006

**Objectives and expected results:** (Source FA: AFS/2006/018-368)

**Overall objective:**

- To contribute to more accessible, affordable quality primary health care for the poorest communities **in all nine provinces.**

**Specific objective:**

- District health service delivery strengthened through co-operations aiming at mutual partnerships between Government and non-profit providers for the delivery of primary health care services, including HIV and AIDS services, within the global structure of the primary health care system.

**Expected results:**

**Result 1:** All nine provincial departments of health and selected district municipalities have made together significant steps towards operating an integrated district health system in cooperation with non-profit organisations.

**Result 2:** An increased number of non-profit organisations in all nine provinces have built up stronger capacities to define their role, to negotiate partnerships with provincial health departments and district municipalities and to manage and deliver PHC, HIV and AIDS services.

**Result 3:** Provincial departments of health and selected district municipalities in all nine provinces are able to identify and to support the role of non-profit organisations in the management, delivery and monitoring of PHC services, including HIV and AIDS.

**Activities:**

**(Result 1)**

- Further develop a skills analysis strategy for the programme in the additional incorporated provincial departments with the objective to strengthen capacities in the areas of partnership development.
- Establish provincial and district task teams in the "new" provinces and district comprising representatives from provincial and district health departments and non-profit organisations.
- Establish specific strategies for further roll out within Provinces.
- Clarify and document responsibilities of provincial and district departments of health for various health functions and services and ongoing adjust both in terms of the legislative requirements and in terms of local efficiencies and best practice with the support of adequate external expertise where appropriate.
- Conduct a needs analysis for each district in order to elaborate and implement a strategy for developing the required capacities.
- Provide technical support to provinces and districts for medium-term expenditure planning aiming at the integration and sub-contracting of non-profit providers in order to ensure sustainability of the partnership.
- Ensure data collection of NPO activities and integration in the District Health Information System (DHIS).

**(Result 2)**

- Undertake identification and consultation processes with non-profit organisation and service providers and to profile potential programme partners and identify gaps and under-capacity.

- Develop a programme of technical assistance for non-profit organisations, in areas such as programme planning, management, basic accounting, monitoring, evaluation and report writing in partnership with the Provincial Task Teams.
- Further Research and develop a career development framework for personnel working in non-profit organisations.
- Provide technical assistance and support to the Health Sector Education and Training Authority (SETA), in the development and ongoing update of standards and access to education equivalencies' for health workers in non-profit organisations to enhance career development in conjunction with the National Department of Health and non-profit providers.

**(Result 3)**

- Prepare district specific calls for proposals with detailed criteria for the identification and selection of a number and range of non-profit providers for PHC services.
- Develop in conjunction with the Department of Health and Provincial Task Teams province and district specific frameworks for collaboration between Government and non-profit providers, including:
  - Legal aspects (in line with municipal system);
  - Fiscal aspects and
  - Enforcement measures.
- Undertake province and district specific research & analysis of PHC.
- Review province and district specific packages and develop local profiles with the support of appropriate external expertise.
- Undertake baseline studies surveys in identified districts. Make further ongoing surveys & data reviews throughout the programme.
- Develop comprehensive and integrated systems for the monitoring, evaluation and quality assurance of community-based primary health care services.
- Agree between Government and non-profit organisation on plans and award contracts for PHC.
- Undertake cost benefit analyses and performance audits to ascertain the cost effectiveness and sustainability of services provided by non-profit providers.

**Other information on the programme:****4.7.9.2 Intervention no 2**

<b>Title:</b> SuCoP for HIV/AIDS - Strengthening Systems to Support the South African Comprehensive Plan for HIV and AIDS Prevention, Treatment and Care Programme
--

**Budget:** EUR 27,236,783**Start and end date:** 2004-2009**Objectives and expected results:** (Source FA: AFS/2004/016-827)**Overall objective:**

- Contribute to the improvement of the health status of the country, in particular of the poor, through the strengthening of health services delivery at National, Provincial & District levels by providing focussed support for identified Health Priorities.

**Specific objective:**

- Promote integrated health & social service delivery to meet the challenges outlined in the Comprehensive Plan for HIV and AIDS.
- Ameliorate the direct and indirect impact of HIV and AIDS on economic social and particularly, in educational & health development in South Africa.

**Expected results:****Result 1:**

The capacity of National, Provincial and District Health Services to implement the Comprehensive Plan for HIV and AIDS is strengthened. (SERVICES)

**Result 2:**

The legal, regulatory and management systems for the delivery of health care are consolidated. (SYSTEMS).

**Result 3**

The capacity of the DOH to manage the human resource pool at national, provincial and district health service level is enhanced and improved (PEOPLE).

**Result 4**

The scope and coverage of the health promotion & prevention programme is expanded (PUBLIC).

**Activities:****Result 1**

- Improve the delivery of primary health care including the detection, treatment, follow-up and care of HIV and AIDS, TB and Mental Illness (MI).
- Support the development of statistical information particularly data collection mechanisms and systems and the review of TB registers and other health system (performance) measures.
- Support the monitoring system of implementation of the Primary Health Care (PHC) package including rationalising and simplifying treatment protocols. and monitoring patient compliance to reduce defaulter rates.
- Improve the quality of care and knowledge development through capacity building including staff training, rolling out best practices and application of treatment and care protocols, especially to those with HIV and AIDS, TB and mental illness.

**Result 2:**

- Improve the management of finance, procurement of supplies and services and distribution networks.
- Support the development of the Social Health Insurance Scheme.
- Improve the capacity and effectiveness of the Medicines Regulatory Authority (MRA).
- Support the development of Health Information Systems, as part of the Epidemiological Surveillance Systems for the monitoring of infectious & chronic diseases.

**Result 3**

- Improved capacity of health care management and staff to deliver comprehensive health services.
- Support the establishment of an NHS. Human Resource (HR) database.
- Support management & supervisory staff training and the development of a professional cadre of managers.
- Developed EU-SA inter and intra-institutional co-operative programmes.

**Result 4**

- Expand multimedia healthy lifestyles promotion campaigns of the Department
- Identified and documented, through research and development programmes, the psycho-social behaviours risk factors that are determinants of risk behaviour.

#### **4.7.9.3 Intervention no 3**

**Title:** SA/1001/000 - PARTNERSHIP FOR THE DELIVERY OF PRIMARY HEALTH CARE INCLUDING HIV/AIDS (PDPHC)

**Budget:** EUR 24.999.887

**Start and end date:** 2002 - 2008

**Objectives and expected results:** Source FA AFS/2001/000-706

##### **Overall objective:**

More accessible, affordable, quality primary health care for the poorest communities in five target provinces (Northern Province, Eastern Cape, KwaZulu Natal, Western Cape and Gauteng).

##### **Specific objective:**

- District health service delivery strengthened through primary health care partnerships between government and NGOs in five target provinces especially including HIV/AIDS within the global structure of the primary health care system.

*This will be achieved through a framework of financial and technical support to Primary Health Care organisations, provinces and municipalities that includes skills analysis and development, support for selected provinces and emerging district municipalities to deliver primary health care services, targeting HIV/AIDS in particular, in some of the poorest areas in South Africa. The programme will take fully into account the Governments' new Presidential Programme, The Integrated Sustainable Rural Development Strategy (ISRDS) and the Urban Renewal Strategy (DRS).*

- Build upon the EC financed Public Health Sector Support Programmes and the district support programmes to non-government providers, particularly in the strengthening of DHS and support to non-governmental health care providers

##### **Expected results:**

###### **Result 1**

- The five target provincial departments of health and selected district municipalities together are able to operate an integrated district health system including a component of partnerships with non-profit organisations.

###### **Result 2**

- An increased number of non-profit organisations in the five target provinces better able to identify and define their role and to negotiate and implement service partnerships with provincial health departments and district municipalities for the delivery of PHC services, especially related to HIV/AIDS.

###### **Result 3**

- Provincial departments of health and selected district municipalities in the five target provinces able to identify and to support the role of non-profit organisations in PHC service delivery and evaluation, especially related to HIV/AIDS.

##### **Activities**

###### **Related to Result 1:**

- Skills Analysis Strategy for the programme will be developed with the objective to strengthen capacities in the areas of partnership development for the national and provincial departments of health and a capacity building programme will be implemented with the support of external expertise. The National Programme Management Unit (NPMU) within the National DoH will ensure the overall management and monitoring of the programme.
- Provincial Task Teams (PIT) will be established comprising representatives from provincial and district health departments and non-profit organisations to ensure the participation of all stakeholders in this partnership development.
- Initially two districts within each of the five target provinces will be identified by the provinces,
- Provincial departments of health and district authority responsibilities for various health functions and services will be clarified and documented.
- Needs analysis surveys contracted-out and conducted for each district in order to elaborate and implement a technical assistance and training programme.

- Technical support to provinces and districts will be provided for medium-term expenditure planning aiming at the integration and sub-contracting of non-profit providers.

#### Related to Result 2:

- Non-profit organisation identification and consultation will be undertaken in each province on the basis of the DFID study to profile potential programme partners and identify gaps and under-capacity;
- A programme of technical assistance for non-profit organisations to develop capacity in areas such as programming planning, management, basic accounting, monitoring, evaluation and report writing will be developed in partnership with the PTT, together with systems for monitoring the impact and implementation of non-profit providers by the NPMU;
- Research and development of a career development framework for personnel working in non-profit organisations will be undertaken and implemented;
- Technical assistance will be provided to support the health SETA, in the development of standards and access to education 'equivalencies' for health workers in non-profit organisations to enhance career development in conjunction with the National DoH and non-profit providers.

#### Related to Result 3:

- Calls for proposals will be prepared with detailed criteria for the identification and selection of a number and range of non-profit providers for PHC services;
- A framework for collaboration between the Government and non-profit providers, including:
  - Legal aspects (in line with municipal system)
  - Quality Assurance measures
  - Fiscal aspects
  - Enforcement measures,

will be developed by the NPMU in conjunction with the DoH and PTT;

- Research & analysis of the HIV/AIDS Continuum of Care within the PHC context will be undertaken;
- Packages for HIV/AIDS Continuum of Care within the PHC package will be reviewed by PTT and local profiles developed with the support of external expertise;
- Baseline studies/household surveys will be undertaken in identified districts & provinces in Year 1 under the responsibility of the NPMU. Further ongoing surveys & data reviews will be throughout the programme;
- Plans will be agreed and contracts awarded for HIV /AIDS Continuum of Care partnerships within the PHC package between government and non-profit organisations in each target province;
- Cost benefit analyses and performance audits will be undertaken to ascertain and ensure the cost effectiveness and sustainability of services provided by non-profit providers.

#### 4.7.9.4 Intervention no 4

**Title:** Higher Education HIV & AIDS (HEAIDS)

**Budget:** EUR 16,731,226

**Start and end date:** 2004

**Objectives and expected results:** contract: 146306

#### Overall objective:

- "To reduce the spread of HIV/AIDS in the higher education sub-sector, to mitigate its impact through planning and capacity development and to manage the impact of the pandemic in a way that reflects the ethical, social, knowledge transmission and production responsibilities that are the mission of the Higher Education Institutions in society and South Africa." - Financing Agreement between the European Commission and the South African government 0/2004.

**Specific objective:**

- The Programme will support South Africa's Department of Education in achieving its vision of a national education and training system which contributes towards improving the quality of life and prosperity of all its citizens, specifically with respect to the Higher Education sub-sector.

**Expected results:**

- **R1:** The roles and responsibilities of the HEIs and the sector in addressing the pandemic and in developing and implementing appropriate policies are defined.
- **R2:** Norms & Standards for sustainable funding models and mechanisms at institutional level with respect to the challenges posed by HIV&AIDS are developed.
- **R3:** The specific role to be played by teacher education faculties in addressing the pandemic are identified and clarified.
- **R4:** Best-practice with respect to, inter alia, prevention, behavioural change, care & support, gender (including masculinities), curriculum integration etc. is identified, investigated, tested and replicated.
- **R5:** Knowledge generation, assimilation and dissemination with respect to the Higher Education sub-sector, the Education sector and the population as a whole are supported.
- **R6:** HEIs' Human Resource capacities and systems development with respect to the challenges posed by HIV&AIDS are supported.

**Activities**

**Related to R1:**

- Identify and evaluate existing Institutional policies.
- Evaluate the implementation of Institutional policies and their effectiveness in addressing the pandemic.
- Determine the extent and nature of the constraints to policy implementation.
- Formulate institutional and sectoral HIV&AIDS policies.

**Related to R2:**

- Describe the scope, nature, adequacy and sustainability of current funding models, with respect to emerging institutional responses.
- Determine the applicability of local and international funding models and best practice.
- Develop norms and standards for the funding of HIV&AIDS interventions at institutional level.
- Provide the necessary human and material resources to develop, implement, test and refine the approved funding model/s.

**Related to R3:**

- Investigate and establish the particular role, which can be played by educators in mitigating the spread and impact of HIV&AIDS in their schools and communities.
- Identify, document and investigate the various models of integration of HIV&AIDS into teacher education curricula.
- Design, develop and pilot HIV&AIDS modules (including content, material and capacity requirements) for integration with teacher education curricula (pre-service, in-service and distance).
- Evaluate and determine the appropriateness and effectiveness of HIV&AIDS related modules, activities and materials.

**Related to R4:**

- With respect to each of the areas of intervention (behavioural change, care & support etc.) document and evaluate intervention models and identify contextualised best practices.
- Design and deliver capacity development interventions in identified areas of need.

- Provide and develop human and material resources and sector appropriate materials to promote and support the delivery of services in the selected intervention areas.
- Introduce standardised Institutional response interventions across the sector.

**Related to R5:**

- Undertake a situational analysis of in-country sectoral research systems, structures and capacities with respect to the social impact and consequences of the pandemic.
- Design and commission quantitative and qualitative research on the scale, scope and nature of HIV&AIDS and their impact on the sector.
- Increase the number of post-graduate social research Programmes that relate to HIV&AIDS.
- Improve the assimilation and dissemination of sectoral and sectoral relevant research and information.

**Related to R6:**

- Conduct an audit of current strategies, capacities and systems of/in Institutional Human Resources Departments with respect to the pandemic.
- Establish risk profiles for all institutional staff.
- Design and pilot appropriate workplace interventions: prevention, care and support Programmes, etc.



## **5 Annex 9: Country case study Zambia**

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

Country case study  
Zambia

## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>153</b>
1.1.1	Country context of EC support.....	153
1.1.2	EU funds between 2002-2010 .....	153
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>154</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	154
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	154
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	156
1.2.4	JC 14 Increased or maintained quality of service provision due to EC support .....	160
<b>1.3</b>	<b>EQ2- Affordability of health care services: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>160</b>
1.3.1	JC 21 The cost of basic health care services is reduced for households due to EC support.....	160
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to the poor and persons with special health care needs supported by the EC .....	161
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC.....	162
1.3.4	JC 24 Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC .....	163
<b>1.4</b>	<b>EQ3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>164</b>
1.4.1	JC 31 Increase in availability of primary health care facilities due to EC support .....	164
1.4.2	JC 32 Increase in availability of secondary health care facilities due to EC support .....	164
<b>1.5</b>	<b>EQ4- Health service utilisation related to MNCH: To what extent has EC support to health contributed to improving health service utilisation related to MNCH? .....</b>	<b>165</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	165
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	165
1.5.3	JC 43 Children better protected from key health threats as a result of EC support.....	166
<b>1.6</b>	<b>EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?.....</b>	<b>168</b>
1.6.1	JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	168
1.6.2	JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.....	170
<b>1.7</b>	<b>Annex .....</b>	<b>172</b>
1.7.1	Key documentation used for the analysis .....	172
1.7.2	EU funds between 2002-2010 –detailed listing .....	174
1.7.3	Overview of funds committed to the country's health sector between 2002-2010 (decisions) .....	177

1.7.4	Overview of main programmes/funds and sectors .....	178
1.7.5	Details of programmes.....	179
1.7.6	Details of GBS programmes with health related indicators. ....	182

**List of Figures**

Figure 1:	Ratio of professional staff to population by province .....	157
Figure 2:	Densities of health workers in Zambia and in the African Region per 1,000 population .....	158
Figure 3:	Trends in percentage of children under five who slept under a bednet on the night before the survey by type of net, Zambia 2001-2002 and 2007. ....	167

**List of Tables**

Table 1:	Health Facilities by Type, Size and Ownership, 2008 Zambia .....	155
Table 2:	Staffing Levels and Staff/Population Ratios, 2005 .....	157
Table 3:	Human Resources for Health: Staffing Levels and Ratios, 2007 .....	157
Table 4:	Levels of utilisation by age group: rural versus urban facilities, 2004-2007 .....	162
Table 5:	Malnutrition of children age under five, Zambia 1991-2007 .....	166
Table 6:	Immunisation coverage among 1-year-olds (%), Zambia: 1985-2009 .....	166

## 5.1 Introduction

### 5.1.1 Country context of EC support

President Levy Mwanawasa took office in early 2002, after winning elections with a narrow margin, was re-elected in 2006, but died in mid 2008. Overall, his ruling period was seen as an improvement over the previous 10 years, when Frederick Chiluba's presidency had increasingly turned into financial mismanagement and corruption. However, under his successor, President Rupiah Banda initial commitments to promote fiscal transparency and accountability and fight corruption do not seem to hold. Elections in 2011 brought in a new President, Michael Sata.

There are about 13 million Zambians, with a relatively high urbanisation rate (35%). About two-thirds of Zambians live in poverty. Per capita annual incomes are well below their levels at independence and, at USD 1,500, place the country among the world's poorest nations, with social indicators like life expectancy declining. However, in recent years, the economy is improving, with substantial HIPC debt relief in 2005, real GDP growth and restored prices of its key export commodity, copper.

The country is hit hard by the HIV/AIDS epidemic, with a prevalence rate among adults of about 15% and many aids orphans. Malaria was and still is a primary public health problem in Zambia.

The Country Strategy Paper for Zambia (2001-2007), under the 9<sup>th</sup> EDF, focussed on transport infrastructure and capacity building for public finance management, private sector development and agriculture funding, apart from allocating EUR 10 million to be delivered through sector support, which was then used to specifically target human resource for health retention.

During this period there was limited direct involvement in the health sector foreseen. Main expenditure during this period was still related to the previous 8<sup>th</sup> EDF, where EUR 4 million support was initiated to a District Basket Fund and a similar amount allocated to improve safe blood supplies.

Under the 10<sup>th</sup> EDF, a new Country Strategy Paper for 2008–13 was signed with a budget of EUR 489.8 million. Key areas for action were to be: GBS (for a total of EUR 225 million), transport infrastructure and human development/health. The focus was set on improved access to healthcare across the country, but especially for children, women and those living in very rural and disadvantaged areas. This resulted in a EUR 35 million allocation to the "Supporting Public Health Service Delivery in Zambia" programme.

This EUR 35 million Sector Policy Support Programme (SPSP) aims to contribute to the expansion of integrated public health services in the drive to attain the MDGs as planned in the Fifth Zambian National Development Plan (FNDP) 2006-2010, and as detailed in the national health sector strategic plans (NHSP 2006-2011). The operating modality will be direct untargeted budget support to the National Treasury, in three annual fixed tranches and three variable tranches. The period of execution lasts 72 months from the signing of the Financing Agreement, in 2009. The programme will therefore primarily contribute to the priorities of the NHSP, i.e. addressing the human resource crisis, a number of public health priorities and a range of support systems priorities.

### 5.1.2 EU funds between 2002-2010

*Full details of EC support are given in Annex 5.7.2.*

EU funding for projects is provided in the form of grants, contracts and increasingly budget support.

Overall, the EU allocated around EUR 50 million to the Zambian health sector in the 2002-2010 period. By far the largest share is the recent (2009) EUR 35 million allocation to "Supporting Public Health Service Delivery in Zambia," expressing the new commitment to the health sector under the 10<sup>th</sup> EDF.

Other major allocations were EUR 8.5 million as health budget support under the 9<sup>th</sup> EDF, which was to succeed support to a District Basket Fund under the 8<sup>th</sup> EDF. For the latter purpose still EUR 2 million were used during the period under study. The EUR 8.5 million SBS was specifically for health worker retention in the light of the human resources for health crisis.

Finally, some smaller amounts were allocated to discrete other activities, like TB control strengthening, some HIV work through NGOs, the safe blood transfusion programme, and the Demographic and Health Survey (DHS) 2007.

90% of the total amount is channelled through the public sector and mostly to basic health services.

With substantial support over the years to the health sector from other donors, most notably including several EU member states, the impact of EC support to health, as the CSE of 2006 remarked, "is difficult to measure because EC does not intervene alone, donors are numerous and indicators are not sufficiently developed."

The mixed results of the GBS for the health sector are quite well covered in the “evaluation of budget support” synthesis report and are not fully treated in this Case Study. Of particular interest is the identified “crowding in” effect for the country’s health budget of the budget support. Also of interest is the statement that the exposed fraud in the health sector was not the result of GBS as such, but exposure thanks to better scrutiny due to GBS procedures. The inference that the report makes on linking the relative recent increases in overall government health budget (thanks to GBS/SBS) with some improved health indicators is tempting, but this attribution remains uncertain. The evidence is not discussed in this synthesis report.

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

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

#### **Indicators**

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

#### **5.2.1.1 Findings per indicators**

**I-111:** Proper essential drug distribution is a long-standing and during the period under scrutiny still largely unresolved issue, resulting in frequent stock-outages.

The EC did not contribute to the adoption of essential drug guarantees and protocols.

**I-112:** The public sector delivers around 60% of health care in Zambia, next to inputs from the churches (30%), mine hospitals in the Copperbelt, and a small private sector in urban areas. The churches have their own parallel drug procurement and distribution system, with probably less stock-outages.

Also, the “Zambia Millennium Development Goals Progress Report 2008” mentions the inadequate procurement, supply and logistical management procedures for drugs and medical in the country.<sup>213</sup>

The EC provides support to procurement of essential drugs through its sector budget support. However, the EC is not directly involved in what seems to be the main bottleneck in drug availability: the drug supply chain.

The EC “Supporting public health service delivery in Zambia’ (EDF 10) programme has the goal to ensure availability of adequate, quality, efficacious, safe and affordable essential drugs and medical supplies at all levels, through effective procurement management and cooperation with pharmaceutical companies.<sup>214</sup> The Mid-term report concludes that the provision of drugs and pharmaceuticals has been much improved and stock-outs are less reported. But the existing pharmaceutical structures and systems need more investments in human, material and financial resources to be fully operational.<sup>215</sup> In general, EC contribution to progress in this area appears to be marginal.

#### **5.2.1.2 Resume of the JC**

Zambia has long been known to suffer from an inappropriate drug distribution system, resulting in a high percentage of stock-outages in the peripheral health centres. There may be some recent improvement through some new initiative supported by other donors. The EC provides support to procurement of essential drugs through its sector budget support. However, the EC is not directly involved in the drug supply chain.

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

#### **Indicators**

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

---

<sup>213</sup> [http://www.moh.gov.zm/index.php/downloads-portal/cat\\_view/12-reports](http://www.moh.gov.zm/index.php/downloads-portal/cat_view/12-reports)

<sup>214</sup> 10th EDF Zambia CSP (A-envelope), Supporting public health service delivery in Zambia, Sector Policy Support Programme, Sector budget support

<sup>215</sup> Zambia NHSP IV, MTR, Final Report, 17/11/2008

- I-123 Increased proportion of health facilities with adequate budget for maintenance and recurrent expenditures

### 5.2.2.1 Findings per indicators

**I-121** The Ministry of Health has health facilities classified as either hospitals (three levels at district, provincial and central levels respectively), Urban and Rural Health Centres or Health Posts. Through these facilities the Government aims to provide a Basic Health Care Package (BHCP). The BHCP has 11 priority areas for health services: child health; nutrition; environmental health; control and management of communicable diseases, including malaria, tuberculosis, STIs, and HIV/AIDS; mental health; control and management of non-communicable diseases; epidemic and disaster prevention, preparedness and response; school health; and oral health. The National Health Strategy 2006-10 states that the “challenge is that though the BHCP has been defined and implemented at certain levels, little progress has been made in using the packages for actual decision making in the allocation of resources to priority areas.”<sup>216</sup>

Table 35: Health Facilities by Type, Size and Ownership, 2008 Zambia<sup>217</sup>

Type of Facility	Number of		Number of Health Facilities by Ownership			Total Facilities	
	Beds	Cots	Government/ State Owned	Faith-based (CHAZ)	Private	Number	%
3 <sup>rd</sup> Level Hospitals	2,532	417	6	0	0	6	0.3%
2 <sup>nd</sup> Level Hospitals	4,204	827	13	3	5	21	1.0%
1 <sup>st</sup> Level Hospitals	6,016	859	39	29	4	72	5.0%
Health Centres: Urban	1,814	300	206	6	53	265	17.0%
Rural	9,224	559	930	77	22	1,029	66.0%
Health Posts	198	11	161	2	8	171	11.0%
<b>TOTAL</b>	<b>23,988</b>	<b>2,973</b>	<b>1,355</b>	<b>117</b>	<b>92</b>	<b>1,564</b>	<b>100.0%</b>

Note: 3<sup>rd</sup> Level Hospitals include the Cancer Diseases Hospital located at the UTH (Opened in 2007)

Source: Health Institutions in Zambia, Ministry of Health, 2008

Source: MoH Joint Annual Review 2008

In early 2009: District Hospitals are found in most of the 72 districts. The target for Health Centres is 1,385 HCs, but currently there are a total of 1,294. The target for Health Posts is to have 3,000 HPs, but currently there are only 171.<sup>218</sup>

Some documents with more details on health facilities, still indicated at various websites, including the MoH, prove not to be accessible anymore. However, it may still be ascertained that not much has changed in terms of the number of health facilities over the past decade. Adjustment to better delivery of the BHCP would require, among others, an increased number of Health Posts, which has been identified but not implemented yet.

So, the mix of primary and secondary health facilities did not change during 2002-2010.

The ‘Ministry of Health 2011 Action Plan’ concluded that “While the distribution of health facilities in urban areas is better, long waiting time before a patient sees a health provider demonstrates the need to increase the number of facilities or expand the existing ones. The main drivers of physical accessibility bottlenecks include insufficient or inappropriate infrastructure, poor scheduling of services leading to missed opportunities; inaccessibility due to geography and seasonal variation; and inadequate outreach posts and resources (fuel, vehicle, bicycle, motor-bike, boats) for outreach services, scattered population in rural areas; unreachable terrains – mountains, valleys, plains, rivers; and inadequate resources for infrastructure development.”<sup>219</sup>

Through the EC MDG contract Zambia has to guarantee equitable service delivery in particular in health, education, and transport infrastructure throughout the country, so as to reduce the gap

<sup>216</sup> [http://www.who.int/nha/country/zmb/Zambia\\_NH\\_Strategic\\_plan,2006-2010%20.pdf](http://www.who.int/nha/country/zmb/Zambia_NH_Strategic_plan,2006-2010%20.pdf), p.27

<sup>217</sup> MoH Joint Annual Review 2008

<sup>218</sup> WHO Country Office Zambia, Annual Report 2008, [www.afro.who.int/index.php?](http://www.afro.who.int/index.php?) p.8

<sup>219</sup> Ministry of Health 2011 Action Plan, January 2011, [www.moh.gov.zm/](http://www.moh.gov.zm/), p.7

between urban and rural areas; expressed through the indicator of utilisation rate increase of PHCs.<sup>220</sup> The same for the PRSB II,<sup>221</sup> PRSB I 3<sup>rd</sup> and 5<sup>th</sup> tranche<sup>222</sup>, and V/SYSMIN.<sup>223</sup>

In short, no evidence directly relevant to the indicator has been found, the situation appears to have been more or less unchanged over the evaluation period, and no statement can be made regarding EC contribution to change in this indicator.

**I-122** No information on quality of services, including availability of equipment by facility could be identified, although there are references to reports like the 'Zambia National Health Atlas' (but not available).

No EC contribution could be identified.

**I-123** No information on budgets for maintenance and recurrent expenditures has been found. The 'Ministry of Health 2011 Action Plan' states that the national budget planned for infrastructure development (construction and rehabilitation of health facilities) totals ZMK 116.6 billion, out of a total budget of ZMK 804.1 billion, without donor contributions. Targets are hospitals completed in yr1 are 8, yr2 10, and yr7 10, health posts completed 125/50/50, and facilities rehabilitated 50/60/60 respectively.<sup>224</sup>

No EC interventions on construction or maintenance.

### 5.2.2.2 Resume of the JC

While Zambia has a reasonably well developed network of Health Centres and Primary District Hospitals, there is an identified shortage of Health Posts. There has not been much change to the infrastructure over the past decade. Presumably, staffing issues due to the Human Resource for Health crisis are a higher priority. No evidence of EC support could be found.

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

#### Indicators

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

#### 5.2.3.1 Findings per indicators

**I-131** High staff attrition rates attributed to the migration of health professionals and HIV/AIDS related deaths have led to a recognised human resource crisis affecting basic services. It can be reasonably speculated that this has led to a deterioration in the nation's health status. Further analysis has revealed quite a few additional factors that have led to the human resources crisis, including poor conditions of service, in particular in remote areas and a freeze on appointments in the public (and thus health) sector from 2003 in compliance with HIPC requirements.

The table shows key health staffing levels from a 2005 report (NHSP 2006-2011); in other words, less than 50% of the recommended establishment was present mid-way through the evaluation period. These averages conceal that the situation in remote provinces like Northern and Luapula provinces is much worse than that in Lusaka province (see Figure 1 below).

---

<sup>220</sup> Agreement No. ZM FED/2008/020-949, Millennium Development Goals Contract for Zambia (MDG-C) 2009-2014, (ZA/005/08), EDF X

<sup>221</sup> Agreement No.9588IZA, Poverty Reduction Budget Support Programme II 2007-2008 (PRBS II), ZA/001106, EDF IX

<sup>222</sup> Agreement N° 91141ZA, Poverty Reduction Budget Support (2004-2006), ZA/003103, EDF IX

<sup>223</sup> Agreement No.6322/ZA, Structural Adjustment and Sysmin Support Programme (SAF V/SYSMIN), ZAI7200/006, EDF VIII

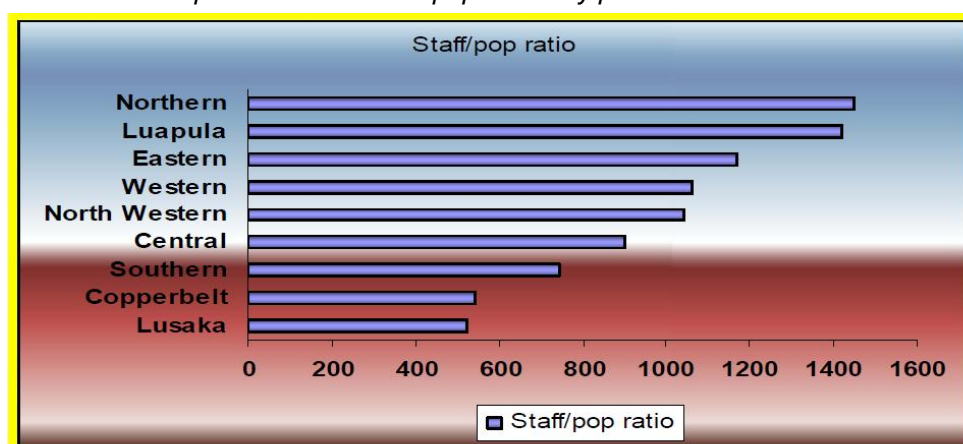
<sup>224</sup> Ministry of Health 2011 Action Plan, January 2011, [www.moh.gov.zm/](http://www.moh.gov.zm/), pp.38 and 136



Table 36: Staffing Levels and Staff/Population Ratios, 2005<sup>225</sup>

Staff Category	STAFFING LEVELS			STAFF/POPULATION RATIOS		
	Existing Staff	Recommended Establishment (2005)	Variance	Existing Staff	Existing Staff/Population Ratios, 1:	Recommended Staff/Population Ratios, 1:
Doctors	646	2,300	1,654	646	17,589	4,940
Nurses	6,096	16,732	10,636	6,096	1,864	679
Mid Wives	2,273	5,600	3,327	2,273	4,999	2,029
Clinical Officers	1,161	4,000	2,839	1,161	9,787	2,841

Source: MoH. 2005. National Health Strategic Plan 2006-10, p.22

Figure 10: Ratio of professional staff to population by province<sup>226</sup>

Source: Ministry of Health HRIS Database

The 2007 Joint Annual Review shows a similar situation with little improvement as there is still a 40% shortfall in human resources for health (see Table 3).

Table 37: Human Resources for Health: Staffing Levels and Ratios, 2007<sup>227</sup>

Zambia 2007: Human Resources for Health (HRH) Staffing Levels and Ratios Staff category	Total HRH Needed	Authorised Staff Establishment	Percentage Shortfall	Staff : Population Ratio	Staff per 1 000 pop.
Medical doctors	1,778	1,290	27%	1 : 9,660	0.10
Nurses	14,053	8,165	42%	1 : 1,526	0.66
Midwives	4,751	2,775	42%	1 : 4,491	0.22
Medical Licentiate	547	79	86%	1 : 157,739	0.01
Clinical Officers	3,737	2,657	29%	1 : 4,690	0.21
EHT	2,555	1,276	50%	1 : 9,766	0.10
Pharmacy	1,238	693	44%	1 : 17,982	0.06
Laboratory	1,403	697	50%	1 : 17,879	0.06
Radiography	732	327	55%	1 : 38,108	0.03
Paramedical Other	1,379	485	65%	1 : 25,694	0.04
Teaching staff	422	237	44%	1 : 52,579	0.02
Administration	7,769	3,952	49%	1 : 3,153	0.32
Support staff	11,040	8,250	25%	1 : 1,510	0.66
<b>Total</b>	<b>51,404</b>	<b>30,883</b>	<b>40%</b>	<b>1 : 404</b>	<b>2.48</b>

Source: 2007 Health Sector Joint Annual Review

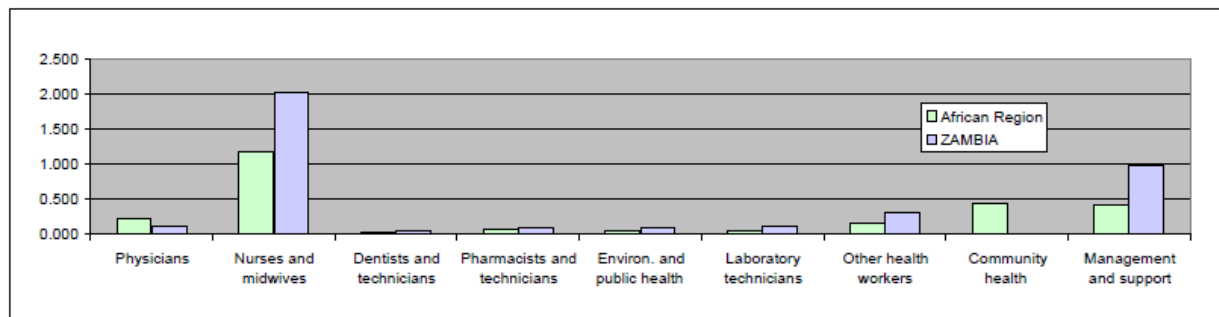
<sup>225</sup> MoH. 2005. National Health Strategic Plan 2006-10, p.22, [http://www.who.int/nha/country/zmb/Zambia\\_NH\\_Strategic\\_plan,2006-2010%20.pdf](http://www.who.int/nha/country/zmb/Zambia_NH_Strategic_plan,2006-2010%20.pdf).

<sup>226</sup> Ibid, p.23

<sup>227</sup> 2007 Health Sector Joint Annual Review

The 2008 Joint Annual Review commented that critical shortages of health workers persisted. Since the commencement of implementation of the HRH Strategic Plan in 2006, the authorised staff establishment has increased from 23,176 in 2005 to 31,048 in 2008 or from 45% to 60% of the estimated total requirement of 51,414.

Figure 11: Densities of health workers in Zambia and in the African Region per 1,000 population<sup>228</sup>



Source: Country Health System Fact Sheet 2006, Zambia

Despite government efforts to improve the human resource situation in the country, unqualified staffs run a significant number of health centres in rural areas and several others have only one qualified staff. The main constraints affecting human resource availability include lack of a comprehensive strategy; policy and coordination framework specifying mechanisms of engagement; support and remuneration for community health workers; high staff attrition rates; poor distribution; low training output; inadequate funding for recruitment and retention; and long bureaucratic employment process. The MoH has ambitious plans to improve the situation with training of community health workers and lay providers; in-service and pre-service training; increased training output from health colleges; scale up the retention scheme for core health workers; increase number of skilled health workers in post; just to mention a few ones.<sup>229</sup>

The Mid-Term Review of the 'Zambia National Health Strategic Plan IV' reveals that progress is made in newly defined job descriptions, the retention scheme has been expanded to include next to doctors, additional numbers of tutors, enrolled nurses and midwives, clinical officers and environmental health technologists. However, distribution over the various regions remains largely unchanged. Over the review period, the main achievement in the area of HR development has been the comprehensive assessment done in May-June 2008 of all 39 health training institutions. A national Training Operational Plan and a Training and Development plan have been developed that now await implementation.<sup>230</sup>

While the situation is still unsatisfactory, it appears that EC support contributed to some improvement. The EC SPS "Supporting public health service delivery in Zambia" programme has a human resource component. The EC participates with other cooperating partners in the sector policy dialogue, the monitoring of the implementation of the NHSP 2006-2011 and the sector performance assessment.<sup>231</sup> The Assessment for the disbursement of the 2nd Tranche reports concludes that the implementation of the Human Resource for Health Strategic Plan in 2009 faced challenges as the contributors to the Human Resources Basket were among the co-operating partners that withheld the funding. This resulted in the cessation of the direct entry mid-wifery training programme and the deferring of planned increased intake of health worker training. Furthermore, the inequity among the regions remained, as most of the health personnel are employed in urban areas. The Zambia Health Worker Retention Scheme has aimed to address this inequity by attracting core workers with incentives to the more deprived and remote areas of the country. The total number of health workers on the staff retention scheme increased from 656 in 2008 to 860 in 2009, against the target of 1,650, and the scheme has continued to expand to accommodate core health workers, other than medical doctors.

<sup>228</sup> Country Health System Fact Sheet 2006, Zambia, <http://www.afro.who.int/en/zambia/country-health-profile.html>

<sup>229</sup> MoH, Jan. 2011. Ministry of Health 2011 Action Plan., pp.7 and 14

<sup>230</sup> Report of the Mid-Term Review of the Zambia National Health Strategic Plan NHSP IV, 2006-2010, 2008, pp.xvi-xvii

<sup>231</sup> 10th EDF Zambia CSP. Supporting public health service delivery in Zambia. Sector Policy Support Programme:

Sector budget support (centralised management), DAC CODE 12220

The total number of staff in the health sector stands at 27,524 which is 54% of the approved establishment. The available number of professional health workers in the public sector is 15,159 leaving a deficit of 24,201 against the establishment.<sup>232</sup>

The EC “Retention of Human Resources for Health Sector” programme’s objective is “To ensure an adequate and equitable distribution of appropriately motivated, skilled and equitably distributed health workers providing quality services”.<sup>233</sup> One of the specific targets “no district in Zambia presents in 2008 a ratio above 7000”, was fulfilled in most of the districts, except Chilubi with a ratio of 16,325, Shangombo with 9,362, and Milenge with 8,659 in 2008.<sup>234</sup>

In summary, Zambia continues to suffer from serious human resources shortages in health. There may have been some improvements, and several EC programmes may have contributed.

**I-132** Several initiatives, including support from the EC, have been applied at various levels within the health sector, aimed at addressing the human resource crisis, including increased levels of training.

For instance, the ‘Retention of Human Resources for Health Sector’ includes that the pre-service and in-service training improvement, and the training output by expanding the number of training places available should be increased. No information is available how successful the MoH was.

**I-133** At the time when the HRSP was developed in 2006, there was no definitive data on health worker attrition. The findings of the Public Expenditure Tracking Surveys (PETS) and the Quantitative Service Delivery Surveys (QSDS) indicate that current health worker attrition rates are very high and particularly pronounced in Rural Health Centres (RHCs). Attrition rates among health personnel have been increasing in the recent years, particularly among doctors (9.8% per annum) and nurses (5.3% per annum). In addition to emigration, sources of attrition include deaths, dismissals, resignations, retirements and expiry of contracts. Emigration and HIV/AIDS are major sources. For example, the estimated number of doctors trained in Zambia and practicing in the United States and Canada in 2002-2003 was equal to 11% of those working in Zambia. United Kingdom has recruited a significant number of trained Zambian nurses.<sup>235</sup> No information has been gathered to date on the time trend in emigration.

Despite an average 5% increase in the number of health staff employed in the period 2005- 2009, this has been essentially lost with the average attrition rate of 4% per annum from 2007- 2009.<sup>236</sup> Another study concludes that in 2005 resignations, which represented 13% of the attrition rate increased to 28% in 2008. These were followed by death and discharges which were 23% and 10%. Anecdotal evidence suggests that voluntary attrition is slowing down and a major contributing factor is the Retention Scheme.<sup>237</sup>

The HR initiatives also include emphasis on improved retention. EC support of EUR 8.5 million SBS was specifically for health worker retention in the light of the human resources for health crisis, and includes a target of deployment and retention of health workers. The problems remain in rural areas, though there monetary and non-monetary benefits. Since no time series data have been found, it is impossible to make an estimate of how effectively EC support contributed to lessening attrition.

Absenteeism and tardiness are common, due to death and illness, in-service trainings, moonlighting in private practice, and weak overall HRM systems. A 2005-2006 World Bank facility survey revealed that nearly 10% of staff were not on site at the time of the survey. In a self-reported survey about absenteeism, 21% of staff reported being absent an average of five days per month and 43% reported being tardy on four days per month. These averages are higher among staff at RHCs, where 30% of staff reported being absent an average of six days per month.<sup>238</sup>

The EC likely contributed through its SBS “Supporting public health service delivery in Zambia” (10<sup>th</sup> EDF) indirectly to reduce absenteeism rates through the programme of stocking up health workers, on the tedious and long-lasting process of the MoH, when CBoH was merged into the MoH in 2006, of

<sup>232</sup> Assessment for the disbursement of the 2nd Tranche – Financing Agreement: FED/2008/020-950, Supporting Public Health Service Delivery in Zambia 2009 – 2011, (May 2010), p.10

<sup>233</sup> Agreement No. 95851ZA, Retention of Human Resources for Health Sector ZAI70241001, EDF IX, May 2003

<sup>234</sup> AIDCO/C1/AR D(2008)19272, p.6

<sup>235</sup> Human Resources for Health - Country Profile, Zambia, Sep 2010, [http://www.hrh-observatory.afro.who.int/images/Document\\_Centre/zambia\\_hrh\\_country\\_profile.pdf](http://www.hrh-observatory.afro.who.int/images/Document_Centre/zambia_hrh_country_profile.pdf)

<sup>236</sup> Assessment for the disbursement of the 2nd Tranche – Financing Agreement: FED/2008/020-950, Supporting Public Health Service Delivery in Zambia 2009 – 2011, (May 2010), p.10.

<sup>237</sup> J Campbell, and M Caffrey. 2009. Zambia: Taking forward action on Human Resources for Health with DFID/OGAC and other partners. P.30, [http://www.who.int/workforcealliance/knowledge/publications/partner/tfa\\_zambia.pdf](http://www.who.int/workforcealliance/knowledge/publications/partner/tfa_zambia.pdf)

<sup>238</sup> Human Resources for Health - Country Profile, Zambia, Sep 2010, [http://www.hrh-observatory.afro.who.int/images/Document\\_Centre/zambia\\_hrh\\_country\\_profile.pdf](http://www.hrh-observatory.afro.who.int/images/Document_Centre/zambia_hrh_country_profile.pdf)

reabsorbing all the different categories of staff into the public service and onto the government payroll. Further likely contributions from the EC were run through the “Retention of Human Resources for Health Sector” programme.

### 5.2.3.2 Resume of the JC

Human resources for health are seen as a major problem for the Zambian health sector, fully recognised during the early years of the decade. Many factors contribute to the shortage, and based on this analysis a range of initiatives have been put in place to revert this trend. There seems to be progress during the latter half of the decade, although shortages continue to exist.

The EC support, through SBS, under the 9<sup>th</sup> EDF and Retention of Human Resources programme, is likely to have contributed to this positive trend. However, any serious assessment would have to be tempered by an examination of Zambian health professional immigration to EU-member England.

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

#### Indicators

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

#### 5.2.4.1 Findings per indicators

**I-141** No information available

Under the PRBS II, a contract for a project estimate on the revision of the Health Management Information System (HMIS) was launched in 2009.<sup>239</sup> The aim of the HMIS was in particular to set up a modern and integrated hospital HMIS database that should be a flexible, independent and user friendly. A pilot study has been launched to selected hospitals. No documents were available giving insight on the outcome of the pilot and its roll-out to all Zambian hospitals.

According to the EUD, the EC has contributed to the improvement of quality assurance mechanisms at hospital level, through its support to the revision of the HMIS. Specifically worth highlighting is the EC contribution to the process of monitoring and evaluation. Further, through support to the Health Profession Council of Zambia, the EC contributed indirectly to the development of health care standards at national level.

**I-142** No information available. However, the serious staff shortages, with quite a few health centres, in particular in the rural areas, reportedly without staff or with unqualified staff, do not bode well for proper treatment in these facilities.

**I-143** No information available.

#### 5.2.4.2 Resume of the JC

No information relevant to this JC has been found.

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

#### 5.3.1 JC 21 The cost of basic health care services is reduced for households due to EC support

#### Indicators

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

---

<sup>239</sup> CRIS contract number: 223811.

### 5.3.1.1 Findings per indicators

**I-211** According to WHO 2011 data, the share of total health expenditure accounted for by out of pocket spending rose from 27.8% to 30.2% between 2002 and 2009.

No evidence of EC contribution in the area was identified.

**I-212** There are no social security schemes that play a role in health care financing in Zambia.

**I-213** Only a tiny fraction of the population (around 1%) has any form of medical insurance, with only some studies on the way to look at expansion of this mechanism. One should distinguish between medical and health insurance on the one hand and medical schemes on the other hand. In the case of Zambia, the former are regulated insurers, whereas the latter are effectively unregulated at present. Whether regulated or not, the penetration of any kind of health insurance remains low. According to FinScope, only 1.2% of adults report having medical insurance of any kind. This amounts to only about 90,000 people. MoH plans on establishing a Social Health Insurance (SHI), but process has ground to a halt due to internal fraud in 2009, which resulted in suspending of funds of international donors.<sup>240</sup> According to another study, only two companies are recorded to have undertaken private health insurance, and that only 7% of the total formal workforce is covered by health insurance scheme through employer financed health care. Therefore it can be concluded that the remaining are either covered by membership schemes, 'fee for service' schemes, cost sharing, purchase discount cards and capitation schemes, or in most instances, they are not insured by any medical insurance scheme at all.<sup>241</sup>

All people will have access to publicly financed health facilities or church-based facilities. For both they may be required to contribute through user fees. Apart from the mine sector, there are no pooling mechanisms for the great majority of people.

The EC programmes accomplished in Zambia focused on health indicators to reach MDGs. No evidence was found that EC is involved in any work related to the creation of health insurance schemes.

### 5.3.1.2 Resume of the JC

A major change in health finance policy has been the abolishment of user fees in the rural areas in 2006. The EC will pick up some of the increased cost to the government of this policy through its recent health budget support programme. This is the only evidence of EC contribution related to this JC.

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

#### Indicators

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

<sup>240</sup>

[http://www.cenfri.org/documents/cost%20of%20health/Terms%20of%20reference\\_Zambian%20health%20insurance\\_26%2010%202009\\_final.pdf](http://www.cenfri.org/documents/cost%20of%20health/Terms%20of%20reference_Zambian%20health%20insurance_26%2010%202009_final.pdf)

<sup>241</sup> J Chibuye. 2010. Assessing the Impact of Health Financing Mechanism in Zambia, <http://www.search4dev.nl/document/192414>, p.26

### 5.3.2.1 Findings per indicators

**I-221** User fees have been abolished in the rural areas since 2006. In other areas, exemption schemes for vulnerable groups are (formally) in place. ART (treatment for HIV/Aids) is freely available as from 2005. The abolishment of user fees explicitly took the extreme poverty in the rural areas as a base for this change in policy. Free ART addresses the need of positive HIV/Aids patients. Almost three quarters of funding for HIV and AIDS Zambia is from foreign donors, and it has been reported that HIV programmes are amongst some of the worst affected by the corruption scandal and resulting disruptions in donor funding. The majority of Zambia's donor funding comes from PEPFAR (U.S. President's Emergency Plan for AIDS Relief) (50%), followed by the Global Fund and the World Bank.<sup>242</sup> The EC funded projects 'Comprehensive HIV/AIDS prevention, care and treatment: Institutionalised and effective coordination and referral structures in Mansa District' and the 'Integration of HIV/AIDS/STD Interventions Into Reproductive Health and Child Survival' Programmes in Zambia (Project No E-03-104) did not focus on cost waiver schemes. However, the overall awareness raising and HIV/AIDS education of population, and in particular the youth, in project areas were seen as successful. No evidence has been gathered of EC contribution in this area.

**I-222** The abolishment of user fees in the rural areas led, during the middle years of the evaluation period, to a noticeable increase of health care consumption in those areas.

Table 38: Levels of utilisation by age group: rural versus urban facilities, 2004-2007<sup>243</sup>

Years	Urban facilities: under-5		Urban facilities: 5+		Rural facilities: under-5		Rural facilities: 5+	
	Total visits	Change (%)	Total visits	Change (%)	Total visits	Change (%)	Total visits	Change (%)
2004q2-2005q1	751,631	–	929,156	–	1,641,309	–	1,672,640	–
2005q2-2006q1	861,345	15%	958,212	3%	1,787,859	9%	1,786,312	7%
2006q2-2007q1	700,180	-19%	997,851	4%	1,916,960	7%	2,762,174	55%

Source: <http://www.equinet africa.org/bibl/docs/Dis57FINchitah.pdf>

The 2002 DHS showed that 22% of urban and 30% of rural patients were turned away from health facilities because they could not pre-pay for services.

### 5.3.2.2 Resume of the JC

Apart from picking up some of the cost of user fee abolishment for the rural poor, the EC's contribution to protect groups with special health care needs has been limited. Free HIV/Aids is financed through other donors.

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

#### Indicators

- I-231 EC supported technical assistance, provides expertise on health care finances
- I-233 EC supports enhanced communication, cooperation between MoH and MoF/planning

### 5.3.3.1 Findings per indicators

**I-231** No information available

**I-233** The PRBS I fostered the dialogue between line ministries (especially Health and Education) and the Minister of Finance and National Planning (MOFNP) on intersectoral allocations.<sup>244</sup> One can thoroughly conclude that PRBS II and the MDG-Contract continued in fostering the coordination among line ministries, in particular health and education, though it is not mentioned directly in relevant documents. The EAMR 01/2011 states that the Supporting Public Health Service Delivery in Zambia - Sector Budget Support has improved dialogue on sector policy between EU and MoH, and the communication and coordination between MoH and MoFNPN/A.<sup>245</sup>

<sup>242</sup> <http://www.avert.org/aids-zambia.htm#contentTable5>

<sup>243</sup> <http://www.equinet africa.org/bibl/docs/Dis57FINchitah.pdf>

<sup>244</sup> Quoted in PRSB II

<sup>245</sup> EAMR 01/2011, p.13



The Joint Evaluation of the General Budget Support concludes that “GRZ and PRBS partners have been successful in setting up an institutionalized dialogue process. This mechanism served as the platform for discussing all relevant issues, including funding and disbursement procedures, conditionality, capacity-building and institutional reform.” Further, the report states that “Regarding policy and governance reforms, budget support has performed below its potential. While achievements in PFM reforms and the strengthening of the Auditor General can be related to the budget support process, the instrument was not effective in realising broader objectives. The PRBS group was not able to set up a coherent incentive system through conditionality and alignment that could have compensated weaknesses of GRZ.” Moreover Inter-ministerial incoherency remained: “Given the broad setting of the FNDP, the plan did not function as an instrument fostering a more integrated set up of sector ministries and promoting the relative strength of MFNP vis-à-vis powerful sector ministries. It is true, that one has to distinguish between sectors and their specific degrees of ownership and engagement for concrete policy reform. However, the weak integrative capacity of the MFNP despite of its relatively high commitment for budget support has set strong limits to overall government ownership and for advancing a more comprehensive, cross-sector strategies.”<sup>246</sup>

### 5.3.3.2 Resume of the JC

The EC through its PRBS I, PRBS II, and the MDG-Contract funded health care financing, and cooperation and dialogue among line ministries. However, weaknesses remain as outlined in the Joint Evaluation of the General Budget Report (see also EQ5).

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

#### Indicators

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

#### 5.3.4.1 Findings per indicators

**I-241** EC contribution to expand Research and Development has been made, in Zambia, mainly through the regional project of “development of malaria vaccines and their multi-centre trials” the overall objective of the project was to control the ever-increasing malaria mortality and morbidity in Africa through the coverage of an effective malaria vaccine. The project aims at strengthening a Pan-African network that promotes human and institutional capacity needed for clinical development and evaluation of malaria vaccines.

In December 2003, a Financial Agreement (FA) was signed by the EC and the African Caribbean and Pacific (ACP) group. In March 2004, the EC through the Europe Aid Co-operation Office (AIDCO) granted AMANET, the Africa Malaria Network Trust, a contract for EUR 6,700,000 / 9 ACP RPR 05 to strengthen the Pan-African network in the development of operational evaluation centres promoting human and institutional capacity, and capability for clinical development and evaluation of malaria vaccines.

The Tropical Disease Research Centre (TDRC) in Ndola was one among 12 institutions to be selected to join this network and develop human resource capacity, acquire essential equipment and undertake complete field site characterization to be in a position to conduct malaria vaccine trials (phases Ib and IIb) at international quality and ICH GCP standards (EUR 250,000 from AMANET).

The 2007 AMANET Report mentioned the good results after posting a qualified and experienced expert to support the team in the field. AMANET has intensified its fund-raising activities which are rewarded by the European Developing Countries Clinical Trials Partnership (EDCTP), the Bill and Melinda Gates Foundation, and the new EC’s European Malaria Vaccine Development Association Consortium (EMVDA), in addition to the EC-AIDCO grant.

The grant income for the 2006 period totals EUR 2,673,014, and has been contributed as follows in EUR

- i. The Ministry of Development Cooperation, Netherlands (DGIS) 355,000
- ii. AIDCO of European Commission 1,145,962
- iii. Bill and Melinda Gates Foundation (USD 1,199,657) EUR 932,134

<sup>246</sup> Evaluation of budget support in Zambia, Synthesis report (draft), 1 April 2011, pp.ii-vi



- iv. EDCTP Africa Office 84,830
- v. INDEPTH Network – MCTA 47,243
- vi. Outgoing MIM Secretariat in Stockholm, Sweden (USD 88,797) EUR 68,995
- vii. Burroughs Welcome Fund (USD 25,000) EUR 19,425
- viii. Exxon Mobil Foundation (USD 25,000) EUR 19,425

Another project can be included in this chapter related to research and development is the Zambia Demographic and Health Survey 2007 funded by the EC and undertaken through collaborative efforts of the UNFPA, MoH and the Central Statistical Office.<sup>247</sup>

*I-242* Not applicable to the country.

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

### **5.4.1 JC 31 Increase in availability of primary health care facilities due to EC support**

#### **Indicators**

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

#### **5.4.1.1 Findings per indicators**

*I-311* The average availability of primary care facilities may be just under 1/10,000 population, but this ratio will be lower in quite a few of the more remote areas. There is a recognised major shortfall of recommended number of Health Posts to deliver the Basic Health Package. This may start being addressed in the coming years, supported by the EC. No evidence has suggested that the EC contributed to an improvement in this indicator over the evaluation period.

*I-312* Geographic access to healthcare varies greatly between urban and rural areas: 99% of urban households reside within five kilometres of a health facility, compared to 50% of rural households (PRSP, 2002). This did not change over the last decade. According to MoH, the numbers are 99% and 46% in 2010, respectively.<sup>248</sup> No evidence has been found of EC contribution to improvement in this indicator.

#### **5.4.1.2 Resume of the JC**

No evidence relevant to EC contribution related to this JC has been found.

### **5.4.2 JC 32 Increase in availability of secondary health care facilities due to EC support**

#### **Indicators**

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

#### **5.4.2.1 Findings per indicators**

*I-321* The number of beds in hospitals will be close, but bit below 19/10,000 population. Over the past decade this number has not changed.

*I-322* All districts in the country have a district hospital. More detailed information about geographic access is, however, not available.

*I-323* Only one figure of 3% births by Caesarean sections is known, for 2007 (6.2% in urban and 1.2% rural areas).<sup>249</sup> No time trend data available. This low rate may be an indicator of low level care and badly equipped hospitals.

---

<sup>247</sup> Particip (2008) EC support for health sector, Country case study Zambia.

<sup>248</sup> Ministry of Health 2011 Action Plan, January 2011, [www.moh.gov.zm/](http://www.moh.gov.zm/)

<sup>249</sup> Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC),

No EC interventions on this indicator. However, the “Retention of Human Resources for Health Sector” and the “Supporting Public Health Service Delivery In Zambia” programmes in Zambia support health workers development and retention. As no time trend has been established, it is impossible to offer a comment on possible EC contribution.

#### 5.4.2.2 Resume of the JC

No information has been gathered which would permit a judgment on EC contribution related to this JC.

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

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

##### Indicators

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

##### 5.5.1.1 Findings per indicators

**I-411** The 2007 DHS reports 46.5% of the deliveries have been supervised by a skilled provider (doctor, clinical officer and nurse/midwife), pretty similar to the 2002 DHS with 43%. So, there appears to have been no improvement over a substantial stretch of the evaluation period.

The first health indicator of the MDG-Contract calls for an increase of the institutional deliveries from a base line of 45% in 2007 to 50% in 2010.<sup>250</sup>

The EC did not contribute directly to this indicator. However, as indicated in the previous indicators, we can conclude that the EC may have backed up to the overall positive developments.

**I-412** ANC4+percentage was reportedly 60% in 2007, with ‘at least one ANC visit’ to be 94% in 2007. The 2002 DHS reports a similar percentage for at least one ANC percentage, but a higher ANC4+ of 71%. So, there has been possibly some decline in full number of ANC visits over the past years. The rural-urban differences are low (ANC 4+ rural 61.2%, and urban 58.6%). In total 2.1% do not receive any antenatal care, with 2.7% in rural and 1.0% in urban areas. One critical component is that a quarter of women continue to delay the initiation of antenatal care until after their sixth month of pregnancy, thus missing out on potential benefits of early antenatal care services.<sup>251</sup>

The EC did not contribute to trends on antenatal care.

**I-413** In 2002 (DHS), current use of contraception among women of modern methods was 25%. In 2007 this percentage had gone up to 40%. The monitoring of the HSSP was based on the performance of the districts, which will be measured through the quarterly reporting system under FAMS. Performance indicators included contraceptive prevalence rate, and condom use.<sup>252</sup> There is no evidence that EC support contributed to the improvement in this indicator.

##### 5.5.1.2 Resume of the JC

There is little evidence of EC contribution related to this JC.

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

##### Indicators

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

University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007.

Calverton, Maryland, USA: CSO and Macro International Inc., p.132

<sup>250</sup> Agreement N° ZM FED/2008/020-949, Millennium Development Goals Contract (MDG-C) for Zambia 2009-2014, (ZA/005/08), EDF X

<sup>251</sup> Zambia DHS 2007, pp.125-126

<sup>252</sup> Agreement No 60651ZA, Health Sector Support Programme (ZAI70241000), EDF VIII

### 5.5.2.1 Findings

**I-421** Child malnutrition is alarming in Zambia. The DHS 2007 summarises it as the following. Overall, 45% of children under five are stunted (short for their age) and 21% are severely stunted, 5% are wasted (thin for their height), and 15% are underweight.<sup>253</sup>

The nutritional status of children age under five did not improve over a substantial stretch of the evaluation period, and there is no evidence that EC support contributed to containing this worsening problem.

Table 39: Malnutrition of children age under five, Zambia 1991-2007<sup>254</sup>

	2002 ZDHS	2007 ZDHS
Stunting	47	45
Wasting	5	5
Underweight	28	15

Source: The National Food and Nutrition Policy, p.13, 2007 Data from Zambia NDHS

**I-422** Both DPT3 and measles vaccinations are every year reported to be at least 80% (between 80-85% for the last decade), so remarkably unchanged. Full immunization coverage in 2004 stood at 80%.<sup>255</sup>

Table 40: Immunisation coverage among 1-year-olds (%), Zambia: 1985-2009<sup>256</sup>

Location	2009	2008	2007	2006	2005	2000
Measles (MCV)	85	85	85	85	85	85
Diphtheria tetanus toxoid and pertussis (DTP3)	81	81	81	81	82	85
Hepatitis B (HepB3)	80	80	80	80	82	
Hib (Hib3)	81	81	81	81	82	
BCG	92	92	92	92	92	94
Polio (Pol3)	83	83	83	83	84	85

Source: WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

Key Performance indicator for the MDG-Based Tranche (2008-2010 Performance assessment framework (PAF)) was to increase the immunisation rate from the baseline of 62% in 2007 to 70% in 2010.<sup>257</sup> Further interventions of the EC with targets of immunisation coverage increase are found in the 'Poverty Reduction Budget Support (2004-2006)' under the 9<sup>th</sup> EDF (p.6 and 9).

### 5.5.2.2 Resume of the JC

Immunisation rates have remained relatively high and remarkably stable over the past years, around 80%. No information is available on the proportion of children with growth monitoring. However, malnutrition of children under five is high.

Although, the EC did not specifically support these aspects, the MDG contract and the PRBS (2004-2006) included targets of immunisation rates to be reached to pay tranches.

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

#### Indicators

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

#### 5.5.3.1 Findings per indicators

**I-431** Between 2003 and 2006, over four million nets were distributed countrywide through channels such as the Community-Based Malaria Prevention and Control Programme (CBMPCP), the School Health Programme (SHP), Malaria in Pregnancy (MIP), and other malaria control initiatives and

<sup>253</sup> Zambia DHS 2007, p. xxiii and 156f

<sup>254</sup> The National Food and Nutrition Policy, p.13, 2007 Data from Zambia NDHS

<sup>255</sup> Health Statistical Bulletin 2004

<sup>256</sup> WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

<sup>257</sup> Agreement N° ZM FED/2008/020-949, Millennium Development Goals Contract (MDG-C) for Zambia 2009-2014, (ZA/005/08), EDF X, p.10

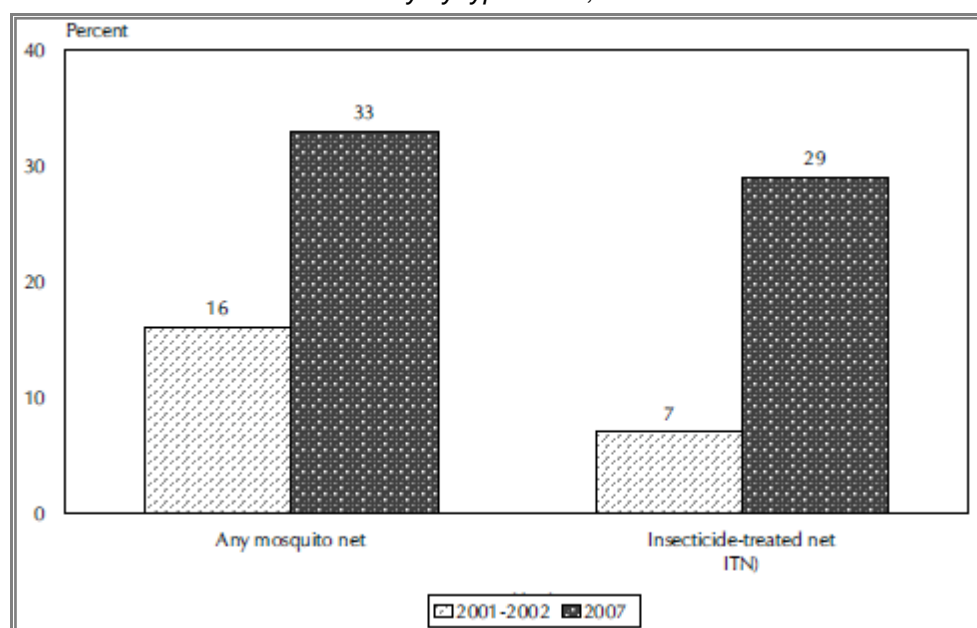
programmes. In 2007 alone, 3.5 million long-lasting ITNs were distributed, representing a significant achievement in the fight against malaria. On average, each household owns 0.9 ITNs in 2007.<sup>258</sup>

More than a quarter of children under age five slept under an ITN the night before the survey (30% in urban areas and 28% in rural areas). Luapula had the highest percentage of children under age five sleeping under an ITN (56%), while Southern had the lowest percentage (16%). Children in households in the highest wealth quintiles (33%) were more likely than children in households in the lowest wealth quintiles (19%) to sleep under an ITN. The rates for any type of bednet are higher and are respectively around one-third of children under age five, both in rural and urban areas.<sup>259</sup>

Time trends, illustrated in the chart below, appear to be not optimistic.

The EC programme “Supporting public health service delivery in Zambia’ (10<sup>th</sup> EDF) included this indicator, but no report is available if this target of 45% of children under age five slept under an ITN in 2010 is reached.

Figure 12: Trends in percentage of children under five who slept under a bednet on the night before the survey by type of net, Zambia 2001-2002 and 2007.<sup>260</sup>



Source: Zambia DHS 2007

The GFATM projects distributed until today about 8.3 million ITNs and LLINs through the National Malaria Control Centre (NMCC).<sup>261</sup> The MoH could continue its malaria roll back programmes with GFATM funds. The WHO reported in 2009 that malaria deaths reported from health facilities in Zambia have declined by 66%. The decline in Zambia was especially steep after 3.6 million long-lasting insecticidal nets were distributed between 2006 and 2008. During this period malaria deaths declined 47%.<sup>262</sup>

No direct EC interventions are found.

**I-432** According to the WHO, 17% of deaths among children under age five were caused by diarrhoea (period 2000-2003), and is the fourth leading of cause of deaths after neonatal causes (which includes diarrhoea during neonatal period), pneumonia and malaria.<sup>263</sup> The under-five mortality remains very high in Zambia, although the latest DHS in 2007 shows a decrease from 199 in 1992 to 119 per 1,000 births in 2007.<sup>264</sup>

No evidence of EC contribution to this improvement has been found.

<sup>258</sup> Zambia DHS 2007, pp.177-178

<sup>259</sup> Ibid. 179

<sup>260</sup> Ibid. p.181

<sup>261</sup> <http://portfolio.theglobalfund.org/en/Country/Index/ZAM/>

<sup>262</sup> [http://www.who.int/mediacentre/news/releases/2009/malaria\\_deaths\\_zambia\\_20090423/en/index.html](http://www.who.int/mediacentre/news/releases/2009/malaria_deaths_zambia_20090423/en/index.html)

<sup>263</sup> Mortality Country Fact Sheet 2006, Zambia, [http://www.who.int/whosis/mort/profiles/mort\\_afro\\_zam\\_zambia.pdf](http://www.who.int/whosis/mort/profiles/mort_afro_zam_zambia.pdf)

<sup>264</sup> ZDHS 2007, p.117, <http://www.measuredhs.com/pubs/pdf/FR211/FR211%5Brevised-05-12-2009%5D.pdf>

**I-433** In 2007, 67% of children with diarrhoea were reported to be receiving ORT in the health facilities. No time trend is available at the facility level. From the household perspective there are some time trend figures available for use of ORT: 48% in 2001 compared to 56% in 2007 (UNICEF, Child Info).

According to the DHS 2007 (p. xxii), the majority (74%) of children were treated with some type of oral rehydration therapy (ORT) or increased fluids: 60% were treated with solution prepared from an oral rehydration salt (ORS) packet; 10% were given recommended home fluids (RHF) prepared at home; and 34% were given increased fluids. 16% of children with diarrhoea did not receive any type of treatment at all. The 2001-2002 DHS (p. xxiv) reports that 43% of children were taken to a health facility; 67% of children with diarrhoea were treated with some form of oral rehydration therapy; 53% were given a solution prepared with oral rehydration salts (ORS); and 40% were given increased fluids. 21% of children with diarrhoea did not receive any type of treatment.<sup>265</sup>

No evidence of EC contribution to this improvement has been found.

### 5.5.3.2 Resume of the JC

A relatively high percentage of children sleep under bed nets. No more recent data are available. There are several national programmes that enforce the distribution of bednets and ITNs, mainly within roll back malaria programmes (e.g. National Malaria Control Centre (NMCC)) financed mainly by GFATM and WB. Under five mortality is still very high. However, the prevalence of diarrhoea decreased and ORT treatment increased slightly between the two DHS surveyed.

Apparently, the contributions to the District Basket fund, and SBS for Human Resource retention in the earlier part of the 2002-2010 period could not contribute to an improvement of this situation. The new contributions to the 'Supporting Public Health Service Delivery In Zambia' programme are too recent to expect any measurable impact.

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

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

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

#### 5.6.1.1 Findings

**I-511** As summarised in the next two indicators, the EC contributed to decentralised strengthening of the health system with the HSSP programme, and the PEFAM and the V/SYSIM programmes. They contributed to accountability and transparency of the health system in Zambia. The whole process is also based on regular budgeting and reporting on health indicator development.

**I-512** The EC is a major player in supporting PFM in Zambia. The EC supports PFM through its 9<sup>th</sup> EDF 'EC Support to the Public Expenditure Management and Financial Accountability (PEMFA) Reform Programme' composed of EUR 15.5 million budget support and EUR 42.5 million complementary support (period 2006-2012).<sup>266</sup> In November 2003, GRZ with the support of a number of co-operating partners led by the World Bank completed a comprehensive review of the system for public financial management which was summarised in the PEMFA Report. The conclusion in the PEMFA Report is that, despite recent progress such as MTEF and ABB, there is still considerable room for improvement in particular in areas related to budget execution, financial reporting, audits and procurement.

---

<sup>265</sup> Ibid. p.150

<sup>266</sup> Agreement N°94221ZA, EC Support to the Public Expenditure Management and Financial Accountability (PEMFA) Reform Programme (EC - PEMFA Support Programme), ZA/003105, EDF IX

Through SAP V/SYSMIN,<sup>267</sup> the EC financed technical assistance to the Government in the implementation of the "Matrix of Corrective Measures" as well as in the preparation of the MTEF and the Activity Based Budget (ABB). The EC also provided technical assistance to the Government for the preparation of the PRSP and poverty related indicators as well as training programmes. Under the on-going PRBS 01, an amount of GBP 7 million has been allocated for capacity building activities related to direct budget support, namely EUR 2.5 million for PEMFA; GBP 4 million for PRSP monitoring, including specific support to the Ministries of Education and Health; GBP 0.25 million for transparency and visibility, including Parliament oversight; and GBP 0.25 million for audit and evaluation. Other Cooperating Partners very active in this area are the IMF, WB, DFID, NW, SW and NW.

Evaluations during the 1990s confirmed the relevance of this support, and pointed to the need for close monitoring of, and continued support for, improvements in public finances. The Poverty Reduction Budget Support (PRBS I 2004-2006, EUR 117 million) aimed to support the implementation of the PRSP, whilst contributing to improved macroeconomic stability and focusing on Public Finance Management (PFM) reform. To mitigate the perceived (fiduciary) risk associated with a low starting point on PFM, the programme was based on a very large variable component (over 90% of total), with 60% linked to PFM indicators.<sup>268</sup>

The specific objectives of the PRBS II (2007-2008) are reflected in (i) continued need for macroeconomic stability to sustain broad-based economic growth; (ii) further support in service delivery improvements, especially health and education (priority areas of the FNPD); and (iii) continued strengthening of PFM.<sup>269</sup>

The overall objective of the PEMFA programme is to improve efficiency, effectiveness and accountability in the management and utilisation of public financial resources to support the implementation of Zambia's Poverty Reduction Strategy (PRS), National Development Plan (NDP). PEMFA should contribute to an improved and strengthened PFM system ensuring that public resources are effectively and efficiently channelled to priority areas in accordance with the NDP priorities.

The 'PFM Annual Monitoring Report' (01/2009-10/2010) states that it is recognised that not enough has been done to tackle the pervasive culture of corruption in public life. Special concern is given to the mismanagement in the Road and Health sectors. The most significant recent case of alleged corruption relate to the Health sector. A whistle-blower alerted the Anti-Corruption Commission (ACC) in 2009 to the embezzlement by top Government officials of over USD 2 million from the Ministry of Health. This led to the suspension of Dutch and Swedish bilateral aid in the sector. Following investigations from the OAG, the Government elaborated a roadmap to improve audit and procurement systems in audit and stores in various departments of the Ministry. The Action Plan approved by Government and CPs in 2009 is currently being implemented and donors' funds have been reimbursed in June 2010.

The GBS-III MDG-Contract's (2009-2014) expected result is: "The EC support will contribute to improved public finance management, enhanced service delivery in the social sectors, and the promotion of structural reforms that enable job creation and pro-poor growth." The general condition for tranche release is the satisfactory progress in the implementation of Zambia's PFM reform (Sources of verification are: PEMFA reports, Joint Assessment Report (PRBS Review), PEFA reviews, ad hoc PERs, Quarterly Expenditure Reports, Minutes Budget Execution working Group, Dialogue with GRZ Joint Assessment Report (PRBS Review), strategy). The indicator for measurement is the proportion of local authorities using new finance and audit procedures for paying the tranches.<sup>270</sup>

The Joint Evaluation of the General Budget Support concludes that the quality of policy processes, especially related to transparent and accountable, public financial management in Zambia is still low due to capacity shortages, coordination problems and several political challenges.<sup>271</sup>

**I-513** The institutional reform of the health sector embodied in decentralisation, de-linkage and restructuring of the Ministry of Health will produce a more efficient, manageable and accountable system of health service delivery. The Central Board of Health is the major institution supporting and

<sup>267</sup> Agreement No 6322/ZA, Structural Adjustment and Sysmin Support Programme (SAF V / SYSMIN) ZAI7200/006, EDF VIII

<sup>268</sup> Agreement N° 91141ZA, Poverty Reduction Budget Support (2004-2006) ZA/003103, EDF IX

<sup>269</sup> Agreement/Vo.9588/ZA, Poverty Reduction Budget Support Programme II 2007-2008 (PRBS II) ZA/001106, EDF IX

<sup>270</sup> Agreement N° ZM FED/2008/020-949, Millennium Development Goals Contract (MDG-C) for Zambia 2009-2014 (ZA/005/08), EDF X

<sup>271</sup> Evaluation of budget support in Zambia, Synthesis report (draft), 1 April 2011, p.138



overseeing the decentralisation process and has taken over most of the functions carried out by the Health Reforms Implementation Team. Some of the instruments to support and monitor districts are already drafted; others are still to be introduced. Meanwhile the decentralisation process is well underway and the financial management system is in place although the capacity of some districts, while the de-linkage process is unfinished, remains weak. The introduction of autonomous local management boards is intended to counteract the constraints of an entrenched bureaucracy although whilst the National Health Services Act gave legal status to the boards it did not go far enough and revisions are necessary.

We found that the EC supported the Ministry of Health in the decentralising efforts with the Health Sector Support Programme (HSSP) (period 1999-2002).<sup>272</sup> The purpose of this programme was to improve the management, accountability and performance of districts in their delivery of health services to the Zambian population. The project is evaluated as being successful with constraints such as coordination between the CBoH and MoH, no precise monitoring information available, some misuse of money on district level, beside others. The effectiveness of the programme is more efficient on district than on national level<sup>273</sup>

Insofar the EC V/SYMIN and the PEMFA programmes contributed to decentralized capacity building to strengthen health policy capabilities at provincial, district, and local levels cannot be assessed.

### 5.6.1.2 Resume of the JC

The EC is a major player in supporting PFM in Zambia through the PEMFA programme and the V/SYMIN programme. During the early period of this evaluation the EC committed support with the HSSP programme for the decentralisation process through strengthening the district health services, and their accountability. One can thoroughly conclude that those programmes contributed to the overall health policy strategy process and documentation. Corruption remains a problem in all levels.

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

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

#### 5.6.2.1 Findings

**I-521** As outlined above (JC 51) the EC contributed to the overall process of accountability and transparency of the health system. Corruption, in particular in the MoH, and questionable PFM practices in certain line Ministries remain as a problem.<sup>274</sup>

On the policy front, the Delegation continued to play a very active role in the group of Cooperating Partners which followed-up on the dialogue with GRZ initiated in the second part of 2009, notably on Health and Roads, and more generally with the MoFNP on the preparations for the 1<sup>st</sup> PRBS review.<sup>275</sup>

The EC V/SYMIN and the PEMFA programmes are essential programmes in tackling these problems.

**I-522** See I-512.

**I-523** PEMFA was also focusing in 2009 on the implementation of the Integrated Financial Management Information System (IFMIS), on the finalisation of the Procurement Reforms and the enhancement of the internal control and audit system. The progress is reported as following in 2010: The introduction of a new Procurement Law and the forthcoming Procurement Regulations have an impact on the transparency and effectiveness in the use of public resources, even though capacity building is needed at ministries' level to fully implement the new provisions. IFMIS has been put back on track, and the benefits of such a system, in terms of reporting, accounting and commitment control,

---

<sup>272</sup> Agreement No 60651ZA, Health Sector Support Programme, ZAI70241000, EDF VIII

<sup>273</sup> Monitoring Report ROM MR-00047.01 - 27/10/00, and MR-00047.02 – 06/12/01

<sup>274</sup> EAMR 01/2011

<sup>275</sup> EAMR 07/2010



should be visible in the near future. The GRZ has informed in 2010 CPs that Government is in the process of developing a PEMFA successor programme that will focus on few critical areas of PFM, namely IFMIS implementation, Treasury and Cash Management, Internal Audit, Procurement Reforms, Review/Enactment of laws relating to PFM, strengthening M&E.<sup>276</sup>

#### **5.6.2.2 Resume of the JC**

The EC V/SYMIN and the EC PEMFA programmes are essential programmes in tackling these problems. However, corruption remains a problem. The conclusion in the PEMFA Report is that, despite recent progress such as MTEF and ABB, there is still considerable room for improvement in particular in areas related to budget execution, financial reporting, audits and procurement.

---

<sup>276</sup> PFM Annual Monitoring Report, ZAMBIA, January 2009 to October 2010

## 5.7 Annex

### 5.7.1 Key documentation used for the analysis

#### 5.7.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluation</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
D-014-062 Health Sector Support	ok		MR 1 and 2		
D-018559- Retention for Human Resources for Health	ok			<ul style="list-style-type: none"> <li>• Disbursement note 1<sup>st</sup> tranche</li> <li>• Assessment for the disbursement of the 1stTranche</li> <li>• Assessment for the disbursement of the 2nd Tranche</li> <li>• Assessment EUD on variable tranche 2008</li> <li>Assessment EUD on variable tranche 3rd 2008</li> </ul>	
D-020950 Supporting Public health service 2009				<ul style="list-style-type: none"> <li>• JAR 2007, 2008,2009</li> <li>• PAF 2008,2009, 2010</li> <li>• PFM 2009</li> <li>• Progress report 2008</li> <li>• MTR 2008</li> <li>• Assessment for disbursement 1<sup>st</sup> and second tranche</li> </ul>	
C-65311_ Integration HIV-AIDs, STD intervention s			ROM	Interim report 2007	Final report
C-226017 Strengthening the inclusion of CSO_HIV- AIDS				Mission report	
Strengthening tuberculosis, AIDS and Malaria prevention programmes (STAMPP)			3MR		
D-13524 Strengthening of Zambian Safe blood transfusion programme			1MR		
<b>GBS</b>					
GBS D- 015-065 Saf v - sysmin	ok				
D- 016-366 PRBS 2003-2006	ok				audit
D-0185-69S PRBS II	ok			<ul style="list-style-type: none"> <li>• Request for disbursement</li> <li>• JAR 2007, 2008,2009</li> <li>• PFM 2008,2009, 2010</li> </ul>	
D-020-949-GBS PRBS III – MDG contract	ok				

**5.7.1.2 EC documentation on the health sector in the country**

<i>Source</i>	<i>Explored</i>
CSE	available
EAMR	available
Country note from old health eval	available
Paris Declaration	Country evaluation phase 1 and 2, thematic case study on untied aid
Danida Joint Evaluation	available
Joint Budget support evaluation Zambia – draft synthesis report, April 2011	available

**5.7.1.3 Other sources**

10th EDF Zambia CSP. Supporting public health service delivery in Zambia. Sector Policy Support Programme:

2007 Health Sector Joint Annual Review 2009-2014, (ZA/005/08), EDF X.

Agreement N° 91141ZA, Poverty Reduction Budget Support (2004-2006), ZA/003103, EDF IX

Agreement N° ZM FED/2008/020-949, Millennium Development Goals Contract (MDG-C) for Zambia

Agreement N°94221ZA, EC Support to the Public Expenditure Management and Financial Accountability (PEMFA) Reform Programme (EC - PEMFA Support Programme), ZA/003105, EDF IX

Agreement No 60651ZA, Health Sector Support Programme, ZAI70241000, EDF VIII

Agreement No 6322/ZA, Structural Adjustment and Sysmin Support Programme (SAF V / SYSMIN) ZAI7200/006, EDF VIII

Agreement No. 95851ZA, Retention of Human Resources for Health Sector ZAI70241001, EDF IX, May 2003

Agreement No.95881ZA, Poverty Reduction Budget Support Programme II 2007-2008 (PRBS II), ZA/001106, EDF IX

AIDCO/C1/AR D(2008)19272, p.6

Assessment for the disbursement of the 2nd Tranche – Financing Agreement: FED/2008/020-950, Supporting Public Health Service Delivery in Zambia 2009 – 2011, (May 2010).

Central Statistical Office (CSO), Ministry of Health (MOH), Tropical Diseases Research Centre (TDRC),

Country Health System Fact Sheet 2006, Zambia

EAMR 01/2011

EAMR 07/2010

Health Statistical Bulletin 2004

HO Country Office Zambia, Annual Report 2008, [www.afro.who.int/index.php?](http://www.afro.who.int/index.php?) p.8

Human Resources for Health - Country Profile, Zambia, Sep 2010, [http://www.hrh-observatory.afro.who.int/images/Document\\_Centre/zambia\\_hrh\\_country\\_profile.pdf](http://www.hrh-observatory.afro.who.int/images/Document_Centre/zambia_hrh_country_profile.pdf)

J Campbell, and M Caffrey. 2009. Zambia: Taking forward action on Human Resources for Health with DFID/OGAC and other partners. P.30, [http://www.who.int/workforcealliance/knowledge/publications/partner/tfa\\_zambia.pdf](http://www.who.int/workforcealliance/knowledge/publications/partner/tfa_zambia.pdf)

J Chibuye. 2010. Assessing the Impact of Health Financing Mechanism in Zambia, <http://www.search4dev.nl/document/192414>, p.26

Ministry of Health 2011 Action Plan, January 2011, [www.moh.gov.zm/](http://www.moh.gov.zm/)

MoH Joint Annual Review 2008

MoH. 2005. National Health Strategic Plan 2006-10.

Monitoring Report ROM MR-00047.01 - 27/10/00, and MR-00047.02 – 06/12/01

PFM Annual Monitoring Report, ZAMBIA, January 2009 to October 2010

Report of the Mid-Term Review of the Zambia National Health Strategic Plan NHSP IV, 2006-2010, 2008.

The National Food and Nutrition Policy, p.13, 2007 Data from Zambia NDHS

University of Zambia, and Macro International Inc. 2009. Zambia Demographic and Health Survey 2007.

WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>  
Zambia DHS 2007.

**Weblinks**

[http://www.cenfri.org/documents/cost%20of%20health/Terms%20of%20reference\\_Zambian%20health%20insurance\\_26%2010%202009\\_final.pdf](http://www.cenfri.org/documents/cost%20of%20health/Terms%20of%20reference_Zambian%20health%20insurance_26%2010%202009_final.pdf)

<http://www.equinetafrica.org/bibl/docs/Dis57FINchitah.pdf>

[http://www.moh.gov.zm/index.php/downloads-portal/cat\\_view/12-reports](http://www.moh.gov.zm/index.php/downloads-portal/cat_view/12-reports)

<http://www.tradingeconomics.com/zambia/out-of-pocket-health-expenditure-percent-of-private-expenditure-on-health-wb-data.html>

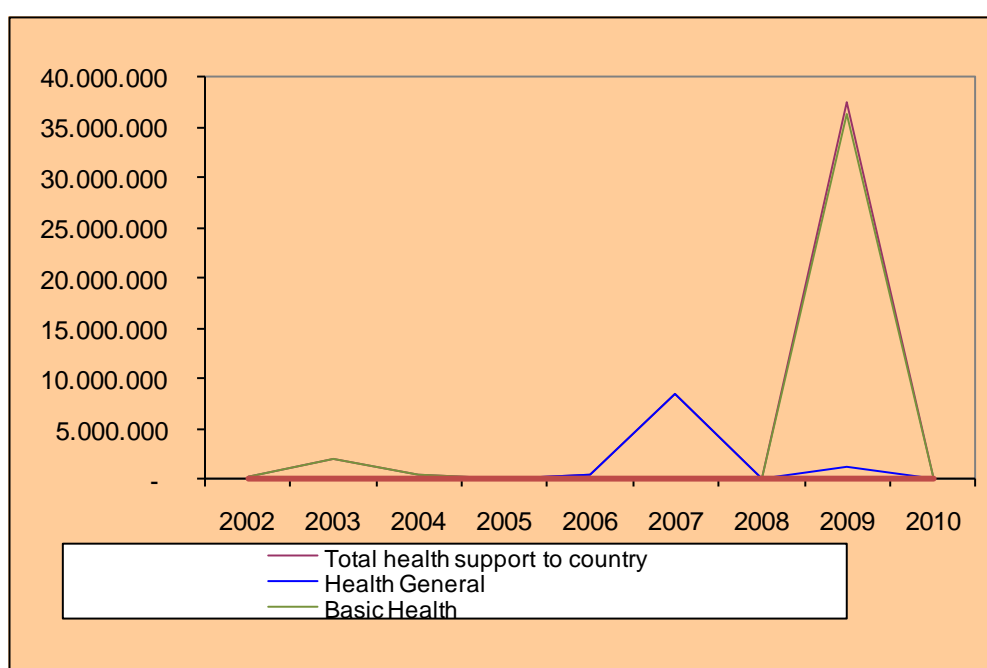
[http://www.who.int/nha/country/zmb/Zambia\\_NH\\_Strategic\\_plan,2006-2010%20.pdf](http://www.who.int/nha/country/zmb/Zambia_NH_Strategic_plan,2006-2010%20.pdf)

[http://www.who.int/nha/country/zmb/Zambia\\_NH\\_Strategic\\_plan,2006-2010%20.pdf](http://www.who.int/nha/country/zmb/Zambia_NH_Strategic_plan,2006-2010%20.pdf)

**5.7.2 EU funds between 2002-2010 –detailed listing**

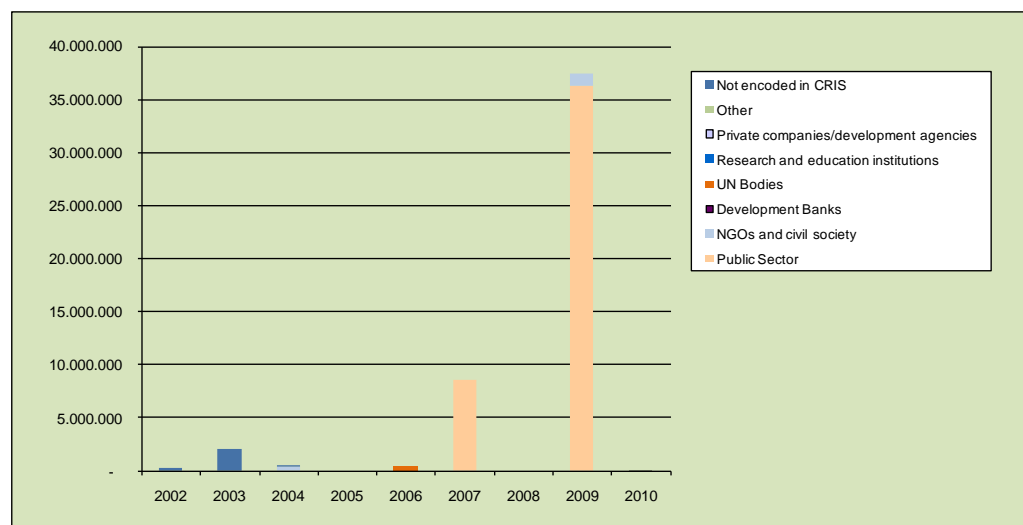
**5.7.2.1 Per Subsector**

Year	Total health support to country	Health General	Basic Health	SRH
2002	249.056	-	249.056	-
2003	2.074.767	-	2.074.767	-
2004	476.782	-	476.782	-
2005	151.502	129.822	21.680	-
2006	400.000	400.000	-	-
2007	8.571.450	8.571.450	-	-
2008	-	-	-	-
2009	37.489.937	1.267.437	36.222.500	-
2010	133.479	133.479	-	-
<b>Total</b>	<b>49.546.972</b>	<b>10.502.187</b>	<b>39.044.785</b>	-



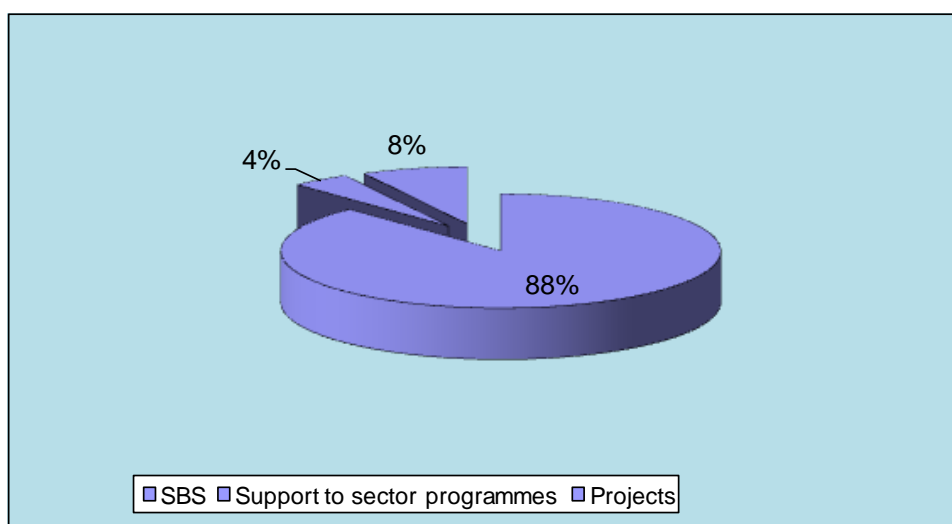
5.7.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	-	-	249.056	249.056
2003	-	-	-	-	-	-	-	2.074.767	2.074.767
2004	-	452.081	-	-	-	-	-	24.701	476.782
2005	-	-	-	-	-	-	-	151.502	151.502
2006	-	-	-	400.000	-	-	-	-	400.000
2007	8.571.450	-	-	-	-	-	-	-	8.571.450
2008	-	-	-	-	-	-	-	-	0
2009	36.267.437	1.222.500	-	-	-	-	-	-	37.489.937
2010	-	-	-	-	-	133.479	-	-	133.479
<b>Total</b>	<b>44.838.887</b>	<b>1.674.581</b>	<b>0</b>	<b>400.000</b>	<b>0</b>	<b>133.479</b>	<b>0</b>	<b>2.500.026</b>	<b>49.546.972</b>



5.7.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (already included in SSP)	Total health support	GBS related to health
2002	-	-	249.056	-	<b>249.056</b>	15.000.000
2003	-	2.074.767	-	2.074.767	<b>2.074.767</b>	-
2004	-	24.701	452.081	24.701	<b>476.782</b>	115.190.000
2005	-	21.680	129.822	21.680	<b>151.502</b>	122.400
2006	-	-	400.000	-	<b>400.000</b>	363.760
2007	8.571.450	-	-	-	<b>8.571.450</b>	60.000.000
2008	-	-	-	-	-	250.000
2009	35.000.000	-	2.489.937	-	<b>37.489.937</b>	256.517.437
2010	-	-	133.479	-	<b>133.479</b>	-
<b>Total</b>	<b>43.571.450</b>	<b>2.121.148</b>	<b>3.854.375</b>	<b>2.121.148</b>	<b>49.546.972</b>	-



### 5.7.3 Overview of funds committed to the country's health sector between 2002-2010 (decisions)

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Committed amount for the intervention</i>
HEALTH SECTOR SUPP. PROGR. (CONTRIB. TO POOLED DONOR FUNDS) SUPPORT OF DISTRICT BASKET (BASKET FUND)	FED/1998/ 014-062	1998	EUR 2,121,148
B76000 - PVD	ONG-PVD/2003/004-562	2003	EUR 452,081
TECHNICAL COOPERATION FACILITY	FED/2004/016-586	2004	EUR 529,822
Retention for Human Resources for Health	FED/2006/018-559	2006	EUR 8,571,450
PRBS 02 (2007-2008)	FED/2006/018-569	2006	EUR 1,267,437
SUPPORTING PUBLIC HEALTH SERVICE DELIVERY IN ZAMBIA CRIS REF. 2008/198-54	FED/2008/020-950	2008	EUR 35,000,000
Global commitment for in-country calls for proposals -Objective 1- PVD projects - Non State Actors - AAP 2008	DCI-NSAPVD/2008/020-081	2008	EUR 1,222,500
Technical Cooperation Facility (TCF) III	FED/2009/021-433	2009	EUR 133,479
	(blank)	(blank)	EUR 249,056
<b>Grand Total</b>			<b>EUR 49,546,972</b>



## 5.7.4 Overview of main programmes/funds and sectors

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Contract title</i>	<i>Contract number</i>	<i>Contract year</i>	<i>Implementation starting date</i>	<i>Closing Date</i>	<i>Contracting party</i>	<i>Total per contract</i>
<b>SUPPORTING PUBLIC HEALTH SERVICE DELIVERY IN ZAMBIA CRIS REF. 2008/198-54</b>	FED/2008/020-950	2008	Supporting public health service delivery in Zambia	212105	2009	31.07.2009		REPUBLIC OF ZAMBIA	EUR 35,000,000
<b>PRBS 02 (2007-2008)</b>	FED/2006/018-569	2006	P.E.1 - Health Management Information System (HMIS)	223811	2009	Implementation		REPUBLIC OF ZAMBIA	EUR 1,267,437
<b>Retention for Human Resources for Health</b>	FED/2006/018-559	2006	RETENTION OF HUMAN RESOURCES FOR HEALTH SECTOR	196636	2007	01.12.2006	23.09.2009	REPUBLIC OF ZAMBIA	EUR 8,571,450
<b>HEALTH SECTOR SUPP. (CONTRIB. TO POOLED FUNDS) SUPPORT OF BASKET (BASKET FUND)</b>	FED/1998/ 014-062	1998	CBOH 3RD TRANCHE HBF; ZMK 7,013,363,455.35	175999	2003	29.01.2003	02.06.2005		EUR 1,390,073
			CBOH SPECIAL TRANCHE HBF FOR FOOD CRISIS AREAS; ZMK 3,454,500,000.00	176000	2003	29.01.2003	02.06.2005		EUR 684,694
			HEALTH SECTOR SUPPORT PROG. EU BASKET FUND	176002	2005	29.05.2005	02.08.2005		EUR 21,680
			MID TERM REVIEW OF THE NATIONAL HEALTH STRATEGIC PLAN; BASKET FUND; ZMK 134,286,750.00	176001	2004	26.09.2003	29.11.2004		EUR 4,701

## 5.7.5 Details of programmes

### 5.7.5.1 Intervention no 1

**Title:** SUPPORTING PUBLIC HEALTH SERVICE DELIVERY IN ZAMBIA CRIS REF. 2008/198-54)

**Budget:** EUR 35,000,000

**Start and end date:** 2009 -

**Objectives and expected results:**

**Overall objective:**

- Contribute to the overall goal of the National Health Strategic Plan 2006-2011(NHSP)
- "To further improve health service delivery in order to significantly contribute to the attainment of the health Millennium Development Goals and national health priorities"

**Specific objective:**

- Significantly contribute to the expansion of integrated public
- Health services in the drive to attain the MDGs as planned in the Fifth Zambian National Development Plan (FNDP) 2006-2010, and as detailed in the health sector strategic plans (NHSP)

**Expected results:**

The Sector Policy Support Programme shares the priorities stated in the NHSP 2006-2011; the expected results of the SPSP, aligned to these same plans, include public health outcomes as well as systems strengthening in crucial areas such as HR, M&E, planning/budgeting and procurement, all through the meta-outcome of alignment and harmonisation of external support with continued consultative sector dialogue among stakeholders.

**A Human Resource Crisis**

- Human Resources: To provide a well motivated, committed and skilled professional workforce who will deliver cost effective quality health care services as close to the family as possible.

**B Public Health Priorities**

- *Integrated Child Health and Nutrition:* To reduce Under-5 Mortality Ratio (MR) by 20%, from the current level of 168 per 1,000 live births to 134 by 2011, and significantly improve nutrition
- *Integrated Reproductive Health:* To increase access to integrated reproductive health and family planning services that reduce the Maternal Mortality Ratio (MMR) by one quarter, from 729 per 100,000 live births to 547 by 2011
- *HIV/AIDS, STIs and Blood Safety:* To halt and begin to reduce the spread of HIV/AIDS and STIs by increasing access to quality HIV/AIDS, STI and blood safety interventions
- *Tuberculosis (TB):* To halt and begin to reduce the spread of TB through effective interventions
- *Malaria:* To halt and reduce the incidence of malaria by 75% and mortality due to malaria in children under five by 20%
- *Epidemics Control and Public Health Surveillance:* To significantly improve public health surveillance and control of epidemics, so as to reduce morbidity and mortality associated with epidemics
- *Environmental Health and Food Safety:* To promote and improve hygiene and universal access to safe and adequate water, food safety and acceptable sanitation, with the aim of reducing the incidence of water and food borne diseases

**C Support Systems Priorities**

- *Essential Drugs and Medical Supplies:* To ensure availability of adequate, quality, efficacious, safe and affordable essential drugs and medical supplies at all levels, through effective procurement management and cooperation with pharmaceutical companies
- *Infrastructure and Equipment (Infrastructure, Medical Equipment, Laboratory Support and Medical Imaging):* To significantly improve on the availability, distribution and condition of essential infrastructure and equipment so as to improve equity of access to essential health services
- *Systems strengthening: (M&E, HMIS, FAMS, Procurement and R&D):* To strengthen existing operational systems, financing mechanisms and governance arrangements for efficient and effective delivery of health services

- *Health Systems Governance: (Governance and Health Care Financing):* To provide a comprehensive policy and legal framework and systems for effective coordination, implementation and monitoring of health services.

### **5.7.5.2 Intervention no 2**

**Title:** Retention for Human Resources for Health

**Budget:** EUR 8,571,450

**Start and end date:** 01.12.2006 - 23.09.2009

**Objectives and expected results:** Source: FED/2006/018-559

#### **Overall objective:**

The general objective should derive from the National Health Strategic Plan 2006-2010 which articulates it in the following manner:

- Vision: Equity of access to assured quality, cost-effective and affordable health services as close to the family as possible.
- To further improve health service delivery in order to significantly contribute to the attainment of the health Millennium Development Goals and national health priorities.

#### **Specific objective;**

- To provide cost effective quality health services as close to the family as possible in order to ensure equity of access in health service delivery and contribute to the human and socio-economic development of the nation.

#### **Expected results:**

*(Sector support programmes, especially when framed within existing sector plans and sector dialogue mechanisms, should adopt existing logical frameworks, in order to adhere to one single harmonised M&E framework and joint assessments. The results and main activities of the Zambia Human Resources for Health Strategic Plan 2006-2010 are therefore directly taken from the Plan, as follows (attached IS a logframe with more detailed activities, Indicators and Means of verification)):*

1. An effective, ongoing and coordinated approach to planning across the sector;
2. Increased numbers of equitably distributed staff;
3. Improved performance of health workers;
4. Improved human resource planning, management and development systems at all levels.

#### **Activities:**

##### **1. An effective, ongoing and coordinated approach to planning across the sector**

- Ensure human resource planning is coordinated across the health sector and is based on the best available data
- Develop monitoring and evaluation systems to track progress of the implementation of the HRH Plan, make adjustments/ modifications and inform further development of the plan

##### **2. Increased numbers of equitably distributed staff**

- Increasing training output by expanding the number of training places available
- Increase the number of applicants for training by widening participation
- Strengthen in-service training system
- Increase numbers of skilled health workers in post
- Improve the deployment and retention of health workers

##### **3. Improved performance of health workers**

- Improve the quality of pre-service training
- Improve the quality and cost effectiveness of in-service training
- Improve performance management capacity and tools
- Improve occupational health and work place policies

##### **4. Improved human resource planning, management and development systems at all levels**

- Strengthen HR planning, management and development capacity at all levels, using long and short-term TA following a review of the HR function

### 5.7.5.3 Intervention no 3

**Title:** HEALTH SECTOR SUPP. PROGR. (CONTRIB. TO POOLED DONOR FUNDS) SUPPORT OF DISTRICT BASKET (BASKET FUND)

**Budget:** EUR 2,121,148 (only activities after 1998 are taken into account)

**Start and end date:** 1998

**Objectives and expected results:**

**Overall objective:**

Since this intervention falls within a more comprehensive integrated sector support project which is embodied in the Health Sector Reforms, its overall objective is that of the entire sector programme namely

- To improve access to, and quality of, a national package of essential health services in a decentralised health care delivery system with long-term improvements in the health status of the Zambian population realised.
- To improve the management, accountability and performance of districts in their delivery of health services to the Zambian population.

**Expected results:**

- Better management of available resources through essential packages and improved financial and performance accountability at district level.
- Re-direction of funding from funding through centrally managed projects towards funding for activities defined by communities and districts, and from the higher to the more cost-effective lower levels of the referral system.
- Adherence to the defined priority health concerns identified in the MOH strategic plan.
- Successful implementation of the five year rolling investment programme and annual budget for recurrent costs and grants.

**Activities:**

To produce those results, the programme will involve the

- support to the implementation of the Strategic Plan and
- the decentralisation of the health system, by directing funds into a common basket through which support for the recurrent budget is to be channelled to districts (using a single set of planning, budgeting, disbursement, accounting and auditing mechanisms).

It also implies a continuous dialogue with GRZ and attendance at basket Steering Committee.

### 5.7.5.4 Intervention no 4

**Title:** PRBS 02 (2007-2008), Health Management Information System (HMIS):

**Budget:** EUR 1,267,437

**Start and end date:** 2009

**Objectives and expected results:**

**Overall objective:**

To contribute to improved monitoring of poverty reduction in Zambia with emphasis on the Millennium Development Goals.

**Specific objective:**

Further strengthen the HMIS capacity to monitor the health sector performance in Zambia, particularly at district level

**Expected results:**

- Revised HMIS that is integrated, flexible and responsive to the needs of all users
- Capacity of Staff developed to ensure sustainable functioning HMIS
- Strengthened ICT infrastructure of the HMIS

**Activities:**

**Related to:** Revised HMIS that is integrated, flexible and responsive to the needs of all users

Roll-out of the updated DHIS 1.4 to all districts

Set up a modern, integrated Hospital HMIS database that is flexible, platform independent, user-friendly and able to handle all necessary data sources.

Workshop to develop and agree minimum Hospital HMIS

Pilot the Hospital HMIS tools in selected Hospitals

Review and finalise Hospital HMIS tools

Roll-out of the Hospital HMIS tools to all Hospitals

Set up a modern, integrated Community HMIS database that is flexible, platform independent, user-friendly and able to handle all necessary data sources.

Consultancy – Set up integrated Community HMIS database – flexible and user-friendly

**Related to: Capacity of Staff developed to ensure sustainable functioning HMIS**

Develop basic training package specific to HMIS data management Tool

Technical Support on DHIS 1.4 data for Information Officers

Training workshop for all DHIOs and DMS on the updated HMIS 1.4

Institutionalisation of the HMIS in-service curricula

**Related to: Strengthen ICT infrastructure of the HMIS**

Finalise PA indicators and Standard Reports in DHIS

Establish MoH HMIS help desk and hotline

Consultancy to set-up HMIS Help desk and hotline and provide short to medium term support

Advanced DHIS training for HMIS Unit including MOH ICT programmers in South Africa

Annual Revision workshop of key performance indicators and Minimum Data set 2010

**5.7.6 Details of GBS programmes with health related indicators.****5.7.6.1 Intervention no 5**

**Title:** PRBS 02 (2007-2008),

**Budget:** EUR 10,000,000

**Start and end date:** 2006

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

To contribute to the reduction of poverty by supporting the implementation of the FNDP, linking budget support to outcomes

**Specific objective:**

Continued need for macro-economic stability to sustain broad-based economic growth

Further support in service delivery improvements, especially **health and education** (priority areas of the FNDP) continued strengthening of PFM

**Expected results:**

As regards to the first objective, the proposed PRBS02 will contribute to closing the identified external and internal financing gaps under the FNDPI

Concerning the second objective, the support will contribute to the resources available for expenditures in the priority areas and create **clear incentives via outcome-based indicators, particularly in health and education**

As regards the third objective, the funds will continue to strengthen budget management and enhance incentives for reform by focussing on outcomes of PFM. Support to a more comprehensive reform programme of PFM is provided through the Public Expenditure Management and Financial Accountability (PEMF A) programme.

**Capacity building funds** will accompany the PRBS02 operation, and will focus on strengthening data quality, as well as civil society involvement in assessing the impact of PRBS operations

## 6 Annex 10: Country case study Egypt

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

### Country Case study

### EGYPT





## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>187</b>
1.1.1	Country context of EC support.....	187
1.1.2	EU funds between 2002-2010 .....	188
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>189</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	189
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	190
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	193
1.2.4	JC 14 Increased or maintained quality of service provision due to EC support .....	195
<b>1.3</b>	<b>EQ2- Affordability of health: to what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>196</b>
1.3.1	JC 21 The cost of basic health care services are reduced for households due to EC support .....	196
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC .....	198
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC .....	198
1.3.4	JC 24 Global research partnerships to develop new treatments and medicines relevant to poor countries supported by the EC .....	199
<b>1.4</b>	<b>EQ3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>199</b>
1.4.1	JC 31 Increase in availability of primary health care facilities .....	199
1.4.2	JC 32 Increase in availability of secondary health care facilities.....	200
<b>1.5</b>	<b>EQ4- Health service utilisation related to MCH: To what extent has EC support to health contributed to improving health service utilisation related to MCH?.....</b>	<b>203</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	203
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	204
1.5.3	JC 43 Children better protected from key health threats as a result of EC support .....	205
<b>1.6</b>	<b>EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?.....</b>	<b>207</b>
1.6.1	JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	207
1.6.2	JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.....	210
<b>1.7</b>	<b>Annex .....</b>	<b>212</b>
1.7.1	Key documentation used for the analysis .....	212
1.7.2	EU funds between 2002-2010 –detailed listing: .....	214
1.7.3	Overview of funds committed to the country’s health sector .....	216
1.7.4	Overview of main programmes/funds and sectors .....	217
1.7.5	Description of main EC intervention .....	218

**List of Figures**

Figure 1:	Client Satisfaction with public and private health services, Egypt 2005.....	196
Figure 2:	Beds per 1,000 population, Egypt: 2003 .....	201

**List of Tables**

Table 1:	Overview of funds committed to the country's health sector, Egypt.....	189
Table 2:	Distribution of health facilities across Egypt, 200 <sup>5</sup> .....	191
Table 3:	Health workforce, Egypt: 2001-2005 .....	193
Table 4:	Percentage of caesarean deliveries by background characteristics .....	202
Table 5	Children malnutrition, children aged <5 years, Egypt; 1978-2008.....	204
Table 6	Immunisation coverage among 1-year-old, Egypt: 1980-2009.....	205
Table 7:	Treatment of children under age five during diarrhoea, Egypt: 2005 and 2008 .....	206
Table 8:	Treatment of children under age five during diarrhoea, Egypt: .....	207

## 6.1 Introduction

### 6.1.1 Country context of EC support

Egypt is one of the most populous countries in Africa and the Middle East. The great majority of its estimated 81 million people live along the banks of the Nile River. The large areas of the Sahara Desert are sparsely inhabited, causing challenges to service delivery. About half of Egypt's residents live in urban areas, with most spread across the densely populated centres of greater Cairo, Alexandria and other major cities in the Nile Delta. There is a significant welfare gap between Lower (Northern) Egypt and the disadvantaged Upper (Southern) region of Egypt.

The economy of Egypt is one of the most diversified in the Middle East, with sectors such as tourism, agriculture, industry and service at almost equal production levels. It has, nonetheless, been a chronic economic under-performer, characterised by rampant corruption, public-sector mismanagement, and over-regulation of the private sector to the profit of elites.

In early 2011, Egypt underwent a revolution, which resulted in the ousting of President Hosni Mubarak after nearly 30 years in power. Subsequent months have seen a bitter struggle between secular liberal forces, Islamic fundamentalists, and Mubarak-era nostalgists to consolidate power. The outcome is yet uncertain.

Despite its poor economic performance, social indicators have improved remarkably over the last decade and Egypt made significant progress towards achieving some of the United Nation's Millennium Development Goals (MDGs). Egypt achieved the MDG of halving the proportion of population living in extreme poverty in 2005 and the panel "Household Income, Expenditure and Consumption Survey" (HIECS) conducted in February 2008 based on the same households interviewed in February 2005, showed a reduction in the prevalence of poverty from 23% to about 20%. Gender disparities in education were reduced somewhat, though they remain high in the labour market, where women account only for 22% of the labour force. Progress in infant and under-five mortality rates reductions have also been remarkable. Between 1990 and 2010 these two measures declined by 50% and 56%, respectively. Nevertheless, significant disparities within regions, wealth status and gender remain. Trends in child nutrition, by contrast, have been negative and are a source of concern. Perhaps the most serious failure has been the failure to create jobs for the burgeoning ranks of Egypt's increasingly well-educated and internationally networked young persons.

The Delegation of the European Union to Egypt, officially opened in 1978, deals with the broad political and economic agenda between the EU and Egypt, and in particular plays a role in the implementation and monitoring of the European Neighbourhood Action Plan with Egypt.

The strategic framework for cooperation of the EU with Egypt is framed in the "Country Strategic Paper" (CSP) drafted under the "European Neighbourhood Partnership Instrument" (ENPI) for the period 2007-2013. One of the three strategic objectives relates to socio-economic sustainability of the development progress. A total of Euro 558 million was allocated to the 2007-2010 National Indicative Programme to support the three priorities. This marked the first time that the health sector is officially made focal sector in the EC cooperation strategy in Egypt.

Government strategies are reflected in the five-year National Development Plans (the current being for the period 2007-2012) and defined more closely in the Government priorities presented to Parliament. A "National Health Investment Plan" (NHIP) was endorsed by the Government of Egypt in 2007. According to the 1st Tranche Compliance Report of the Health Sector Policy Support Programme II, the main goal of this plan was to upgrade, based upon the Family Health Model, approximately 4,500 pre-selected existing Primary Health Care facilities.<sup>277</sup>

Egypt has committed itself to promote education and health services and to direct the subsidies to target the poor within a comprehensive social safety net.<sup>278</sup> The health policy of the last Presidential Election Program aimed at introducing a new vision for reforming the health insurance systems through a program of "health insurance for each citizen." Through its health sector reform programme, the government is committed to pursuing the family health model and increasing the number of family health units. In addition to the problems of a young population, however, the Ministry of Health and Population (MoHP) is also faced with the rising importance of chronic diseases (diabetes, heart conditions, etc.). Some of this is related to the fact that, while the Egyptian population is still young on average, the population in older age cohorts is rising. Some of it is also due to poor health behaviours

<sup>277</sup> Health Sector Policy Support Programme II, 1st Tranche Compliance Report, p.2

<sup>278</sup> <http://www.mop.gov.eg/english/sixth%20five%20year.html>

(e.g., diabetes is linked to obesity). The rise in chronic conditions strengthens the case for putting in place a sustainable health insurance system.

According to the Egyptian MoHP, the main impact of the Revolution on health policy has been to strengthen the inclusive, participatory approach to identifying priorities, as opposed to a technocratic one.

### **6.1.2 EU funds between 2002-2010**

As displayed in the Table 1 below, in 1998, the first EC Support to the Health Sector Reform Programme, a programme Support to Sector Programme (SSP) which was expected to end in 2005 and actually ended in 2007, was launched with a budget of EUR 110 million. In the event, less than half was actually committed. The project, implemented by the Egyptian government, was co-financed with the World Bank, with participation, as well, by USAID and the African Development Bank. The specific objectives were to improve the health status of the population in five Governorates (eventually reduced to two) through the establishment of a financially sustainable “Basic Benefit Package” (BBP) of necessary preventive, curative and public health services; and to strengthen the MoHP policy making, planning, monitoring and regulatory role, within a client-driven and decentralised operational framework. The BBP (apart from salaries, equipment, and maintenance, which remained under the state budget) was to be financed through a Family Health Fund. In general, the HSRP supported government’s move towards a family health model better suited to a country in which a large proportion of the population lives in poverty. There was a substantial infrastructure and equipment component. In general, though, as found by the December 2010 Egypt EC Country Strategy Evaluation (CSE), the early years of EC support to the social sector in Egypt tended to solidify the status quo, rather than dynamically advancing reform. The HSRP experienced major procurement delays, although there was a burst of progress in its final years.<sup>279</sup> As the CSE in 2010 noted, there was little Government commitment to reform at the time and the Project Management Unit approach, supported by heavy TA, promoted little Government ownership.

The follow-up Health Sector Policy Support Programme or HSPSP-I was launched in 12/2006 with Euro 88 million in EU support, and was expected to end by 12/2011 (initially, the end of the operational implementation phase of the HSPSP was 31<sup>st</sup> December 2009. Given the difficulties in achieving some benchmarks, it has been extended twice until 31<sup>st</sup> July 2011). This was the first Sector Budget Support (SBS) intervention in Egypt. Egypt continued reform in the health sector by further rolling out the family health model, while the EU continued providing substantial assistance to underpin the reform. There was special emphasis on reform of the Health Insurance Organization (HI) to increase coverage, adequacy, and financial sustainability of health care finance. This responded, in part, to comments made by evaluators of HSRP. The aim of the reform remained universal access, financial sustainability and enhanced quality of healthcare. The EC’s HSPSP-I programme had four components: A) Fiscal comprehensiveness transparency, sustainability; B) Sector wide health insurance system; C) Legal, regulatory and institutional framework; D) Quality based health care services based on the Integrated Family Health Model. Based on the Compliance Assessments related to release of the first and second tranches, there was substantial progress in policy reform at the MoHP in a broad range of areas, as well as demonstrable results at lower levels. The same story is told by EAMR reports. This evidence is presented in assessing the Indicators below. In general, though, as warned in the answer to EQ 6 of the December 2010 EC Country Strategy Evaluation, even by the time of the HSPSP, a general reform vision was only gradually taking form, and criteria were highly process-oriented, rather than focusing on the actual health outcomes that are the main concern of this EQ.

In 2009, the HSPSP II was launched (with an expected end date of 2012) aiming to improve access to and quality of public primary health care. This intervention focuses on improvement of the primary health care provider network which is the backbone of the health sector reform. Quality issues will be addressed by strengthening the facility accreditation system, an area in which EC support has already had some positive impact (see below).

Although the EC’s health programmes are large, the EC assistance accounts for less than 5% of Government of Egypt spending on health. The EC’s potential impact must therefore be seen in this context.

It is also to be noted, that until HSPSP-II, indicators in EC-financed project were process- or activity oriented, and provided little basis on which to assess actual impact on service delivery or health outcomes. For that reason, many of the conclusions here are tentative or indirect – EC technical

---

<sup>279</sup> EAMR July 2005, EAMR January 2007.

assistance and policy support almost certainly contributed to progress in health outcomes, but often we cannot be more specific.

Table 41: Overview of funds committed to the country's health sector, Egypt

Title of the intervention	Decision number	Decision starting year	Committed amount for the intervention
EC Support to the Health Sector Reform Programme (EGY/B7-4100/IB/98/1050)	MED/1998/004-295	1998	EUR 49,085,882
ALLOCATION GLOBALE MEDA 2005/2006	MED/2005/017-088	2005	EUR 90,162
Support to health sector reform	MED/2006/018-249	2006	EUR 87,690,294
Research, development and innovation	MED/2006/018-252	2006	EUR 755,790
ALLOCATION GLOBALE MEDA 2006/2007	MED/2006/018-255	2006	EUR 195,195
ALLOCATION GLOBALE ENPI COOPERATION SUD 2007	ENPI/2007/019-080	2007	EUR 127,658
HSPSP II-Health Sector Policy Support Programme II	ENPI/2009/020-494	2009	EUR 107,700,000
<b>Grand Total</b>			<b>EUR 245,644,981</b>

Source: CRIS database, Particip GmbH analysis

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

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

#### Indicators

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

#### 6.2.1.1 Findings per indicators

**I-111:** The 1971 Egyptian Constitution, in articles 16 and 17, obligates the State to provide health services and health insurance for its citizens.<sup>280</sup> Egypt has also ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1982, making the provision of this treaty part of the domestic legal system according to article 151 of the Constitution. The ICESCR protects the right to access to essential medicines under article 12(1). Consequently, the Egyptian government has an obligation to respect, protect and fulfil its obligations under the ICESCR including access to medicines.

Under Egypt's domestic law, Presidential Decree No. 242/1996 on the Regulation of the Ministry of Health and Population specifies the goals of the MoHP, from "preserving citizens' health" by means of "providing preventive and therapeutic health services" to "working towards improving the health of individuals."<sup>281</sup> The Decree also specifies the full range of the Ministry's mandate, which includes "working towards making medicines available and taking the necessary steps to ensure their quality and efficacy."

The Medicines Control Technical Committee (MCTC) establishes guidelines for provincial inspection services for drugs and medical devices. The National Organization for Drug Control and Research (NODCAR) represents the empowered national regulatory authority for quality control. The National Drug Policy (NDP) was formulated and issued in 2001 and is integrated into the overall National Health Policy. The national Essential Drug List (EDL) was approved in 1998. The drugs included in the EDL are quoted in generic terms, and are classified according to type of providers. The list of essential drugs needed for the basic package of services have to be made universally available.

<sup>280</sup> Art. 16, Egyptian Constitution: "The State shall provide cultural, social and health services, and shall make a special effort to ensure villages easy and regular access to them, to improve the villages' standard [of living]." Art. 17: "The State shall provide social and health insurance, and disability, unemployment and retirement benefits to all citizens, in accordance with the law."

<sup>281</sup> Presidential Decree 242/1996, the Official Gazette, Issue 30, 1 August 1996, quoted in: The TRIPS Agreement and Egypt's Responsibility to Protect the Right to Health, Right to Health Program Egyptian Initiative for Personal Rights, January 2005, p.22, [http://eipr.org/sites/default/files/reports/pdf/TripsReport\\_EIPR\\_2005\\_EN.pdf](http://eipr.org/sites/default/files/reports/pdf/TripsReport_EIPR_2005_EN.pdf)



Specific components and conditionalities regarding access to the essential drugs for the entire population have not been a key feature of EC support. However, while EC support in the health sector in Egypt has not directly focused on pharmaceuticals, by providing policy support to developing and rolling out the family health model, it has promoted more rational and equitable policy in the area (see, for example, the discussion of the next Indicator).

In the framework of the HSPSP, a new essential drug list for primary health care facilities that includes additional treatments for chronic diseases as diabetes has been developed.<sup>282</sup>

**I-112:** Several years into the evaluation period, a study on prices of 35 medicines in Egypt revealed that their availability was essentially 100%, even in public-sector pharmacies.<sup>283</sup> The study added, however, that the prices of medicines are high, making essential medicines unobtainable for many. Furthermore, there are large differences in the prices for the same medicine, depending on region and provider. Despite high prices, the consumption of pharmaceuticals in Egypt has been growing at about 10% per year.

Pharmaceuticals, as stated above, were not a key direct focus area for the EC. However, through its sector support and sector budget support interventions, the EC has consistently provided assistance for improved pharmaceuticals policy in the context of improving access to basic drugs in the context of the family health model and strengthened health system finance. Not surprising, actual impact on availability is impossible to ascertain in the complex context of TRIPs, income-related growth in demand, changes in the burden of disease (i.e., greater demand for drugs related to non-communicable disease and chronic conditions) the role of private sector, and the incentive structure for physicians (a substantial number of whom also have a financial interest in pharmacies). However, under the HSRP (1998-2005), the family health model in the pilot Governorates was supported by adapting the essential drugs list for primary health care facilities, promoting rational drug use at the Governorate and district level, and training staff in drug procurement and distribution. The HRSP specific objective that the health status of the population in a minimum of three Governorates be improved through the establishment of a financially sustainable BBP of necessary preventive, curative and public health services was achieved by 2005.<sup>284</sup> Access to essential medicines is part of the BBP, so indirectly, this is some evidence that EC support probably contributed to improvement in the Indicator. The design of an Essential Drug List for primary health care facilities was identified as a concrete achievement of the HSPSP.<sup>285</sup>

According to the report National Health Accounts<sup>286</sup>, spending on pharmaceuticals and private clinics accounted for half of all health spending in Egypt in 2007/08 (25.9% and 23.8%, respectively).

### 6.2.1.2 Resume of the JC

We addressed this JC based on two indicators, the first on the legal status of access to essential medicines and the second on availability of essential medicines. Access is ensured by law but, in fact, high prices put essential medicines out of the reach of many Egyptians. Consumption of medicines has grown rapidly and availability, as measured by the accepted WHO-HAI approach is good.

EC support to health sector reform promoted the family health model, in which universal access to medicines is a basic component, but most EC support in the pharmaceuticals area appears to have been indirect. Compliance Reports of the HSPSP identify significant contributions to advancing the availability of the Basic Benefit Package, improved health care finance, and promoted the family health model, and it is safe to assume that the EC has had a positive indirect impact on the pharmaceutical dimension of health care quality.

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

### Indicators

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

---

<sup>282</sup> EAMR-External Assistance Management Report 2009

<sup>283</sup> WHO/HAI Medicine Prices Project. Medicine in Egypt, Survey Report. The prices people have to pay for medicines in Egypt, July 2004, <http://www.docstoc.com/docs/43772776/THE-MEDICINES-IN-EGYPT>.

<sup>284</sup> MONITORING REPORT, EGYPT – EGY – EC Support to the Health Sector Reform, Programme in Egypt. MR-10134.03 – 20/06/05

<sup>285</sup> EAMR 7/2009

<sup>286</sup> United States Agency for International Development (2010): National Health Accounts 2007/2008 : Egypt Report, September 2010, p.13

- I-123 Increased proportion of health facilities with adequate budget for maintenance and recurrent expenditures

### 6.2.2.1 Findings per indicators

**I-121** The MoHP does not expect all facilities to offer all basic health services. For example, district and general hospitals do not routinely offer child immunisation services, but integrated hospitals do; mobile units rarely offer immunisation, but they offer family planning services, ante-natal care (ANC), and curative care; and health offices primarily offer child immunisation and family planning. Health offices are often located adjacent to hospitals, so higher-level services may be conveniently accessed, even if they are not in the same building or under the same manager. In total, 35% of facilities offer some level of each of the assessed basic child, maternal and reproductive health services. As expected, MCH/urban health units and rural health units are more likely to offer the package of assessed services (39% and 51%, respectively). NGO facilities rarely offer child immunisation or growth-monitoring services. Essentially all facilities have at least one physician assigned.

A new classification of primary health care units, based upon the Family Health Model (units and centres) has been endorsed by the MoHP. The National Investment Plan aims at modernising and standardising the PHC network upon these FHM national standards. According to the EU Delegation (a point to be repeated several times below) EU policy dialogue, technical assistance, and SBS played a decisive role in introducing the PHC-oriented family health model into Egyptian health policy.

Table 42: *Distribution of health facilities across Egypt, 2005*<sup>287</sup>

Health facilities	Number 2005
Rural health units	3,006
Rural health centres	268
Rural hospitals	323
Urban health centres	298
Maternal and children health centres	195
Health offices	338
District clinic	78
Total	4,506

Source: Central Administration of Integrated Health Care (CAIHC)

EC support under the HSRP (1998-2007) improved availability of primary health care infrastructure in the three pilot Governorates, although progress was made only towards the end of the programme. 125 Family Health Units were constructed or rehabilitated, mostly in rural areas, and nearly 200 were equipped.<sup>288</sup> Given the over-commitment to tertiary facilities that is being addressed by Egypt's health policy reform, it may safely be concluded that this EC support contributed to improving the facility mix.<sup>289</sup>

Supported by policy analysis from the HSPSP, the Health National Investment Plan calling for the upgrading of over 2,000 Family Health Units was implemented in 21 Governorates.<sup>290</sup>

According to the 1st Tranche Compliance Report of HSPSP-II, the first phase of the National Health Investment Plan (NHIP), earmarked with a total budget of more than EGB two billion, had been assigned to physically upgrade at least 2,000 PHC facilities by the end of 2010.<sup>291</sup> It is reported under the HSPSP third compliance report, that 1,800 Health Units were already physically upgraded based on the Family Health Model in September 2010.<sup>292</sup>

Technical assistance and policy dialogue at the MoHP level, according the HSPSP compliance reports, significantly contributed to the improvement in MoHP's policy in this area. Such support included studies on facility utilisation, costing studies, needs assessment, and financial analysis demonstrating the inequity of the pre-reform health system. Action 14.1 of the HSPSP-II programme expanded and strengthened the accreditation of primary care health facilities for quality assurance and controlled and developed an accreditation system for non-primary health-care facilities (with hospitals

<sup>287</sup> WHO Eastern Mediterranean Regional Health System Observatory: Health Systems Profile- Egypt, 8 HEALTH SERVICE DELIVERY, p.62, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Egypt/Health%20service%20delivery.pdf>

<sup>288</sup> EAMR 1/2007

<sup>289</sup> ROM Monitoring Report 10134.03 of 20/06/2005 and ROM Monitoring Report 28/06/2006.

<sup>290</sup> EAMR 7/2009

<sup>291</sup> Health Sector Policy Support Programme II, 1st Tranche Compliance Report, p.2

<sup>292</sup> Health Sector Policy Support Programme, 3rd Tranche Compliance Report, 26



as priority). The accreditation assessment system was field tested in the pilot Governorates, especially at the primary health care level of Family Health Care Centres and Family Health Units. This is a continuation of progress achieved under HSPSP, already noted as a success in Compliance Reports.<sup>293</sup> Though accreditation does not directly improve the mix between primary and secondary health care facilities in the country, it provides the MoHP with data on the quality of health facilities. Therefore, these actions can be interpreted as a necessary step towards suitable health care facilities planning.

**I-122** No time-series data have been found relating to this Indicator, however, a study at the beginning of the evaluation period, gives a snapshot of the situation at that time (in 2002).<sup>294</sup>

89% of facilities had regular electricity or a generator with fuel. Year-round, onsite water was available at 86% of facilities, with almost all (96%) indicating that their water was normally supplied through a piped system. Large facilities had multiple locations for providing client consultations and examinations, but small facilities often had only one location. Although water was present in each service area in most facilities (62%), soap for hand-washing was rarely present in each assessed service delivery area in a facility (15%).

When assessing procedures used in the principal location in a facility where equipment to be reused is sterilized or high-level disinfected for reuse, 78% of facilities (96% of general service hospitals, but only 33% of fever hospitals) had functioning equipment for either high-level disinfection or sterilization of reusable equipment. Only 45% (75% of general service hospitals) had the equipment, staff present who knew the correct processing time and temperature, and equipment with an automatic timing device. The equipment and knowledge for processing family planning and delivery equipment were somewhat better, with 78% of family planning equipment processed in an area with functioning equipment and staff who knew the correct processing time and temperature. This was true for 77% of delivery service equipment.

36% of general service hospitals (69% of fever hospitals) and few other facilities had all items available that were assessed for supporting high-quality, 24-hour emergency services (overnight or inpatient beds; at least two secondary-level qualified staff; 24-hour onsite or on-call staffing, with a duty schedule present; access to 24-hour emergency communication; a client latrine; and an onsite water source). All elements, plus a year-round onsite water supply and a 24-hour regular supply of electricity (or a generator), were available at 53% of general service hospitals (66% of fever hospitals).

As described above under Indicator I-211, the HSRP contributed a significant amount of equipment to clinics, especially in Sohag, and policy reforms supported under HSPSP and HSPSP-II (including those related to accreditation) have assisted the Government of Egypt to rationalise infrastructure and facilities policy, including equipment. As said above, there appears to have been some involvement of HSPSP in equipment provision. According to its financial agreement, some input indicators of the HSPSP-II are directly reflecting investments in infrastructure and equipment at PHC level under its first specific objective.<sup>295</sup> 3) to physically recondition and equip 18% of the total PHC public facilities. However, there is no evidence in the HSPSP II compliance report whether this indicator had been achieved.

In the framework of the Perinatal Care Program of Excellence (PCPE), the following outputs have been achieved in terms of equipment: 1) 12 PCPE centres were equipped to provide quality perinatal care, 2) 903 FHUs were equipped with necessary IMNCI equipment and supplies; 3) 46 Incubators were procured in the targeted district hospitals. Additional numbers of equipment is due to savings from price reductions. Additional equipment was distributed as per MoH requests in the targeted locations.<sup>296</sup>

**I-123** No information has been found related to this Indicator.

### 6.2.2.2 Resume of the JC

We found that EC support contributed to improving the mix of primary and higher-level health care facilities in Egypt and to improvements in equipment at lower-level facilities. Most of this direct support

---

<sup>293</sup> ANNEX 2. HEALTH SECTOR POLICY REFORM PROGRAMME (EUR 88 m): COMPLIANCE REPORT FOR THE RELEASE OF 1st TRANCHE (EUR 30 m), p.16

<sup>294</sup> Ministry of Health and Population (MOHP) [Egypt], El-Zanaty Associates, and ORC Macro. 2003. Egypt Service Provision Assessment Survey 2002. Calverton, Maryland: Ministry of Health and Population, El-Zanaty Associates, and ORC Macro, p. xvii, <http://www.measuredhs.com/pubs/pdf/SPA5/00FrontMatter.pdf>

<sup>295</sup> Specific objective 1: The quality of services provided by PHC network is improved

<sup>296</sup> Egypt's Mutual Accountability Mechanism In the Health Sector, PCPE Mutual Accountability report and matrix, June 2011

for infrastructure and equipment occurred in the context of the World Bank co-financed HRSP at the beginning of the evaluation period. However, follow-up programmes have continued to support improved facilities and investment planning, better accreditation, etc. Under the HSPSP, there occurred visible improvements in the quality of health services, infrastructure as well as motivation of staff; increased utilisation and client satisfaction, in pilot areas covered by the programme. Support of improved policies has continued since, including improved accreditation of health facilities.<sup>297</sup> More generally, policy dialogue in which the EU participated and TA were fundamental in encouraging and supporting the MoHP's re-orientation towards PHC and family health.

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

#### Indicators

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

#### 6.2.3.1 Findings per indicators

**I-131** The number, distribution and skills of the health workforce do not correspond to the health needs of Egypt. There is a striking excess of physicians in over-served regions, and a simple increase in the number of doctors would do little to address the problems of the poor. Even at the level of a national average, there are more than two physicians per thousand population, which is about five times the number expected for countries of similar economic status. Terms of employment and the recruiting system are distorted, with recruitment into the public sector often serving physicians merely as a means of recruiting private-sector clients to be treated after hours.

The table below show that there was an increase in health workers in Egypt over a period of four years covering the early half of the evaluation period. 50% of the health workforce is employed by the MoHP (Note that a significant number of these also work for their own account in MoHP public facilities after hours.) Substantial numbers are employed by the Health Insurance Organization (HIO), the Curative Care Organization (CCO), the General Organization for Teaching Hospitals and Institutes (GOTH & I), NGOs, and by the private sector. Doctors and technicians may be self-employed. In total numbers, in 2009, there are about a quarter million (225,565) physicians practicing in Egypt, 280 thousand nursing personnel, 1,777 midwives, 33,476 dentists, 133,107 pharmacists (2004), and 1,724 dental technicians/assistants (2004).<sup>298</sup>

Table 43: Health workforce, Egypt: 2001-2005<sup>299</sup>

Personnel per 10,000 population	2001	2004	2005
Physicians	6.13	6.27	6.53
Dentists	0.85	0.97	1.00
Pharmacists	0.44	0.93	1.07
Nurses	12.43	13.51	13.75
Paramedical staff	3.7	3.9	4.0
Midwives	N/A	N/A	0.40
Community health workers	0.9	1.0	1.08
Others	N/A	N/A	24.44

Source: Central Administration of Integrated Health Care (CAIHC)

A simple search on "human resources" in EC EAMRs and ROMs yields no significant hits. There have been some contributions to training (see I-132 below) and no doubt the human resource issue has been addressed by TA and policy dialogue in the context of sector budget support programmes, but it is not possible to find any concrete EC impact related to this Indicator.

According to its financial agreement, the HSPSP-II includes indicators concerning the minimum staffing of the PHC units under its first specific objective:<sup>300</sup> to implement and monitor PHC staff

<sup>297</sup> MONITORING REPORT, EGYPT – EC Support to the Health Sector Reform Programme in Egypt. MR-10134.04 – 28/06/06, p.2

<sup>298</sup> WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

<sup>299</sup> WHO Eastern Mediterranean Regional Health System Observatory: Health Systems Profile- Egypt, 7 HUMAN RESOURCES, p.45, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Egypt/Human%20resources.pdf>

retention strategies and measures -PHC facility minimum qualified staff pattern: 1 Family Physician, two nurses. In fact, it seems that minimum staffing is still problematic, especially in Upper Egypt. However, there is no evidence in the HSPSP II compliance report whether this indicator had been achieved.

**I-132** By 2002, the beginning of the evaluation period (between 2002 and 2005), only about half of health workers had received continuing education, but supervision was strong.<sup>301</sup> Continuing education for all categories of health worker continues to be fragmented and uncoordinated. Continuing education remains an individual choice among practitioners rather than a requirement. Of importance, though, is that an increasing number of doctors, even in underserved regions, have international experience, often in the Gulf, but a surprising number are US, UK or Commonwealth-certified (English being the most common foreign language learned). These are essentially international medical migrants who have returned to their country of origin.

Conditions for employment offered by the MoHP are determined by the Ministry of Finance (MoF) in negotiation with Central Agency for Organization and Administration (CAOA). In general, the human resource management function in the public sector is limited by a number of constraints. The MoHP lacks a national human resource plan, and performance review is limited and unreliable. Finally, pay and prospects for promotion are not in practice linked to work performance. Lack of an incentive system where compensation and advancement are linked to productivity and quality, and lack of adequate career development opportunities for public employees, does not provide employees with enough motivation to perform well nor to be committed to their job.

There are serious inequities in the number of available human resources among the various regions. There are substantial variations in the geographic distribution of health manpower with Upper Egypt being under-served. Urban governorates have higher number of physicians of various specialties compared to rural governorates. Many physicians in rural areas are new graduates and often lack clinical experience to provide quality care.<sup>302</sup>

Human resource development was one of the complementary components of the EC supported HSRP in the first half of the evaluation period.<sup>303</sup> It included incorporation of family health themes in the primary/secondary curriculum, assistance with the design of training of trainers programmes and launching of initial training programmes, assistance in design of continuing and in-service education, and assistance with the development of effective approaches to supervision of health workers. According to EAMR 1/2007, about 1,000 physicians received training under HRSP financing.

One of the goals of the HSPSP-I was a long-term planning and reorientation of human resources, with outputs appropriate in volume, profile and distribution, skilled to manage the reformed services and the new paradigm for health. Unfortunately, the only available ROM report does not evaluate this target.<sup>304</sup> The HSPSP-II includes as a target a project law concerning the revalidation of doctors.

The working plan for the on-going EC funded HSPSP-II programme includes the following expected result: "The personnel of 1,000 Health Care Units is trained to reach Family Health Units standard requirements."<sup>305</sup> Available EAMR's do not provide information on whether this goal has been achieved and no ROM is available. The HSPSP-II is an on going programme and only the first tranche (of four foreseen) has been released.

**I-133** We have no concrete information on either this or the next indicator. In the overall reform process, the MoHP has certainly looked at human resource needs and issues, and EC sector budget support has supported such analysis. The streamlining of the PHC staff subsidy policy (decrees 075 and 060) is reported to have positively influenced the staff stability of qualified personnel. However, a simple search of EAMRs for "human resources" yields no significant information. The main structural

---

<sup>300</sup> Specific objective 1: The quality of service sprovided by PHC network is improved

<sup>301</sup> Ministry of Health and Population (MOHP) [Egypt], EI-Zanaty Associates, and ORC Macro. 2003. Egypt Service Provision Assessment Survey 2002. Calverton, Maryland: Ministry of Health and Population, EI-Zanaty Associates, and ORC Macro, p.xviii, <http://www.measuredhs.com/pubs/pdf/SPA5/00FrontMatter.pdf>

<sup>302</sup> WHO Eastern Mediterranean Regional Health System Observatory: Health Systems Profile- Egypt, 7 HUMAN RESOURCES, p.45, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Egypt/Human%20resources.pdf>, 2005

<sup>303</sup> SPECIFIC FINANCING AGREEMENT between THE EUROPEAN COMMUNITY and THE ARAB REPUBLIC OF EGYPT, EC Support to the Health Sector Reform Programme, p.19 ; and MONITORING REPORT, EGYPT – EC Support to the Health Sector Reform Programme in Egypt. MR-10134.04 – 28/06/06, p.2

<sup>304</sup> FINANCING AGR.EEMENT BETWEEN THE EUROPEAN COMMUNITY AND THE ARAB REPUBLIC OF EGYPT, Health Sector Policy Support Programme, Project Number: MED/2006/018-249

<sup>305</sup> Health Sector Policy Support Programme. Formulation Study. EC ref n°: 2008/160418. FORMULATION REPORT, February 2009, p.36

problem related to attrition and absenteeism in Egypt is attrition / absenteeism “on the job,” which is to say that physicians offer low-quality services in their public capacity, but entice patients to visit them in their private capacity. The main problem is the low pay of physicians in the public sector, a problem which the EC support programme has no doubt helped to analyse, but which it has not directly contributed to alleviating.

### 6.2.3.2 Resume of the JC

There was some contribution of the EC to the training of human resource for health, but it would not be possible, based on the evidence, to identify a concrete impact. Similarly, policy analysis and dialogue supported by the EC has certainly contributed to improved understanding of human resource constraints, but this cannot be assumed to have contributed to any change in the Indicators above as stated. Whether interventions in pilot Governorates have been rolled out is not known, and how successful the ministry and the local authorities, in particular in the economically poor and disadvantaged regions are to address training, absenteeism, workforce motivation besides others cannot be assessed based on available documentation.

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

### Indicators

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

### 6.2.4.1 Findings per indicators

**I-141** The accreditation strengthening accomplished under HSPSP –I and HSPSP-II can be assumed to have contributed to better quality assurance.

**I-142** In 2010, development of guidelines was under development (e.g., for haemodialysis<sup>306</sup>, at the Alexandria university children’s hospital,<sup>307</sup> and Practice Guidelines for Family Physicians<sup>308</sup> had been developed). However, from the sources available, it appears that the development, dissemination and application of clinical guidelines are scattered throughout the country despite of the central organized Egyptian Health Sector Reform Program (HSRP) mentioned above.

The EC supported health reform programmes in Egypt did not explicitly contribute to the development and dissemination of guidelines. However, development of a curriculum and accreditation criteria for the Family Medicine specialty are closely related and can be judged to be a contribution to improvement in this Indicator. According to the HSPSP third compliance report, sixteen clinical guidelines had been developed to provide standard guidance for the most common diseases encountered at primary and secondary levels of health care. These guidelines were assessed as an important tool in which to streamline the medical approach in a country where the medical curriculum may vary from one university to another.<sup>309</sup>

**I-143** A study in Lower and Upper Egypt researching client satisfaction of primary health centres stated that patient satisfaction was high for accessibility, waiting area conditions and performance of doctors and nurses. The main complaints concerned the availability of prescribed drugs and laboratory investigations. Additionally, the level of privacy in the consultation room was described as unsatisfactory by 33% of patients.<sup>310</sup> Another study on client satisfaction of reproductive health services revealed that beneficiaries at the units implementing the HSPSP-II were more satisfied with the quality of services.<sup>311</sup>

<sup>306</sup> Ahmed AM, Allam MF, Habil ES, Metwally AM, Ibrahiem NA, Radwan M, El-Gaafary MM, Afifi A, Gadallah M. 2010. Development of practice guidelines for hemodialysis in Egypt. *Indian J Nephrol.* 2010 Oct;20(4):193-202.

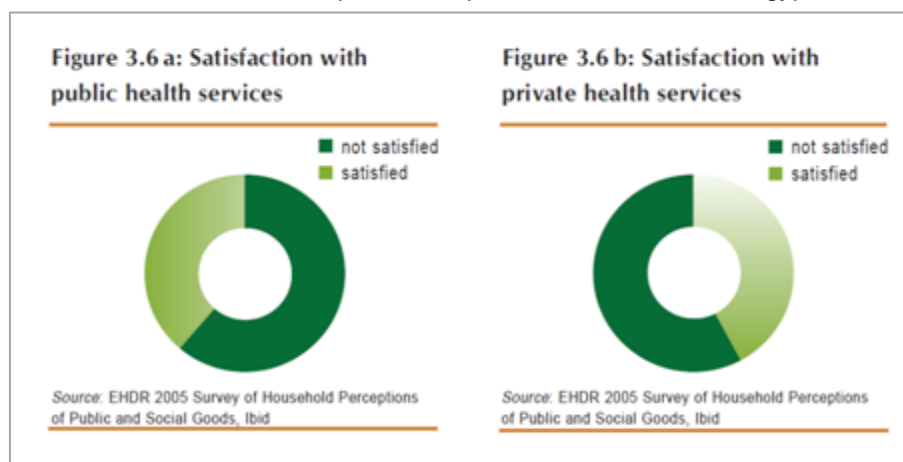
<sup>307</sup> <http://www.alexmed.edu.eg/node/612>

<sup>308</sup> <http://www.drguide.mohp.gov.eg/newsite/e-learning/ICD10/Practice%20Guidelines%20For%20Family%20Physicians%20Volume%204.pdf>

<sup>309</sup> Health Sector Policy Support Programme, 3rd Tranche Compliance Report, p.30

<sup>310</sup> M. Gadallah, B. Zaki, M. Rady, W. Anwer and I. Sallam. 2003. Patient satisfaction with primary health care services in two districts in Lower and Upper Egypt, *La Revue de Santé de la Méditerranée orientale*, Vol. 9, NO 3, 2003

<sup>311</sup> Zaky HH, Khattab HA, Galal D. 2007. Assessing the quality of reproductive health services in Egypt via exit interviews. *Matern Child Health J.* 2007 May;11(3):301-6.

Figure 13: Client Satisfaction with public and private health services, Egypt 2005<sup>312</sup>

Source: EHDR 2005, Survey of Household Perception of Public and Social Goods

#### 6.2.4.2 Resume of the JC

Propagation of standards for facility accreditation has made a significant contribution to improvement in quality of care, although the EC's direct contribution has been limited. Some empirical evidence exists that client satisfaction has increased.<sup>313</sup> However, there is no indication on how the indicator on client satisfaction, that was included in the matrix of the HSPSP-II, has developed.

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

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

##### Indicators

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

##### 6.3.1.1 Findings per indicators

**I-211** WHO data indicate that the share of out of pocket spending in total health expenditure was more or less constant over the evaluation period, changing from 58.8% in 2002 to 57.5% in 2009. According to the latest National Health Accounts report, the burden of household out-of-pocket spending remains high: Egypt has the highest out-of-pocket spending on health of all the middle-income countries in the region. In Egypt, out-of-pocket spending remains the single largest source of health care financing, accounting for 60% of total health spending. Over the past 15 years, the share of out-of-pocket spending to total health spending has increased from 51% to 60%.<sup>314</sup>

Reducing the prevalence of out of pocket payments has been a core EC goal throughout the period covered by the evaluation. One of the targets for HSRP was reduction in out of pocket payments by provision of financially affordable care through the Basic Benefits Package and Family Health Units.<sup>315</sup> Family Health Units will be components of a district-wide network of services headed by a hospital

<sup>312</sup> UNDP. Egypt Human Development Report 2005: Choosing our Future: Towards a New Social Contract, p.57, [http://hdr.undp.org/en/reports/nationalreports/arabstates/egypt/egypt\\_2005\\_en.pdf](http://hdr.undp.org/en/reports/nationalreports/arabstates/egypt/egypt_2005_en.pdf)

<sup>313</sup> Health Sector Policy Support Programme. Formulation Study. EC ref n°: 2008/160418. FORMULATION REPORT, February 2009, p.42

<sup>314</sup> United States Agency for International Development (2010): National Health Accounts 2007/2008 : Egypt Report, September 2010, p.13

<sup>315</sup> SPECIFIC FINANCING AGREEMENT between THE EUROPEAN COMMUNITY and THE ARAB REPUBLIC OF EGYPT, EC Support to the Health Sector Reform Programme, p.19 ; and MONITORING REPORT, EGYPT – EC Support to the Health Sector Reform Programme in Egypt. MR-10134.04 – 28/06/06, p.2



staffed by medical specialists who will deal with the referred cases that cannot be managed by the family doctor. While there was some attention to finance, the evaluation of interventions under MEDA-I concluded that more attention should have been paid to finance. In response, HSPSP-I placed health care finance reform, specifically the reform of the Health Insurance Organization and its coordination with the new concept of the Family Health Fund (FHF) at the centre of its strategy. The FHF has been established to become the main purchasing and contracting agency for primary health care and secondary health care services, provided by the programme-accredited public, private and NGOs facilities. FHF is a mix between insurance and cost-recovery scheme and it is considered a step towards national budgeting. The central FHF is an autonomous body within the MoHP. The FHF, now being piloted in five Governorates, but their experience is not yet well documented. FHF is currently financed from donor money and from the Ministry of Finance.

As evidenced by the Compliance Assessments for the first and second tranches of HSPSP-I, studies and analyses were done, a health insurance law was drafted, etc. A pilot project was implemented in Suez Governorate. Further work aiming to address out of pocket payments is on going under HSPSP-II.<sup>316</sup> In conclusion, the EC has supported work on health care finance reform. Reducing out-of-pocket payments is a key goal of that reform. There is no evidence that the share of out of pocket spending has decreased, and some that it has increased.

**I-212** No information and trend is available.

**I-213** According to its website, the Health Insurance Organization or HIO which is under the MoHP, covers 57% of the population. This represents an increase from about 50% at the beginning of the evaluation period. HIO does not cover the very poor, people who are not in formal or in organised occupations, the unemployed, housewives and unpaid family workers; it does, however, cover students. A study mid-way through the evaluation period characterised the HIO as constrained by insufficient revenues to provide adequate services to its targeted members, and these deficiencies in service provision were in large part responsible for high out-of pocket payments.<sup>317</sup> All of this is still true.

Addressing the low coverage and financial unsustainability of HIO has been a key goal and activity area under EC-supported programmes. Putting the FHF in place, as piloted in five Governorates under HSPSP-I, and merging FHF and HIO, as piloted in Suez Governorate, are strategies to address these issues. Strengthening health care finance had already been identified as a priority under HSRP, although the project evaluation called for more importance to be given to the area.

Despite the actuarial studies, legal analyses, assistance in drafting of health insurance laws, etc., carried out, mostly under HSPSP-I and commented in EAMRs and Compliance Assessments, health finance reform remains an on going project in Egypt. As of 2006, a ROM report stated that financial sustainability was uncertain because FHF was almost entirely supported by donor finance and HIO was not making good on its financial commitments to FHF. As of February 2009, the 13<sup>th</sup> draft of the Health Insurance Law was still being drafted (as noted in the HSPSP-II formulation report).

It is difficult to attribute the observed expansion in HIO coverage to EC support.

In addition to the HIO there are some private health insurance companies but their coverage does not exceed 1% of the population.

### 6.3.1.2 Resume of the JC

There was an increase in the proportion of the population covered by the national Health Insurance Organization (HIO) over the evaluation period. Despite the fact that EC technical assistance, especially under HSPSP-I, devoted a great deal of attention to strengthening the HIO, it is not possible to attribute this expansion to the EC's support. EC provided significant financial support to the establishment of the Family Health Fund, which was piloted in five regions and, in one region, was piloted as an integrated component of the HIO, which corresponds to the long-term policy vision. Putting in place the FHF, as well as the definition of the BBP and the provision of infrastructure for primary health as described under EQ1, will have increased the affordability of health care to populations in the targeted area. Outside those areas, while EC support has contributed tangibly to the development of policies that hold promise for increasing the affordability of health care, EC support does not appear to have actually reduced the price of health care.

<sup>316</sup> Health Sector Policy Support Programme. Formulation Study. EC ref n°: 2008/160418. FORMULATION REPORT, February 2009, p.36 and 43

<sup>317</sup> Policy Brief #3, Pro poor health care for Egypt. The policy brief is based on the 2005 Egypt Human Development Report

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

#### Indicators

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

#### 6.3.2.1 Findings per indicators

**I-221** In principle, the MoHP facilities should be providing free care for the poor.<sup>318</sup> The FHF scheme described above is halfway between a cost-recovery scheme and an insurance fund; it is not a waiver or subsidy scheme. The fact that the poor continue to pay high out-of-pocket fees for private clinic health care strongly suggests that EC assistance has not had significant impact related to this indicator. Increasing health care consumption by the poor is a key goal of HSPSP-II, suggesting that near the end of the evaluation period, the poor were still discouraged from seeking needed care by the high cost involved.<sup>319</sup>

In the framework of the Health Sector Policy Support Programme II, the Delegation decided to support the sub-sector strategy for the development of the public Primary Health Care Provider Network (Family Health Model), in order to improve access of the poor to primary health quality care services.<sup>320</sup>

**I-222** Per capita health care spending in Egypt has consistently grown over the evaluation period. It is difficult, on the basis of documents reviewed, to tease out to what extent this is the result of increased consumption of needed medical care, as opposed to (i) price increases, (ii) increased consumption of non-essential care, (iii) the availability of new treatments and medicines, etc. It is possible that much of the increase may be concentrated among the well-to-do, not the poor. Monitoring indicators in ROM, in Compliance Reports, and in EAMR are very process and activity- or output-oriented; they offer no useful information on the actual impact on health care consumption (clinic visits, treatments received, etc.) or health outcomes.

#### 6.3.2.2 Resume of the JC

The EC has contributed significantly to the development of such schemes through, e.g. technical assistance on health care finance, financing the FHF, development of the BBP, and general health policy strengthening. In the context of this work, a number of groups with special needs have been given prominence, such as women and the very poor. Financial sustainability has been a central concern. However, to use language above, ensuring that groups with special needs received needed care is still a project in progress in Egypt. Based on the two Indicators for this JC, and the material reviewed above, it would not be impossible to attribute to EC assistance a concrete increase in consumption of needed care for special groups to the EC. The most one could say is that, in pilot Governorates which have benefited from infrastructure development, equipment supply, and piloting of FHF, it is not unlikely that such groups increased their consumption of needed care.

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

#### Indicators

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

#### 6.3.3.1 Findings per indicators

**I-231** The significant input of EC technical assistance to health finance reform has been described above. This runs through all three major interventions, but applies especially to HSPSP-I, which

<sup>318</sup> Mapping of healthcare financing in Eastern Mediterranean Region, Arab Republic of Egypt, p.69, <http://gis.emro.who.int/HealthSystemObservatory/PDF/Health%20Care%20Financing/Mapping%20Health%20Care%20Financing%20-%20Egypt.pdf>

<sup>319</sup> Health Sector Policy Support Programme. Formulation Study. EC ref n°: 2008/160418. FORMULATION REPORT, February 2009, pp.42-43

<sup>320</sup> EAMR-External Assistance Management Report 2009



provided actuarial analysis, health finance modelling, legal assistance, etc. There has been significant progress in designing a reform programme, although much remained to be done at the end of the evaluation period (e.g., in February 2009, a health insurance law had still not been passed). In five Governorates, the FHF financed in large part by the EC under HRSP had been piloted and, in Suez Governorate, the proposed merging of FHF and HIO had been piloted.

**I-232** No information available.

### 6.3.3.2 Resume of the JC

The EC, through technical assistance, contributed significantly to the elaboration of improved health finance policies in Egypt, although much remained to be done at the end of the evaluation period. Enhancing the affordability of services, in addition to guaranteeing the sustainability of the system, were key concerns.

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

#### Indicators

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

#### 6.3.4.1 Findings per indicators

**I-241** No information available.

**I-242** No information available.

#### 6.3.4.2 Resume of the JC

Due to non-availability of information no assessment can be made on this JC.

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

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

#### Indicators

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

#### 6.4.1.1 Findings per indicators

**I-311** As mentioned in the first indicator of this assessment, the constitution assures access to health services to all.<sup>321</sup> This includes the goal of guaranteeing universal access to primary health care for the entire population. In 2009, there were 0.7 primary health care units and centres per 10,000 population in Egypt, and in total 17.3 hospital beds per 10,000 population.<sup>322</sup> No information on time trend has been found.

MoHP is the major provider of primary, preventive, and curative care, with more than 3,645 health facilities and 66,440 beds. Service delivery units are organized along geographic (rural and urban), structural (health units, health centres. and hospitals), functional (maternal child health centres), or programmatic (immunization and diarrheal disease control) criteria. Hospital services are provided through:

- Integrated hospitals (20 to 60 beds), with primary and specialized medical services in rural areas, equipped with surgical theatres, x-ray equipment, laboratories and have a catchment population between 10,000 and 25,000;

<sup>321</sup> [http://www.cabinet.gov.eg/AboutEgypt/Egyptian\\_constitution.aspx](http://www.cabinet.gov.eg/AboutEgypt/Egyptian_constitution.aspx)

<sup>322</sup> WHO EMRO Country Profile Egypt, <http://www.emro.who.int/emrinfo/>

- District hospitals (100 to 200 beds), more specialized with a catchment population between 50,000 and 100,000;
- General hospitals (more than 200 beds) with all medical specialties, available at Governorate capital;
- Specialty hospitals, in urban areas with subspecialties (eye, psychiatric, chest (34), fever (88), heart, ophthalmology (31), tumours, gynaecology, and obstetrics).<sup>323</sup>

Unfortunately, no time-series data are available. However, HSRP provided and equipped over 100 Family Health Units and, under HSPSP-I, according to the Compliance Assessment for release of the second tranche, 494 units in the five pilot Governorates had been accredited by the end of 2007, as well as 182 in non-pilot Governorates. These steps, combined with design of the BBP, establishment of the essential drugs list, and other measures described, would have had the impact of expanding the supply of primary health care.

Result 1 of the HSPSP-II concerns the modernisation of the PHC and targets that around 1,000 Family Health Units or Centres will be physically reconditioned, personnel will be trained to reach Family Health Model standards, in order to be accredited according to nationally approved quality standards.<sup>324</sup>

According to the 3rd Tranche Compliance Report of the HSPSP, the authority in charge of investment planning in the health sector - the Technical Support Office of the MoHP - developed a sanitary map based on the Google Earth software and GPS mapping method. This mapping tool, which covers the whole of Egyptian territory, enabled the Government to select 4,591 Primary Health Care units eligible for an upgrade based on the Family Health Model. The criteria used for selecting the facilities were mainly based on geographical access and as consequence, 324 existing facilities were kept-out of this investment plan.<sup>325</sup>

**I-312** Due to the extreme density of the Egyptian population, geographical access to health care is not an issue for most of the population. Egypt has an extensive network of physicians and facilities with 95% of Egyptians living within five km of a health facility of some type, however, access to and utilization of the system is not equitable across income groups, governorates and gender.<sup>326</sup> This said, for the small number of persons (Many Bedouin) living in remote desert areas, access to health care facilities is very poor and ensuring it extremely expensive.

#### 6.4.1.2 Resume of the JC

Egypt has a dense network of primary health facilities and physicians. Unfortunately, no information and trends are available for the number of primary health care facilities per 10,000 population to make a proper assessment. There were approximately 4,500 rural health units available in 2006/07 and the government planned to increase this number in its National Development Plan 2007-2012 up to 7,200 by 2011/12. EC support has provided primary health clinics, equipped them, and supported policy reforms to improve their effectiveness and make them more affordable for the poor.

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

##### Indicators

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

##### 6.4.2.1 Findings per indicators

**I-321** Total hospitals beds per 1,000 population in Egypt showed a decrease over the late 1980s and early 1990s, and currently stand at 2.1 beds per 1,000 persons, a number comparable to neighbouring countries and others with similar levels of economic development. Hospital bed occupancy rates are

---

<sup>323</sup> FINANCING AGREEMENT BETWEEN THE EUROPEAN COMMUNITY AND THE ARAB REPUBLIC OF EGYPT, Health Sector Policy Support Programme, Project Number: MED/2006/018-249, p.21

<sup>324</sup> FA of HSPSP-II

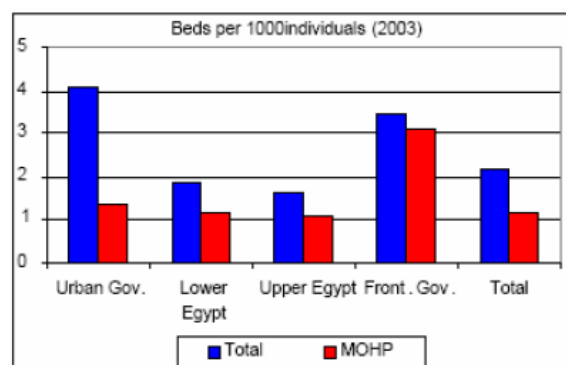
<sup>325</sup> Health Sector Policy Support Programme, 3rd Tranche Compliance Report, 25

<sup>326</sup> WHO Eastern Mediterranean Regional Health System Observatory: Health Systems Profile- Egypt, 8 HEALTH SERVICE DELIVERY,  
<http://gis.emro.who.int/HealthSystemObservatory/PDF/Egypt/Health%20service%20delivery.pdf>

low in Egypt, and hospitals offer too many simple outpatient procedures which should be performed at the clinic level.

The spatial distribution of beds and bed occupancy rates is highly skewed. The distribution of hospital resources is inequitably distributed in favour of the wealthier urban governorates. Upper Egypt, which is the poorest region in Egypt, consistently had the lowest number of hospital beds and physicians per capita. There are significant income and regional disparities in access to and utilization of hospital services. In addition to regional disparities in the distribution of the hospital services, there are inequities in the access to and utilization of hospital services by region and by income levels. The richest quintile of the population utilized, respectively, 2.3 and 1.6 times as much as the poorest quintile households on hospital and outpatient services.

Figure 14: Beds per 1,000 population, Egypt: 2003



Source: MOHP

**I-322** See I-312. Geographical access is not an issue in Egypt, save for the small population living in remote desert regions, although we have no data disaggregated by type of health facility.

**I-323** Almost three in ten deliveries were by caesarean section with an increase from 7% in 1995 (DHS 1995)<sup>327</sup> to 28% in 2008 (DHS 2008). The table below shows that women delivering in a private health facility were slightly more likely than women delivering in a government facility to have a caesarean delivery. The likelihood of a caesarean delivery increased with the age of the mother and decreased with the child's birth order. 37% of urban births were caesarean deliveries compared to 22% of rural births. Considering place of residence, urban Lower Egypt had the highest proportion of caesarean deliveries (43%) followed by the Urban Governorates (39%). The likelihood of a Caesarean delivery increased with both the mother's educational status and was greater among women working for cash than among other women. The rate of Caesarean deliveries peaked at 45% among women in the highest wealth quintile compared to 14% among women in the lowest quintile.<sup>328</sup>

<sup>327</sup> El-Zanaty, Fatma, Enas M. Hussein, Gihan A. Shawky, Ann A. Way, and Sunita Kishor. 1996. Egypt Demographic and Health Survey 1995. Calverton, Maryland [USA]: National Population Council [Egypt] and Macro International Inc.

<sup>328</sup> El-Zanaty, Fatma and Ann Way. 2009. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International, p.135

Table 44: Percentage of caesarean deliveries by background characteristics<sup>329</sup>

Background characteristics	DHS 2008
Place of delivery	
Public health facility	33.2
Private health facility	41.7
At home/don't know/missing	na
Urban-rural residence	
Urban	37.1
Rural	22.0
Place of residence	
Urban governorates	38.5
Lower Egypt	30.9
Urban	43.2
Rural	27.4
Upper Egypt	19.9
Urban	30.9
Rural	15.8
Frontier governorates	20.0
Education	
No education	17.8
Some primary	18.4
Primary complete / some secondary	24.9
Secondary complete / higher	34.5
Work status	
Working for cash	42.3
Not working for cash	34.5
Wealth index	
Lowest	13.6
Second	19.2
Middle	26.2
Fourth	35.8
Highest	44.9
Total	27.6

Source: Egypt Demographic and Health Survey 2008.

None of the three assessed EC supported health sector policy support programmes addressed caesarean sections per se. Anyway, their objectives on quality improvement of health and facility health care units/centres and hospital (e.g. through accreditation programmes), increase of facility use (also for the poor), reduction of out of pocket payments, health insurance coverage increase, and others, might result in a further increase in caesarean sections, but which will be also depend in future on birth attendance recommendations by the MoHP. The 2004 CSE noted an improvement in reproductive health in Sohag under the HSRP, and DHS data presented in the Compliance Assessment for the second tranche of HSPSP-I show significant improvements in maternal health between 2005 and 2008 (e.g. an increase in the number of deliveries attended by a skilled health worker from 74 to 79% nationwide).

#### 6.4.2.2 Resume of the JC

Geographical access to health care is not a major issue in Egypt because the population is so densely distributed. The small population living in remote areas admittedly has poor access to health facilities, but it must also be recognised that providing such access would be extremely expensive. The EC contributed directly to the construction and equipping of Family Health Units. More important, however, has been the emphasis of the EC's sector budget support programmes on accreditation, development of an essential drug list, quality management, and health insurance reform, all with the purpose of improving financial access to better-quality and more appropriate health care.

<sup>329</sup> Id.

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

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

#### Indicators

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

#### 6.5.1.1 Findings per indicators

**I-411** Births attended by skilled health personnel increased constantly from 35% in 1988 to 46% in 1995, 69% in 2003, and to 79% in 2008. The rate for women aged 15-19 was 79% in 2008.<sup>330</sup> In total, 71.7% of women gave birth in health facilities, of which 44.8% were in private health facilities and 26.9% in public health facilities in 2008. The urban-rural gap is large: there were 85.5% of births in any health facility in urban areas, and 63.6% in rural areas respectively. Women with no education were more likely to give birth at home (48.5%) compared to women with completed secondary / higher education (13.2%). Regarding the wealth quintiles, women are more likely to give birth in any health facility when they are wealthy than poor women (45.4% lowest income quintile and 94.6% highest wealth quintile).<sup>331</sup>

The 2004 CSE reports that in Sohag, which benefited from the HSRP, there had been an increase in women's access to maternal health services. The strong place of maternal health in the Basic Benefit Package whose elaboration was supported, in part, by the EC, can safely be assumed to have contributed to the increase in the proportion of births taking place under proper supervision. Improved reproductive health is one of the expected results of HSPSP-II.

**I-412** The WHO Global Health Observatory Repository data base does not provide any time-series regarding ante-natal care coverage. The DHS reports that in 2008, 66% of pregnant women received at least four ante-natal care visits, and 74% at least one visit.<sup>332</sup> Based on data found, it has not been possible to establish a time trend over the evaluation period. The baseline for comparison unfortunately far antedates the evaluation period, but an improving trend over the evaluation period can safely be inferred: the Egypt DHS 1988 stated that 53% of pregnant women received any pre-natal care, with higher rates for women completed secondary education / higher (80.8%) compared to 41.8% for women with no education. It was also higher in urban areas (69.2%) than in rural areas (41.7%). Regional disparities were high (e.g. rural Lower Egypt with 40.1% and Urban Governorates with 74.7%).

**I-413** Egypt, in part because of aggressive US AID support for family planning, was an early and aggressive adopter of national family planning policy. The contraceptive prevalence rate, according to the DHS, was 60.3% in 2008 with a much lower rate for women aged 15-19 years, 23.4%. Only 2.9% of women reported unmet need for family planning in 2008.<sup>333</sup>

Again, the baseline is the 1988 DHS, admittedly long before the beginning of the evaluation period, estimated that the contraceptive use was 37.8%. Clearly, there has been a strong long-term increase, but it cannot be excluded that this took place largely before the evaluation period, not can the strong influence of the massive US AID programme in family planning be ignored.

#### 6.5.1.2 Resume of the JC

The three indicators show remarkable improvements over the last decades. Egyptian women are today more likely to give birth under proper supervision, receive antenatal care, and practice family planning. These improvements are best established by comparing the DHS 2008 and 1988, a period for which unfortunately, the baseline far antedates the evaluation period. It cannot be excluded that most of the improvement antedated the evaluation period and that much was due to the strong support of another donor, US AID. However, the 2004 CSE found that the HSRP project had improved reproductive health care in at least one region (Sohag), and reproductive health figures prominently in

<sup>330</sup> WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/>

<sup>331</sup> El-Zanaty, Fatma and Ann Way. 2009. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International.

<sup>332</sup> <http://apps.who.int/ghodata/#>

<sup>333</sup> WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

HSPSP-II, as well as indirectly in other activities financed by the EC (e.g. development of the Basic Benefit Package). But geographical, educational and economic differentials remained almost unchanged. Women with no-education are less likely to use modern family planning methods, are more likely to deliver at home, and are less likely to use ant-natal care coverage; the same figures we see for the wealthy quintile groups (the lower the quintile the lower the rates). Furthermore, urban areas have quite often the double percentage rates than rural areas. The rural Upper Egypt governorates are generally the governorates with the lowest level of modern health care development. The GPS planning approach, the standardization and the integration of the PHC services and the roll-out of the programme on the FHM have most likely had an impact on MCH services.

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

#### Indicators

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

#### 6.5.2.1 Findings

**I-421** There are no data available on growth monitoring, but some indirect observations can be made. An examination of the height-for-age data from the 2008 DHS indicates that there is considerable chronic malnutrition among Egyptian children. Overall, 29% of children under age five were stunted, and 14% were severely stunted. Stunting was existent even among children under six months of age. Stunting levels increased rapidly with age, from 17% among children less than six months of age to 41% among children 18-23 months, before falling to 24% among children age four and older. Levels of stunting were slightly higher for male children than for female children.

Overall, the 2008 DHS results indicated that 7% of children under age five were wasted, i.e. severely malnourished.

The table below presents trends in the nutritional status in Egypt and shows that the proportion of wasted and stunted children increased since 1978, as well as for overweight and under-weight-children aged below five years. Taking 2003 and 2008 as the years roughly spanning the evaluation period, we see a steadily worsening trend in wasting and stunting and a more than doubling of the proportion of under-5s overweight. The increase of the malnutrition rate is a real concern in Egypt.

Table 45 Children malnutrition, children aged <5 years, Egypt; 1978-2008<sup>334</sup>

Nutrition status	Sex	2008	2005	2003	2000	1996	1993	1991	1988	1978
Wasted	M	8.8	5.7	5.3	3.4		5.8	3.9	5.4	2.6
	F	7.1	4.9	5.2	3.0		5.5	4.3	3.7	1.8
	T	7.9	5.3	5.2	3.2	7.5	5.7	4.1	4.5	2.2
Stunted	M	33.0	25.4	22.4	26.6		36.4	31.8	35.7	37
	F	28.4	22.2	18	22.6		33.4	30.7	34.1	36.1
	T	30.7	23.8	20.3	24.6	26.3	34.9	31.3	34.9	36.6
Underweight	M	8.1	6.6	10.2	5.0		11.6	8.6	11.9	11.7
	F	5.4	4.2	7.0	3.4		9.8	7.9	9.0	11.6
	T	6.8	5.4	8.7	4.3	10.2	10.8	8.2	10.5	11.6
Overweight	M	19.8	14.4	8.9	18.9	14.7	15.1	15.9	7.4	
	F	21.2	13.8	9.4	17.4	14.7	13.6	13.8	6.1	
	T	20.5	14.1	9.2	18.2	14.7	14.4	14.9	6.8	3.8

Source: WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

There is no information on the coverage of regularly growth monitoring in Egypt family health centres that have been supported by the EC either directly or via policy advice offer growth monitoring.

**I-422** Immunisation is integrated into the family health model that was supported by the EC throughout the evaluation period. Immunisation is for all children, and it is free of charge.<sup>335</sup>

<sup>334</sup> WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

<sup>335</sup> Imam IZ. 1985. Immunization and primary health care in Egypt. Trop Geogr Med. 1985 Sep;37(3):S65-6.



Today, the immunisation coverage of the 1-year-olds is virtually universal for all major vaccines, and showed a remarkable increase over the last 30 years (see table below). However, major immunisation rates essentially “peaked out” at near universal immunisation by 2000, before the beginning of the evaluation period. It is not possible, then to say that EC assistance contributed to an improvement in immunisation rates in 2002-10.

Table 46 Immunisation coverage among 1-year-old, Egypt: 1980-2009<sup>336</sup>

	2009	2005	2000	1995	1990	1985	1980
Measles (MCV)	95	98	98	89	86	74	41
Diphtheria tetanus toxoid and pertussis (DTP3)	97	98	98	88	87	84	57
Hepatitis B (HepB3)	97	98	98	74	N/A	N/A	N/A
BCG	98	98	98	93	89	80	50
Polio (Pol3)	97	98	98	90	87	84	67

Source: WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

Given the widespread coverage of the immunisation in program in Egypt, the socio-economic differences are small. Girls are slightly more likely than boys to be fully immunised. By residence, the percentages fully immunised varied from 86% in the Frontier Governorates to 94% in the Urban Governorates and Lower Egypt.<sup>337</sup>

### 6.5.2.2 Resume of the JC

In Egypt, the immunisation is almost universal today, and was almost universal at the beginning of the evaluation period. The GPS planning, the integration of the PHC, the standardization and the roll-out of the FHM have positively contributed to strengthening MCH services and PHC programmes. EC interventions related to the family health model may have helped to provide a foundation.

Child nutrition trends are worrying. Rates of wasting and stunting have increased over the evaluation period and rates of overweight increased dramatically, suggesting that, even though family health units offer growth monitoring, EC support made no contribution to improving child nutritional health. It can, of course, be speculated that, absent EC support, the trend would be worse.

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

#### Indicators

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

#### 6.5.3.1 Findings per indicators

**I-431** No information on the coverage and trends on the use of bednets is available.

**I-432** In 2008, an estimated 2,145 children below five years died of diarrhoeal diseases in Egypt.<sup>338</sup> No information has been found on the time trend over the evaluation period.

No specific EC interventions are documented in the programme and evaluation reports.

**I-433** By 1985, 98% of Egyptian mothers had heard of ORT, 73% knew how to mix it properly, 64% had used it at some time in the past, 58% had used it in the child's last diarrheal episode, and 83% of those currently breastfeeding had continued during the most recent episode. There were moderately low ORT rates through 1983, rapid increases in 1984 and 1985, and stable rates since then.<sup>339</sup> A more recent study claims that the mortality reduction of diarrhoeal diseases resulted in a decline of commitment to control diarrhoeal diseases activities in Egypt, and that diarrhoea remains the main cause of death among children.<sup>340</sup>

<sup>336</sup> WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

<sup>337</sup> El-Zanaty, Fatma and Ann Way. 2009. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International

<sup>338</sup> WHO Mortality data, 20011, <http://www.who.int/healthinfo/statistics/mortality/en/index.html>

<sup>339</sup> Miller PC. Trends in the management of childhood diarrhoea in Egypt: 1979-1990. J Diarrhoeal Dis Res. 1992 Dec;10(4):193-200.

<sup>340</sup> Langsten R, Hill K. Diarrhoeal disease, oral rehydration, and childhood mortality in rural Egypt. J Trop Pediatr. 1994 Oct;40(5):272-8.



The results of Egypt DHS 2008 survey reveal further need for education of mothers and an increase of ORT use. Nearly one-quarter of children were not given any treatment for diarrhoea. Virtually all ever-married women age 15-49 (96%) were aware of the availability of packets of oral rehydration salts that can be used to prevent dehydration. However, only 28% of children suffering from diarrhoea were given a solution prepared using a packet of oral rehydration salts. In 3% of the cases, the child was given a solution of sugar and salt (i.e., a recommended home fluid (RHF)). Antibiotics and anti-diarrheal medications are generally not recommended to treat diarrhoea in young children. However, antibiotics were given to one-third of the children with diarrhoea, 15% received anti-motility drugs, and 34% were given other drugs. The results also showed that feeding practices during diarrheal episodes were not optimal. Fluids were increased for only 11% of the children ill with diarrhoea. In 31% of the cases, the mother said that the child was either given nothing to drink (12%) or much less fluid than normal (19%), while 29% of the children received somewhat less than the normal amount of liquids (see table below).<sup>341</sup>

Data presented in tables below show no improvement in the treatment of diarrhoea between 2000 and 2003 or between 2005 and 2008. Between 2005 and 2008, the proportion of children receiving no treatment at all increased by 6%.

Table 47: Treatment of children under age five during diarrhoea, Egypt: 2005 and 2008<sup>342</sup>

<i>Drugs/other treatment</i>	<i>2008</i>	<i>2005</i>
Any drug/ other treatment	76.7	77.9
ORT	28.4	35.7
ORS packet	28.4	33.5
Homemade SS solution	2.9	2.7
Antibiotic pill/syrup/injection	33.1	25.7
Antimotility	14.8	14.4
IV	0.4	0.1
Zinc	0.3	0.8
Other/unknown pill/syrup/injection	33.8	45.7
Home remedy	2.3	0.6
No drug/other treatment given/ missing	23.3	17.2

Source: Egypt Demographic and Health Survey 2008.

<sup>341</sup> El-Zanaty, Fatma and Ann Way. 2009. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International

<sup>342</sup> El-Zanaty, Fatma and Ann Way. 2006. Egypt Demographic and Health Survey 2005. Cairo, Egypt: Ministry of Health and Population, National Population Council, El-Zanaty and Associates, and ORC Macro; and Id.

Table 48: Treatment of children under age five during diarrhoea, Egypt: <sup>343</sup>

	1988	1992	1995	1997	2000	2003
<b>Per cent treated with</b>						
ORT	28.7					
Medicine	56.7					
Intravenous fluids	3.9					
Treatment given	33.5					
ORS packets		50.4	40.2	38.4	33.7	28.2
RHS at home			4.8	7.7	5.0	9.1
Either ORS or RHS			42.7	42.1	37.1	33.6
Increased fluids			44.9	27.3		30.6
Antibiotics			30.5	38.4	23.7	21.2
Other pill					30.5	34.6
IV					7.7	6.2
Home remedy/other			46.7	22.8	6.9	6.2
None			0.7	17.7	20.1	15.5

Source: Egypt Demographic and Health Survey 2005. No specific EC interventions to increase ORS treatment are documented in the programme and evaluation reports.

### 6.5.3.2 Resume of the JC

We have found not solid evidence on the trend in child death rates from diarrhoeal disease over the evaluation period. If, as is perhaps probable, they declined, it represents further progress following the dramatic declines of the 1980s and 1990s. There is no evidence of improved management of diarrhoeal episodes via ORT or other means over the evaluation period.

No information was available for children sleeping under insecticide treated bednets.

No specific EC interventions were conducted to reduce prevalence of and mortality due to diarrhoea, and improve ORS treatment coverage in the project pilot governorates. However, the Family Health Model, support in the insurance issue, training of medical workforce, and quality assurance of health and family health units/centres are likely to have contributed to improvements in child health.

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

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

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

<sup>343</sup> Hussein Abdel-Aziz Sayed, Magued I. Osman, Fatma E1-Zanaty, and Ann A. Way. 1989. Egypt Demographic and Health Survey 1988. Egypt National Population Council and Institute for Resource Development/Macro Systems Inc.

Fatma H. El-Zanaty, Hussein A. A. Sayed, Hassan H. M. Zaky, and Ann A. Way. 1993. Egypt Demographic and Health Survey 1992. Egypt National Population Council and Institute for Resource Development/Macro Systems Inc.

El-Zanaty, Fatma, Enas M. Hussein, Gihan A. Shawky, Ann A. Way, and Sunita Kishor. 1996. Egypt Demographic and Health Survey 1995. Calverton, Maryland [USA]: National Population Council [Egypt] and Macro International Inc. Egypt Interim Demographic and Health Survey 1997.

El-Zanaty, Fatma and Ann Way. 2001 *Egypt Demographic and Health Survey 2000*. Calverton, Maryland [USA]: Ministry of Health and Population [Egypt], National Population Council and ORC Macro

El-Zanaty, Fatma and Ann A. Way. 2004. *Egypt Interim Demographic and Health Survey 2003*. Ministry of Health and Population Council, El-Zanaty and Associates, and ORC Macro.

### 6.6.1.1 Findings

**I-511** It was not until the adoption of the National Strategy for Development in 2000 and the Fifth Five Year Plan (2002-2007), which integrates into the poverty dimension a focus on social sectors, that the EC started supporting the health sector.<sup>344</sup> It is only since 2007 that the government has developed a National Strategic Health Plan, along with plans for sub-sectors. This coincides with the CSP 2007-2013, which makes health a EC focal sector as well as with the two major health sector reform/policy support programmes (2006 and 2009) which are aligned on the Egyptian Government's Sector Reform (SP) Strategy.

The project and document reviewed give no clear evidence whether and how the EC has participated in the elaboration of this national strategy or the sub-sector plans, the design of the indicators or the monitoring tool. According to the formulation report of the HSPSP II<sup>345</sup> *"the only developed plan that the EC support can firmly relate to, between 2007-2009, is the 'Health National Investment Plan'. It displays the expansion of the network of remodelled or newly constructed and accredited primary health care facilities implementing the Family Health Model"*. In the framework of the National Investment Plan, the HSPSP-II has ensured the continuity of the HSPSP towards the development upon the Family Health Model of the primary health care public service provision. In September 2010, the execution of this National Investment Plan was well engaged and more than 1.800 Health Units were already physically upgraded based on the Family Health Model. On 30<sup>th</sup> April 2011, a total of 1.982 units were physically reconditioned based on the Family Health Model and 160 were under (re) construction.<sup>346</sup>

Furthermore, the same formulation report noted that the existing national health strategic plan has no clear timeframe and is not always budgeted. This has been recognised by the EU Delegation, which has been in negotiation to strengthen the plan, according to the formulation report.<sup>347</sup>

The CSE of 2010 notes that the *"SBS (Support to health sector reform, 2006) has enabled reform measures to be implemented, thus supporting and lending credibility to the reform-minded official"* but raises doubt on the contribution of the SBS on a strategic level of the health reform. The explanation put forward lays in the fact that reform measures were not used as SBS disbursement triggers in the health sector. Thus the CSE concludes: *"The extent to which reform measures retained for SBS disbursement purposes effectively announced the implementation of an overhaul in the sectors' management and policies remains uncertain: important policy decisions such as those (.) relative to general health insurance have not yet been taken and sector wide strategies have not yet been elaborated in these important sectors. More generally, the GoE's commitment to reform was not evidenced by the budgetary allocations to the water, health or education sectors which did not change from previous funding trends.* The National Health Accounts analysis of 2007 also noted the need for significant budgetary re-allocations.

Continuing to quote the CSE, *The eventual outcomes of the reform measures implemented with Commission support will only be measurable in a few years' time: fragile steps in the direction of overall reforms have been made but time will tell whether sufficiently wide political backing existed to enable their full implementation and ensure their sustainable and lasting effects.*"<sup>348</sup>

In conclusion, the EC is supporting the implementation of the actual sector strategy reform of the government, but there is no clear evidence whether it has supported the design of the strategy or its sub plans through concrete analyses other than actuarial simulations. However, DUD staff report that political dialogue with the Egyptian authorities focused on the need for an internal sector budget reallocation (e.g. FHF fiscal sustainability, increase of HIO budget, decrease of PTES budget, and better targeting of the poor). The political dialogue was also focused on the fiscal implication related with the setup of the new Social Health Insurance (funding of the coverage of the poor, role of the Ministry of Social Solidarity).

What can be said without hesitation is that the EU's policy dialogue, technical assistance, and budget support consistently strengthened the move towards primary health care and a family health orientation.

**I-512** The documents revised make clear that the EU Delegation has maintained regular policy dialogues with the ministry of health (MoHP) and that this dialogue can be qualified as excellent and

<sup>344</sup> ADE (2010), Evaluation of the European Commission's Support with Egypt, Country Level Evaluation.

<sup>345</sup> Conseil Santé (2009), Health Sector Policy Support Programme - Formulation Study.

<sup>346</sup> Health Sector Policy Support Programme, 3rd Tranche Compliance Report, p.25-27

<sup>347</sup> Ibid.

<sup>348</sup> ADE (2010), Evaluation of the European Commission's Support with Egypt, Country Level Evaluation. Vol 1, p. 124.

transparent.<sup>349</sup> (See comment above.) The ROM report of the HSPSP I programme, 2008 notes that the policy dialogue has contributed to the overall efficiency of the sector programme. Furthermore the EUD is seen as a front rank player in the health dialogue.<sup>350</sup> The CSE 2010 notes that the policy dialogue has enabled the discussion of sensitive issues, such as the PFM reform or – more specific to the health sector – the health insurance reform. This, according to the CSE, may lead to more profound changes and eventual adoption of wide reforms in the coming years.<sup>351</sup>

More specific on the question whether policy dialogue has included PFM, accountability and capacity building, the information is less obvious. The same ROM report highlights that strong efforts seem to have been made to improve PFM. The International Monetary Fund and the World Bank have expressed reasonable satisfaction with progress in this area, but at the same time, many serious problems remain unresolved in the PFM area. The ROM report also highlights that *“the SPSP is helping to improve PFM, although in a limited way and with some success.”*

**I 513** The health sector reform of the Egyptian government has a clear decentralisation focus. Thus, the financial agreement of the EC programme “Support to health sector reform” formulates as one of expected results: “A health system governance, with a clear division of responsibilities between the MoHP, Governorates and district health authorities, purchasers; providers, and beneficiaries” with one expected result being “Credible fiscal transactions through a Single Treasury Account and fiscal decentralization. The Parliament will need reviewing budget execution and will have the possibility to reallocate financial resources according to the documented sector needs and requirements.”<sup>352</sup>

The compliance report number two assesses the progress of two activities as follow:<sup>353</sup>

Activity no 13.2: “Start implementing updated master plan with a priority on five FHM existing Governorates and on another five Governorates selected among the 10 poorest”

A master plan for 10 priority Governorates has been published. Furthermore the assessment notes: “the Government of Egypt has gone beyond the expected result by approving a National Investment Plan which covers all 27 Governorates and by already having launched the implementation phase”

Activity no 4.2. “Assess progress in preparing the launching of PBB in selected items in health budget chapter and finalise road-map for completing PBB implementation for population-based programmes and related decentralisation requirements.”

The compliance report notes that an automation system has been developed to improve the communication among decentralised Accounting Units and the MoF. This new system will enhance the information system in order to inter alia better prepare and monitor the budget execution / preparation. In its general conclusion the compliance report is less positive with the achievements: “Strictly speaking, no road-map for completing PBB in the health sector was formulated. However, essential elements were built up in line with a future linkage between the budget and performance indicators. As a consequence of the amendment to budget law No. 87/2005 article 4, it can be reasonably expected that there will be a progressive expansion of PBB. The amendment of budget law No. 87/2005 article 4 can thus be considered a road-map for completing PBB.”

### 6.6.1.2 Resume of the JC

The EC holds close and good contacts to the Ministry of health and the Ministry of Finance policy dialogue. This includes also sensitive issues such as PFM reform or more specific to the health sector, the health insurance reform. It is clear that the EC supports the reform efforts of the GoE. Thus, no evidence could be found whether the EC has actively contributed to the strategic policy process in the health sector. As concerning capacity building on decentralised level, the EC has financed through its HSPSP I, central units in charge of developing road maps for decentralisation of health budgets as well as the national investment plan from which the 27 local Governorates will benefit. Taking a broad view, the EU has been a decisive player in the MoHP’s transition from a curative, hospital-based approach to health care to a PHC, family medicine-oriented one.

<sup>349</sup> European Commission (2008) Monitoring Report ‘Health Sector Policy Support Programme (HSPSP)’, MR-108141.01, 11/2008.

<sup>350</sup> European Commission (2008) Monitoring Report ‘Health Sector Policy Support Programme (HSPSP)’, MR-108141.01, 11/2008.

<sup>351</sup> ADE (2010), Evaluation of the European Commission’s Support with Egypt, Country Level Evaluation.

<sup>352</sup> European Commission (2006), Financial Agreement - Support to health sector reform (MED/2006/018-249).

<sup>353</sup> European Commission Delegation to Egypt (2008). Compliance report for the release of 2nd tranche of EC support health sector policy support program decision med/2006/18249.

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

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

#### 6.6.2.1 Findings

**I-521** The third ROM report of the EC programme “Support to the health reform, 1998”<sup>354</sup>, highlights some difficulties related to accountability of funds that the EC transfers to the Family health Fund (FHF) which then is not disbursed by the later. The ROM report highlights the need for a better organisation, including financial accountability. This is seen in relation with the need for a strategy on the future organisation of health financing. The ROM report suggests twinning the FHF and/or HIO with a European Health Insurance in order to accelerate the process.<sup>355</sup>

The ROM of 2008<sup>356</sup> monitoring the Health Sector Policy Support Programme (HSPSPI) notes that many of the SPSP conditionalities, especially those of relevance to the MoF, are not targets of the sector programme of the government.

Joint reviews take place twice a year; the summary reports are only available in Arabic

**I-522** As also highlighted by different sources, no MTEF exists in the health sector.

The efforts of the EUD to contribute to the elaboration of a MTEF seem to be not very successful. According to the ROM of 2008<sup>357</sup>, “*the monitors understand from the European Commission Delegation (ECD) that the EC guideline for use of a Medium Term Expenditure Framework (MTEF) has been discarded*”, as an annual budget is used in Egypt along with comprehensive and sophisticated medium and long term expenditure projections, supported by the International Monetary Fund Budget Sector. According to the ROM, the MoF addresses well the need of the sector reform, nevertheless the ROM report suggests protecting against possible cuts in public expenditure in the case the macroeconomic situation deteriorates.

According to the Compliance Assessment for the release of First Tranche for the HSPSP; the approved FY07 detailed budget has been published in 1,500 copies and widely disseminated in all Ministries, Governorates, Universities and several Business Associations / Chambers of Commerce. The Budget’s Statistical Overviews and a summary in English are posted on MoF’s website.<sup>358</sup>

On more general issues related to the health budget planning and its execution, some progress has been made in regard to budget execution and systematisation (Single Treasury Account (STA), performance based budgeting -PBB) during the implementation period of the HSPSP, according to the ROM report 2008.<sup>359</sup> E.g. in the second half of 2008, the Family Planning Department of the MoHP has tested a PBB approach. The ROM report notes that there has been positive contribution and achievement in the establishment of the STA, the planned move to performance-based budgeting and the increased clarity of the Annual Budget at both the central and Ministerial levels.

The contribution of the SPSP to improving M&E and donor coordination is achieved through the DAG, the periodic reviews and the direct policy dialogue maintained by the EUD.

<sup>354</sup> European Commission (2005), Monitoring Report no 3, “EC Support to the Health Sector Reform”, MR-10134.03 – 20/06/05.

<sup>355</sup> European Commission (2005), Monitoring Report no 3, “EC Support to the Health Sector Reform”, MR-10134.03 – 20/06/05.

<sup>356</sup> European Commission (2008), Monitoring Report no 1, “Health Sector Policy Support Programme (HSPSP)” MR-108141.01, 28/11/2008.

<sup>357</sup> European Commission (2008), Monitoring Report no 1, “Health Sector Policy Support Programme (HSPSP)” MR-108141.01, 28/11/2008.

<sup>358</sup> Health Sector Policy Support Programme: Compliance Assessment for the release of First Tranche, Note for the attention of Mr R. Weber, European Union, Delegation of the European Commission in Egypt, Cairo, p.8

<sup>359</sup> European Commission (2008), Monitoring Report no 1, “Health Sector Policy Support Programme (HSPSP)” MR-108141.01, 28/11/2008.



The EUD places high priority on capacity development and there is a renewed emphasis on this issue within the MoHP and the sector programme, according to the ROM report of 2008. The SPSP makes provision for appropriate TA but to date the MoHP has not requested external TA until end of 2008.

Two TA FWC were launched since 2008 (both are available in CRIS). In the framework of the HSPSP, the Ministry of Health submitted to the EC Delegation a request for mobilising a Technical Expertise in area of healthcare facilities design in June 2009. A FWC procedure was consequently launched. According to the EAMR 2009, the unused budget earmarked for TA was supposed to be transferred to the third tranche as part of the budget support.<sup>360</sup>

**I-523** The ROM report of the Health Sector Policy Support Programme (HSPSP II)<sup>361</sup> notes that no data are available on procurement issues but that it is likely that the any procurement financed by the MoHP with SBS funds can only use their own procurement system.

No further information was available in the documents reviewed.

#### 6.6.2.2 Resume of the JC

The EC contribution to the strengthening of the operational, institutional and procedural system seems quite limited in scope, but overall positive, according to the documents reviewed. This is due on the one side on no direct interventions tackling these issues as well as the specific context of the GoE (no MTEF).

Furthermore, the document review reveals the reluctance of the GoE and specifically the MoHP to make use of technical assistance, which then limits the possibility of the EC to contribute to capacity building on issues related to transparent and accountable budgeting processes

---

<sup>360</sup> EAMR-External Assistance Management Report 2009

<sup>361</sup> European Commission (2008) Monitoring Report 'Health Sector Policy Support Programme (HSPSP)', MR-108141.01, 11/2008.

## 6.7 Annex

### 6.7.1 Key documentation used for the analysis

#### 6.7.1.1 Project documentation of main interventions

<i>Intervention</i>	<i>TAP</i>	<i>Evaluations</i>	<i>ROM</i>	<i>Progress (MTR)</i>	<i>Final reports</i>
HSPSP II-Health Sector Policy Support Programme II (2010)-ENPI/2009/020-494	available	Not available	Not available	Formulation report available	Not available
Support to health sector reform (2006...) MED/2006/018-249	available	Not available	available	Compliance report available	Not available
Support to health sector reform (1998) MED/1998/004-295	available	Not available	Available: MR 1, 2 and 3	Not available	Not available
(MED/2006/018-252) Contract 213554 Evidence based telemedicine and decision support system for remote and rural underserved regions in Egypt using e-health platforms	available		available	Not available	Not available
(MED/2006/018-252) Contract 213666 Development of anti-hepatitis C virus (HCV) drug from blue green algae					

#### 6.7.1.2 EC documentation on the health sector in the country

<i>Source</i>	<i>Explored</i>
CSE	ADE (2010), Evaluation of the European Commission's Support with Egypt, Country Level Evaluation.
EAMR	Available from 2005 until 2009
Country note from old health evaluation	Not available
Other Evaluations	

#### 6.7.1.3 Bibliography

ADE (2010), Evaluation of the European Commission's Support with Egypt, Country Level Evaluation.

Ahmed AM, Allam MF, Habil ES, Metwally AM, Ibrahiem NA, Radwan M, El-Gaafary MM, Afifi A, Gadallah M. 2010. Development of practice guidelines for hemodialysis in Egypt. Indian J Nephrol. 2010 Oct;20(4):193-202.

Conseil Santé (2009), Health Sector Policy Support Programme - Formulation Study.

EAMR 7/2009

EAMR 1/2007

EAMR 7/2005,

EAMR-External Assistance Management Report 2009

EAMR-External Assistance Management Report 2010

EC Support to the Health Sector Reform Programme, Project Number DG1B/EG/B7-4100/1B1050/98, Commission of the European Communities Government of Egypt

Egypt's Mutual Accountability Mechanism In the Health Sector, June 2011



- Egypt's Mutual Accountability Mechanism In the Health Sector, HSPSP Mutual Accountability report and matrix, June 2011
- Egypt's Mutual Accountability Mechanism In the Health Sector, PCPE Mutual Accountability report and matrix, June 2011
- El-Zanaty, Fatma, Enas M. Hussein, Gihan A. Shawky, Ann A. Way, and Sunita Kishor. 1996. Egypt Demographic and Health Survey 1995. Calverton, Maryland [USA]: National Population Council [Egypt] and Macro International Inc.
- El-Zanaty, Fatma and Ann A. Way. 2004. *Egypt Interim Demographic and Health Survey 2003*. Ministry of Health and Population Council, El-Zanaty and Associates, and ORC Macro.
- El-Zanaty, Fatma and Ann Way. 2001 Egypt Demographic and Health Survey 2000. Calverton, Maryland [USA]:
- El-Zanaty, Fatma and Ann Way. 2006. Egypt Demographic and Health Survey 2005. Cairo, Egypt: Ministry of
- El-Zanaty, Fatma and Ann Way. 2009. Egypt Demographic and Health Survey 2008. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International.
- European Commission (2005), Monitoring Report no 3, "EC Support to the Health Sector Reform", MR-10134.03 – 20/06/05.
- European Commission (2006), Financial Agreement - Support to health sector reform (MED/2006/018-249).
- European Commission (2008), Monitoring Report no 1, "Health Sector Policy Support Programme (HSPSP)" MR-108141.01, 28/11/2008.
- European Commission Delegation to Egypt (2008). Compliance report for the release of 2nd tranche of EC support health sector policy support program decision med/2006/18249.
- MONITORING REPORT, EGYPT – EC Support to the Health Sector Reform Programme in Egypt. MR-10134.04 – 28/06/06.
- Fatma H. El-Zanaty, Hussein A. A. Sayed, Hassan H. M. Zaky, and Ann A. Way. 1993. Egypt Demographic and Health Survey 1992. Egypt National Population Council and Institute for Resource Development/Macro Systems Inc.
- Financing agreement between the European community and the Arab Republic of Egypt, Health Sector Policy Support Programme, Project Number: MED/2006/018-249.
- Health and Population, National Population Council, El-Zanaty and Associates, and ORC Macro; and Id.
- Health Sector Policy Support Programme, 3rd Tranche Compliance Report
- Health Sector Policy Support Programme II, 1st Tranche Compliance Report
- Health Sector Policy Support Programme (HSPSP), Request for amendment including extension of Commission Decisions and/or Financing Agreements, Explanatory Note
- Health Sector Policy Support Programme: Compliance Assessment for the release of First Tranche, Note for the attention of Mr R. Weber, European Union, Delegation of the European Commission in Egypt, Cairo
- Health Sector Policy Support Programme (HSPSP), European Union Delegation of the European Union to Egypt, Note for the file, State of play of the Programme's targets and conditions for the release of the last tranche, 2010
- Health Sector Policy Support Programme (HSPSP), European Union Delegation of the European Commission in Egypt, HSPSP Third Tranche to be disbursed in 2010, Current assessment (28th October 2009)
- Health Sector Policy Support Programme (HSPSP), D-018249, MR-108141.01, Kevin Lyonette and Maria Paalman , 28/11/2008
- Hussein Abdel-Aziz Sayed, Maged I. Osman, Fatma El-Zanaty, and Ann A. Way. 1989. Egypt Demographic and Health Survey 1988. Egypt National Population Council and Institute for Resource Development/Macro Systems Inc.
- Imam IZ. 1985. Immunization and primary health care in Egypt. *Trop Geogr Med.* 1985 Sep;37(3).
- Langsten R, Hill K. Diarrhoeal disease, oral rehydration, and childhood mortality in rural Egypt. *J Trop Pediatr.* 1994 Oct;40(5).
- M. Gadallah, B. Zaki, M. Rady, W. Anwer and I. Sallam. 2003. Patient satisfaction with primary health care services in two districts in Lower and Upper Egypt, *La Revue de Santé de la Méditerranée orientale*, Vol. 9, NO 3, 2003.

Mapping of healthcare financing in Eastern Mediterranean Region, Arab Republic of Egypt.

Miller PC. Trends in the management of childhood diarrhoea in Egypt: 1979-1990. J Diarrhoeal Dis Res. 1992 Dec;10(4).

Ministry of Health and Population (MoHP) [Egypt], El-Zanaty Associates, and ORC Macro. 2003. Egypt Service Provision Assessment Survey 2002. Calverton, Maryland: Ministry of Health and Population, El-Zanaty Associates, and ORC Macro.

Policy Brief #3, Pro poor health care for Egypt. The policy brief is based on the 2005 Egypt Human Development Report.

Presidential Decree 242/1996, the Official Gazette, Issue 30, 1 August 1996, quoted in: The TRIPS Agreement and Egypt's Responsibility to Protect the Right to Health, Right to Health Program Egyptian Initiative for Personal Rights, January 2005,

Request for amendment including extension of Commission Decisions and/or Financing Agreements, Explanatory Note

UNDP. Egypt Human Development Report 2005: Choosing our Future: Towards a New Social Contract.

United States Agency for International Development (2010): National Health Accounts 2007/2008 : Egypt Report, September 2010

USAID (2011): Egypt Health and population legacy review Volume 1, March 2011

WHO Eastern Mediterranean Regional Health System Observatory: Health Systems Profile- Egypt, 8 HEALTH SERVICE DELIVERY.

WHO Eastern Mediterranean Regional Health System Observatory: Health Systems Profile- Egypt, 7 HUMAN RESOURCES.

WHO/HAI Medicine Prices Project. Medicine in Egypt, Survey Report. The prices people have to pay for medicines in Egypt, July 2004.

Zaky HH, Khattab HA, Galal D. 2007. Assessing the quality of reproductive health services in Egypt via exit interviews. Matern Child Health J. 2007 May;11(3):301-6.

## Weblinks

<http://apps.who.int/ghodata/#>

<http://www.alexmed.edu.eg/node/612>

[http://www.cabinet.gov.eg/AboutEgypt/Egyptian\\_constitution.aspx](http://www.cabinet.gov.eg/AboutEgypt/Egyptian_constitution.aspx)

<http://www.drguide.mohp.gov.eg/newsite/e-learning/ICD10/Practice%20Guidelines%20For%20Family%20Physicians%20Volume%204.pdf>

<http://www.mop.gov.eg/english/sixth%20five%20year.html>

<http://gis.emro.who.int/HealthSystemObservatory/PDF/Egypt/Human%20resources.pdf>,

<http://www.tradingeconomics.com/egypt/out-of-pocket-health-expenditure-percent-of-private-expenditure-on-health-wb-data.html>;

[http://eipr.org/sites/default/files/reports/pdf/TripsReport\\_EIPR\\_2005\\_EN.pdf](http://eipr.org/sites/default/files/reports/pdf/TripsReport_EIPR_2005_EN.pdf)

WHO EMRO Country Profile Egypt, <http://www.emro.who.int/emrinfo/>

WHO Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

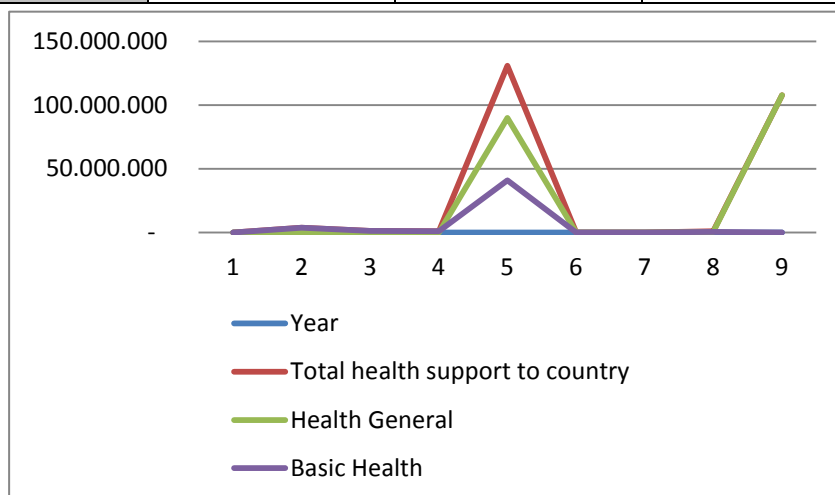
WHO Mortality data, 20011, <http://www.who.int/healthinfo/statistics/mortality/en/index.html>

## 6.7.2 EU funds between 2002-2010 –detailed listing:

### 6.7.2.1 Per Subsector

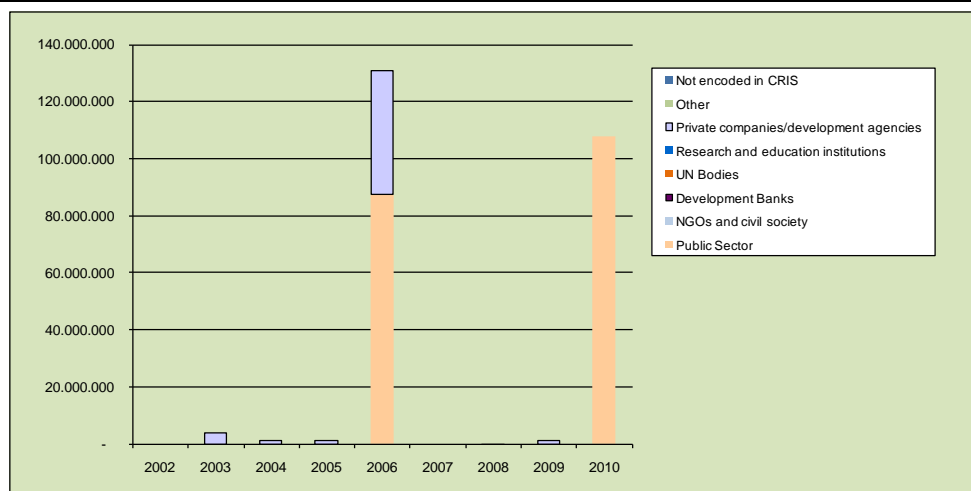
Year	Health General	Basic Health	SRH	Total health support to country
2002	-	-	-	-
2003	-	3,685,947	-	<b>3,685,947</b>
2004	-	1,251,720	-	<b>1,251,720</b>
2005	-	973,409	-	<b>973,409</b>
2006	87,640,410	43,174,806	-	<b>130,815,216</b>
2007	-	-	-	-
2008	127,658	-	-	<b>127,658</b>
2009	504,809	586,221	-	<b>1,091,030</b>

2010	107,700,000	-	-	<b>107,700,000</b>
<b>Total</b>	<b>195,972,878</b>	<b>49,672,104</b>	-	<b>245,644,981</b>



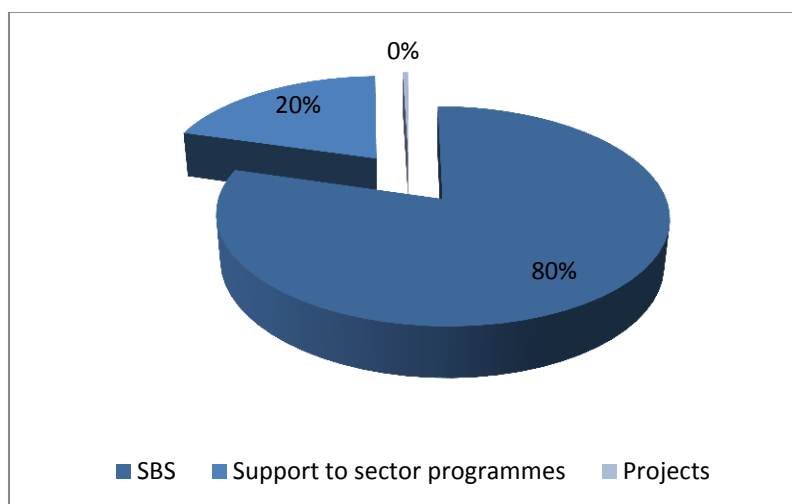
### 6.7.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	-	-	-	0
2003	-	-	-	-	-	3,685,947	-	-	3,685,947
2004	-	199,900	-	-	-	1,051,820	-	-	1,251,720
2005	-	-	-	-	-	973,409	-	-	973,409
2006	87,355,054	-	-	-	-	43,460,162	-	-	130,815,216
2007	-	-	-	-	-	-	-	-	0
2008	-	-	-	-	-	127,658	-	-	127,658
2009	250,981	-	-	-	-	840,049	-	-	1,091,030
2010	107,700,000	-	-	-	-	-	-	-	107,700,000
<b>Total</b>	<b>195,306,035</b>	<b>199,900</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50,139,046</b>	<b>0</b>	<b>0</b>	<b>245,644,981</b>



### 6.7.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	-	-	-	-
2003	-	3,685,947	-	-	3,685,947	-
2004	-	1,251,720	-	-	1,251,720	-
2005	-	973,409	-	-	973,409	-
2006	87,355,054	43,174,806	285,356	-	130,815,216	-
2007	-	-	-	-	-	-
2008	-	-	127,658	-	127,658	-
2009	335,240	-	755,790	-	1,091,030	-
2010	107,700,000	-	-	-	107,700,000	-
<b>Total</b>	<b>195,390,294</b>	<b>49,085,882</b>	<b>1,168,805</b>	-	<b>245,644,981</b>	-



### 6.7.3 Overview of funds committed to the country's health sector

Title of the intervention	Decision number	Decision starting year	Committed amount for the intervention
EC Support to the Health Sector Reform Programme (EGY/B7-4100/IB/98/1050)	MED/1998/004-295	1998	EUR 49,085,882
ALLOCATION GLOBALE MEDA 2005/2006	MED/2005/017-088	2005	EUR 90,162
Support to health sector reform	MED/2006/018-249	2006	EUR 87,690,294
Research, development and innovation	MED/2006/018-252	2006	EUR 755,790
ALLOCATION GLOBALE MEDA 2006/2007	MED/2006/018-255	2006	EUR 195,195
ALLOCATION GLOBALE ENPI COOPERATION SUD 2007	ENPI/2007/019-080	2007	EUR 127,658
HSPSP II-Health Sector Policy Support Programme II	ENPI/2009/020-494	2009	EUR 107,700,000
<b>Grand Total</b>			<b>EUR 245,644,981</b>

## 6.7.4 Overview of main programmes/funds and sectors

<i>Title of the intervention</i>	<i>Decision number</i>	<i>Decision starting year</i>	<i>Contract title</i>	<i>Contract number</i>	<i>Contract year</i>	<i>Implementation starting date</i>	<i>Closing Date</i>	<i>Contracting party</i>	<i>Total per contract</i>
<b>HSPSP II-Health Sector Policy Support Programme II</b>	ENPI/2009/020-494	2009	Health sector policy support programme II	256046	<b>2010</b>			JUMHURIYAT MISR AL ARABIYAH	EUR 107,700,000
<b>Support to health sector reform</b>	MED/2006/018-249	2006	HOSPITAL GENERAL AND INTERIOR DESIGN	210444	<b>2009</b>			COWI BELGIUM SPRL	EUR 193,086
			HSPSP: Health Sector Policy Support Programme	132325	<b>2006</b>			JUMHURIYAT MISR AL ARABIYAH	EUR 87,355,054
			PRIMARY HEALTH CARE PROVIDER NETWORK, REVIEW OF THE NATIONAL STRATEGY	213633	<b>2009</b>		<b>08.07.2010</b>	EUROPEAN CONSULTANTS ORGANISATION SPRL	EUR 142,154
<b>EC Support to the Health Sector Reform Programme (EGY/B7-4100/IB/98/1050)</b>	MED/1998/004-295				1998				EUR 49,085,882

## 6.7.5 Description of main EC intervention

### 6.7.5.1 Intervention no 1 (Extraction & resume of the Financial Agreement ENPI/2009/020-494; Technical and administrative provisions)

**Title:** HSPSP II-Health Sector Policy Support Programme II

**Budget:** EUR 107,700,000

**Start and end date:** 2009

**Objectives and expected results:**

**Overall objective:**

The second Sector BS aims at supporting the Health Sector Reform Programme in Egypt by improving access to and quality of Public Primary Health Care. This intervention will focus on the improvement of the Primary Health Care provider network which, by being the backbone of the Health Sector Reform, will better provide the whole population and especially the poor, with an access to affordable basic quality health care. (source EAMR)

Financial agreement

- support the Government of the Arab Republic of Egypt in implementing its Health Sector Reform Programme by improving access to quality Primary Health Care.

**Specific objective:**

- improve the quality of the health services provided by the public PHC Provider Network
- improve client satisfaction and utilisation rates of the upgraded public PHC Provider Network facilities: and strengthen the systemic, social and financial sustainability of the Family Health Model.

NB: The specific objectives of the HSPSP-II do not only entail quantitative and qualitative improvement of PHC services through the national roll-out of the Family Health Model. But also address the utilisation and universal access of these services by beneficiaries.

**Expected results:**

- The HSPSP-II aims to achieve following three main results through the four phase gradual implementation of activities:

**Result /Activity 1:**

Around 1.000 primary health care units (representing about 18% of the total of public primary health care facilities) will be upgraded following the guidelines of the Family Health Model, thereby improving the geographical access of the Egyptian population to quality PHC services. The approach will entail the following:

- A standardised model for building and equipping facilities will be used for the infrastructure development of the PHC Provider Network, thereby improving investment effectiveness.
- Training needs assessments will be carried-out in all the physically reconditioned and reequipped primary health care Family Health Units Centres. The key staff of these units will be trained in technical and managerial skills targeted to official standards.
- Once facilities are physically upgraded and re-equipped and the staff trained, the primary health care Family Health Units/Centres will take steps towards accreditation by the MoB Quality Department in conformity with nationally approved standards of quality.
- Stability in the staffing levels of qualified key staff (in particular family health doctors and nurses) will be monitored and strengthened by the programme.

The availability of a set of essential medicines will be improved at reformed or accredited PHC facility level (the measurement will be based on a random sample of 100 accredited facilities).

**Result /Activity 2:**

The better coverage of the Egyptian population with quality integrated PHC services' will translated into higher consumption of quality health services and a higher degree of client satisfaction and will be measured as follows:

- The utilisation rate of the accredited facilities will be monitored using the routine data of the National Health Information Centre;
- Household surveys and exit-polls will be designed to measure the utilisation rate of the PHC Provider Network by the catchment area population and the poor. The surveys will explore and provide relevant and accurate information "from the field" concerning:
- PHC facilities infrastructure, equipment. and essential non-medical and medical supplies (availability of essential medicines including for chronic diseases such Arterial Hypertension (AHT). diabetes)
- Enrolment and re-enrolment of uninsured catchment area population
- The official service charges and the out-of-pocket expenditures will be measured for monitoring purposes only;
- Awareness level of catchment area population about exemption policies for the poor in reformed facilities.
- Overall utilisation rates in the catchment area including for the poor; satisfaction rate of the catchment area population in reformed facilities.

**Result /Activity 3:**

The **social and fiscal sustainability of the PHC Provider Network will be strengthened and increase in enrolment** if catchment area populations covered by reformed facilities, which reflects a higher quality PHC services provision, increased confidence of the population in the quality of care provided and implementation of a streamlined performance-based incentive policy. This approach will entail the following:

- The established contractual relationship between the accredited Family health Units/Centres and the Family Health Fund will be promoted and monitored;
- The enrolment of the population in the catchments areas of contracted facilities will be promoted and monitored (measuring the confidence and the willingness of the population to subscribe to and participate in the reformed PHC system);
- In the governorates where the new social health insurance is established, the enrolment of the poor previously identified by the Ministry of Social Solidarity will be targeted by the MoH;
- The financial stance of the existing PHC public purchasing entities will be monitored and strengthened;
- The PHC staff retention policy will be streamlined. The legislation defining the parameters for staff incentive payments will be updated and applied to all PHC Units.

**6.7.5.2 Intervention no 2**

<b>Title:</b> Support to health sector reform
---

**Budget:** EUR 87,690,294

**Start and end date:** 2006

**Objectives and expected results:** (Source: MED/2006/018-249)

**Overall objective:**

Accompany the reform of health sector in its strategic short, medium and long term objectives by rolling-out and developing relevant experiments of HSRP 1 into *an Integrated Health System*, centred on the Family health model, promoting good governance and fiscal, financial, institutional and technical sustainability.



**Specific objective:****a. To ensure fiscal and financial sustainability**

- To strengthen fiscal comprehensiveness, transparency sustainability and effectiveness
- To restructure a financially-sound sector-wide health insurance system

**b. To ensure governance and institutional sustainability**

- To streamline the legal, regulatory and institutional framework for the health care sector

**c. To endure technical and professional sustainability**

- To strengthen and facilitate the reorganisation of the service delivery along the family health model piloted during phase one.

**Expected results:**

- A *health system governance*, with a clear division of responsibilities between the MoHP, Governorates and district health authorities, purchasers; providers, and beneficiaries.
- A *health insurance system* properly organized and managed by a single payer, capable to generate revenues as a mix of premium-based and taxation-based sources, financially sustainable, able to cover the whole population, offering a negotiated and defined EBP, capable to contract public and private providers, and to remunerate them according to a stated mechanism.
- *Regular review and adaptation* of an evidence-based BBP delivered through the FHM as epidemiological, technical and economic developments require, and/or, as increased funding permits, including additional essential services based on a constant scrutiny, according to the GBO and DALY assessment methodology.
- Sound investment planning based on rationalisation of the *health-care infrastructure*, mainly at primary and secondary and eventually tertiary levels, with an expansion of the FHM beyond the geographic areas presently covered and based on HSRP pilot Governorates.
- Long-term *planning and reorientation of human resources*, with outputs appropriate in volume, profile and distribution, skilled to manage the reformed services and the new paradigm for health.
- A *well-established and rolled-out system of quality assurance and continuous quality improvement*, with CPD-based revalidation of staff, the adoption of clinical guidelines, formal and compulsory accreditation of facilities, and formal quality audit and supervision, supporting performance-based budgeting and remuneration.

**Activities:****Component A: Strengthened Fiscal Comprehensiveness, Transparency, Sustainability and Effectiveness**

- The programme will support macro-economic policies geared to fostering long term sustainability of the health sector financing, in a general framework that aligns the sector to the needed and ongoing reforms in the Egyptian fiscal and treasury system.
- Credible fiscal transactions have to be done through a Single Treasury Account and fiscal decentralization. The Parliament will need reviewing budget execution and will have the possibility to reallocate financial resources according to the documented sector needs and requirements.
- Published long-term forecasts and coherent design and implementation of fiscal rules will promote, inter alia, a fair participation of the private sector in the health insurance industry as well as of private investors in the delivery of competitive quality services in the needed volume and profile.
- Appropriate regulations, accounting mechanisms and institutional investments will be put in place in order to allow for a successful PBB test-case in the health sector, aligned with the current programme the EC is supporting in the water sector, thus maximizing the impact on the overall public sector.

**Component B: Financially-Sound Restructured Sector-Wide Health Insurance System**

- A single national social health insurance organisation willing corporate a reformed HIO and the FHF, that will expand into the new organisation.

- The BSP for the whole population will include primary and secondary care services and providers will be remunerated by means of clear and agreed mechanisms
- The extended coverage of beneficiaries and possibly compulsory schemes will allow for a larger risk-pooling and for a progressive decrease of PTES scheme, that will be covered by the national fund, divesting payment from the budget and addressing the needs of the poor by the increased risk-pooling and premium formula flexible recalculation, besides economies of scale due to the progressive inevitable downsizing of inefficiencies in the system.
- Any adopted remuneration managed by the public purchaser will require autonomy of the provider, a contract between the purchaser and the provider, a system of enrolment of clients, and calculated formulae to adjust allocations for age, sex and clinical variables of the enrolled population. It could be complemented by a system of incentives, for example for good execution of prevention programmes, quality improvement, savings based on appropriateness of care delivered or achieved benchmarks.

### Component C: Streamlined Legal, Regulatory and Institutional Framework

### Component D: Reorganised Quality-Based Health Care Services centred on Integrated Family Health Model

- A needs-based master plan will be developed according to guidelines elaborated since 1999 by the USAID funded TA, and updated by the MoHP Health Reform Technical Support Office. In parallel, major development work will begin in terms of reforming the sector management and organization, based on central level institutions pivotal reorganization. In the emergency-care area, issues such as planning in a wider perspective than the (relatively simple) improvement of clinical care quality and competence need to be addressed as first aid can become the flagship activity for the health system. The complex and articulated body of norms that allows for the establishment of a proper unified national system for emergency may rely on a strong European added value and on several Member States' good practice.

#### 6.7.5.3 Intervention no 3

**Title:** EC Support to the Health Sector Reform Programme (EGY/B7-4100/IB/98/1050)

**Budget:** EUR 49,085,882

**Start and end date:** 1998

**Objectives and expected results:** ( Source: MED/1998/004-295)

#### Overall objective:

The long-term objectives of the Egyptian Government's Health Sector Reform Programme (HSRP) are to:

- provide universal access to health care services and formal health insurance coverage,
- promote equity in both the financing and delivery of care,
- improve the allocative and technical efficiency of the service delivery system,
- improve the quality of the services,
- promote the system's long run financial sustainability.

#### Specific objective:

The specific objectives of the EC Support to HSRP are:

- to improve the health status of the population in a minimum of three governorates through the establishment of a financially sustainable "basic package" of necessary preventive, curative and public health services;
- to strengthen MoP's policy making, planning, monitoring and regulatory role, within a client-driven and decentralised operational framework.

#### Expected results:

The expected results of EC support to the HSRP in the targeted governorates will be:

- financially sustainable health system providing universal access to an integrated and comprehensive "basic health care package";
- a flexible and efficiently managed health care delivery system;
- the basis for a fully national primary and, eventually, secondary and tertiary Egyptian health care service.

The programme will make a significant contribution to Egypt's medium-term plan to reduce national:

- infant mortality rates from 38/1,000 to 29/1,000;
- under-five mortality from 84/1,000 to 64/1,000;
- deaths of women due to pregnancy and delivery from 160/100,000 to 90/100,000.

Eventually, a basis for an effective primary and secondary and tertiary health care service will be accessible to all Egyptians.

**Activities:**

During the initial five-year programme phase, and in conjunction with GoE activities and support provided by other donors, the EC will support:

- the development of district health plans to serve as the basis for comprehensive governorate health plans to be finalised in a minimum of three governorates of Egypt;
- the development and provision of basic packages of preventive, curative and public health services covering a minimum of three governorates of Egypt;
- human resources development, institutional re-structuring, and rationalisation, including rational drug use, by the central, governorate and district levels of the MoHP and other associated bodies;
- the MoHP in introducing new human resource policies and practices geared to the HSRP in a minimum of three governorates;
- the development of a viable health insurance system to assure the financing of universal access to a "basic package" of necessary preventive and curative and public health services in a minimum of three governorates;
- the MoHP in developing policy options to define the roles and responsibilities of bodies operating at the central, governorate and district levels.

## 7 Annex 11: Country case study Moldova

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

Country case study

MOLDOVA



## Table of content

<b>1.1</b>	<b>Introduction .....</b>	<b>227</b>
1.1.1	Country context of EC support.....	227
1.1.2	EU funds between 2002-2010: .....	227
<b>1.2</b>	<b>EQ1- Quality of health services: To what extent has EC support contributed to enhancing the quality of health services? .....</b>	<b>231</b>
1.2.1	JC 11 Availability of essential drugs improved due to EC support .....	231
1.2.2	JC 12 Improved availability of quality health infrastructure (physical structure of facilities, equipment) due to EC support.....	231
1.2.3	JC 13 Improved availability of qualified human resources for health due to EC support .....	233
1.2.4	JC 14 Increased or maintained quality of service provision .....	235
<b>1.3</b>	<b>EQ2- Affordability of health: To what extent has EC support to health contributed to increasing affordability of health care, especially for the poor? .....</b>	<b>236</b>
1.3.1	JC 21 The cost of basic health care services are reduced for households due to EC support.....	236
1.3.2	JC 22 Increased development and sustainability of special schemes to ensure availability of health care to groups with special health care needs supported by the EC .....	239
1.3.3	JC 23 Improvements in health finance policies to enhance affordability of services supported by the EC .....	240
<b>1.4</b>	<b>EQ3- Health facilities availability: To what extent has EC support contributed to improving geographical availability of health facilities especially for the poor?.....</b>	<b>241</b>
1.4.1	JC 31 Increase in availability of primary health care facilities .....	241
1.4.2	JC 32 Increase in availability of secondary health care facilities.....	242
<b>1.5</b>	<b>EQ4- Health service utilisation related to MCH: To what extent has EC support to health contributed to improving health service utilisation related to MCH?.....</b>	<b>243</b>
1.5.1	JC 41 Increased use of appropriate ante-natal and maternal health care supported by the EC .....	243
1.5.2	JC 42 Increased use of services and facilities to support health care for children supported by the EC .....	243
1.5.3	JC 43 Children better protected from key health threats as a result of EC support.....	245
<b>1.6</b>	<b>EQ5- Management and Governance: To what extent has EC support to health contributed to strengthening the management and governance of the health system?.....</b>	<b>245</b>
1.6.1	JC51 Improved availability of policy analysis and data for health sector management and governance due to EC support.....	245
1.6.2	JC52 Strengthened and operational institutional and procedural system related to transparency and accountability issues at national and sub-national level due to EC support.....	247
<b>1.7</b>	<b>Annex .....</b>	<b>249</b>
1.7.1	Key documentation used for the analysis .....	249
1.7.2	EC contribution per sector, modality and channel .....	251
1.7.3	Overview of EC support to the health sector during 2002-2010.....	254
1.7.4	Details of programmes.....	256

### Table of tables

Table 1:	Overview of funds committed to the country's health sector, Moldova, 2002-2010.....	229
----------	---	-----

Table 2:	Number of physicians and nurses per 100,000 populations .....	233
Table 3:	Health expenditures in Moldova, 2000-2009 .....	237
Table 4:	Out-of pocket payments for health care in 2000-2005, Moldova.....	237
Table 5:	Social health insurance contributions by sources, % .....	238
Table 6:	Immunisation coverage among 1-year olds, Moldova: 2000-2009.....	244
Table 7:	HSDS sections: SPSP targets .....	257

**Table of Figures**

Figure 1:	Relative utilisation of health services by category of insured (average for 2005–2006) .....	240
Figure 2:	Hospital beds per 1,000 people, Moldova: 1980-2008 .....	242



## 7.1 Introduction

### 7.1.1 Country context of EC support

Prior to independence, Moldova had, even by Soviet standards, a dense health system. After independence, it found itself afflicted with a classic bundle of structural weaknesses (information taken from 2007 CSE).

- A commitment to universal treatment on demand that was financially unsustainable.
- Absence of a functioning health insurance system combined with crumbling fiscal transfers to the health system. The results were low salaries, decrepit infrastructure and chronic shortages of needed supplies and medicines.
- Too many specialised physicians, not enough family practitioners.
- Over-allocation of resources to secondary acute care facilities, under-allocation to primary health care.
- Absence of a health-promotion approach.

Finally, and setting Moldova apart, brain drain of doctors and nurses to positions in Europe was significant.

Significant rationalisation of facilities and human resources began in the mid- to late-1990s. Major health sector reforms, including the introduction of compulsory health insurance which now covers around 82% of the population, date from 2008.

Moldova guarantees a minimum package of free medical assistance. The minimum package of services includes the following:

- Primary health care services provided by a family doctor in an ambulatory care unit or at home;
- Consultations with specialists in polyclinics and hospitals (when patient is included on the family doctor's list and is referred by the family doctor);
- A limited range of diagnostic tests and elementary investigations conducted in ambulatory laboratories (when prescribed by the family doctor);
- Immunisation (through National Immunisation Programme);
- Urgent and emergency services in life-threatening situations;
- Hospital care for treatment of tuberculosis, mental disorders, cancer, asthma, diabetes, HIV/AIDS and some other infectious diseases.<sup>362</sup>

The poorest country in Europe, characterised by heavy alcohol and tobacco consumption, Moldova, scores poorly on a wide range of health indicators. Yet, as documented by many of the Indicators below, significant improvements in some of the most important of these have been reported over the last ten years.

### 7.1.2 EU funds between 2002-2010:

*Full details of EC support are given in Annex 1.1.1.*

EU health sector support in Moldova dates back to the mid-1990s under Tacis. During the present evaluation period, Support to Health Reform II under the Tacis Action Plan 2001 was implemented 2001-2003, Health Promotion and Disease Prevention under the Tacis Action Plan 2003 was implemented 2003-2005, together with Public Health Reform (2005-2007). Support to Health Reform: Strengthening the Primary Health Care in Moldova (2008-2010) was implemented under Tacis Action Plan 2005. Under the same budget line, a project Supply of Medical Equipment to Primary Health Centres in Moldova was funded. Moreover, the EU co-funded the project Capacity assessment and modernisation of the Republican Clinical Hospital in Chisinau.

These interventions, and some other, more specialised ones (e.g. Work on Migration of Health Professionals and Health Care Needs of Migrants implemented by IOM under the Migration and Asylum budget line) are dwarfed by the ENPI-financed Health Sector Policy Support Programme (HSPSP). HSPSP was designed to support the 2008-2017 Health Sector Development Strategy, which stressed four goals: (i) Improving stewardship of the health system, (ii) improving health system funding and payment mechanisms for health services, (iii) organising and providing health services in

<sup>362</sup> Atun R, Richardson E, Shishkin S, Kacevicius G, Ciocanu M, Sava V and Ancker S. Moldova: Health system review. *Health Systems in Transition*. 2008;10(5): 1–138.

line with requirements and tailored to individual needs and (iv) generating and assuring the necessary resources for the health system. As noted in the 2008 Delegation Note Budget Support<sup>363</sup> 2008 First Tranche, the Government of Moldova had prepared a Medium-term Expenditure Framework (MTEF) for health. The note also considered the general situation regarding public financial management, citing improvements that would permit the first tranche to go ahead.

In general, the EU's support to the health sector has been targeted at re-organising the MoH, better policy making and resource allocation mechanisms, increasing the supply of family physicians and health promotion activities, strengthening primary health care and, in particular, improving financial management in the health system. In the CSP/NIP 2002-2006<sup>364</sup>, health sector interventions were classified as sub-priorities under priority "Support for institutional, legal, and administrative reform." The same held for the CSP/NIP 2004-2006. There appeared to be a slight strategic shift in the 2007-2010 ENPI NIP<sup>365</sup>, where health is moved to the focal sector 'Poverty Reduction' and increased access to health care (including infrastructure support) was foreseen, with indicators given including concrete health outcome measures.

---

<sup>363</sup> Delegation of the European Union/Moldova, Delegation Note on 2008 Budget Support First Tranche, 2008

<sup>364</sup> European Commission and Government of the Republic of South Africa, South Africa – European Community Country Strategy Paper and Multi-annual Indicative Programme for the period 2003-2005

<sup>365</sup> European Commission and Government of the Republic of South Africa, South Africa – European Community Joint Country Strategy Paper for the period 2007-2013

Table 49: Overview of funds committed to the country's health sector, Moldova, 2002-2010

<i>Decisions Title</i>	<i>Contracts Title</i>	<i>Decision No</i>	<i>Contract year</i>	<i>Contracted amount per contract</i>
MO0101 Moldova AP 2001	Health promotion and disease prevention	TACIS/2001/000-546	2002	<b>EUR 2,754,162</b>
	Mental Health Development in Moldova - IBPP01-0167	TACIS/2001/000-553	2002	<b>EUR 157,206</b>
	Feasibility Study for the Implementation of a National Health Insurance System in Moldova	TACIS/2001/000-546	2003	<b>EUR 49,864</b>
Tacis Support Expenditure 2004 (BA)	Survey on HIV/AIDS awareness in Ukraine and Moldova	TACIS/2004/006-202	2004	<b>EUR 18,500</b>
	TOR for the project Development of integrated social services for vulnerable families and children at risk	TACIS/2004/006-202	2004	<b>EUR 20,699</b>
	TOR Public Health Reform, Moldova	TACIS/2004/006-202	2004	<b>EUR 22,815</b>
<b>Moldova 2003 Tacis Action Programme</b>	<b>Developing a comprehensive community-based intervention for monitoring and improving the reproductive health of young people and prevent violence in Laloveni, Moldova</b>	(blank)	2006	<b>EUR 43,721</b>
	<b>Increasing the social and professional integration of young people with mental disabilities - graduates of four auxiliary boarding schools in Moldova</b>	(blank)	2006	<b>EUR 49,924</b>
	<b>Public Health Reform in Moldova</b>	TACIS/2003/005-604	2005	<b>EUR 1,936,880</b>
	<b>Supply of IT Hardware Equipment for Public Health Care reform Moldova</b>	TACIS/2003/005-604	2006	<b>EUR 348,960</b>
Tacis Programme for Accompanying measures 2005-2006	Developing a framework for the introduction of a SWAP to the health care system in Moldova	TACIS/2005/017-749	2006	<b>EUR 187,286</b>
	Preparation ToR for service contract Support to health reform by strengthening of PHC in Moldova	TACIS/2005/017-749	2006	<b>EUR 34,703</b>
Contribution to the FSP for Moldova under the 2006 Budget of the EC	Capacity-Building of the Social Targeting Unit of the Ministry of Health and Social Protection of Moldova	FOOD/2006/018-310	2006	<b>EUR 111,707</b>
<b>TACIS 2005 Moldova Action Programme</b>	Preparation of Technical Specifications for Supply Contract for 'Support to Health Reform in Moldova'	(blank)	2007	<b>EUR 103,610</b>
	Health Sector Policy Support Programme (SPSP) Formulation Study, Moldova, ENPI 2008	TACIS/2005/017-094	2008	<b>EUR 134,727</b>

**Particip GmbH**

Thematic evaluation of the European Commission support to the health sector

<i>Decisions Title</i>	<i>Contracts Title</i>	<i>Decision No</i>	<i>Contract year</i>	<i>Contracted amount per contract</i>
	<b>Supply of medical equipment to Primary Health Care centres in Moldova (EuropeAid/126263/C/SUP/MD)</b>	TACIS/2005/017-094	2008	<b>EUR 3,773,175</b>
	<b>Support to Health Reform and Strengthening of Primary Health Care in Moldova</b>	TACIS/2005/017-094	2008	<b>EUR 1,199,976</b>
<b>Community Budget contribution to the NIF - ENPI East Region</b>	<b>MD-01 Capacity assessment and modernisation of the Republican Clinical Hospital (RCH) project in Chisinau</b>	ENPI/2007/019-549	2008	<b>EUR 3,000,000</b>
Global commitment for global in-country calls for proposal - Objective 1- PVD Projects - Non State Actors	Developing and piloting sheltered housing service for people with mentally illness in Moldova	DCI-NSAPVD/2007/019-615	2008	<b>EUR 220,972</b>
Community Budget contribution to the NIF - ENPI East Region	"CEB-01 Lead IFI remuneration for project Capacity assessment and modernisation of the Republican Clinical Hospital"" in Chisinau (Republic of Moldova)"	ENPI/2007/019-549	2010	<b>EUR 100,000</b>
<b>Health Sector Policy Support Programme</b>	<b>Evaluation of ENPI 2008 / 019 - 655 Health SPSP</b>	ENPI/2008/019-655	2009	<b>EUR 148,100</b>
	<b>Sector Policy Support Programme Health</b>	DCI-MIGR/2010/022-215	2009	<b>EUR 42,000,000</b>
	<b>Health Sector Budget Support Related Technical Assistance</b>	ENPI/2008/019-655	2010	<b>EUR 2,992,753</b>
EIDHR 2009 Annual Action Programme - CBSS (Country Based Support Schemes)	Rehabilitation of torture victims from Moldova	(blank)	2010	<b>EUR 150,000</b>
Thematic Programme for Migration and Asylum AAP 2010 part 2 - Action Fiche 1 Moldova	Better managing the mobility of health professionals in the Republic of Moldova	DCI-MIGR/2010/022-215	2010	<b>EUR 2,000,000</b>
		<b>Total</b>		<b>EUR 61,559,739</b>

Source: CRIS database analysis, Particip GmbH, last extraction 2/2011)

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

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

#### Indicators

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

#### 7.2.1.1 Findings per indicators

**I-111:** The Indicator asks whether access to essential medicines and technologies is enshrined in policy documents setting forth citizens' entitlements. In fact, there is no section explicitly devoted to essential medicines in the national health policy. An essential drug list was prepared in 1998 on the basis of WHO recommendations and is updated regularly.

The policy matrix of the Health SPSP aimed at increasing annual allocation for compensated drugs by 30% in 2008 and by 40% in 2009 and 2010. According to the Review Mission Report (2009)<sup>366</sup> allocations for compensated drugs increased by 44.5% in 2009 compared with 2008, thus exceeding the target of 40%. Consequently the Health SPSP, by influencing allocations for compensated drugs, contributed to policy regarding the availability of essential drugs and technologies.

**I-112-** No data obtained. In the WHO World Health Statistics, which covers pharmaceutical availability, there is no line for Moldova. No information has been found in other sources. The EC seems not to have supported interventions directly related to this indicator. However, by strengthening health care finance through mandatory health insurance, the EC has indirectly relieved hospitals of the necessity of relying on pharmaceutical sales to raise general revenue. This financial strengthening, together with the policy matrix of the SPSP, would be consistent with more reliable drug supply.

#### 7.2.1.2 Resume of the JC

Besides contributions of the Health SPSP, no further EU programmes have focused on pharmaceuticals, but they have contributed to overall health sector reforms that could safely be assumed to contribute to improvements in access to needed medicines.

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

#### Indicators

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

#### 7.2.2.1 Findings per indicators

**I-121** The WHO World Health Statistics database does not distinguish between primary and secondary facilities and, as said, no data are reported for Moldova.

A priority focus of the EC's engagement under both Tacis and ENPI has been to strengthen the role of the primary health care sector. However, none of the programmes dealt specifically with the issue of facility allocation, and no statistics are available from strategic and project-related documents cited above (HSPSP reviews, etc.). However, restoring and increasing rural PHC infrastructure was a potential use of ENPI funds in 2007-2010. The HSPSP evaluation of November 2009 reported (p. 11)<sup>367</sup> that, following a review of investment norms, the rehabilitation of primary health care infrastructure started in 2007. It reported, under Objective 4.2, strengthening the technical and material base of institutions and facilities in the health system (p. 26), that review and rehabilitation performance requirements regarding PHC facilities had been fully achieved in 2008 and 2009.<sup>368</sup> The Review Mission report of October 2010 stated (p. 34) that, while rehabilitation of PHC infrastructure was ongoing, progress was slower than expected, perhaps because standards were out of line with

<sup>366</sup> EC (2009) Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Review Mission Report

<sup>367</sup> EC (2009) Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Review Mission Report

<sup>368</sup> EC (2010) Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Review Mission Report, Evaluation of ENPI SPSP Health Policy Matrix 2010

either budget available or actual workload of the centres. There is need to ensure that structure standards guiding rehabilitation are adapted to the situation. 16 centres were undertaking rehabilitation or reconstruction. Tenders were prepared for rehabilitating another four centres.

No information has been found regarding needed investments in secondary health facilities, so this information is of only limited relevance to the Indicator as stated. Nonetheless, rationalisation of infrastructure is a goal of the HSPSP. There has been a significant drop in the number of acute care hospital beds per 10,000 populations, mostly in the late 1990s, but continuing from 110 to 84 between 2002 and 2006.<sup>369</sup> This occurred in the context of resource rationalisation, however, it is not reported that PHC infrastructure was improved as a direct consequence.

In passing, the same report states (p. 80) that rationalisation of tertiary (republican) hospital infrastructure has proven much more difficult, as these are “prestige” institutions. Starting in 2008 and lasting until 2013, the EU co-funded the project “Capacity assessment and modernization of the Republican Clinical Hospital in Chisinau” with a EUR 3 million grant. However, no information is available on the progress of this project.

In summary, the EC has contributed to increase in PHC infrastructure, which would represent an improvement in the Indicator.

**I-122** It is reported that, as of 2005, the proportion of secondary facilities with outdated or non-functioning is unacceptably high, approaching 80% in areas outside Chisinau.<sup>370</sup>

The premises of most hospitals have exceeded the international standard of a 25-33 year operating life from the year of construction, depending on the type of infrastructure and the services provided by the institution. The average age of a typical Moldovan healthcare institution is about 45 years. Especially difficult is the situation of district healthcare institutions, which are facing major deficiencies in this regard. The level of equipment deficiency (i.e. equipment that is outdated or dysfunctional) varies between 60% in the national institutions and 80% in district institutions. In district healthcare institutions 20% of the equipment is out of order, while in the national hospitals 10% of the equipment is not functional.<sup>371</sup>

However, most of the equipment financed through EC support seems to be properly installed and functioning. The final report of 2010<sup>372</sup> to inspect the equipment supplied so as to detect any defect arisen since the provisional acceptance and to assess the training provided to PHC personnel by the suppliers, reported that 80% of the items delivered are correctly installed and in working condition; 5% are still in storage rooms, waiting for rooms to be ready, 1% are defective and have been sent for repair and 14% were not received or moved to another clinic, by decision of the MoH or for some unknown reason.

The Review Mission Report “Evaluation of ENPI SPSP Health Policy Matrix 2010” stated that significant progress is made regarding management of medical devices. The regulatory framework is being reviewed with Government endorsement; a Pilot Centre of Medical Technologies is established; the Drugs Agency is being transformed into Agency of Drugs and Medical Devices; a pilot database based on Open MEDIS IT is being installed in six large medical institutions providing medical services at Republican and Municipal levels.

In summary, the EC has contributed to improvements in the equipment situation (and to the prevention of further deterioration). No quantitative estimate can be made on information gathered to date.

### 7.2.2.2 Resume of the JC

The focus of the EC’s Tacis engagement has improved policy making and improved financial management in the health sector. It did not address health infrastructure head-on, but did contribute to better resource management, planning and rationalisation of infrastructure. The HSPSP, while continuing the emphasis on financial management, has also worked on improving the availability of PHC infrastructure. There has been some progress reported in improving PHC infrastructure (including equipment). The EU delegation in Moldova mentioned in this regard the project “Supply of medical equipment to Primary Health Care Centres in Moldova”, under which basic equipment to 187

---

<sup>369</sup> Atun et al., op. cit, p. 76.

<sup>370</sup> Atun et al., op. cit, p. 79-80.

<sup>371</sup> [http://ms.gov.md/\\_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf](http://ms.gov.md/_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf)

<sup>372</sup> EC (2010) To inspect the equipment supplied so as to detect any defect arisen since the provisional acceptance and to assess the training provided to PHC personnel by the suppliers, Final Report + Annexes Moldova, EC ref no. 2007/144446, 2010



primary health care institutions, mostly in rural areas, has been delivered. However, no project documentation is available to the evaluation. A significant and needed reduction in acute-care hospital beds was achieved, mostly before, but continuing into first half of the evaluation period. Improvements in health sector financing, including increases in share in public expenditure, increasing use of compulsory health insurance and increased decentralisation of financial management to facilities may have increased the share of facilities with adequate current budgets, but there is no hard evidence of this.

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

#### Indicators

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

#### 7.2.3.1 Findings per indicators

**I-131** The problem over the evaluation period in Moldova, as in many ex-Soviet countries, was not too few doctors, it was too many doctors and, among doctors, too many specialists as opposed to family practitioners and too few practicing in rural areas. Following a brutal drop from 360 physicians per 100,000 population to 260 physicians between 1998 and 2002, the level has risen modestly, but is still well below its peak in the 1990s.<sup>373</sup> Much the same trend occurred for nurses, although reductions started earlier. The number of nurses dropped from 1,010 nurses per 100,000 population in 1992 to 640 nurses per 100,000 population in 2001. No information is available in the World Health Report statistical annexes. The WHO Global Health Observatory country page for Moldova reports 267 doctors per 100,000 population and 665 nurses and midwives.<sup>374</sup> These figures relate to 2008; no information on trend is available from this source. However, when compared to the data in the table below, they may provide evidence of further rationalisation in the late years of the evaluation period.

Table 50: Number of physicians and nurses per 100,000 populations<sup>375</sup>

	1995	2000	2005	2006
Number of physicians per 100,000 population	351.30	317.98	308.27	311.08
Number of nurses per 100,000 population	940.08	768.81	706.42	702.66

Source: [http://ms.gov.md/\\_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf](http://ms.gov.md/_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf)

Through its Tacis programmes in the early part of the evaluation period, the EC supported training of primary health care physicians. The support to the medical care re-orientation from a specialised/hospital based approach to a family medicine based approach and the separation of primary and secondary health care have largely contributed to a better access to health services. Particularly the fact that the number of family doctors has increased from 1,529 in 2000 to 2,005 in 2007 (Activity Report, MoH, 2007) points to a positive impact, due to EC support, at least to some extent.

The Ministry of Health reported that, out of 331 family care physicians completing their residence in 2002-2007, only 207 actually went into family care practice<sup>376</sup>. Incentives to attract physicians to under-served areas have also had only limited success. Incentives are provided to physicians and medical assistants willing to cover posts in disadvantaged areas. Since 2006 some 155 physicians and 457 medical assistants were posted in disadvantaged areas benefitting of this scheme. But this scheme is not specifically targeting family doctors. All physicians who accept such posting get bonuses. The MoH files show that there are more specialists than family doctors that receive these bonuses.

<sup>373</sup> Atun et al. op. cit., Ibid., pp. 80-83.

<sup>374</sup> <http://www.who.int/gho/countries/mda.pdf>

<sup>375</sup> Health For All database, WHO Copenhagen, quoted in: The European Union's ENPI Programme for Moldova Framework Contract Lot 8: 2008/147522. Sector Policy Support Programme (SPSP) Formulation Study, Final Report, p.29

<sup>376</sup> [http://ms.gov.md/\\_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf](http://ms.gov.md/_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf)



Human resource planning in health is still dominated by the Soviet manpower planning approach, heavily dependent on fixed ratios of requirements per target population member. However, the HSPSP contributed to a human resource strategy for the health sector. Technical assistance was provided by WHO with EC support and the resulting strategy through 2020 was discussed with other donors such as the World Bank.

**I-132** EC supported projects, especially the Support to Health Sector Reform and Strengthening PHC and Health Promotion and Disease Prevention project, addressed this indicator.

Regarding the former project, the CSE Moldova, 2007 saw significant impact of EC support. SHSR 1 assessed the training needs of doctors and contributed to a successful effort to increase the supply of family doctors (as required by the new primary health care orientation) by re-training specialists. The sharp increase in the number of family doctors in the late 1990s (admittedly prior to the evaluation period) demonstrates a tangible EC project impact. The following Public Health Reform Project improved the knowledge and skills of health policy-makers in strategic planning, finance, performance monitoring and information systems. The national School of Public Health was supported via a twinning arrangement with the University of Rennes, with the aim of providing an internationally accredited Masters in Public Health degree. Study tours have helped Moldovan health policy-makers to examine the approaches used in European countries such as the Netherlands and Lithuania. The overall positive impression of the project has also been confirmed by the 2010 Completion Report<sup>377</sup>.

ROM Report No. 2(2010)<sup>378</sup> on the Support to Health Sector Reform and Strengthening PHC emphasised achievements in component three (strengthening the capacities, knowledge and skills of practitioners in PHC): 52 instead of the planned 40 trainers were trained within the Training of Trainers programme; 280 Family Doctors and Nurses participated in two-week trainings in communication and management; 44 coordinators of PHC Centres have passed three-day management training.

The project Health Promotion and Disease Prevention similarly contributed to some extent to the achievement of improved availability and standards of health worker training. The ROM Report No.6 (2007)<sup>379</sup> stated that activities were carried out on time and the following successful results related to HP & DP were delivered: (i) Strategy; (ii) Curricula for under-graduates and post-graduates; (iii) Action Programmes (APs); (iv) Training manuals and (v) Guidelines on programmes planning/implementation/evaluation. The results were achieved in close cooperation with relevant stakeholders, piloted and interactively improved. For example, curricula were prepared by local university professors and supervised by EU experts, then they were tested during national and regional seminars and during the two Summer Schools organised by the project. There were many training and public awareness events and more than 2,000 persons were trained on HP and DP issues.

**I-133** No statistics are available on health worker attrition or brain drain. However, these problems are explicitly addressed for the first time in the Health Sector Human Resource Strategy produced with EC HSPSP support. The EC, through its Migration and Asylum budget line, financed a project implemented by IOM that aimed at better management of the migration of medical personnel. The tendency of the best trained medical personnel migrate to Europe, leaving the older and less technically qualified behind, continues to be a problem. The increasing alignment of physician training on EU standards may, as an unanticipated and unwelcome side-effect, promote this. Salary inducements and free accommodation are offered to doctors and nurses who work outside the capital, but have not effectively addressed distortions in the availability of properly qualified medical staff. No quantitative estimates of EC impact have been found.

### 7.2.3.2 Resume of the JC

There have been significant improvements over the evaluation period in aggregate characteristics of the health work force. The number of doctors has dropped, and the proportion of doctors practicing family medicine has increased. We have no information so far on trends in medical brain drain, but the EC has supported at least better information of the subject. There is a persistent shortage of medical personnel willing to work in rural regions, despite inducements put in place. In all, however, it is safe to state that the EC's support helped to address the human resources for health problem in Moldova

---

<sup>377</sup> ICON et al. (2010) Support to Health Reform; Strengthening of Primary Health Care in Moldova. Completion Report.

<sup>378</sup> EC (2010) Monitoring Report MR-113980.02, 05/02/2010, Support to Health Reform and Strengthening of Primary Health Care in Moldova

<sup>379</sup> EC (2007) Monitoring Report, MR-40475.06, 21/09/07, The Health Promotion and Disease Prevention Project

over the evaluation period. Through the HSPSP, the first human resources strategic plan for health has been formulated under EC financing.

#### 7.2.4 JC 14 Increased or maintained quality of service provision

##### Indicators

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

##### 7.2.4.1 Findings per indicators

**I-141** As of the 2009-2011 MoH institutional development plan, the development of quality control mechanisms was still at the stage of being identified as a step to be taken.<sup>380</sup> The implementation of a DRG approach in hospitals in 2013 will contribute to improved quality, and the MoH, supported by WHO, is developing a nationwide quality management system, including accreditation standards.

According to the Review Mission Report “Evaluation of ENPI SPSP Health Policy Matrix 2010” some achievements indicate that EC support contributed to an increased existence of quality assurance mechanisms in place at facility levels. Quality-enhancing activities are progressing with elaboration of protocols, quality control activities, evaluations, accreditation and audits. The increased role of National Council of Evaluation and Accreditation within the health sector is noted.

**I-142** The evaluation cited above reported that National Clinical Protocols and Standardised Clinical Protocols (now numbering about 200) are used as reference of practice, as standards for evaluation and accreditation by NCEAM, for control by NHIC and for medical auditing by the MoH Thematic Quality Commission. In 2010, 28 clinical protocols, 35 standardized clinical protocols for family doctors, and nine standardized clinical protocols for intensive neonatology were developed and approved by MoH orders.

ROM report Nr. 2 (2010) Support to Health Sector Reform and strengthening PHC provided information on EC support for this indicator. This project was funded within the National Action Programme 2005 and aimed at strengthening the capacity and improving the performance of the PHC system in Moldova. While stating that a lack of achievement indicators makes an assessment of project success difficult, the ROM report pointed out that some “hints” can be deduced from the administrative reports. For instance, establishment of 40 Author Groups to draft Clinical Protocols reflected in Progress Report No.1, suggests that 44 Protocols were developed. However, in assessing the efficiency of implementation to date, the ROM report focused on the development of Clinical Protocols. 20 Clinical Protocols from the 30 drafted were approved by the Experts' Board of the MoH. These were produced as a laminated double-sided page and become part of a folder of Clinical Protocols to be distributed to family doctors. The project completion report<sup>381</sup> noted that four rounds of trainings, each consisting of four regional sessions, on disease management based on developed and approved work place protocols (WPPs) were carried out with the participation of MoH specialists, expert consultants and 1,118 family physician participants.

According to the HSPSP Review Mission Report 2009, due to development and enforcement of standard protocols for about 90 diseases, clinical protocols now normalise case management across the various levels of the health system starting from the level of family doctor or medical assistant. Adherence of providers to the standard protocols is verified during the evaluation and accreditation process managed by the National Council of Evaluation and Accreditation in Medicine (NCEAM).

**I-143** The European Health Observatory reported that, as of the mid-2000s, data collected referred almost entirely to inputs and production, not patient satisfaction.<sup>382</sup> Survey evidence cited revealed deep dissatisfaction with the state of health care, but these surveys were all taken at the very beginning of the evaluation period. Complaints procedures were deemed inadequate and patient avenues for choice before treatment and recompense in the event of error were very limited. Nonetheless, the same study cited (p. 125) surveys that revealed an increase in the perceived quality of primary health care services.

<sup>380</sup> [http://ms.gov.md/\\_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf](http://ms.gov.md/_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf)

<sup>381</sup> ICON et al. (2010) Support to Health Reform; Strengthening of Primary Health Care in Moldova. Completion Report.

<sup>382</sup> Atun et al. op. cit, p. 28

It appears that the situation has improved to some extent. According to the HSPSP Review Mission Report 2009, in 2007 the Charter of Patients Rights has been enforced in the country. The Charter is exposed on the waiting rooms of health centres. Patients have the right to be informed of the treatment proposed and providers must make patients sign a declaration of informed consent to the treatment. The satisfaction of users with the public health services was been surveyed in 2008 and the results show improvement of patients' satisfaction (54%) as compared to similar previous surveys which showed high levels of dissatisfaction.

Likewise, the Review Mission Report „Evaluation of ENPI SPSP Health Policy Matrix 2010 also emphasised this improvement. There, it is stated that a NHIC survey on patient satisfaction was done in 2009 and results are included in the MOH 2009 activity report (published 2010). 2,960 insured persons were interviewed, including 1,769 persons in district and municipal hospitals and 1,191 persons in Republican hospitals. The majority of the interviewed persons assessed the volume and quality of delivered services positively (82.7% in Republican hospitals, 91.4% in rayon hospitals). There is solid evidence of improvement of this Indicator over the evaluation period, to which the HSPSP contributed.

Furthermore under the Public Health Reform Project<sup>383</sup>, community-based working groups in two pilot regions have been formed, including NGOs, to carry out surveys and campaigns on health services and patients' rights in the community.

#### **7.2.4.2 Resume of the JC**

The MoH institutional plan 2009-2011 and the MoH hospital master plan 2009-2018 are both in the process of developing quality control mechanisms for hospitals and health facilities. The implementation of DGRs and the development of a national quality management system with WHO support will also contribute to improved quality. The overall aim is that patients' satisfaction with health care will increase.

Over the evaluation period, the EC HSPSP contributed to improved quality. The overall anticipated result of the EC funded HSPSP is improved public health sector performance. It is assumed that a better functioning public health system leads to improved outputs (quality and quantities of services) which leads to improved outcomes (individual patient health) which leads to improved results (aggregated population health amongst the compulsorily insured) which leads to improved impact (aggregated population health and well-being). The evidence presented above supports the hypothesis that there has been an impact due to EC support, at least to some extent. The Support to Health Reform and Strengthening of Primary Health Care project also contributed to improved quality by developing and disseminating clinical protocols in the area of family medicine. Two consecutive surveys on patient satisfaction showed that patient satisfaction had increased.

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

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

##### **Indicators**

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

##### **7.3.1.1 Findings per indicators**

**I-211** By the beginning of the evaluation period, the collapse of public fiscal support for the health care system had led to an explosion of out-of-pocket payments, which were already institutionalized in the form of under-the-table payments under the unsustainable Soviet-style medical system. Evidence is cited suggesting that half of all health care expenditure was out of pocket, with 80% of this being spent on pharmaceuticals.<sup>384</sup>

---

<sup>383</sup> EC (2008): The Public Health Reform Project, Final report.

<sup>384</sup> Arun et al., op. cit., pp. 49-50.

The table below is calculated from the WHO National Health Accounts (supported in part by the EC under the HSPSP) for Moldova.<sup>385</sup>

As they show, the significant shift has been in the share of general government health expenditure financed via compulsory health insurance, which has eased fiscal pressure and allowed government to expand resources available to the sector. However, the public / private split has remained stable and out of pocket spending as a share of total spending has not changed.

Of most interest may be the near-doubling in the share of out-of-pocket health spending as a share of total household consumption expenditure. Some of this represents the fact that, as incomes rise over time, the share spent on health care is typically observed to rise, as well. As shown, the share of total health expenditure financed out of pocket has changed little.

Table 51: Health expenditures in Moldova, 2000-2009

<b>Breakdown of Health Expenditure (%)</b>			
	<b>2000</b>	<b>2005</b>	<b>2009</b>
Total expenditure on health	100	100	100
of which			
Government	52.6	49.8	53.7
of which			
Social security funds	0	70.5	79.8
Private	47.4	50.2	46.3
of which			
Out of pocket	97.9	97.2	97.8
Out of pocket as share of total health expenditure	46.4	48.8	45.3
Out of pocket expenditure per capita (PPP USD)	USD 125	USD 428	USD 910
Out of pocket health expenditure as share of total household private consumption expenditure (%)	3.2	4.4	6.1

Source: Evaluation of the ENP 2008/019-655, Health SPSP in Moldova, Framework Contract BENEf - Lot 11, Project No: 2009/214697, Review Mission Report, Oct 2010,

According to the old health field visit report<sup>386</sup> the Transparency International – Moldova (2006) survey reports that 65% of respondents sometimes, often or always have to pay unofficially for public health care; expenditures that are not included in official figures. Hence, the out-of-pocket expenditures for health care services might even be higher in Moldova.

There are serious data inconsistencies related to health finance, however. In strong contradiction to the National Health Accounts data above, the following table, which shows alternative data from the National Bureau of Statistics, indicates that the ratio of out-of-pocket payments to total expenditures on health decreased from 65% in 2000 to 42% in 2005.<sup>387</sup>

Table 52: Out-of-pocket payments for health care in 2000-2005, Moldova

	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Out-of-pocket payments, mln. Lei	919	954	1,070	1,184	1,306	1,402
Drugs and medical goods, mln. Lei	843	864	939	1,045	1,133	1,224
Medical services, mln Lei	77	90	115	139	173	178
Out-of-pocket payments in real terms	100	96	98	97	96	92
Out-of-pocket payments to total expenditures on health %	64.7	60.8	52.3	51.5	45.8	42.3

Source: Evaluation of Health Financing Reform in the Republic of Moldova, Report to the World Health Organization European Office by Sergey Shishkin, Gintaras Kacevicius and Mihai Ciocanu, 2006, p. 14

In summary, we have two alternative data sources, one finding that the share of out of pocket spending remained roughly constant between 2000 and 2009 and the other indicating a significant decrease between 2000 and 2005.

<sup>385</sup> <http://www.who.int/nha/country/mda/en/>

<sup>386</sup> Old health evaluation field visit report (2007) Extractions for Moldova

<sup>387</sup> Evaluation of Health Financing Reform in the Republic of Moldova, Report to the World Health Organization European Office by Sergey Shishkin, Gintaras Kacevicius and Mihai Ciocanu, 2006, p. 14

Both the HSPSP and Health Sector Reform projects supported expansion of health insurance, which may have contributed to reducing out-of-pocket expenditures.

**I-212** As seen in the first table above, the share of total health care expenditure financed out of social security schemes rose dramatically in the wake of the introduction of compulsory health insurance in 2004.

The social health insurance (SHI) model in Moldova combines a range of revenue sources: payroll tax, general taxes, flat rate contributions and contribution from state budget.

Table 53: Social health insurance contributions by sources, %<sup>388</sup>

	2003	2004	2005
Employer and employee contributions	10.2	31.6	31.8
Contributions of other categories of individuals	0.0	0.4	0.7
State contributions	88.7	66.7	65.5
Other non-contributory income	0.0	1.3	2.0
Total	100	100	100

Source: <http://www.who.int/nha/country/mda/en/>

EC support has financed substantial provision (by WHO) of technical assistance for the reform of health care finance in Moldova. The project purpose of the Public Health Reform in Moldova was formulated as: 'To strengthen management capacity in the health system (including the health insurance system) through support for training, health finance, performance measurement and information systems, including piloting of initiatives in two regions, accompanied by public awareness campaigns of aims and objectives of health sector reform and patients' rights'.<sup>1</sup> The second Monitoring Report states that none of the Objectively Verifiable Indicators were achieved. But, the project reviewed the methodology on costing of health services and on determining the tariffs presently applied in medical-sanitary institutions and identified discrepancies between normative acts and real costs of services. A DRG system is being implemented.

**I-213** While mandatory health insurance was legally in force as early as 1998, it was not until 2004 that the law became effective. EC TA (Takis), support to the MoH helped to develop the normative framework that made implementation of mandatory health insurance possible.

Between 2004, when the Mandatory Health Insurance Company (MHIC) was established, and 2008 its revenues increased more than three-fold but the proportion of population covered under the insurance scheme remained largely unchanged. The de facto priority has been to increase funding for facilities and salaries and to ensure good financial protection for those who are already insured under the scheme, rather than to expand coverage.

That has changed as new consideration is now being given to expanding mandatory coverage to include, e.g. the military and police. The HSPSP has directly targeted insurance coverage as listed in the policy matrix under activity 3.b. Elaboration by the MoH and National Health Insurance Coverage (NHIC) of a plan to increase the coverage of population by compulsory health insurance<sup>389</sup>. According to the review mission report, a new mechanism has been established to assess applicants in terms of their income, assets, etc. Law No. 22-XVI, which amends the existing law on health insurance (adopted on 2<sup>nd</sup> February 2009), provides for the automatic inclusion of those found eligible for support under the Law on Social Support into the NHIC, with full subsidy from the government. 218,000 individuals would eventually qualify. Out of these, it was estimated that 92,500, or 42%, are uninsured. At present, new targeting mechanisms to make align subsidies more closely with poverty are being designed and consideration is being given to widening the scope of mandatory coverage.

The EC HSPSP Review concludes that all the quantitative criteria for the "R2: Funding of the healthcare system and mechanisms of payment for healthcare services" are met. This includes: Increase the funds of the mandatory health insurance; Elaboration by the MoH and National Health

<sup>388</sup> Ibid, pp.9-10

<sup>389</sup> EC (2010) Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Review Mission Report



Insurance Company (NHIC) of a plan to increase the coverage of population by compulsory health insurance; and Increase of coverage of population by compulsory health insurance to over 80%.

To conclude, coverage in the mandatory national insurance scheme is a bit over 80%. Priority was originally given to deepening, not broadening coverage. That has changed, in part with support from EC programmes, and policies are in place to increase the proportion of the population covered.

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

#### Indicators

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

#### 7.3.2.1 Findings per indicators

**I-221** The state pays mandatory health insurance contributions for children, students, the officially registered unemployed, pensioners and pregnant women.<sup>390</sup> The Reserve Fund of the compulsory health insurance scheme is available to finance health care for the uninsured (disproportionately poor) population. While the introduction of health insurance has reduced the burden on the poor, out-of-pocket payments remain high and 20% of the population remains outside the insurance umbrella. As stated above, consideration is currently being given to aligning health insurance subsidies more closely with poverty.

One significant recent change in policy was the approval of Law No. 22–XVI on 2 February 2009, which amended the existing Law on Mandatory Health Insurance, to ensure that all those registered as poor under the recently approved Law on Social Support would automatically receive fully subsidized health insurance.

The EC has not directly supported subsidies. However, by helping to support the expansion of mandatory health insurance, it has supported Government in providing such subsidies and special schemes. The stronger financial base for the health system has opened up fiscal space to pay greater attention to the health needs of the poor.

**I-222** There is evidence from the mid-2000s that the introduction of compulsory health insurance had impact on service utilisation. In 2005, the average number of visits to a family doctor was 3.3 for the insured population and 0.9 for the uninsured.<sup>391</sup> Controlling for rural-urban location, the uninsured are much less likely to obtain health care at the secondary or tertiary levels than the insured. Introduction of social insurance was followed by a significant increase in the utilisation of emergency ambulance visits, and those with health insurance are far more likely to avail themselves of emergency services than those without.

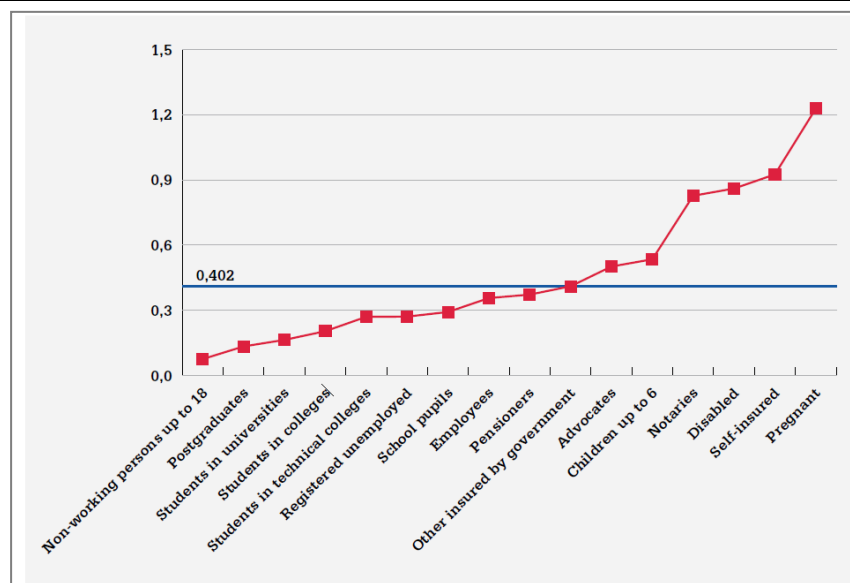
The Figure below shows the health care utilisation among insured population in Moldova (2005-2006 average). However, reinforcing the need to improve public insurance, according to estimates the utilisation of health care was 2.3 times higher among the self-insured (i.e. privately insured) than the average figure for all insured.<sup>392</sup>

<sup>390</sup> Atun et al., op cit., p. 41.

<sup>391</sup> Atun et al., op cit., p.94 ff.

<sup>392</sup> Extending population coverage in the national health insurance scheme in the Republic of Moldova. Strategic options, by: Matthew Jowett and Sergey Shishkin, pp.17-18

Figure 15: Relative utilisation of health services by category of insured (average for 2005–2006)



Source: *Extending population coverage in the national health insurance scheme in the Republic of Moldova. Strategic options*, by: Matthew Jowett and Sergey Shishkin

Unfortunately, no time series data are available. The “snapshot” observations of the difference in health care consumption between insured and uninsured, combined with the expansion of insurance supported by the EC, make it safe to conclude that the EC has made some contribution to this Indicator at national level. Unfortunately, disparities in health insurance coverage have both socioeconomic and geographical dimensions, with lower coverage in rural areas than in urban areas and with poor or extremely poor households most at risk of being uninsured. The most vulnerable sectors would appear to be rural poor and extremely poor households, as these are the only sectors that appear to have been adversely affected by the introduction of mandatory social health insurance, with utilization rates actually falling in 2004.<sup>393</sup>

### 7.3.2.2 Resume of the JC

The Republic of Moldova has mechanisms in place for health care coverage of the uninsured and disadvantaged/poor population. This includes: mandatory health insurance subsidised for special groups and a minimum package of free medical assistance. There is evidence that persons in the government insurance scheme are more likely to seek health care than the uninsured. Since the EC contributed to expansion of mandatory health insurance, it can be inferred that the EC indirectly contributed to increase consumption of health care. However, the need to better align health care insurance subsidies to the poor has been identified.

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

#### Indicators

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

#### 7.3.3.1 Findings per indicators

**I-231** From Tacis through the ENPI sector policy support programmes, technical assistance for health care financial reform (provided mostly by WHO) has been a major theme of EC support. The EC supported development of the health MTEF, the production of national health accounts and development of the normative framework that permitted the rolling out of mandatory health insurance

<sup>393</sup> Atun R, Richardson E, Shishkin S, Kacevicius G, Ciocanu M, Sava V and Ancker S. Moldova: Health system review. *Health Systems in Transition*. 2008; 10(5): 1–138; p.130



in 2004. Continuing to work with WHO, the EC has recently supported efforts to better align health insurance subsidies with poverty and to extend coverage to currently excluded groups.

**I-232** Under HSSP, the actions just listed improved communication between the MoH and MoF, although differences of opinion still persist; typically with MoF wishing to tie budget to number of facilities and MoH seeking to maintain the same budget with a smaller number of facilities so as to improve services. Joint groups to develop accounting frameworks have been put in place and there has been training and capacity building in public financial management. The financial planning unit at the MoH has been strengthened and financial reporting units have been established in all hospitals.

### 7.3.3.2 Resume of the JC

Since Tacis, EC-financed technical assistance and policy advisory work has stressed improvements in health care finance to enhance affordability of health care. Among the major contributions has been support for the MTEF, for national health accounts, for the development of the normative framework for implementation of compulsory national health insurance in 2004 and for ongoing work to better target subsidies and expand coverage.

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

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

#### Indicators

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

#### 7.4.1.1 Findings per indicators

**I-311** The number of primary health care units per 10,000 population decreased from 31 in 2000, to 23 in 2009.<sup>394</sup>

In the late 1990s, in the Republic of Moldova, local governments reconfigured many small hospitals as primary care facilities.<sup>395</sup>

Given the dense health network that existed in Moldova, a decrease in the number of primary facilities per capita is a negative sign; this may represent rationalisation.

**I-312** No information available. The National Hospital Master Plan 2009-2018<sup>396</sup> stated that the hospitals' locations are spread all over the country, showing no inequality in distribution between the areas in the northern and southern part of Moldova (Transnistria is not included). People of rural Moldova can reach a hospital within acceptable distance; there is no district whose population is not able to reach a hospital within an acceptable amount of time.

#### 7.4.1.2 Resume of the JC

The EC has generally supported rationalisation of facilities. Geographical access to a health care facility at the appropriate level is not a problem in Moldova. The regional distribution of hospitals is even. According to National Hospital Master Plan, Moldovan people can reach a hospital within acceptable distance. The number of primary health care units in the country decreased, but these may well have been underutilised prior to the evaluation period.

None of the assessed EC supported projects contributed directly to geographical access; however, as described under EQ 1, the EC supported rationalisation of facilities, rehabilitation, improvements in equipment, etc.

<sup>394</sup> European health for all database (HFA-DB), WHO/Europe, <http://data.euro.who.int/hfad/>

<sup>395</sup> Martin McKee. Reducing hospital beds: what are the lessons to be learned? European Observatory on Health Systems and Policies, Policy brief no. 6, 2004

<sup>396</sup> [http://ms.gov.md/\\_files/8201-1-Hospital%2520Master%2520PLan.pdf](http://ms.gov.md/_files/8201-1-Hospital%2520Master%2520PLan.pdf)

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

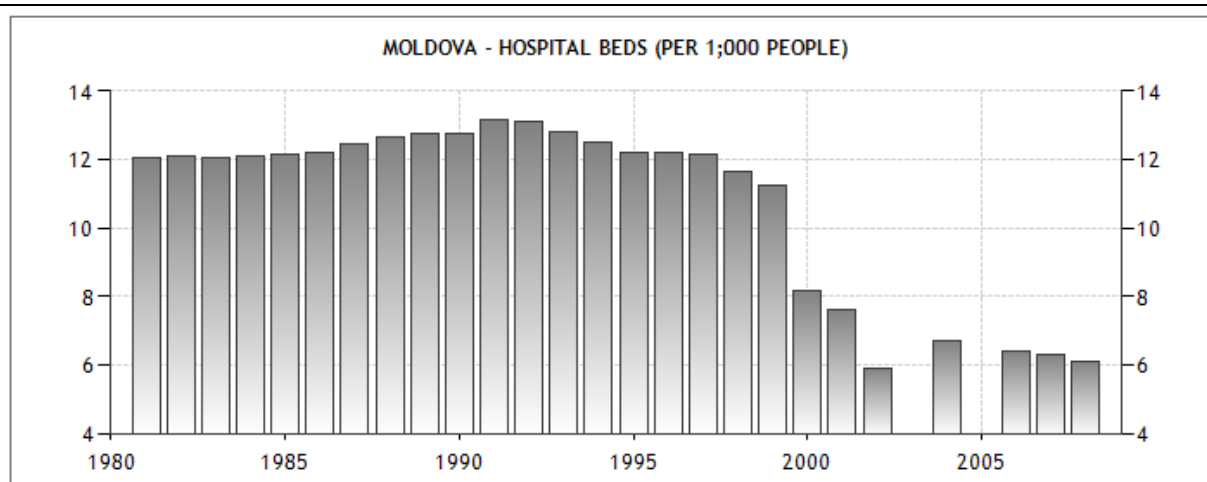
### Indicators

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

#### 7.4.2.1 Findings per indicators

**I-321** By 1999 the public health care sector in Moldova faced serious deterioration. A first phase of reform saw significant and needed restructuring. By 2004, the number of hospitals had decreased from 253 to 65. The number of beds decreased from 45.665 to 20.752.<sup>397</sup> The number of hospitals beds per 1,000 population, as shown in Figure 2 below, decreased from around 13 in the early 1990s to slightly above six in 2008.

Figure 16: Hospital beds per 1,000 people, Moldova: 1980-2008<sup>398</sup>



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

The EC contributed to improved policy and planning, mostly as described under EQ 1, although not directly to the restructuring.

**I-322** No information could be obtained. As pointed out above, geographical access to appropriate health care facilities is not an issue in Moldova.

**I-323** In Moldova, the caesarean sections per 1,000 live births increased constantly from 19.82 in 1980 to 131.61 in 2010, still low by international standards<sup>399</sup>.

No direct EC funding regarding this indicator could be found. However, the Support to Health Reform and Strengthening of Primary Health Care in Moldova with its quality assurance put in place may have supported this development.

#### 7.4.2.2 Resume of the JC

The restructuring of hospital care in Moldova after independence resulted in a closure of the majority of hospitals. Some small hospitals were reorganised as primary health care units. The number of caesarean sections increased over the last thirty years, yet remains small compared to many other countries. The increase might be a result of quality improvement of hospitals in terms of technical equipment, guidelines and trained staff.

There is no evidence that EC contributed to National Hospital Master Plan, or to the production of guidelines regarding caesarean sections. However, the EC generally supported the rationalisation, rehabilitation and equipping of health facilities, including accreditation and quality management.

<sup>397</sup> The European Union's ENPI Programme for Moldova Framework Contract Lot 8: 2008/147522. Sector Policy Support Programme (SPSP) Formulation Study, Final Report, p.12

<sup>398</sup> <http://www.tradingeconomics.com/moldova/hospital-beds-per-1-000-people-wb-data.html>

<sup>399</sup> European health for all database (HFA-DB), WHO/Europe, <http://data.euro.who.int/hfad/>

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

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

#### Indicators

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

#### 7.5.1.1 Findings per indicators

**I-411** Virtually all births in Moldova occur in proper facilities under appropriate supervision. There is no evidence of EC contribution.

**I-412** Results of the Demographic and Health Survey (DHS) 2005, the only DHS in Moldova, showed that 97% of women in Moldova were provided with antenatal care by a medical doctor and, in only rare cases (less than 1%), by another medical professional such as a nurse. The proportion of women who received antenatal care from a doctor did not vary significantly by background characteristics, although the proportion was slightly lower (94-95%) among women with four or more births, from the lowest wealth quintile, living in the South region. Still, even in these cases, 4% or less of women did not receive any antenatal care provided by a health professional. Nine of ten women (89%) had four or more visits to a doctor during pregnancy without significant differences by urban-rural residence.<sup>400</sup> The 1997 Reproductive Health Survey also indicated high levels of antenatal care coverage that are not significantly different from levels indicated in the DHS 2005 survey.<sup>401</sup>

There is no evidence of direct EC support; the EC may have indirectly contributed by supporting the strengthening of primary health care.

**I-413** The contraceptive prevalence rate was 68% in the 2005 DHS Survey.<sup>402</sup> The information available is very limited and provided no evidence of direct EC support. However, according to the old health field visit report EC contributions have had indirect positive influences on these issues. Accordingly, the project "Health, rights and choice for everyone, integrating development issues into sexual health and rights framework" has been also implemented in Moldova by the Family Planning Association of Moldova (FPAM) within the framework of the European Network International Planned Parenthood Federation. The Estonian Sexual Health Association was the lead agency of this project whose aims included the improvement of public knowledge (youth) on sexual and reproductive health and rights issues. This might have contributed to an increased proportion of women using modern family planning.

#### 7.5.1.2 Resume of the JC

The situation regarding deliveries and antenatal care is satisfactory in Moldova; there is no evidence of improvement, although the EC may have indirectly contributed to the satisfactory situation by strengthening primary health care. The same is true of contraceptive prevalence.

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

#### Indicators

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

#### 7.5.2.1 Findings

**I-421** No information could be obtained on the percentage of children being regularly growth monitored. However, the DHS 2005 monitored 1,498 children under five for whom complete and

<sup>400</sup> Ibid, p.113

<sup>401</sup> National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. 2006. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, p.111,112

<sup>402</sup> Ibid, p.98

plausible anthropometric data were collected. The results were that, at the national level, about 8% of children under five were moderately stunted (several percentage points higher than the 2.3% in the national reference population—while the proportion severely stunted was about 2%. 4% of children were wasted (about two percentage points higher than the national reference population) and the proportion severely wasted was about 1%. About 4% of children were underweight, and the proportion of severely underweight was less than 1%.<sup>403</sup>

There is no evidence of direct EC support for regular growth monitoring of children under age five. But the national clinical protocols developed and disseminated with EC support within the Health SPSP Moldova<sup>404</sup> programme, may have contributed to better growth monitoring.

**I-422** Moldova has a long time standing National Immunisation Programme, which is integrated into primary health care and preventive services. Moldova has implemented a complex information system allowing monthly monitoring of vaccination coverage, drop-out rates, vaccine wastage rates and vaccine and supplies stocks down to the service provision level. A significant upgrade and improvement of its cold chain and vaccine supply at all levels was achieved and in 2004 Moldova was granted the WHO certificate for effective vaccine storage management.<sup>405</sup> The immunisation calendar for Moldova, approved by the National Immunisation Program for the years 2001 to 2005, included all of WHO recommended vaccines, as well as three doses of hepatitis B (HepB) vaccine and one dose of vaccination for mumps and rubella. The vaccines against measles, mumps and rubella are now usually administered as one injection (MMR), whereas before they were administered separately. In addition, an “immunisation certificate” has come into use since distribution began in 2002.

According to the DHS 2005, overall, 85% of children age 15-26 months were fully immunised with the nine antigens stipulated by the National Immunisation Program. No children were identified as not having received any vaccine. The highest rate of specific immunisation coverage (over 99%) was for the BCG vaccine. More than 98% of children were vaccinated with the first doses of HepB, DTP and polio, confirming the high access of children to immunisation services in Moldova. The coverage with subsequent doses was slightly less, however, with 95% of children receiving the three recommended doses of HepB and polio and 94% receiving the three recommended doses of DTP vaccine. The decrease in coverage with subsequent doses reflects immunisation drop-out rates. Drop-out rates represent the proportion of children who received the first and second dose of vaccine but who do not follow through with receiving the third dose. The drop-out rates were 5% for DTP, 4% for polio and 3% for HepB. The proportion of children vaccinated against measles was 91% and the proportion of those vaccinated against mumps and rubella was 89%.

Table 54 shows the development of the immunisation coverage among one-year olds in Moldova.

Table 54: *Immunisation coverage among 1-year olds, Moldova: 2000-2009*<sup>406</sup>

Vaccine	2009	2005	2000
Measles (MCV)	90	97	89
Diphtheria tetanus toxoid and pertussis (DTP3)	85	98	95
Hepatitis B (HepB3)	89	99	92
Hib (Hib3)	47		
BCG	96	99	99
Polio (Pol3)	87	99	97

Source: Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

There is no evidence for direct EC support for the Moldovan immunisation plan, apart from general support for the strengthening of primary health care. The quality improvement of health care facilities supports the continuation of relatively high immunisation coverage. However, no explanation has been found for the decline in DTP3 and polio vaccination over the period.

<sup>403</sup> Ibid, pp.152f

<sup>404</sup> Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Framework Contract BENEf - Lot 11, Project No: 2009/214697, Review Mission Report, Oct 2010, p.40

<sup>405</sup> Global Alliance for Vaccines and Immunisation (GAVI), The Government of the Republic of Moldova. Immunisation Services, Injection Safety and New and Under-Used Vaccines. 2007, p.3

<sup>406</sup> Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>

### 7.5.2.2 Resume of the JC

Regarding the proportion of children being growth-monitored, no information could be collected. However, primary health care and preventive services go down to the community level, one can assume that some monitoring is underway, but data are not accessible. In total, about 8% of children under five were stunted, 2% severely stunted, 4% are wasted and about 4% are underweight in 2005.

Immunisation rates are high in Moldova, but there were inexplicable declines in several important rates. There is no evidence that the EC contributed directly to improvements in these indicators (or in the case of immunisation, avoidance of greater declines). However, the EC's involvement in generally strengthening the primary health system and promoting the family health model may have indirectly contributed.

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

#### Indicators

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

#### 7.5.3.1 Findings per indicators

**I-431** Not relevant for Moldova.

**I-432** No information available.

**I-433** The DHS 2005 shows that 7% of children under age five had diarrhoea in the two weeks preceding the survey. A considerably higher prevalence was seen in children 6-11 months and 12-23 months (13% and 11%, respectively). Girls were more likely to have diarrhoea (9%) than boys (6%). Overall, 61% of mothers knew about ORS. The level of awareness generally increased with the mother's age, her education level and the wealth quintile of the household. There were significant differences in knowledge between mothers from rural areas (55%) and those from urban areas (70%). No information about proportion of children treated with ORS was obtained in this survey.<sup>407</sup> As above, the only EC contribution to improvement in this area would have been its general contribution to the strengthening of primary health care.

#### 7.5.3.2 Resume of the JC

The DHS 2005 showed that 7% of children under age five had diarrhoea in the two weeks preceding the survey. Knowledge about ORS treatment was 62%. No data could be obtained about the proportion of children having diarrhoea treated with ORS and the death rates caused by diarrhoea.

Searching all relevant EC documents did not result in any information about EC contributions concerning diarrhoea.

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

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

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

#### 7.6.1.1 Findings

**I-511** Activities related to I-512 EC policy dialogue incorporated PFM and also contributed to the overall health policy strategy process and related documents, especially budget documents. In

<sup>407</sup> Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Framework Contract BENEf - Lot 11, Project No: 2009/214697, Review Mission Report, Oct 2010, pp.135f



promoting transparency and accountability in health PFM, the EC acted in concert with other donors. According to the HSPSP PFM Final Monitoring Report 2010, activities across a broad range contributed to improve PFM. EC sector support also helped to produce the Health Human Resources Development Plan.

**I-512** According to the CSE Moldova (2007) the successful experience with SHR I laid the foundation for three subsequent Tacis projects “SHR II” (implemented 2001-03), “Health Promotion” (HP) and “Disease Prevention (DP)” (2003-05) and the ongoing “Public Health Reform” (2005-07). All of these projects stressed improved management practices and all had had significant impacts on current practices in the Moldovan health system. Health has thus figured in all CSPs and NIPs, and is being carried over into the new ENPI Action Plan. Although activities undertaken have been modest, health also has a place in Tacis regional and cross-border strategy documents. Advice and TA on overall health policy strategy, including PFM, accountability and capacity building have been provided across a wide range of topics in all EC health interventions.

Besides this general statement about improved management practices, the documents reviewed also provide more specific information about PFM, accountability and capacity building measures related to the Health Sector Policy Support Programme.

- The HSPSP formulation report identified improved PFM as a first priority and identified improved institutional capacity at all levels as needed. Among follow-ups to this has been strengthening the health finance unit at the MoH, designing accounting frameworks and putting accounting unity in place at all hospitals.

Capacity building was less developed than TA in the EC’s support, for several reasons. First among these was the difficulty experienced by the MoH in retaining capacity once in place. Second, the impact of capacity building was limited by the institutional culture in place, suggesting a need for fundamental reform. This was accomplished through the EC’s concentration on re-tooling the health system towards primary health care and reforming health care finance. Third, the most pressing need in the early years of the evaluation period was to generate financial resources for the health sector, without which added capacity would be incapable of functioning.

Within the MoH new directions (Health Financing, Strategy Monitoring) were established to support policy making and monitoring. In one of the relatively few capacity building interventions, directors of all MoH sections were enrolled in masters in health sector management or in courses in general management given by the School of Health Management or the Academy of Public Administration.

PFM was integrated into HSPSP policy dialogue. According to the HSPSP PFM Final Monitoring Report 2010, a major achievement was the completion of an “unified set of methodologies concerning budget formulation for all four components – State Budget, State Social Insurance Fund and Mandatory Health Insurance Fund and ATU budgets”. The current procedures and methodological norms for detailed budget planning have been revised and adjusted to comply with best international practices. These effectively facilitate the implementation of budgetary legislation through the FMIS. Methodologies and instructions are being completed by tools providing for a model, methodologies and guidelines for the following:

A macro-fiscal forecasting model was put in place, as well as guidelines for producing a range of needed financial inputs, including cost estimates. Standard procedures for programme budgeting and a standard format for budget proposals were devised and promulgated.

**I-513** There is evidence that the projects under the ENPI and TACIS instrument contributed to decentralised capacity building. An exception is the putting in place of accounting units in all hospitals. In addition, the Public Health Reform Project<sup>408</sup> provided support to this indicator. Accordingly, existing information systems were assessed to determine how well they met the needs of managers/decision makers at various levels, including regional level. The needs of the health insurance system were also covered in this assessment.

### **7.6.1.2 Resume of the JC**

All major EC interventions have incorporated technical assistance, and policy dialogue aimed at strengthening management and governance of the health system. The two main concerns over the evaluation period were strengthening the primary health care orientation of the system and reforming health care finance in order to get additional resources into the system. Capacity building, to the extent it was provided, revolved around these two goals; for example, training of physicians in family

---

<sup>408</sup> EC (2008): The Public Health Reform Project, Final report.

health protocols, training MoH managers in financial management, designing accounting tool for PFM, etc. “Capacity building” in the broadest sense was second to TA and systemic reform as these, plus the lack of financial resources, were limiting the effectiveness of the capacity already available. Transparency and accountability of health PFM, much of it involving the new compulsory health insurance system, were key points in policy matrices and policy dialogue not only on the part of the EC, but other donors, as well. There has been substantial progress on all these points over the evaluation period. Further progress is being worked on, e.g. in the on going adjustment and reform of the mandatory national health insurance system.

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

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

#### 7.6.2.1 Findings

**I-521** See discussion above and in Indicator I-232. As part of the overall PFM reform process, the audit function has been strengthened.

**I-522** Based on the documents reviewed there is ample evidence that EC supported increased competencies in MoH for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF. The MTEF itself, as well as the National Health Accounts, benefited from Tacis support.

This indicator is somewhat relevant to donor coordination. According to the HSPSP formulation report the donor coordination responsibilities within the sectors are devolved to the ministries. The MoH has the role to lead health donor coordination and, in consultation with the donors, has developed a regulation document “Coordination and Monitoring Activity of the External Aid in the Health Sector”. The document was approved at the regular External Assistance Coordination Meeting, with participation of donor community, on February 29, 2008. The Department for International Relations and External Assistance has the responsibility to lead the activities related to coordination and monitoring of external assistance in the sector, as well as to organise quarterly donor coordination meetings. As with the national coordination committee, the Department responsible in the MOH will be responsible for (i) aligning the programs of external aid with the government’s strategies and programs; (ii) analysing results and monitor external assistance programs; (iii) analysing problems resulting from project implementation and propose solutions to increase efficiency and sustainability of the project results; and (iv) considering changes and amendments to the loan agreements as well as state guarantee agreements for loans. The first two donor coordination meetings took place in 2006 but regular health coordination meetings between the MoH and its main donors exist since 2007.

**I 523** The HSPSP Report Review 2009 focused on achievements related to this indicator. According to the report, achievements in the area of the third component (public procurement) have been very satisfactory:

- through secondary legislation advancing through 19 Government acts,
- through guidelines issued for public procurement in the health sector,
- through a positive decision to add MoH to the “electronic procurement” pilot and
- through intensified training throughout the health sector, allowing amongst others to observe new minimum standards for equipments of primary health care providers.

#### 7.6.2.2 Resume of the JC

This JC was assessed by three indicators: (1) EC contributed to the overall process of accountability and transparency of the health system (division of roles between MoH and MoF/planning and responsibility, auditing, budget reviews, etc.), (2) EC supported increased competencies in Ministry of Health for establishing and monitoring Annual Work Plans and Budgets linked to health sector plans and MTEF (if existing) and (3) EC supported procurement reform to enhance accountability and transparency and thus lower incidences of mis-procurement. For the first indicator no information was



available. The second indicator pointed to some evidence related to MoH competencies to establish and monitor Annual Work Plans and Budgets. Likewise, information related to the third indicator illustrates how EC support contributed towards achieving enhanced accountability and transparency.

There is no evidence regarding EC explicitly contributed to better defining relations between MoH and MoF. However, there is some evidence that the EC helped the MoH establish improved linkage between budgetary processes and the METF and contributed to improving procurement. Moreover, communication between MoH and MoF, as described under I-232 has been well established for years and benefits from the improved budgeting and accounting systems in MoH, systems which the EC supported.

## 7.7 Annex

### 7.7.1 Key documentation used for the analysis

#### 7.7.1.1 Project documentation of main interventions

Intervention	TAP	Evaluation	ROM	Progress (MTR)	Final reports/other
Health Sector Policy Support Programme (ENPI/2008/019-655)	Not available	Review Mission Report EVALUATION OF ENPI SPSP HEALTH POLICY MATRIX 2010		Review Mission Report 11/2009  PFM Final Monitoring Report 2009/2010	Formulation Report
Technical Assistance related to the Health Sector Budget Support (c228860)			MR 22/06/2011		
Health Promotion and Disease Prevention			ROM Report Nr. 6, 2007		
Public Health Reform 2005 (TACIS/2003/005-604)	Not available		ROM Report Nr.1, 2005 ROM Report Nr.2, 2006		Final Report 2008
Support to the Health Reform and Strengthening of Primary HC			ROM Report Nr.2, 2010		Completion Report, 2010

#### 7.7.1.2 EC documentation on the health sector in the country

Source	Explored
CSE	Country Level Evaluation Moldova, 2007
EAMR	EAMR Extractions Moldova (no relevant info)
Country note from old health evaluation	Old health field visit report
Other - C14446	Final Report 2010, To inspect the equipment supplied so as to detect any defect arisen since the provisional acceptance and to assess the training provided to PHC personnel by the suppliers
C-150107: Developing and piloting sheltered housing service for people with mentally illness in Moldova	ROM NR. 1, 2010
CSP	Moldova CSP I and CSP II

#### 7.7.1.3 Other sources

Atun R, Richardson E, Shishkin S, Kacevicius G, Ciocanu M, Sava V and Ancker S. Moldova: Health system review. Health Systems in Transition. 2008; 10(5): 1–138.

EC (2007) Monitoring Report, MR-40475.06, 21/09/07, The Health Promotion and Disease Prevention Project

EC (2006) Monitoring Report, Moldova – MDA - Republic Health Reform in Moldova, MR-40517.02, 21/02/2006

EC (2009) Evaluation of ENPI 2008/019-655 Health SPSP in Moldova, Review Mission Report

EC (2010) Monitoring Report MR-113980.02, 05/02/2010, Support to Health Reform and Strengthening of Primary Health Care in Moldova.

EC (2010) To inspect the equipment supplied so as to detect any defect arisen since the provisional acceptance and to assess the training provided to PHC personnel by the suppliers, Final Report + Annexes Moldova, EC ref no. 2007/144446, 2010

EC (2008) Evaluation of ENPI 2008/019-655 Health SPSP in Moldova – Review Mission Report: Evaluation of ENPI SPSP Health Policy Matrix 2010

- EC (2008): The Public Health Reform Project, Final report.
- European health for all database (HFA-DB), WHO/Europe, <http://data.euro.who.int/hfad/>
- Evaluation of Health Financing Reform in the Republic of Moldova, Report to the World Health Organization European Office by Sergey Shishkin, Gintaras Kacevicius and Mihai Ciocanu, 2006.
- Extending population coverage in the national health insurance scheme in the Republic of Moldova. Strategic options, by: Matthew Jowett and Sergey Shishkin.
- Global Alliance for Vaccines and Immunisation (GAVI), The Government of the Republic of Moldova. Immunisation Services, Injection Safety and New and Under-Used Vaccines. 2007.
- Global Health Observatory Data Repository, <http://apps.who.int/ghodata/#>
- Health For All database, WHO Copenhagen, quoted in: The European Union's ENPI Programme for Moldova
- ICON et al. (2010) Support to Health Reform; Strengthening of Primary Health Care in Moldova. Completion Report.
- MacLehose, L. in McKee, M. (ed.) Health care systems in transition: Republic of Moldova. Copenhagen, European Observatory on Health Care Systems, 4(5) (2002).
- Martin McKee. Reducing hospital beds: what are the lessons to be learned? European Observatory on Health Systems and Policies, Policy brief no. 6, 2004.
- National Scientific and Applied Center for Preventive Medicine (NCPM) [Moldova] and ORC Macro. 2006. Moldova Demographic and Health Survey 2005. Calverton, Maryland: National Scientific and Applied Center for Preventive Medicine of the Ministry of Health and Social Protection and ORC Macro, p.111,112
- Republic Of Moldova, National Hospital Master Plan, 2009-2018, Final Report. Top consult köln, [http://ms.gov.md/\\_files/8201-1-Hospital%2520Master%2520PLan.pdf](http://ms.gov.md/_files/8201-1-Hospital%2520Master%2520PLan.pdf)
- Review Mission Report, Evaluation of ENPI 2008/019-655 Health SPSP, Moldova, Nov. 2009.
- European Union's ENPI Programme for Moldova Framework Contract Lot 8: 2008/147522. Sector Policy Support Programme (SPSP) Formulation Study, Final Report.

**Web sources**

- [http://ms.gov.md/\\_files/1024-National%2520Health%2520Policy%2520Republicof%2520Moldova.pdf#](http://ms.gov.md/_files/1024-National%2520Health%2520Policy%2520Republicof%2520Moldova.pdf#)
- [http://ms.gov.md/\\_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf](http://ms.gov.md/_files/2579-plan%2520dezvoltare%2520instituti%25202009-2011.pdf)
- [http://ms.gov.md/\\_files/8201-1-Hospital%2520Master%2520PLan.pdf](http://ms.gov.md/_files/8201-1-Hospital%2520Master%2520PLan.pdf)
- [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/103566/E88552.pdf](http://www.euro.who.int/__data/assets/pdf_file/0003/103566/E88552.pdf)
- <http://www.taxrates.cc/html/moldova-tax-rates.html>
- <http://www.tradingeconomics.com/moldova/hospital-beds-per-1-000-people-wb-data.html>
- <http://www.who.int/gho/countries/mda.pdf>
- <http://www.who.int/nha/country/mda/en/>

**7.7.1.4 Legislation supporting major health care reforms and policy measures**

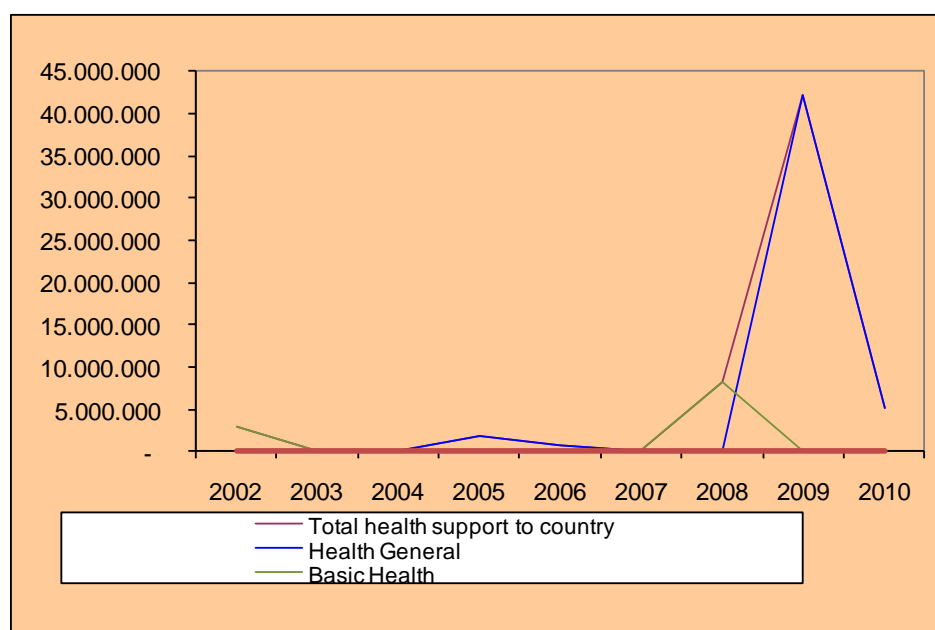
- Year Legislation
- 1993, amended 1998 Law on Pharmaceutical Activity
- 1994 Constitution of the Republic of Moldova
- 1995 Law on Health Protection
- 1995 Basic Law on Health Care
- 1996, amended 2003, 2005 Law on the Budget System and Process
- 1997 Law on Pharmaceuticals
- 1997 Government Decree No. 1134 Regarding the Statement of the Concept of Reforming the Health-Care System of the Republic Of Moldova in New Economic Conditions for the period 1997–2003
- 1998, amended 2003, 2004, 2005 and 2007 Law on Mandatory Social Health Insurance
- 1998, amended 2007 Law Concerning Psychiatric Assistance and Guarantees of Patient Rights
- 1999, overridden by the Public Law on Local Public Administration Administration Law (2003)

- 1999 Regulation on Fees for Health Services
- 2002, approved 2003 Law on Evaluation and Accreditation in Health Care No. 552-XIII
- 2002 Statute of the National Health Insurance Company, approved by Government Resolution No. 156
- 2003 Basic Benefits Package of Health Care Services under Mandatory Health Insurance, approved by
- Government Resolution No. 1591
- 2007 Government Decision on the Health System Development Strategy for the period 2007–2016
- 2007 National Health Policy 2007–2021, approved by Government Decision No. 886

## 7.7.2 EC contribution per sector, modality and channel

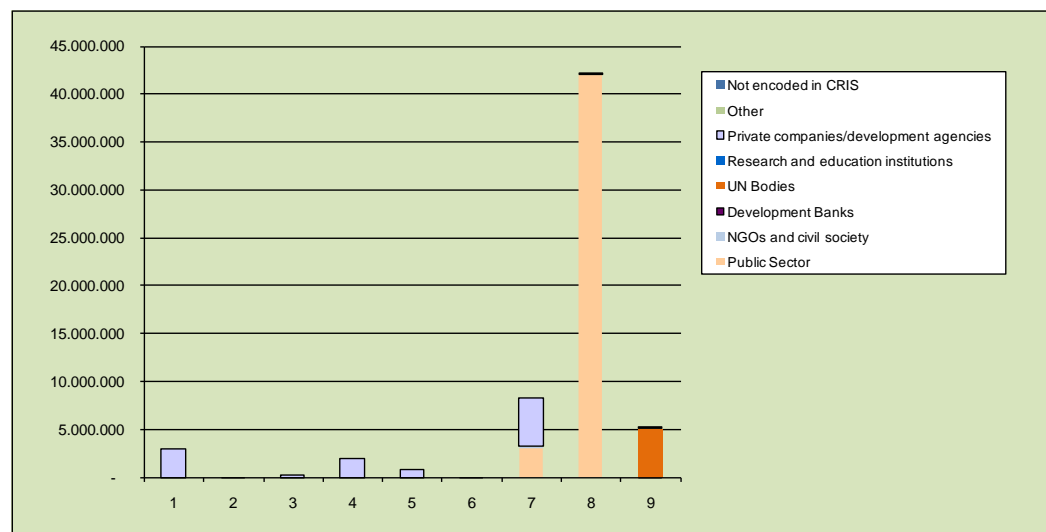
### 7.7.2.1 Per Subsector

Year	Health General	Basic Health	SRH	Total health support to the country
2002	-	2.911.368	-	2.911.368
2003	49.864	-	-	49.864
2004	43.514	18.500	-	62.014
2005	1.936.880	-	-	1.936.880
2006	732.580	-	43.721	776.301
2007	103.610	-	-	103.610
2008	134.727	8.194.123	-	8.328.850
2009	42.148.100	-	-	42.148.100
2010	5.142.753	100.000	-	5.242.753
<b>Total</b>	<b>50.292.028</b>	<b>11.223.990</b>	<b>43.721</b>	<b>61.559.739</b>



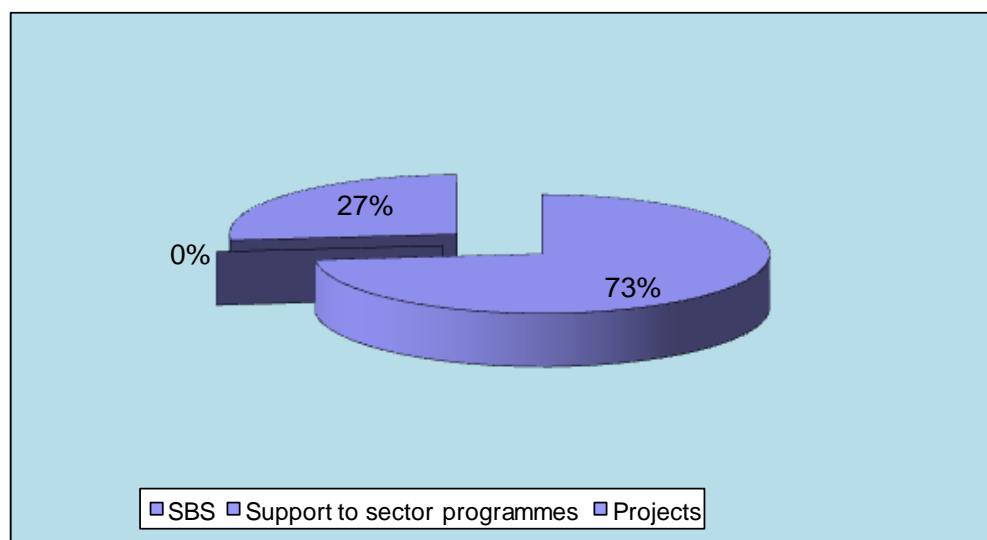
7.7.2.2 Per Channel

Year	Public Sector	NGOs and civil society	Development Banks	UN Bodies	Research and education institutions	Private companies/development agencies	Other	Not encoded in CRIS	Total
2002	-	-	-	-	-	2,911,368	-	-	2,911,368
2003	-	-	-	-	-	49,864	-	-	49,864
2004	-	18,500	-	-	-	43,514	-	-	62,014
2005	-	-	-	-	-	1,936,880	-	-	1,936,880
2006	-	43,721	-	-	-	732,580	-	-	776,301
2007	-	-	-	-	-	103,610	-	-	103,610
2008	3,000,000	220,972	-	-	-	5,107,878	-	-	8,328,850
2009	42,000,000	-	-	-	-	148,100	-	-	42,148,100
2010	-	-	100,000	4,992,753	-	150,000	-	-	5,242,753
Total	45,000,000	283,192	100,000	4,992,753	0	11,183,794	0	0	61,559,739



## 7.7.2.3 Per Modality

Year	SBS	Support to sector programmes	Projects	Potential pool funding (funds already included in support to sector programme)	Total health support	GBS related to health
2002	-	-	2,911,368	-	2,911,368	-
2003	-	-	49,864	-	49,864	-
2004	-	-	62,014	-	62,014	-
2005	-	-	1,936,880	-	1,936,880	-
2006	-	-	776,301	-	776,301	-
2007	-	-	103,610	-	103,610	-
2008	-	-	8,328,850	-	8,328,850	-
2009	42,148,100	-	-	-	42,148,100	-
2010	2,992,753	-	2,250,000	-	5,242,753	-
<b>Total</b>	<b>45,140,853</b>	-	<b>16,418,886</b>	-	<b>61,559,739</b>	-



## 7.7.3 Overview of EC support to the health sector during 2002-2010

Decisions Title	Contracts Title	Decision No	Contract number	Contract year	Decision year	Contracted amount per contract
MO0101 Moldova AP 2001	Health promotion and disease prevention	TACIS/2001/000-546	27523	2002	2001	EUR 2,754,162
	Mental Health Development in Moldova - IBPP01-0167	TACIS/2001/000-553	50790	2002	2001	EUR 157,206
	Feasibility Study for the Implementation of a National Health Insurance System in Moldova	TACIS/2001/000-546	73187	2003	2001	EUR 49,864
Tacis Support Expenditure 2004 (BA)	Survey on HIV/AIDS awareness in Ukraine and Moldova	TACIS/2004/006-202	98433	2004	2004	EUR 18,500
	TOR for the project Development of integrated social services for vulnerable families and children at risk	TACIS/2004/006-202	85947	2004	2004	EUR 20,699
	TOR Public Health Reform, Moldova	TACIS/2004/006-202	82372	2004	2004	EUR 22,815
<b>Moldova 2003 Tacis Action Programme</b>	<b>Developing a comprehensive community-based intervention for monitoring and improving the reproductive health of young people and prevent violence in Ialoveni, Moldova</b>	(blank)	101490	2006	2003	EUR 43,721
	<b>Increasing the social and professional integration of young people with mental disabilities - graduates of four auxiliary boarding schools in Moldova</b>	(blank)	121354	2006	2003	EUR 49,924
	<b>Public Health Reform in Moldova</b>	TACIS/2003/005-604	101051	2005	2003	EUR 1,936,880
	<b>Supply of IT Hardware Equipment for Public Health Care reform Moldova</b>	TACIS/2003/005-604	78237	2006	2003	EUR 348,960
Tacis Programme for Accompanying measures 2005-2006	Developing a framework for the introduction of a SWAP to the health care system in Moldova	TACIS/2005/017-749	131015	2006	2005	EUR 187,286
	Preparation ToR for service contract Support to health reform by strengthening of PHC in Moldova	TACIS/2005/017-749	130432	2006	2005	EUR 34,703
Contribution to the FSP for Moldova under the 2006 Budget of the EC	Capacity-Building of the Social Targeting Unit of the Ministry of Health and Social Protection of Moldova	FOOD/2006/018-310	127841	2006	2006	EUR 111,707
<b>TACIS 2005 Moldova Action Programme</b>	Preparation of Technical Specifications for Supply Contract for 'Support to Health Reform in Moldova'	(blank)	144446	2007	2005	EUR 103,610



Decisions Title	Contracts Title	Decision No	Contract number	Contract year	Decision year	Contracted amount per contract
	Health Sector Policy Support Programme (SPSP) Formulation Study, Moldova, ENPI 2008	TACIS/2005/017-094	147522	2008	2005	<b>EUR 134,727</b>
	<b>Supply of medical equipment to Primary Health Care centres in Moldova (EuropeAid/126263/C/SUP/MD)</b>	TACIS/2005/017-094	165565	2008	2005	<b>EUR 3,773,175</b>
	<b>Support to Health Reform and Strengthening of Primary Health Care in Moldova</b>	TACIS/2005/017-094	154538	2008	2005	<b>EUR 1.199.976</b>
Community Budget contribution to the NIF - ENPI East Region	MD-01 Capacity assessment and modernisation of the Republican Clinical Hospital (RCH) project in Chisinau	ENPI/2007/019-549	170804	2008	2007	<b>EUR 3,000,000</b>
Global commitment for global in-country calls for proposal - Objective 1- PVD Projects - Non State Actors	Developing and piloting sheltered housing service for people with mentally illness in Moldova	DCI-NSAPVD/2007/019-615	150107	2008	2007	<b>EUR 220,972</b>
Community Budget contribution to the NIF - ENPI East Region	"CEB-01 Lead IFI remuneration for project Capacity assessment and modernisation of the Republican Clinical Hospital"" in Chisinau (Republic of Moldova)"	ENPI/2007/019-549	250250	2010	2007	<b>EUR 100,000</b>
<b>Health Sector Policy Support Programme</b>	Evaluation of ENPI 2008 / 019 - 655 Health SPSP	ENPI/2008/019-655	214697	2009	2008	<b>EUR 148,100</b>
	Sector Policy Support Programme Health	DCI-MIGR/2010/022-215	203887	2009	2008	<b>EUR 42,000,000</b>
	Health Sector Budget Support Related Technical Assistance	ENPI/2008/019-655	228860	2010	2008	<b>EUR 2,992,753</b>
EIDHR 2009 Annual Action Programme - CBSS (Country Based Support Schemes)	Rehabilitation of torture victims from Moldova	(blank)	225705	2010	2009	<b>EUR 150,000</b>
Thematic Programme for Migration and Asylum AAP 2010 part 2 - Action Fiche 1 Moldova	Better managing the mobility of health professionals in the Republic of Moldova	DCI-MIGR/2010/022-215	251922	2010	2010	<b>EUR 2,000,000</b>
		<b>Total</b>				<b>EUR 61,559,739</b>

## 7.7.4 Details of programmes

### 7.7.4.1 Intervention no 1

**Title:** Public Health Reform in Moldova (*financed under decision Moldova 2003 Tacis Action Programme*) (TACIS/2003/005-604), contract 101051

**Budget:** EUR 1,936,880

**Start and end date:** 2005 – 02.03.2009

**Objectives and expected results:**

- Support the reform and restructuring of the health system in Moldova

*No TAPs with detailed programme information available in CRIS*

### 7.7.4.2 Intervention no 2

**Title:** Health Sector Policy Support Programme (ENPI/2008/019-655)

**Budget:** EUR 46,600,000

**Start and end date:** 2009 – 2011

**Expected results:**

The results of the Health Sector Policy Support Programme itself are not defined directly. Funds are not earmarked. The results and activities of the Programme are then those of the GoM's own Sector Policy, Strategy, and Medium Term Expenditure Framework for the sector.

The impact of improved health sector performance should be improved health. It should however be noted that direct relationships between a health sector interventions and health (particularly medical services which account for the bulk of expenditures), while they can be proven at an individual clinical or intervention level (through for example clinical trials), are not well established at an aggregate or sector level. Academic or statistical measures of health (for example DALYs) misleadingly create the idea that specific quantities of health can be 'bought', and hence 'financed' (by for example donors). The reality is subtler. A number of key health impact indicators are therefore included, including EU standard indicators, but it is not expected that population level impact can be demonstrated during the life cycle of the SPSP.

The beneficiary of the intervention (SPSP funding) is the public health care sector of Moldova. The overall anticipated result should therefore be improved public health sector performance. It is assumed that a better functioning public health system leads to improved outputs (quality and quantities of services) which leads to improved outcomes (individual patient health) which leads to improved results (aggregated population health amongst the compulsorily insured) which leads to improved impact (aggregated population health and well-being) (See standard evaluation framework Figure 2, Section 3.4.5).

There are competing definitions of what 'performance' in a publicly managed service should be. While imprecisely defined, two broad schools can be identified:

- Public Health Policy with an emphasis on: the quality, responsiveness, fairness in (public) health (care) and public health services
- Public Finance Policy with an emphasis on allocative and technical efficiency through the budget cycle within a (medium term) budget constraint framework

The schools overlap but can also be difficult to fully harmonize, particularly at the margin where priority decisions are made. To satisfy both schools specific results to be achieved have been separated in to a two-part policy matrix. The first part relates to:

- Part 1. Public health strategy goals
- Part 2. Public finance strategy goals

The Policy Matrix has been prepared by selecting components from the GOM's own policy and strategy documents.

Part 1 is built around the four 'functions' ('sections') of the HSDS. Part 2 is built around the six 'components' of the PFM performance framework. In each case specific key activities have been selected. These have been selected in collaboration with other domestic and development partners to ensure minimum duplication and maximum compatibility. Full details of the baseline situation with respect to each indicator is given in Annex B.

The 12 public health strategy targets to be monitored during 2008-2010 reflect all four main directions of the HSDS, see Table. In this way, the Policy Matrix provides a selective yet balanced way to monitor and evaluate the implementation of the national health policy and strategy.

Targets 1, 2 and 3 focus on the roles of the Ministry of Health and its subordinated institutions in monitoring and managing the health care sector, and on the CNAM as the main payer of the Moldovan health care system.

Under targets 4, 7, 11 and 12, the emphasis will be on the strengthening of family medicine, being the first priority of the Ministry of Health and the best promise of delivering effective and efficient health care services to the whole population, and because much has been invested in it while at the same time further investment is essential to prevent stagnation or even regress.

Target 5 aims especially at the hospital sector, being the most resource-intensive part of the health care system, and targets 6, 8, 9 and 10 are covering all levels of the health care system.

Because the HSDS does not include quantified or fully SMART targets in many cases, specification on key reform parameters has been agreed and included in collaboration with the MOH and other stakeholders.

Table 55: HSDS sections: SPSP targets

HSDS sections	SPSP targets
improved stewardship of the health care sector	1. strengthening the capacity of the MoH 2. strengthen the capacity for sector monitoring and evaluation
improved funding and payment mechanisms	3. increased funds under mandatory health insurance 4. increased autonomy of services providers 5. increased role of public-private partnerships
improved health services delivery	6. development and improvement of health services quality 7. development of priority sectors 8. reduce the rate of non-contagious diseases 9. implement national programmes against contagious diseases 10. improve patients satisfaction
further development of human and material resources	11. staff development 12.. improved physical infrastructure

A limited number of additional technical assistance and capacity building activities have been formulated and are detailed in chapter 7. It should be noted that - apart from this Health SPSP and its associated TA - the European Union and its member states also have other means at their disposal to express specific interests in elements of the Moldovan health care sector.

An attempt has been made to avoid the SPSP leading to a further proliferation of indicators. On the contrary, much of the activity under the TA associated with the budget support will be aimed at reducing these and other transaction costs (See Benchmark 1.2.).

#### 7.7.4.3 Intervention no 3

**Title:** Better managing the mobility of health professionals in the Republic of Moldova (under the decision Thematic Programme for Migration and Asylum AAP 2010 part 2 - Action Fiche 1 Moldova DCI-MIGR/2010/022-215, Contact: 251922

**Budget:** 2.000.000

**Start and end date:** 01/10/2011 – 30/09/2014

*Annex I (Description of the Action) with detailed programme information is available in CRIS*