EUROPEAN COURT OF AUDITORS

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EC DEVELOPMENT ASSISTANCE TO HEALTH SERVICES IN SUB-SAHARAN AFRICA

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(pursuant to Article 248(4), second subparagraph, EC)

EUROPEAN COURT OF AUDITORS

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GLOSSARY

ACP: African, Caribbean and Pacific States

ACT: artemisinin-based combination therapy (for malaria treatment)

ARV: anti-retroviral

CCM: country coordination mechanism

DOTS: directly observed treatment short course

EC: European Community

ECHO: European Community Humanitarian Office

EDF: European Development Funds

EuropeAid: EuropeAid Co-operation Office

Global Fund: Global Fund to fight AIDS, tuberculosis and malaria

HIPC: highly indebted poor countries debt initiative

HIV/AIDS: human immunodeficiency virus/acquired immune deficiency syndrome

IMF: International Monetary Fund

ITN: insecticide treated bednets (for malaria prevention)

MDGs: Millennium Development Goals

OVC: orphans and vulnerable children

PEPFAR: United States President's Emergency Plan for AIDS Relief

PMTCT: prevention of mother to child transmission

PRBS: poverty reduction budgetary support

SRH: sexual and reproductive health

SWAp: sector-wide approach

USD: United States dollars

VCT: voluntary consulting and testing (for HIV/AIDS)

WHO: World Health Organisation

EXECUTIVE SUMMARY

I.

The objective of the audit was to assess how effective EC assistance has been in contributing to improving health services in sub-Saharan Africa in the context of the EC's commitments to poverty reduction and the millennium development goals (MDGs). The audit examined whether the financial and human resources allocated to the health sector reflected the EC's policy commitments and whether the Commission had accelerated the implementation of this aid. The audit also assessed how effectively the Commission had used various instruments to assist the health sector, notably budget support, projects and the Global Fund to fight AIDS, tuberculosis and malaria (Global Fund).

II.

Overall, EC funding to the health sector has not increased since 2000 as a proportion of its total development assistance despite the Commission's MDG commitments and the health crisis in sub-Saharan Africa. The Commission contributed significant funding to help launch the Global Fund but has not given the same attention to strengthening health systems although this was intended to be its priority (paragraphs 8 to 17). The Commission has had insufficient health expertise to ensure the most effective use of health funding (paragraphs 18 to 20).

III.

The Commission has accelerated the health assistance it manages itself. While the Global Fund has mobilised a large volume of funding, its rate of disbursement has been slower than for the European Development Funds (EDF). There is scope for improving the predictability of the flow of funding from all instruments to enable countries to better budget the resources available for their health sectors (paragraphs 22 to 29).

EXECUTIVE SUMMARY

IV.

The Commission has made little use of Sector Budget Support in the health sector although this instrument could make an important contribution to improving health services. It has used General Budget Support much more widely but its links to the health sector are less direct and the Commission has not used it very effectively (paragraphs 32 to 46). Overall, projects have proved reasonably effective although sustainability is often problematic (paragraphs 47 to 55). The Commission played a key role in setting up the Global Fund, which has already produced significant outputs, but greater involvement by the Commission in Global Fund activities in the beneficiary countries could have made it more effective (paragraphs 56 to 62).

V.

The Commission has not paid sufficient attention to ensuring the different instruments are used together coherently. When choosing which instruments to use, it could also take more account of the situation in individual countries, in particular whether they had a well-defined health sector policy. Given their importance to the effectiveness of each instrument, there is a need for the Commission to contribute more to the development of such policies and to ensure its interventions are integrated into them (paragraphs 63 to 72).

VI.

The report's main recommendations are that the Commission should:

- consider increasing its aid to the health sector during the 10th EDF mid-term review to support its commitment to the health MDGs;
- review how its assistance to the health sector is distributed to ensure it is primarily directed to its policy priority of health systems support;
- ensure each delegation has adequate health expertise either in the delegation or through drawing on the resources of other partners;
- make more use of Sector Budget Support in the health sector and focus its General Budget Support more on improving health services;
- continue to use projects, especially for support to policy development and capacity building, pilot interventions and assistance to poorer regions;
- work more closely with the Global Fund in beneficiary countries;
- establish clearer guidance on when each instrument should be utilised and how they can best be used in combination;
- make greater efforts to contribute to the development of well-defined health sector policies in beneficiary countries.

INTRODUCTION

1. Good health is a major factor in economic growth and development while ill health is both a cause and an effect of poverty. The central place which health occupies in poverty reduction has been recognised in the MDGs which, over the period 2000–15, are intended to be the focus of international development cooperation. Thus three of the eight MDGs directly relate to health: MDG 4: Reduce child mortality; MDG 5: Improve maternal health; MDG 6: Combat HIV/AIDS, malaria and other diseases. However, the United Nations 2007 mid-term review of progress towards the MDGs[1] reported that the projected shortfalls for their achievement are most severe in sub-Saharan Africa as shown in ***Annex I***. ACP ministers of health at their summit in 2007 also expressed grave concerns about other health issues outside the MDGs and the huge challenges faced by health services in addressing them (see ***Annex II***).

2. In 2000 the Commission made poverty reduction the overarching goal of its development policy[2] and also committed itself to assisting developing countries achieve the MDGs. The 2005 'European consensus on development' continued to emphasise these priorities. The Commission's health policy in the context of poverty reduction and the MDGs has been set out in two key initiatives.

(a) In 2000 it launched a policy to accelerate action targeted at HIV/AIDS, malaria, and tuberculosis[3]. The Commission stressed that its main long-term response to improving health, including tackling these diseases, was 'intensified support to strengthen health systems to ensure improved access to prevention and treatment for the poorest.' But it also emphasised that 'the global and national emergency created by these three diseases will not wait for the improvement of health systems; there is also a need for simultaneous actions beyond the traditional health sector'. Hence, the Commission proposed new partnerships and faster delivery mechanisms and this initiative contributed to the creation of the Global Fund in 2001.

[1] The Millennium Development Goals Report 2007. United Nations, New York 2007.

[2] Declaration by the Council and the Commission on the European Community's development policy, 13458/00 of 16 November 2000.

[3] 'Accelerated action targeted at major communicable diseases within the context of poverty reduction'. Communication of the Commission to the Council and the European Parliament, COM(2000) 585 final of 20.9.2000.

(b) While the 2000 policy initiative was focused on HIV/AIDS, malaria and tuberculosis, in 2002 the Commission established a new overall health policy to reflect the poverty reduction objectives of its development policy[4]. It maintained the country programmes as the major focus of EC investment in health and prioritised actions in the areas of promoting public health, strengthening health systems, pro-poor systems of health financing, communicable diseases, and reproductive and sexual health and rights.

(c) These two policies have remained the main basis for Commission interventions in the health sector with the 2000 communication being updated in 2004 to cover the period 2007–11. The main additional initiative, directed at health systems strengthening, was the establishment in 2005 of an EU strategy to address the human resource crisis in the health sector in developing countries.

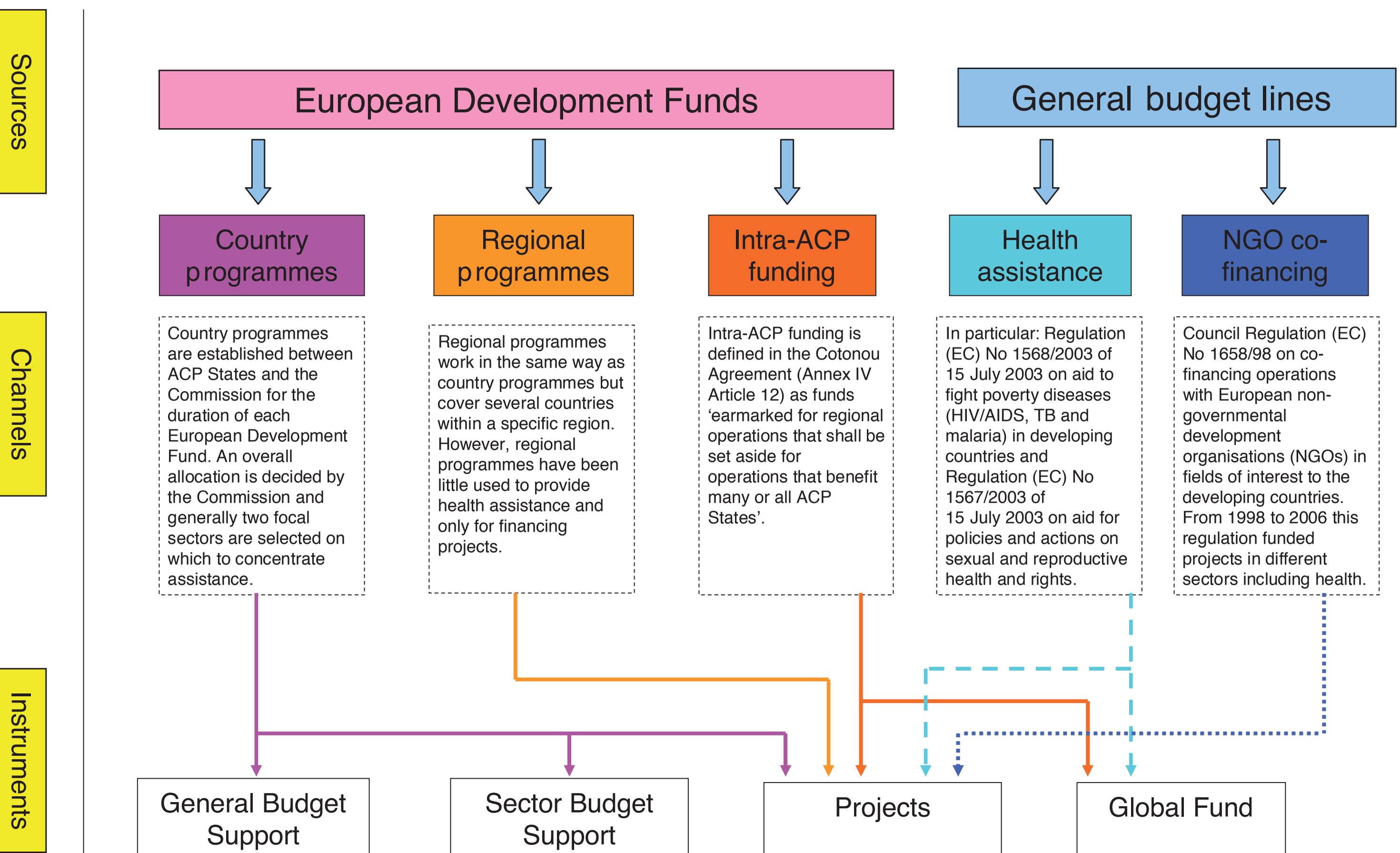
[4] Communication from the Commission to the Council and the European Parliament: 'Health and poverty reduction in developing Countries', COM(2002) 129 final of 22.3.2002.

3. The main sources of EC funding for health assistance, the channels for this funding and the instruments for its implementation are set out in ***Table 1***.

Source: ECA.

TABLE 1

OVERVIEW OF FUNDING MECHANISMS FOR EC HEALTH ASSISTANCE



AUDIT SCOPE AND APPROACH

4. The Court's audit sought to assess how effective EC assistance has been since 2000 in contributing to improving health services in sub-Saharan Africa in the context of poverty reduction. The audit focused on four key questions:

(a) Has the amount of resources allocated by the Commission to the health sector reflected its policy commitments?
(b) Has the Commission accelerated its funding of assistance to the health sector?
(c) Has the Commission used the individual instruments available effectively to contribute to improving health services?
(d) Has the Commission used the range of instruments available coherently to effectively contribute to improving health services?

5. The main audit work carried out to answer these questions was as follows:

(a) a review of documentation on EC health assistance policy;
(b) a review of EDF, general budget line and Global Fund health sector commitments and disbursements;
(c) on-the-spot missions to Kenya, Lesotho, Malawi, Mali and Swaziland;
(d) desk reviews of health interventions in Burundi, Côte d'Ivoire and Ethiopia;
(e) a survey of all 41 EC delegations in sub-Saharan Africa on EC assistance to the health sector[5].

6. The audit was limited to sub-Saharan African countries which receive EDF financing since these are the countries facing the worst health crisis. The audit did not include an examination of how other sectors, for example, water and sanitation, were used to improve health nor how health issues were mainstreamed into interventions in other sectors. It also excluded the audit of health interventions by the European Community Humanitarian Office (ECHO).

[5] Due to the good cooperation of the Commission, replies to the questionnaire were received from 37 of the 41 Commission delegations in sub-Saharan Africa.

OBSERVATIONS ON ALLOCATION AND DISBURSEMENT OF RESOURCES TO THE HEALTH SECTOR

RESOURCES ALLOCATED BY THE COMMISSION TO THE HEALTH SECTOR

7. This section addresses the question whether the financial and human resources allocated by the Commission to the health sector reflect its policy commitments. The Court examined Commission policy statements and European Parliament targets, the allocations made, and the causes and consequences of the level of allocations.

FINANCIAL RESOURCES

The Commission has made strong policy commitments to the health sector

8. The Commission has made strong commitments to the health sector in its health assistance policies. In its 'programme for action' for the 2000 'accelerated action' policy the Commission stated it would 'prioritise within the total development cooperation budget, health, AIDS and population interventions over the next five years (2002–06)[6]. Subsequently, the 2003 progress report on the programme for action[7] referred to a target of 15 % of ninth EDF programmed aid being allocated to health. The 2002 health and poverty reduction policy stressed that far greater efforts had to be made by the international community to support the health sector and that the EC had an important role to play in this.

9. In 2004, in order to show the priority it attached to EC assistance being directed to the health and education MDGs, the European Parliament introduced a specific allocation target in its budgetary remarks for all areas of development cooperation, including the African, Caribbean and Pacific (ACP) States: '(as) the purpose of development cooperation under this heading is primarily its contribution to achieving the MDGs… a minimum of 20 % of total annual commitments will be allocated to activities in the sectors of basic health and education'[8]. In 2006, the Commission formally committed itself to prioritising these sectors in the country programmes covered by the new Development Cooperation Instrument and to meeting the 20 % target[9] taking into account budget support linked to these sectors. Such an approach is difficult to apply in the context of the EDF where, in contrast to the Development Cooperation Instrument context, most budget support is provided through General Budget Support for which there is no recognised method for attributing the assistance to specific sectors. While the Commission did not make a similar undertaking for the EDF, the Parliament nevertheless said that the Commission's undertaking 'should apply to all European development policy spending including the EDF in order to be coherent'[10].

[6] Programme for action: accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, COM(2001) 96 final of 21.2.2001.

[7] Update on EC programme for action: accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, COM(2003) 93 final of 26.2.2003.

[8] General budget of the European Union for the financial year 2004 (OJ C 105, 30.4.2004, p. 1169).

[9] Communication from the Commission to the European Parliament concerning the common position of the Council on the adoption of a regulation of the European Parliament and of the Council establishing a financing instrument for development cooperation. Annex on Article 5 of Development Cooperation Instrument, COM(2006) 628 final of 24.10.2006.

[10] European Parliament 'Report on the implementation of the programming of the 10th European Development Fund'. A6-0042/2008 dated February 2008.

Overall Commission funding to the health sector is below policy commitments and benchmarks, despite significant new support for the Global Fund

10. As ***Table 2*** shows, ninth EDF assistance committed directly[11] to the health sector in sub-Saharan Africa represented 5,5 % of total EDF commitments, well below the 15 % target (see paragraph 8). This was despite an increase from 4,4 % under the eighth EDF due to significant new funding for intra-ACP health interventions, principally in contributions to the Global Fund.

[11] Excluding General Budget Support (see paragraph 12).

TABLE 2

EDF COMMITMENTS TO THE HEALTH SECTOR UNDER EIGHTH AND NINTH EDFS AS A PERCENTAGE OF TOTAL EDF COMMITMENTS IN SUB-SAHARAN AFRICA (MILLION EURO AT 31.12.2007)

	Eighth EDF		**Ninth EDF**	
Total EDF commitments	9 787,0		13 930,7	
Type of health support	Amount of EDF health commitments	% of total EDF commitments	Amount of EDF health commitments	% of total EDF commitments
Health in country programmes	369,3	3,8 %	351,2	2,5 %
Health in regional programmes	13,1	0,1 %	19,7	0,1 %
Health in intra-ACP funded interventions	47,6	0,5 %	399,7	2,9 %
Total	**430,0**	**4,4 %**	**770,6**	**5,5 %**

11. As ***Table 3*** shows, commitments directly to the health sector in country programmes in sub-Saharan Africa have been very low compared with the target set by the European Parliament (see paragraph 9), falling from 5,1 % under the eighth EDF to 3,6 % under the ninth EDF while under the 10th EDF allocations were programmed for just 3,5 %. This was inspite of it being the Commission's policy to use country programmes as its main channel of assistance to the health sector (see paragraph 2). Low health commitments were not compensated for by higher education commitments: combined health and education commitments in country programmes fell from 7,5 % under the eighth EDF to 6,2 % under the ninth EDF and were programmed to remain at this level under the 10th EDF.

TABLE 3

EDF COMMITMENTS TO THE HEALTH SECTOR UNDER EIGHTH AND NINTH EDFS AS A PERCENTAGE OF TOTAL EDF COUNTRY PROGRAMMES IN SUB-SAHARAN AFRICA (MILLION EURO AT 31.12.2007)

	Eighth EDF		Ninth EDF	
Total EDF country programmes	7 268,6		9 793,8	
Health in country programmes	369,3	5,1 %	351,2	3,6 %
Education in country programmes	175,5	2,4 %	255,8	2,6 %
Total health and education in country programmes	544,8	7,5 %	607	6,2 %

12. Apart from the direct funding to the health sector, an assessment of the Commission's support to the health sector in sub-Saharan Africa should also take General Budget Support into account, although in practice it is very difficult to quantify.

(a) Under the seventh and eighth EDFs, 3 240 million euro were committed by the Commission to budgetary support programmes. Up until 2000, counterpart funds arising from the programmes were directly allocated to national health and education budgets, an estimated 800 million euro (80 million euro per annum; 35 % of counterpart funds) being provided to the health sector over the period 1990–99.

(b) Under the ninth EDF, General Budget Support commitments amounted to approximately 2 000 million euro but was no longer earmarked for specific sectors. Although it is not possible to state how much funding was allocated to the health sector, it is estimated that it was lower than under the two previous EDFs. If it is assumed that countries spend the General Budget Support they receive in line with the relative shares of sector budgets, this would mean that approximately 200 million euro was used for health (33 million euro per annum) since health budgets on average make up 9–10 % of total national budgets in sub-Saharan Africa. This percentage is much less than the 35 % previously earmarked for health by the Commission. Moreover, as shown by a 2007 International Monetary Fund (IMF) evaluation of budgetary support to sub-Saharan African, countries on average save up to 70 % of such assistance to reduce their budget deficits[12]. This indicates that the ninth EDF General Budget Support actually used for national health budgets was rather less than 200 million euro.

(c) For the 10th EDF, General Budget Support of approximately 3 300 million euro has been programmed. While this represents an increase compared with the ninth EDF, it is unlikely to lead to as much resources being channelled to health as under the seventh and eighth EDFs.

[12] The IMF and Aid to sub-Saharan Africa. Independent Evaluation Office of the IMF, 2007.

13. A further source of funding for health assistance are the general budget lines (see ***Table 1***). The amounts increased significantly over the period 2003–06, averaging 109 million euro per annum, of which approximately one third was directly committed to sub-Saharan Africa. This compared very favourably to the 22 million euro per annum allocated over the period 1997–2002, but the budget has fallen back to 84 million euro per annum for the period 2007–13.

14. Overall, while it is extremely difficult to calculate a precise figure and recognising the limitations of a purely input based approach, the Court's analysis pointed to an indicative figure of 1 100 million euro to 1 200 million euro being allocated to the health sector in sub-Saharan Africa over the period of the ninth EDF including General Budget Support and general budget line funding. This is estimated to represent an increase in absolute terms of up to 30 % compared with the period covered by the eighth EDF. However, given that there was a more than 40 % increase in total commitments for the ninth EDF compared with the eighth EDF the percentage of EC funding committed to the health sector in sub-Saharan Africa declined. While the 10th EDF represents a 60 % increase compared with the financial allocations of the ninth EDF, health allocations to sub-Saharan Africa are estimated at approximately the same amount as for the ninth EDF. The low country programme allocations to country programme direct health sector interventions in sub-Saharan Africa are in sharp contrast with EC allocations to countries in Asia, where 14 % of the 2007–10 multiannual indicative programme funds were allocated to basic health. This is despite the fact that Asian countries were significantly further advanced towards the health MDGs.

There is a shortage of international assistance for strengthening health systems

15. Starting from the ninth EDF, the Commission and EU Member States sought to find an appropriate division of labour between themselves based on their traditional expertise and perceived comparative advantage. While the division of labour between donors is a sound management principle, it does not ensure that adequate resources are allocated to sub-Saharan African countries to achieve a minimum level of health services and make significant progress towards the health MDGs. Analyses by the Commission, EU Member States and the World Health Organisation (WHO) have identified key issues in the overall level and distribution of health funding which the international community must address (see Box 1).The relative absence from the sector of such a major donor as the Commission[13] has contributed to these shortfalls, and the European Parliament has taken the view that the division of labour principle is not a valid reason for the Commission not to play a key role in the health sector[14].

[13] The European Commission is one of the five largest donors to sub-Saharan Africa along with France, the United Kingdom, the United States and the World Bank.

[14] European Parliament resolution of 24 April 2007 with observations forming an integral part of decision on discharge for implementation of the budget for the sixth, seventh, eighth and ninth EDFs for the financial year 2005. Paragraph 29.

16. The 2007 EU Code of Conduct on Complementarity and the Division of Labour in Development Policy[15] stresses the need to address the problem of donor orphans, which are often fragile States and post-crisis countries. An EC comparative advantage, recognised in both the 2000 and 2005 development policies, was the role it could play in such countries. This is both because it is more frequently represented in these countries than EU Member States and also because of its role in supporting rehabilitation and development after the end of relief operations managed by ECHO. Since a significant part of ECHO's interventions are health-related, there is a particular need to assure follow-up health interventions. In only a limited number of such countries was health selected as a focal sector under the 10th EDF (Angola, Burundi, Côte d'Ivoire, Democratic Republic of the Congo, Liberia and Zimbabwe).

[15] Council of the European Union Note 9558/07, Brussels, 15 May 2007.

BOX 1

KEY ISSUES IN THE OVERALL LEVEL AND DISTRIBUTION OF HEALTH FUNDING

EU Member States and Commission health experts concluded in 2006 both that health's share in overall EU overseas development assistance was insufficient at 6,6 % and that EU health assistance was not correlated to countries' needs in terms of their health financing gap.

DG Development has estimated that, if they were to deliver minimal health services[16], 32 sub-Saharan African countries would have a total financing gap of 9 767 million euro, even if they met the target set by African Heads of State at their 2001 Abuja Summit to allocate 15 % of their national budget to health.

A WHO study on health assistance identified a number of 'health donor orphans' and concluded that there was no clear correlation between a country's health situation and the amount of health assistance it received. More health aid is given to countries with high HIV/AIDS prevalence rates, even if the overall health situation in other countries is as bad or worse[17].

[16] According to the 2001 Commission on Macroeconomics and Health, 30 USD per capita per year is needed to deliver very minimal health services. It does not include key elements such as family planning, tertiary hospitals and emergencies.

[17] Sub-Saharan African countries classified by the WHO study as health donor orphans are: Central African Republic, Cote d'Ivoire, Democratic Republic of the Congo, Ethiopia, Nigeria, Sudan, Togo and Zimbabwe.

17. The relatively large Commission funding for disease-specific interventions compared to that for health systems (see paragraph 10) reflected the fact that over the period 2000–05 it invested significant efforts in drawing up and implementing action programmes for its HIV/AIDS, malaria and tuberculosis policy initiative. On the other hand, it has paid less attention to implementing its broader health policy. The decline since 2000 in Commission assistance to country programmes (see paragraph 11) is part of a wider tendency on the part of the international community to focus on disease-specific interventions at the expense of strengthening health systems[18]. In the Court's survey of Commission delegations in sub-Saharan Africa, 23 out of 27 delegations considered that there was too much disease-specific funding. The Court found that in Ethiopia and Mali, although the two countries had relatively low HIV prevalence rates[19], the external assistance they received for tackling HIV/AIDS was greater than their entire national health budget. The UNDP 2007 mid-term review of the MDGs stressed that weak health systems are a serious obstacle to their achievement.

HUMAN RESOURCES

The Commission does not have adequate health expertise

18. While the Commission itself recognised its lack of health expertise in 2004, citing it as a reason for its limited financial allocations to the health sector[20], the Court found that this problem persists and a human resource strategy to address it has not been developed. Of the 37 delegations in sub-Saharan Africa which replied to the Court's survey, 13 delegations have in total 18 staff with university-level qualifications in health-related fields[21]. Only four of these are permanent officials, of which just one works full-time on health[22]. The Court identified several issues during its on-the-spot audit work (see Box 2). Not only is it essential for delegations in countries where health is an EDF focal sector to have health expertise, but it is also important for other delegations to have access to health expertise for the following reasons:

(a) to manage the health aspects of General Budget Support programmes;
(b) to support and monitor Global Fund operations in the country;
(c) to better supervise the health general budget line and intra-ACP projects;
(d) to ensure HIV/AIDS issues are integrated into all EC interventions.

[18] In particular, the United States President's Emergency Plan for AIDS Relief (PEPFAR) was launched in 2003 to provide 15 billion USD in assistance to combat HIV/AIDS over a five-year period in 15 focus countries, of which 12 were sub-Saharan African countries (including the Republic of South Africa).

[19] According to the demographic and health survey conducted in 2005, the HIV prevalence rate in Ethiopia is 1,4 %. In Mali it is 1,9 %.

[20] Second progress report on the EC programme for action, SEC(2004) 1326 final of 26.10.2004.

[21] Four permanent officials, five local agents, seven contractual agents and two junior experts.

[22] In addition, five local agents (all full-time), seven contractual agents (three full-time, four part-time) and two junior experts (both part-time) also worked on health.

BOX 2

STAFFING ISSUES IDENTIFIED DURING THE COURT'S AUDIT MISSIONS

In Burundi, although health was an important sector under the ninth EDF and a focal sector under the 10th EDF, the delegation had no health expertise. In Kenya, after the departure of a Member State national health expert in August 2006, the delegation was not able to obtain a replacement because no post was available. In Swaziland, the delegation had an official with health training but he had been working on other sectors as health had not been a focal sector in Swaziland under the ninth EDF.

19. Commission headquarters does not have sufficient expertise to provide adequate backup to the delegations in sub-Saharan Africa. In DG Development three officials (only one with a health background) and three detached national/multilateral experts work on health policy issues relating to all developing countries and programming issues in ACP countries. In EuropeAid there are just two health professionals responsible for providing support to all 41 delegations in sub-Saharan Africa.

20. One positive recent measure taken by the Commission to address the lack of health expertise at delegation level was the appointment of a regional HIV/AIDS advisor for southern Africa based in its delegation in Pretoria, but this is an isolated case. There is also scope for delegations to cooperate more in post-conflict countries with ECHO's regionally-based health advisers. Some delegations have also sought to draw on the health expertise of other donors, including EU Member States but such cooperation is still limited and generally not formalised, with the result that mandates given by the Commission to Member States are not adequately defined and do not ensure that the Commission retains its responsibility.

SPEED OF EC FUNDING TO THE HEALTH SECTOR

21. An important aspect of the Commission's health policy since 2000 has been its commitment to accelerate assistance to the health sector, notably to combat poverty-related diseases (see paragraph 2). Predictability of funding has also become a key issue if beneficiary countries are to improve budgeting and implementation of external aid. This section examines the disbursement rate of the different instruments and identifies factors affecting their speed and predictability.

EDF HEALTH SECTOR INTERVENTIONS

EDF assistance to the health sector has accelerated under the ninth EDF

22. The speed of implementation of ninth EDF health sector interventions in sub-Saharan Africa has significantly increased compared with the eighth EDF (see ***Table 4)***. A major factor explaining the acceleration in disbursements is devolution. According to the Court's survey, 77 % of delegations considered devolution had increased the speed of implementation of EDF projects.

TABLE 4

COMPARISON OF PERCENTAGE OF EDF HEALTH INTERVENTIONS IN SUB-SAHARAN AFRICA DISBURSED OVER FIRST FIVE YEARS OF EIGHTH AND NINTH EDFS

	Cumulative percentage of EDF health commitments disbursed during first five years of EDF	
	Eighth EDF	Ninth EDF[1]
Year 1	0 %	0 %
Year 2	1 %	3 %
Year 3	3 %	13 %
Year 4	8 %	25 %
Year 5	18 %	39 %

[1] Excluding transfers to Global Fund (see paragraph 26).

23. Since the Commission allocates funds for the full period of its country strategy papers, this provides a good basis for predictable funding. However, the Court found that, despite devolution, the complex procedures for procuring inputs (works, services, supplies) and approving and implementing work programmes still reduce both the speed and the predictability of the flow of funding to EDF health interventions.

GENERAL BUDGET SUPPORT

Disbursement by the Commission is quick but predictability is an issue

24. Under both the eighth and ninth EDFs General Budget Support proved to be a fast-disbursing instrument as shown in ***Table 5***. The fact that programmes are generally for three years and indicative allocations are set out in country strategy papers for six years also contributes to their predictability.

TABLE 5

GENERAL BUDGET SUPPORT COMMITMENTS DISBURSED OVER FIRST FIVE YEARS OF EIGHTH AND NINTH EDFS

	Cumulative percentage of general budget support commitments disbursed during first five years of EDF	
	Eighth EDF	Ninth EDF
Year 1	12 %	5 %
Year 2	22 %	18 %
Year 3	31 %	38 %
Year 4	55 %	57 %
Year 5	71 %	74 %

25. However, the Court found that speed and predictability were reduced by:

(a) delays in countries making eligible payment requests, mainly due to their problems in collecting data for the performance indicators (e.g. Burundi, Kenya, Mali);
(b) some countries losing their eligibility for General Budget Support, with the result that it is suspended, thus reducing assistance available for health budgets. This was the case in four of the six countries covered by the Court's on-the-spot audit and desk reviews (Ethiopia, Kenya, Lesotho, Malawi) although the Court found that in Ethiopia the international community had found an effective alternative mechanism to ensure a continued flow of funds to the health and other key sectors (see Box 3). One advantage of using Sector Budget Support in parallel with General Budget Support is that, in some circumstances, the former can still be used when the latter has been suspended.

GLOBAL FUND

The Global Fund has disbursed a large volume of funds but the rate of disbursement has been slower than the EDF

26. One of the objectives of setting up the Global Fund was to establish a faster delivery mechanism (see paragraph 2). While the Commission's contributions to the Global Fund, which began under the ninth EDF, have accelerated the speed with which the Commission disburses overall EDF health commitments (see ***Table 6)***, disbursement to the Global Fund is only the first step in channelling this assistance to the final beneficiary.

BOX 3

BUDGET SUPPORT TO ETHIOPIA

In Ethiopia, General Budget Support was suspended in 2005 because of the political situation. However, to ensure that external assistance to key services, including health, was maintained the international community put in place a new multisectoral 'basic services protection programme' providing support directly to regional authorities. Such an approach represents a means of reducing the risk that long term efforts to improve health services may be disrupted by the suspension of General Budget Support.

TABLE 6

EFFECT OF GLOBAL FUND DISBURSEMENTS ON RATE OF DISBURSEMENT OF EDF HEALTH COMMITMENTS

	Cumulative percentage of EDF health commitments disbursed during first five years of EDF		
	Eighth EDF	Ninth EDF (excluding Global Fund)	Ninth EDF (including Global Fund)
Year 1	0 %	0 %	22 %
Year 2	1 %	3 %	24 %
Year 3	3 %	13 %	31 %
Year 4	8 %	25 %	46 %
Year 5	18 %	39 %	55 %

27. In terms of increasing the overall volume of disbursements for combating HIV/AIDS, malaria and tuberculosis, the Global Fund has been effective, its disbursements in sub-Saharan Africa amounting to 2 931 million USD from 2002 to 2007. However, as ***Table 7*** shows, the rate at which the Global Fund disburses in sub-Saharan African countries does not compare favourably with EDF health interventions. For the first round of grants launched in 2002, at the end of their five-year implementation period only 73 % of the budget had been disbursed. The Court's analysis did not indicate an improvement in the disbursement rate of Global Fund grants approved in subsequent years.

TABLE 7

COMPARISON OF CUMULATIVE RATE OF DISBURSEMENT OF GLOBAL FUND AND EDF HEALTH INTERVENTIONS IN SUB-SAHARAN AFRICA

	Global Fund	EDF health interventions
Year 1	2 %	1 %
Year 2	13 %	25 %
Year 3	26 %	36 %

28. Besides the Global Fund's legitimate emphasis on performance-based funding, which means it reduces disbursements to less effective grants, two further factors affecting the rate of disbursement have been:

(a) difficulties of some recipients of Global Fund support in establishing financial, procurement and monitoring systems of the standard required by the Global Fund and in quickly disbursing the funding;
(b) new funding sources such as PEPFAR entering countries during Global Fund grant implementation, which has reduced their absorption capacity.

29. Unlike the EDF, Global Fund grants are approved on the basis of annual funding rounds. Countries do not know if their applications for funding will be approved and for what amount. Thus, over the first six years of the Global Fund only 39 % of grant applications submitted for financing were actually approved.

MANAGEMENT AND EFFECTIVENESS OF INSTRUMENTS

30. The Court examined the three main instruments used to improve health services: budget support, projects, and the Global Fund. This section assesses both how well the Commission has managed them and how effective they have been and how coherently the Commission has used the instruments together. ***Annex III*** contains an overview of interventions in the five countries visited by the Court.

BUDGET SUPPORT

THE USE OF BUDGET SUPPORT BY THE COMMISSION

Budget support has the potential to play a key role in improving health services

31. Budget support has the potential to play a key role in improving health services by increasing funds available to governments for their health budgets, thus allowing them to scale up services, a necessary prerequisite for achieving the MDGs. In addition, it can strengthen the policy and institutional framework through policy dialogue and technical assistance. The Commission, which is one of the biggest providers of budget support, defines it as 'the transfer of financial resources of an external financing agency to the national treasury of a partner country, following the respect by the latter of agreed conditions for payment'[23]. Although it classifies budget support as General Budget Support or Sector Budget Support, in practice the distinction is less clear:

'Budget support can best be described as a spectrum. At one extreme is General Budget Support with dialogue and conditions focused on macro and cross-sectoral issues. At the other extreme is Sector Budget Support focused only on sector specific issues. In between is General Budget Support with sector conditions and dialogue and those Sector Budget Support operations which include some macro and cross-cutting conditions and dialogue'[24].

Sector Budget Support has been little used and the role of General Budget Support in improving health services has not been clear

32. Sector Budget Support, with its focus on one sector, has particular potential for assisting the health sector. However, although it has been Commission policy since 2000 to increase its use, in practice only two sub-Saharan African countries (Mozambique and Zambia) received health sector budget support under the ninth EDF. One reason for this is that the Commission has generally only used health sector budget support in a country if it has health as a focal sector, which is the case in only a limited number of countries. A second reason is that one of the eligibility criteria is the existence of a well-defined health sector policy, which is still not the case in some countries.

[23] European Commission General Budget Support Guidelines 2007 (Page 10).

[24] Note on Sector Budget Support from November 2005 Dublin Workshop of the Strategic Partnership for Africa, a group of bilateral and multilateral donors.

33. General Budget Support has been used much more widely than Sector Budget Support by the Commission, 21 sub-Saharan African countries having received it under the ninth EDF. It has been the Commission's preferred form of budgetary support and, in contrast to sector budget support, the Commission allows its use in addition to funding two focal sectors. Furthermore, more countries are eligible for General Budget Support since an overall national policy, rather than a specific sectoral policy, is an eligibility requirement even though the effectiveness of national policy to a considerable degree depends on the strength of sectoral policies. While General Budget Support has a broader range of objectives than Sector Budget Support, it can also contribute to improving health services if its design includes a sectoral dimension (see paragraph 31). This has traditionally been the case in the Commission's General Budget Support programmes since it has prioritised the health and education sectors and included health sector conditionality and provisions for health policy dialogue with governments.

34. The Court nevertheless found that views varied within the Commission services, particularly between macroeconomists and health professionals, as to how far General Budget Support should have a sectoral dimension. The Court's survey indicated that most delegations perceived improving health services as a key objective of the instrument (see ***Table 8***). On the other hand, the revised 2007 General Budget Support manual considerably reduced the instrument's sectoral dimension compared to the previous 2002 manual, lessening its focus on improving health services.

TABLE 8

DELEGATIONS' PERCEPTION OF THE IMPORTANCE OF GENERAL BUDGET SUPPORT OBJECTIVES

1	2	3	4	5	N/O	Average	GBS objectives
1	1	1	7	18	2	4,43	Reducing poverty
1	0	1	10	16	2	4,43	Improving public finance management
1	1	3	11	12	2	4,14	Providing macroeconomic stability
1	2	4	14	7	2	3,86	Harmonising aid procedures
1	0	8	12	7	2	3,86	Increasing predictability of funding
1	**4**	**5**	**8**	**10**	**2**	**3,79**	**Improving health services**
1	4	6	8	9	2	3,71	Improving education services
3	5	0	9	10	3	3,67	Reducing aid transaction costs

(1 = Not important, 5 = Highly important, N/O = No opinion)

EFFECTIVENESS OF GENERAL BUDGET SUPPORT IN IMPROVING HEALTH SERVICES

35. It is widely recognised that it is very difficult to assess the effectiveness of General Budget Support. While a joint donor evaluation of General Budget Support issued in 2006 represented an important step in evaluating the instrument, it was not without its limitations and the Commission is still working to establish an appropriate evaluation methodology. In its assessment of the instrument's effectiveness the Court focused on the following aspects[25]:

(a) whether the financial inputs provided were associated with increased allocations to and disbursements from national health budgets and whether the inputs were likely to be used for the intended purpose;
(b) whether the policy and institutional framework in the health sector was conducive to the effective delivery of services;
(c) whether delegations were involved in health sector policy dialogues which would contribute to the more effective use of General Budget Support;
(d) whether health performance indicator targets selected as part of the General Budget Support conditionality were achieved and appropriate.

Financial inputs: in most countries examined General Budget Support has not been associated with an increase in health budgetary resources

36. The Court found that in most countries examined General Budget Support did not lead to increased resources being channelled through the national health budget (see Box 4). One important reason for this is that in some cases beneficiary countries decide not to increase budgetary expenditures in a given fiscal year by the same amount as the budgetary support received but instead use the funds to reduce their fiscal deficits (see paragraph 12(b)). Moreover, the Commission has not systematically sought to encourage countries to increase national health budgets through the use of performance indicators targeting such increases in its General Budget Support financing agreements. Thus in only five of the 12 countries examined were health budget allocations included as a performance indicator.

[25] The Court's assessment is based primarily on General Budget Support programmes in Burundi, Ethiopia, Kenya, Lesotho, Malawi and Mali. It also takes into account relevant audit work carried out in other countries in the framework of its statement of assurance on the EDF In particular relating to Ghana, Guinea Bissau, Madagascar, Mozambique, Niger and Sierra Leone.

The Commission's 'dynamic interpretation' of eligibility for General Budget Support puts at risk the effective use of funding for improving health services

37. The effectiveness of General Budget Support in improving health services depends not only on how much is channelled to health spending but also on the soundness of public financial management systems covering its use. As a result of what the Commission terms a 'dynamic interpretation' of eligibility, although sub-Saharan African countries generally have weak public finance management capacity, they may still be eligible for General Budget Support, leading to a high risk of inefficient and ineffective public spending. Funds channelled to the health sector are at particular risk since resource flows to front-line service providers are complex, generally passing through several administrative layers. The Court found that public expenditure tracking surveys or audits tracking public expenditure, although seldom used, have identified public resource leakages on a significant scale in relation to non-wage health expenditures which could have serious consequences for health service delivery[26]. In addition, drug procurement through central medical stores is widely recognised to be a high-risk area.

[26] See, for example, 'Public expenditure tracking surveys — quantitative service delivery surveys in sub-Saharan Africa: a stocktaking study'. Bernard Gauthier. HEC Montreal. September 2006, commissioned by the World Bank.

BOX 4

GENERAL BUDGET SUPPORT AND ITS EFFECT ON HEALTH BUDGETS

In Burundi, while the health development national plan for 2006–10 foresaw an increase in the national budget allocated to health from 3,6 % to 15 % in 2010, the budget allocations for health in 2007 decreased to only 2 %.

In Ethiopia, health budget allocations and expenditure remained low for the period reviewed (2002–07) leaving health services seriously underfunded. While PRBS 2 targeted an increase in the health budget from 6,8 % in 2003 to 7,3 % in 2004, in fact health's share of the budget actually fell to 6,5 %. Although, overall, poverty-related recurrent expenditure in Ethiopia increased significantly after 2000, this was not the case for health, its share of such expenditure being only 15 %.

In Mali, while the financing agreement for General Budget Support required the share of health in the national recurrent budget to increase from 10,5 % to 11,5 % over the period 2002–05, it did not do so and in 2005 fell to 10,2 %.

In Kenya, the health budget allocation increased to 9 % in 2005–06 compared to 7 %–7,5 % in previous years, but expenditure in 2005–06 was just 5,7 % having declined each year since 2001–02 when it was 9 % of total government expenditure.

In Malawi, for the first two years (2005–07) following the resumption of General Budget Support, the government prioritised paying off internal debt and the health budget was only maintained at a level of 10,7 %, lower than in some previous years. However, a significant increase in the budget was planned for 2007–08.

In Lesotho, health expenditure was maintained at previous levels despite the growing health crisis.

38. General Budget Support programmes have not adequately addressed these risks. The 2002 General Budget Support manual foresaw financial audits and compliance tests, particularly in the social sectors, during the course of programme implementation, in addition to the initial appraisal of the quality of public finance management. Such controls are particularly necessary where the capacity of national supreme audit Institutions is low, as is generally the case. However, in practice controls of this kind were not carried out and the Commission dropped the requirement to perform them from its 2007 manual. This states that once the Commission has transferred resources to the national treasury, it will not follow up on how they are used. This is in contrast to the Commission's policy for Sector Budget Support to examine the use of inputs much more closely 'paying attention to the results chain from 'inputs' to 'outputs' to 'results/outcomes'[27]. The Court shares the view of the European Parliament that this is another advantage of Sector Budget Support in terms of its potential effectiveness compared with General Budget Support[28].

Insufficient attention has been paid to strengthening the policy and institutional framework when using General Budget Support to improve health services

39. The Court found that in two countries visited, Malawi and Mali, the effectiveness of General Budget Support channelled to the health sector was likely to be increased by the existence of a sound health sector policy which was supported by donors through a sector-wide approach (SWAp). However, according to the audit survey, in approximately half of the countries which had received General Budget Support under the ninth EDF or were programmed to receive it under the 10th EDF, a health SWAp had not yet been established. This points to the insufficient attention given by the Commission to the importance of ensuring SWAps are established in order to make General Budget Support effective in improving health services.

40. Ministries of health tend to be among the weaker ministries, particularly at regional and district levels, to which extensive decentralisation has taken place in some countries. This limited institutional capacity is a constraint on both the development and implementation of sound health policies. It has been Commission policy to provide technical assistance to strengthen priority sectoral ministries as well as ministries of finance, approximately 10 % of General Budget Support funding being reserved for this purpose[29]. However, in the 12 countries with General Budget Support examined by the Court, in only one case (Niger) were funds allocated for specific technical assistance to the Ministry of Health. The 2007 General Budget Support manual no longer foresees the use of technical assistance to sectoral ministries.

[27] European Commission support to sector programmes guidelines, July 2007.

[28] European Parliament resolution of 22 April 2008 with observations forming an integral part of the decision on discharge in respect of the implementation of the European Union general budget for the financial year 2006, Section III — Commission, point 225.

[29] 'Community support for economic reform programmes and structural adjustment: review and prospects'. COM(2000) 58 final. Brussels 4.2.2000.

The Commission has not taken full advantage of the opportunities for health sector dialogue to improve the effectiveness of General Budget Support

41. One of the potential advantages of budget support is the opportunity it provides to improve effectiveness through policy dialogue between donors and beneficiary governments. While, according to the Court's survey, the great majority of delegations directly participated in a health sector dialogue, the Court found weaknesses in the quality and depth of this dialogue:

(a) the limited health expertise in delegations (see paragraph 18) is not conducive to contributing to high-quality dialogue. The Commission has sought to find economic expertise to work on General Budget Support but has not formed wider teams for such programmes which would also include health (and education) experts. While representation by other donors may, in some circumstances, be used, this was only the case in two delegations and was not covered by a formal written mandate (see paragraph 20);

(b) it is unclear what depth of sectoral dialogue delegations are expected to go into in the context of General Budget Support (see paragraph 34);

(c) discussions on the achievement of performance indicator targets are intended to be a means for establishing a wider health sector dialogue, but the Court found that there was a tendency for the dialogue to be overly focused on the specific indicators, rather than wider health issues, as well as on the amount of the variable tranche to be paid for each indicator rather than on the underlying factors affecting performance.

Only half of the performance indicator targets were met and there are weaknesses in the mechanisms for their use

42. A commendable part of Commission policy on General Budget Support since 2000 has been the focus on results. Thus approximately 30 % of General Budget Support is disbursed through so-called variable-tranche payments depending on the achievement of targets for performance indicators. The indicators have increasingly been selected from beneficiary governments' poverty reduction strategy papers to improve their relevance and national ownership. The need to measure results has also led to significant efforts to strengthen national statistical systems.

43. The Court examined how far the health sector performance indicator targets contained in the Commission's financing agreements had been achieved. It found that overall only 50 % of the health indicator targets had been met. This raises issues about the effectiveness of General Budget Support programmes in helping bring about improvements in health services.

44. The Court found several factors concerning the way health performance indicators were used which also reduced the effectiveness of General Budget Support in contributing to improvements in health services.

(a) The incentive value of performance targets may be reduced both because of the relatively small amounts attached to each indicator and the Commission's policy of making unspent funds available for other EDF assistance to the country, in cases where variable tranches have not been disbursed because targets had not been met.
(b) Governments also had less incentive, and the link to General Budget Support was reduced, when indicators were selected over which governments did not have sufficient control.
(c) Data used were often not reliable so that it was sometimes difficult to be sure whether a target had been achieved or not, particularly when indicators were measured over relatively short 12-month periods, which meant changes were sometimes hard to detect.
(d) Targets set were sometimes under- or overambitious.
(e) Indicators did not sufficiently address qualitative aspects of healthcare.

45. The Court also examined whether General Budget Support had been specifically effective in improving health services for the poorer sections of the population. Analysis by the WHO of health policies contained in poverty reduction strategy papers has shown the generally limited poverty focus of national health policies. This view was also confirmed by the wider evidence gathered by the Court, which showed the high concentration of health personnel and health services in urban areas. Moreover, the Commission's health performance indicators rarely included a poverty dimension, which would have focused improvements in health services on poorer sections of the population and/or poorer regions of the country.

46. The Court's survey asked delegations how they perceived the effectiveness of General Budget Support in improving health services and in meeting other objectives. Their replies confirmed the Court's concerns about the effectiveness of General Budget Support, as currently implemented, in improving health services. On a scale of 1 (low) to 5 (high), Delegations rated its effectiveness in improving health services at only 2,77, the lowest effectiveness rating of eight General Budget Support objectives (see ***Table 9***).

TABLE 9

SUB-SAHARAN EC DELEGATIONS' PERCEPTION OF THE EFFECTIVENESS OF GENERAL BUDGET SUPPORT IN IMPROVING HEALTH SERVICES

1	2	3	4	5	N/O	Average	GBS objectives
1	1	5	8	9	5	3,96	Providing macroeconomic stability
0	0	6	15	3	5	3,88	Improving public finance management
1	1	5	13	5	4	3,80	Harmonising aid procedures
2	1	6	10	5	5	3,63	Reducing aid transaction costs
1	5	7	9	3	4	3,32	Increasing predictability of funding
1	7	6	6	2	7	3,05	Reducing poverty
1	7	8	4	2	7	2,95	Improving education services
3	**8**	**4**	**5**	**2**	**7**	**2,77**	**Improving health services**

(1 = Not important, 5 = Highly important, N/O = No opinion)

PROJECTS

47. The project has traditionally been the main instrument used by the Commission for implementing its development assistance. However, since 2000, the Commission has made Budget Support its preferred form of aid implementation. This has led the Commission to adopt a position in its aid manuals where the project is de facto to be used as an instrument of 'last resort', when other instruments are not feasible. The Court examined a sample of projects to assess their effectiveness in terms of whether they had met, or were likely to meet, their objectives. The effectiveness of projects was classified as 'satisfactory' where they have been, or are likely to be, successful in reaching their objectives, 'partially satisfactory' where they have experienced some problems and have achieved only part of their objectives and 'unsatisfactory' where they have experienced significant problems and have achieved, or are likely to achieve, few of the planned objectives. ***Annex III*** briefly presents the projects examined during the on-the-spot missions while ***Annex IV*** contains the full list of projects covered by the audit.

EDF PROJECTS

Overall EDF projects have been reasonably effective but in most cases their sustainability is in doubt

48. EDF projects can combine the provision of technical assistance, infrastructure and equipment. The Court reviewed the effectiveness of 12 EDF health projects in 12 countries. Project effectiveness was assessed as satisfactory or partially satisfactory in two thirds of the countries despite the relatively complex nature of health sector interventions. The Court's assessment of the effectiveness of EDF projects largely corresponded to the view Commission delegations. In the Court' survey, delegations ranked their effectiveness at 3,11 on a scale of 1 (low) to 5 (high). Positive features of EDF projects were their contribution to improving the quality of policies and service delivery. On the other hand, the projects

examined by the Court in most cases did not specifically target the poorer sections of the population, although they had the potential to have an impact at regional and district level. For most projects the prospects for their sustainability were also not good.

49. The main factors negatively affecting the performance of EDF health projects identified by the Court's audit, some of which are common to EDF projects in other sectors, are set out below.

(a) Projects tended to be too ambitious, particularly in post-conflict situations, both because of the wide range of activities and geographical coverage of some projects and because too much was expected of what projects could achieve without the support of other instruments.
(b) The project implementation timeframe was generally too short, firstly because of long procurement and approval processes (see paragraph 23), and secondly because time was required for changes introduced by the projects to take hold in beneficiary organisations and become sustainable.
(c) The quality of the technical assistance contracted for these projects varied greatly and this had a considerable influence on project results.
(d) Capacity both to deliver health services and work with EDF projects also varied, especially at provincial and district level.
(e) The lack of a sound country health policy reduced project effectiveness, and particularly the prospects for achieving sustainability.
(f) Delegations often did not have the health expertise and, more generally, were frequently under too much pressure to ensure the level of supervision required to maximise the project's prospects of success.

INTRA-ACP PROJECTS

Complex design and implementation arrangements make intra-ACP projects less effective than other types of projects

50. Each intra-ACP project covers a range of countries in different regions of sub-Saharan Africa, and under the ninth EDF they were most frequently being implemented through United Nations agencies. Of the five projects audited, in one case effectiveness was assessed as satisfactory, in two cases as partially satisfactory and in two cases as unsatisfactory. Factors in the management of this type of project which led to their generally modest performance included:

(a) the design of the projects, which generally involved a large number of countries each receiving relatively small allocations for a substantial number of activities. This reduced their potential impact;
(b) the low involvement of Commission delegations in these centrally managed projects and the difficulty Commission headquarters had in adequately monitoring projects which frequently cover numerous countries;
(c) difficulties in agreeing planning and reporting modalities between the Commission and UN bodies and subsequent problems for the UN bodies in complying with these modalities.

GENERAL BUDGET LINE HEALTH PROJECTS

General budget line projects have mainly been effective, with the exception of centrally managed projects, but sustainability is often in doubt

51. General budget line health projects are mainly implemented through NGOs and other non-State actors. The Court examined nine such projects in Kenya, Malawi and Mali. The effectiveness of three projects was assessed as satisfactory and of the other six as partially satisfactory. Commission delegations also had a relatively positive view of such projects since in the Court's survey they ranked their effectiveness at 3,52 on a scale from 1 (low) to 5 (high). Four NGO co-financing projects in Lesotho, Malawi, Mali and Swaziland that were also examined were found to be similarly effective: in one case project effectiveness was considered to be satisfactory, while in the other three cases it was partially satisfactory.

52. Particularly positive aspects of these types of project were:

(a) they were targeted on poverty-related issues and often provided basic services in remoter areas where government services were less present;
(b) in sensitive areas such as HIV/AIDS many people, particularly youth, preferred to be assisted by NGOs rather than visit government health services;
(c) these projects were easier than larger EDF projects for the Commission to supervise, and hence less prone to delay, since all project activities came under one NGO contract;
(d) the projects provided high visibility for relatively low funding.

53. In general, as noted in a recent evaluation of the health budget lines[30], the weak point of such projects is their sustainability and wider impact because:

(a) although the regulations governing the health general budget lines were intended to promote innovative projects, the fact that Commission procedures do not foresee the involvement of national health officials meant that projects were less likely to be taken up into national policies;
(b) the Commission has not established a system to ensure that the lessons learned from successful projects are systematically disseminated;
(c) although successful projects could have been scaled up using EDF financing, this relied on health being selected as a focal sector and delegations and national officials being well-informed on the project at the time of programming, none of which has generally been the case.

54. A further concern is that while the projects themselves have a poverty focus, the award of projects does not adequately take into account the poverty levels of different countries. The NGO co-financing regulation has increasingly sought to address this issue by reducing the number of eligible countries.

[30] Appraisal of the two legal bases on health, AIDS and population, Ecorys Research and Consulting, November 2006.

55. The Court also examined five centrally managed health general budget line projects. Each of these projects covered at least two, and generally several, countries and the countries did not border each other. As for intra-ACP projects, they were assessed as performing less well than projects carried out in a single country. The projects suffered from both the difficulty NGOs had in implementing often complex projects across several countries in different regions and the difficulty the Commission headquarters had in monitoring these projects.

GLOBAL FUND

THE COMMISSION'S MANAGEMENT OF ITS SUPPORT TO THE GLOBAL FUND

The Commission played an important role in the setting up of the Global Fund but has done little to support or monitor it at country level

56. In the framework of its 'accelerated action' policy (see paragraph 2), the Commission has made a significant contribution to the establishment of the Global Fund. It is represented on the Board and is consequently in a position to influence the overall principles according to which it operates (see Box 5). The Global Fund has quickly become a major player in tackling HIV/AIDS, tuberculosis and malaria and by 2007 it had approved grants of 8 947 million USD for 136 countries, of which almost 60 % has been for sub-Saharan Africa.

BOX 5

GLOBAL FUND OPERATING PRINCIPLES

- Operate as a financial instrument, not an implementing entity.
- Make available and leverage additional financial resources.
- Support programmes that reflect national ownership.
- Operate in a balanced way in terms of different regions, diseases and interventions.
- Pursue an integrated and balanced approach to prevention and treatment.
- Evaluate proposals through independent review processes.
- Establish a simplified, rapid and innovative grant-making process and operate transparently, with accountability.

57. Over the period 2001–07, the Commission disbursed a total of 622,5 million euro to the Global Fund from the EDF intra-ACP funds (330 million euro) and the health general budget lines (292,5 million euro). This represented 8,1 % of total contributions to the Global Fund, making the Commission the fourth biggest contributor. However, a recent evaluation of the management of the Global Fund has noted that the Global Fund may experience difficulties in absorbing the increased contributions pledged by donors[31]. This reflects both the lack of capacity of some countries to translate their need for assistance into grant proposals of an acceptable standard and also their subsequent inability to disburse grants received.

[31] Evaluation of the organisational effectiveness and efficiency of the Global Fund to fight AIDS, tuberculosis and malaria'. October 2007 (Macro Consultancy).

58. The significant role played by the Commission headquarters in the setting up of the Global Fund, as well as the considerable resources it has allocated to it, are in contrast to the limited role played in relation to the Global Fund by most Commission delegations. Guidance notes issued by Commission headquarters did not instruct but only 'encouraged' delegations to support Global Fund operations. In none of the three main areas earmarked by Commission headquarters for delegations' involvement have they played an active role:

(a) *actively participating in Global Fund country coordinating mechanisms (CCM) and help strengthen them*: according to the Court's survey, only 35 % of delegations participate in the CCMs. The most common reasons given for not attending were insufficient staff in the delegations and the fact that the health sector was not a focal sector for the Commission;

(b) *reporting on aspects of the Global Fund functioning in country*: according to the Court's survey, just 8 % of delegations reported regularly to Commission headquarters, 59 % reported occasionally while one third had never reported. While the Commission is on the Global Fund board, its lack of feedback on Global Fund operations from delegations has reduced its capacity to act at this level to improve the effectiveness of operations;

(c) *providing technical assistance for developing grant proposals and assisting implementation:* in the face of the lack of capacity of national bodies to draw up grant proposals and then implement them (see paragraph 57), the Global Fund has particularly stressed the need for the international community to provide technical assistance in sub-Saharan Africa to address this problem, but the Commission has not responded to this need.

EFFECTIVENESS OF THE GLOBAL FUND

The Global Fund has made a significant contribution to tackling HIV/AIDS, malaria and tuberculosis but it depends on complementary long-term health system support from donors to become more effective

59. One key measure of the effectiveness of the Global Fund is the output indicators used by the Global Fund to cover what it terms 'Global Fund supported-programmes'.These indicators include outputs not only from programmes financed solely by the Global Fund but also from programmes which the Global Fund co-finances along with national governments and other external assistance. This makes it difficult to determine what outputs can be specifically attributable to the Global Fund[32]. Nevertheless, it is clear that the Global Fund has made a major contribution to the outputs set out in ***Table 10***. In the five countries visited, the Court noted in particular the Global Fund's contribution to scaling up anti-retroviral (ARV) therapy and HIV/counselling and testing, but prevention of mother to child transmission (PMTCT) was proving difficult because of staffing shortages and cultural issues. Some malaria grants experienced procurement delays for ITNs and ACTs. More details of Global Fund interventions examined by the audit are given in ***Annex III***.

[32] Similarly it is difficult to determine from the grant performance reports on the Global Fund website for each grant financed what is the Global Fund contribution's specific contribution to the outputs reported.

TABLE 10

GLOBAL FUND PERFORMANCE INDICATORS FOR ITS THREE SUB-SAHARAN AFRICAN REGIONS (AT 31 DECEMBER 2007)

HIV/AIDS	% of target	Activities
Anti-retroviral therapy	93 %	1 100 000 people on ARV therapy
HIV counselling and testing	101 %	16 million people reached
Prevention of mother to child transmission (PMTCT)	64 %	100 000 HIV positive pregnant received a full course of prevention of mother-to-child transmission
Support to orphans	116 %	2 million orphans provided with care and support
Tuberculosis		
DOTS treatment	86 %	800 000 people on treatment
Malaria		
Insecticide treated nets (ITN)	63 %	35 million nets distributed
Anti-malarial treatment (ACT)	43 %	37 million malaria treatments delivered
Other indicators		
Care and support	107 %	1,7 million people received care and support
People trained	105 %	1,8 million people trained to deliver services

Source: Global Fund.

60. The Global Fund has been faced with the issue of whether it should follow a narrow interpretation of its mandate and focus exclusively on the three diseases or take a broader view and also provide funding for health systems support. In 2007 the Global Fund established a new policy position by which it would 'provide funding for health systems strengthening within the overall framework of funding technically sound proposals focused on the three diseases'[33]. However, it is not yet clear how this concept will be implemented in practice, given the difficulty of isolating specific parts of health systems. The Global Fund has, however, emphasised that the main support for health system strengthening should come from other donors: 'There is an urgent need for their strategies to prioritise substantial long-term health system and infrastructure strengthening with additional finance'[34]. Such finance is important both to achieve a better balance between health systems and disease-specific interventions and to make Global Fund support more effective since weaker health systems can be a bottleneck which reduces countries' absorption capacity for Global Fund grants.

61. The fact that the Global Fund's mandate is to tackle the three diseases means that the amount of support it provides to specific countries reflects more the disease burden in these areas than the overall income poverty levels in the country. That said, the Global Fund has had a poverty focus within countries. Particularly through its extensive use of community-based organisations, it has sought to intervene in the poorer regions of countries which are less well-covered by government health services.

62. The role of the Global Fund in health system strengthening and poverty reduction are issues which have not received adequate attention from the Commission, at either board or country level. This reflects the limited overall involvement of delegations in Global Fund operations and the insufficient priority Commission headquarters has given to ensuring delegations' involvement (see paragraph 58).

COHERENT USE OF INSTRUMENTS AND INTEGRATION IN SECTOR-WIDE APPROACHES

63. The Commission's overall health policy gave budget support a leading role in its strategy for assisting the health sector but stressed too the continuing relevance of other instruments. It also underlined the importance of there being a sound national health policy framework and of working within it:

'Budget support, social sector support, programme and project support can be complementary as long as they support a nationally defined policy framework. Where budget support is not appropriate, Community funding will support programmes and projects within the context of a national framework and will focus on capacity building. Where a national framework is not in place, the Community will facilitate the evolution towards a sector-wide approach. In most developing countries, the Community will, during a period of capacity and confidence building, maintain a mixed portfolio'[35].

[33] Minutes of November 2007 board meeting of the Global Fund.

[34] Global Fund 'Partners in impact — Results report 2007'.

[35] Communication from the Commission to the Council and the European Parliament: 'Health and poverty reduction in developing countries', COM(2002) 129 final of 22.3.2002.

COHERENT MANAGEMENT OF INSTRUMENTS BY THE COMMISSION

The Commission has not developed guidance for coherently managing the different instruments in the health sector

64. The Commission has not developed guidance on when it would be more appropriate to use General Budget Support or Sector Budget Support, or a combination of the two, to respond most effectively to the situation of a given country. While the Commission's manual on Sector Budget Support does point to the benefits of using General Budget Support and Sector Budget Support in combination, the very limited number of health Sector Budget Support programmes financed by the Commission in sub-Saharan Africa has reduced the effectiveness of its General Budget Support (see paragraphs 36 to 46).

65. Guidance is also lacking as to how projects at sectoral level can be linked to General Budget Support to make Commission interventions more effective. The Court found cases where EDF projects had strengthened General Budget Support programmes, even if the two interventions had not been coordinated, and also cases where improved coordination with EDF projects would have benefited General Budget Support interventions (see Box 6).

66. The 2002 health policy, while emphasising the complementary role of different instruments, does not actually make reference to the links between the Global Fund and the instruments managed by the Commission. The Court found that the lack of involvement of delegations in Global Fund operations (see paragraph 58) had led to the Commission continuing to finance EDF projects in the area of HIV/AIDS. Leaving the Global Fund to finance such projects would have allowed the Commission to allocate its support to wider health system issues which lay outside the mandate of the Global Fund.

67. The Commission's General Budget Support and the Global Fund have certain areas of common interest, notably the use of health sector performance indicators and improving related monitoring and evaluation systems, but also in relation to financial and procurement systems. However, the General Budget Support instrument has not worked with the Global Fund in these areas and its financing agreements do not generally make reference to the Global Fund.

BOX 6

LINKS BETWEEN EDF HEALTH PROJECTS AND GENERAL BUDGET SUPPORT

The Court found that in Mali the eighth EDF health sector support project (PASS) increased the effectiveness of General Budget Support by strengthening Ministry of Health capacity even if the PASS project was not specifically designed to complement General Budget Support. On the other hand, a lack of coordination between the two instruments led to the Commission not extending an eighth EDF project in Lesotho on health management information systems although weaknesses in health data were one reason for stopping General Budget Support to Lesotho under the eighth and ninth EDF.

INTEGRATION OF INTERVENTIONS INTO SECTOR-WIDE APPROACHES

Integration of Commission interventions into SWAps is a key factor for their effectiveness but the Commission has not sufficiently supported SWAps

68. A major factor in deciding which combination of instruments will best suit a particular country is whether it has a well-defined sector policy. The Court's survey found that the situation varied considerably from country to country: 10 countries already had SWAps, 10 countries were preparing SWAps, while in 14 countries delegations found health policies to be inadequate.

69. Despite the importance of SWAps in improving the effectiveness of General Budget Support (see paragraph 39) and as one of the eligibility criteria for Sector Budget Support (see paragraph 32), the Commission has not prioritised assisting in their preparation. Thus, according to the Court's survey, in only eight delegations (22 %) had ninth EDF technical assistance projects been used to contribute to the preparation of a health SWAp.

70. While countries with a health SWAp are still a minority, the number has grown since 2000. Thus there are more opportunities for providing sector budget support in the framework of SWAps under the 10th EDF than under the ninth EDF, but this has not led to a significant increase in Sector Budget Support being programmed for this period.

71. A key concern with the project approach is projects' sustainability (see paragraphs 48 and 53). Given that this is dependent on their integration into well-defined and adequately financed sectoral policies, this also points to the need for the Commission to prioritise capacity building projects through the EDF in order to help establish such policies.

72. A major challenge in relation to the Global Fund is to align its procedures, particulary for performance-based funding, with national procedures. At the end of 2007, the Global Fund was participating in health SWAps in just two countries, Malawi and Mozambique but its 2007 strategy signalled its intention to engage more in such funding where adequate national health strategies exist. The frequency with which this approach can be followed depends on how 'adequate' is defined and the support given by the international community, including the Commission, to help countries develop such strategies.

CONCLUSIONS AND RECOMMENDATIONS

RESOURCES

THE LEVEL AND BALANCE OF FINANCIAL RESOURCES ALLOCATED TO THE HEALTH SECTOR DO NOT ADEQUATELY REFLECT THE COMMISSION'S POLICY COMMITMENTS, WHILE HEALTH EXPERTISE IS INSUFFICIENT

73. Financial allocations to the health sector in sub-Saharan Africa have not increased since 2000 as a proportion of its total development assistance despite the Commission's MDG commitments and the health crisis in sub-Saharan Africa. They also fall short of the European Parliament's benchmark of allocating 20 % to basic health and primary and secondary education in country programmes.

74. The Commission has mobilised significant additional funding to contribute to the Global Fund against AIDS, tuberculosis and malaria. However, the Commission has focused on tackling these three diseases rather than on support to health systems, which is its policy priority.

75. The Commission does not have sufficient health expertise to adequately implement its health policy and has not made systematic arrangements to draw on alternative sources of expertise.

RECOMMENDATIONS ON RESOURCE ALLOCATIONS

No 1: In the context of its policy of supporting the achievement of the Millennium Development Goals, the Commission should consider increasing its support to the health sector during the 10th EDF mid-term review, particularly in:

(a) fragile States, as the Commission is considered to have a comparative advantage in these countries;
(b) countries where ECHO has had operations in order to strengthen the link between the relief phase and rehabilitation and development (LRRD) in these countries;
(c) countries which have been found to be health donor orphans.

No 2: The Commission should review the balance of its funding to ensure that this reflects its policy priority of focusing on health system support.

No 3: The Commission should ensure it has sufficient health expertise to adequately implement its health sector policies and interventions and play an effective role in health sector dialogue. To this end it should, as a minimum, ensure that all delegations where health is a focal sector have health specialists. It should assess how far the following options are feasible for ensuring adequate support to other delegations:

(a) establishing health expertise in regional delegations to support delegations without health specialists;
(b) working more closely in post-conflict countries with ECHO health advisers;
(c) forming closer partnerships with World Health Organisation country offices to draw on their expertise;
(d) entering into formal agreements with EU Member States to use their expertise, such agreements to be based on a mandate which ensures the Commission retains responsibility and clearly defines the operating modalities.

THERE HAS BEEN AN INCREASE IN THE SPEED OF IMPLEMENTATION OF EDF HEALTH RESOURCES. THE GLOBAL FUND HAS DISBURSED LARGE AMOUNTS BUT ITS DISBURSEMENT RATE IS RELATIVELY SLOW. THE PREDICTABILITY OF AID FLOWS REMAINS A CHALLENGE FOR ALL INSTRUMENTS

76. There has been a significant improvement in the implementation rate for EDF interventions, at least partly because of devolution.

77. The Global Fund has succeeded in disbursing a large volume of funds but the actual rate of disbursement has been relatively slow mainly because of low absorption capacity in most beneficiary countries.

78. Predictability of funding remains a problem of all instruments, including General Budget Support because countries whose eligibility for this instrument is suspended have less resources available for their health budgets.

RECOMMENDATIONS ON SPEED AND PREDICTABILITY

No 4: The Commission should work more closely with the Global Fund to accelerate the implementation of its programmes by providing technical assistance support to beneficiary countries, both in the preparation of grant applications and in the implementation of grant contracts.

No 5: The Commission should make its budget support for health more predictable by ensuring that it is prepared to intervene with alternative instruments in cases where countries lose their eligibility for budget support.

MANAGEMENT AND EFFECTIVENESS OF INSTRUMENTS

BUDGET SUPPORT HAS NOT YET MADE AN EFFECTIVE CONTRIBUTION TO IMPROVING HEALTH SERVICES, PROJECTS CAN PLAY AN IMPORTANT ROLE IN SUPPORTING THE HEALTH SECTOR, WHILE THE GLOBAL FUND HAS PROVIDED SIGNIFICANT OUTPUTS

79. While the current design of General Budget Support includes links to the health sector, its implementation has not sufficiently exploited these links. Thus, while it has the potential to be an important instrument for improving health services, it is not at present proving effective for this purpose and has not focused on addressing the needs of the poorer sections of the population. Sector Budget Support, which focuses on the health sector, has been little used by the Commission in sub-Saharan Africa.

80. Although weaknesses exist with the project instrument, notably in relation to sustainability, projects have made a useful contribution to assisting the health sector. Generally, the more problematic projects have been those which cover a number of countries, because of the management difficulties this entails.

81. The Global Fund has made a significant contribution to the fight against AIDS, tuberculosis and malaria. However, despite the Commission's important role in the creation of the Global Fund, it has done little to contribute to its effectiveness at country level.

RECOMMENDATIONS ON MANAGEMENT AND EFFECTIVENESS OF INSTRUMENTS

No 6: Greater use should be made of Sector Budget Support. The general requirement that it can only be used if health is a focal sector should be reviewed and the Commission should reconsider its current distribution of resources between Sector Budget Support and General Budget Support.

No 7: The sectoral dimension of General Budget Support should be strengthened by:

(a) using performance indicators and health sector dialogue to encourage countries to respect their commitment to move towards allocating 15 % of their national budget to health and to fully implement their national health budget;
(b) carrying out operational and financial reviews to establish whether health budget resources are being used for their intended purpose;
(c) financing technical assistance with budget support to strengthen health sector policy, institutional capacity in the health sector, and address specific public finance management and procurement weaknesses in the health sector;
(d) improving the quality of input into the health sector dialogue by increasing the level of health expertise in the Commission services or by using other donor expertise based on clear written mandates;
(e) giving greater attention to ensuring that performance indicators are based on sound statistical systems, reflect government's capacity to influence performance and take into account poverty reduction and quality objectives.

No 8: The Commission should take on greater ownership of the Global Fund at country level. As well as giving beneficiary countries more support in the preparation and implementation of Global Fund grants, delegations should report back to headquarters to allow the Commission to intervene more effectively at board level.

No 9: The Commission should make greater use of the project instrument to provide policy and technical support and advice (EDF projects), to finance pilot interventions (health general budget line projects) and to provide healthcare in poorer regions not adequately covered by healthcare services (NGO budget line projects). The role of general budget line projects covering a number of countries and intra-ACP projects should be reconsidered.

THE COMMISSION HAS NOT ESTABLISHED GUIDANCE FOR ENSURING THE COHERENT USE OF THE DIFFERENT INSTRUMENTS TO ASSIST THE HEALTH SECTOR, NOR HAS IT SUFFICIENTLY INTEGRATED ITS INTERVENTIONS INTO SECTOR-WIDE APPROACHES

82. The Commission has not adequately defined the role that each instrument can play in the health sector and how they should be combined for maximum synergy.

83. Given the importance of sound sector-wide approaches to the effectiveness of all instruments, there is a need to reinforce the efforts to support contributing to the design and implementation of such approaches.

RECOMMENDATIONS ON COHERENT USE OF INSTRUMENTS

No 10: The Commission should establish and disseminate clear guidance on when each instrument should be utilised and how they can be used in combination to maximise synergy, including:

(a) defining in what circumstances General Budget Support should be used, when Sector Budget Support should be used and when the two instruments should be used together;
(b) providing for increased and more effective use of the project instrument to support Budget Support and Global Fund interventions in the health sector;
(c) taking account of Global Fund operations whenever the Commission plans a health sector intervention, including through General Budget Support.

No 11: The choice of instruments to be used should take more specific account of the situation of the country and in particular whether it has a well-defined sector policy.

No 12: The Commission should more closely align its health sector interventions, including Global Fund interventions, with SWAps. In countries where SWAps do not yet exist, it should work towards establishing them.

This Special Report was adopted by the Court of Auditors in Luxembourg at its meeting of 19 November 2008.

For the Court of Auditors

Vítor Manuel da Silva Caldeira
President

Source: ECA.

ANNEX I

MILLENNIUM DEVELOPMENT GOALS: 2007 PROGRESS CHART

Goals and targets	Africa		Asia			
	Northern	Sub-Saharan	Eastern	South-eastern	Southern	Western
GOAL 1 | Eradicate extreme poverty and hunger						
Reduce extreme poverty by half	low poverty	very high poverty	moderate poverty	moderate poverty	very high poverty	low poverty
Reduce hunger by half	very low hunger	very high hunger	moderate hunger	moderate hunger	high hunger	moderate hunger
GOAL 2 | Achieve universal primary education						
Universal primary schooling	high enrolment	low enrolment	high enrolment	high enrolment	high enrolment	moderate enrolment
GOAL 3 | Promote gender equality and empower women						
Equal girls' enrolment in primary school	close to parity	almost close to parity	parity	parity	close to parity	close to parity
Women's share of paid employment	low share	medium share	high share	medium share	low share	low share
Women's equal representation in national parliaments	very low representation	low representation	moderate representation	low representation	low representation	very low representation
GOAL 4 | Reduce child mortality						
Reduce mortality of under-five-year-olds by two thirds	low mortality	Very high mortality	low mortality	moderate mortality	high mortality	moderate mortality
Measles immunisation	high coverage	low coverage	moderate coverage	moderate coverage	low coverage	high coverage
GOAL 5 | Improve maternal health						
Reduce maternal mortality by three quarters	moderate mortality	very high mortality	low mortality	high mortality	very high mortality	moderate mortality
GOAL 6 | Combat HIV/AIDS, malaria and other diseases						
Halt and reverse spread of HIV/AIDS	low prevalence	very high prevalence	low prevalence	low prevalence	moderate prevalence	low prevalence
Halt and reverse spread of malaria	low risk	high risk	moderate risk	moderate risk	moderate risk	low risk
Halt and reverse spread of tuberculosis	low mortality	high mortality	moderate mortality	moderate mortality	moderate mortality	low mortality
GOAL 7 | Ensure environmental sustainability						
Reverse loss of forests	low forest cover	medium forest cover	medium forest cover	high forest cover	medium forest cover	low forest cover
Halve proportion without improved drinking water	high coverage	low coverage	moderate coverage	moderate coverage	moderate coverage	high coverage
Halve proportion without sanitation	moderate coverage	very low coverage	very low coverage	low coverage	very low coverage	moderate coverage
Improve the lives of slum-dwellers	moderate proportion of slum-dwellers	very high proportion of slum-dwellers	high proportion of slum-dwellers	moderate proportion of slum-dwellers	high proportion of slum-dwellers	moderate proportion of slum-dwellers
GOAL 8 | Develop a global partnership for development						
Youth unemployment	very high unemployment	high unemployment	low unemployment	high unemployment	moderate unemployment	very high unemployment
Internet users	moderate access	very low access	moderate access	moderate access	low access	moderate access

Source: United Nations.

- Target already met or very close to being met.
- Target is expected to be met by 2015 if prevailing trends persist, or the problem that this target is designed to address is not a serious concern in the region.
- Target is not expected to be met by 2015.
- No progress, or a deterioration or reversal.

Goals and targets	Oceania	Latin America and Caribbean	Commonwealth of Independent States	
			Europe	Asia
GOAL 1 | Eradicate extreme poverty and hunger				
Reduce extreme poverty by half	—	moderate poverty	low poverty	low poverty
Reduce hunger by half	moderate hunger	moderate hunger	very low hunger	high hunger
GOAL 2 | Achieve universal primary education				
Universal primary schooling	moderate enrolment	high enrolment	high enrolment	high enrolment
GOAL 3 | Promote gender equality and empower women				
Equal girls' enrolment in primary school	close to parity	parity	parity	parity
Women's share of paid employment	medium share	high share	high share	high share
Women's equal representation in national parliaments	very low representation	moderate representation	low representation	low representation
GOAL 4 | Reduce child mortality				
Reduce mortality of under-five-year-olds by two thirds	moderate mortality	low mortality	low mortality	moderate mortality
Measles immunisation	low coverage	high coverage	high coverage	high coverage
GOAL 5 | Improve maternal health				
Reduce maternal mortality by three quarters	high mortality	moderate mortality	low mortality	low mortality
GOAL 6 | Combat HIV/AIDS, malaria and other diseases				
Halt and reverse spread of HIV/AIDS	moderate prevalence	moderate prevalence	moderate prevalence	low prevalence
Halt and reverse spread of malaria	low risk	moderate risk	low risk	low risk
Halt and reverse spread of tuberculosis	moderate mortality	low mortality	moderate mortality	moderate mortality
GOAL 7 | Ensure environmental sustainability				
Reverse loss of forests	high forest cover	high forest cover	high forest cover	low forest cover
Halve proportion without improved drinking water	low coverage	high coverage	high coverage	moderate coverage
Halve proportion without sanitation	low coverage	moderate coverage	moderate coverage	moderate coverage
Improve the lives of slum-dwellers	moderate proportion of slum-dwellers	moderate proportion of slum-dwellers	low proportion of slum-dwellers	moderate proportion of slum-dwellers
GOAL 8 | Develop a global partnership for development				
Youth unemployment	low unemployment	high unemployment	high unemployment	high unemployment
Internet users	low access	high access	moderate access	moderate access

ANNEX II

EXTRACT FROM BRUSSELS DECLARATION BY ACP MINISTERS OF HEALTH, OCTOBER 2007

'**N. Recognising** current challenges of health management in ACP States including, inter alia, the lack of human resources, weaknesses of disease alert and surveillance systems, inadequate health information management systems for decision making, poor quality of healthcare, especially universal precautions, blood transfusion and laboratory capacity, low level of indigenous/operational research and development (R & D) in endemic, and communicable diseases such as HIV and AIDS, tuberculosis and malaria, and chronic diseases such as diabetes, hypertension, asthma, as well as those arising out of violence, trauma and accidents, limited preparedness and management of epidemics such as Ebola among others, exorbitant prices of drugs and pharmaceuticals and the need to adequately finance the health sector from annual budgets;

O. Stressing the importance of health systems in ACP States to address the prevention, treatment and management of neglected tropical diseases within the epidemiological context, such as human trypanosomiasis (sleeping sickness), dengue, leprosy, filariasis, onchocerciasis (river blindness), schistosomiasis (Snail fever), and trachoma; chronic and lifestyle diseases, such as hypertension, cancer, sickle cell anaemia and diabetes, emerging and re-emerging diseases, such as Buruli ulcer, haemorrhagic fever, Monkeypox, plague, rabies, as well as mental illness, neurological illnesses, human cerebral meningitis, intestinal worms, and infantile diarrhoea, among others;'

ANNEX III

COUNTRY SUMMARIES

SWAZILAND

OVERVIEW OF HEALTH SITUATION

Swaziland has the worst HIV/AIDS prevalence rate in the world at 34 % of the population. Closely related to this, it also has the highest TB prevalence rate, cases rising from 856 per 100 000 people in 2000 to 1 182 per 100 000 in 2006. Life expectancy has fallen from 60 years in 1998 to just 31 years in 2004. There are an estimated 130 000 orphans and vulnerable children (OVC) in a total population of one million.

Both infant and under-five mortality have increased since 1997, rising from 78 and 106 per 1 000 live births respectively in 1997 to 85 and 120 in 2006. HIV/AIDS is the cause of 47 % of under-five deaths. There has been a rapid rise in maternal mortality from 230 deaths per 100 000 live births in 1999 to 370 in 2006, the principal causes being not only HIV/AIDS but also the limitations of the health system. Health services are increasingly struggling to cope with the huge new disease burden which is added to by a rise in non-communicable diseases which receive little attention.

EDF PROJECTS

HIV/AIDs prevention and care programme (HAPAC)

HAPAC I (2001–05; 2,25 million euro) largely achieved its objectives in relation to developing new VCT services, building up the home-based care network in one of Swaziland's four regions and supporting measures to strengthen the treatment of STIs. The main result of HAPAC II (2006–08; 2 million euro) has been to maintain services set up under HAPAC I but the modest further expansion of services foreseen for this follow-up project have only been achieved to a limited degree. HAPAC II was financed because the sustainability of HAPAC I had not yet been assured but sustainability remains a major problem and some VCT centres were expected to close at the end of the project, in 2008. Better coordination by the Commission with the Global Fund could have allowed the Global Fund to take over operations covered by the project at the end of HAPAC I.

NGO CO-FINANCING GENERAL BUDGET LINE

Integrated HIV/AIDS and livelihood project

This project is intended to assist persons living with HIV/AIDS and orphans and vulnerable children through home-based care and helping them increase food security through growing their own food. The project was still at an early stage. While very relevant, the objectives appeared to be too ambitious for a project of little more than three years.

GLOBAL FUND

Swaziland has so far received the highest per capita support from the Global Fund in the world (105 million USD, approximately 100 USD per capita). The great majority of the funding has been for HIV/AIDS.The low amount of funding for tuberculosis does not reflect the scale of the problem.

The results of Global Fund-supported programmes are rather mixed. Care and support to families and communities affected by HIV/AIDS, VCT services and home-based care components have generally progressed well. On the other hand, parts of the components on ARV treatment and monitoring, PMTCT support, and prevention work amongst youth have been less effective. Global Fund reporting requirements have been a catalyst for improving monitoring and evaluation systems and data reliability.

LESOTHO

OVERVIEW OF HEALTH SITUATION

Lesotho's HIV/AIDS prevalence rate of 23 % is one of the highest. Closely associated with this is the extremely high prevalence of tuberculosis. HIV/AIDS and TB are the main reasons why life expectancy has plummeted since the mid-1990s from 60 years to just 41 years. There are an estimated 180 000 orphans and vulnerable children, approximately 10 % of the population. While malaria does not exist in Lesotho, other concerns include the growing level of non-communicable diseases.

Partly as a result of HIV/AIDS, infant mortality has considerably increased, from an average of 75 per 1 000 live births over the period 1995–99 to 91 over the period 2000–04. At the same time, maternal mortality has risen dramatically from 282 per 100 000 live births in 1993 to 762 in 2004. The deterioration of health indicators also reflects the decline in health services, which are struggling to cope with the higher disease burden. Budgetary resources have not increased to address this situation and are allocated disproportionately to secondary and tertiary care and to urban areas. The country is losing health workers to other countries and due to HIV/AIDS-related deaths.

GENERAL BUDGET SUPPORT

General Budget Support has not been an effective instrument for improving health services. The eighth EDF programme was halted by the Commission because of the government's lack of commitment to public finance management reform and the programme also faced difficulties in providing reliable data for performance indicators. For these reasons support under the ninth EDF, although originally programmed, was not granted.

EDF PROJECTS

The eighth EDF project 'Support to health sector reform' (1,8 million euro) made an important contribution to the health sector decentralisation process in Lesotho, both in its support to the overall planning of the process and its piloting of decentralisation in three districts, even if the pilot phase of nine months was too short. The Government of Lesotho has subsequently extended decentralisation to all 10 districts, although serious capacity and resource constraints exist.

NGO CO-FINANCING PROJECT: HOME-BASED CARE FOR PEOPLE LIVING WITH HIV/AIDS OR TERMINAL ILLNESSES AND OVCS

Overall, this is a successful project with 600 people trained as care providers, each with an average of 10 clients although only limited support is delivered to orphans and vulnerable children. A follow-up project has been launched which addresses food security and income-generating activities to make the project sustainable, but the three-year project duration may be too short to achieve this.

GLOBAL FUND

Under the main grant implemented so far (HIV/AIDS, Round 2) more than 15 000 people are receiving ARV treatment, compared with a target of 12 500, as a result of approximately equal shares of Global Fund and government financing. However, the monitoring system may include people who have dropped out of treatment and those who have died whilst on treatment. Only approximately 30 % of those needing ARVs are receiving them. There has been a large expansion of VCT sites but the number of people being tested for HIV is 20 % less than foreseen. This reflects general problems in the implementation of Lesotho's 'Know your status' campaign. For the care and support for OVCs it was not clearly defined what the support package would include and it was difficult to establish what the OVCs had received. Condom distribution targets have been exceeded but only partly due to Global Fund financing and there was a need to ensure that the condoms distributed to and available in health centres were then actually obtained and used by the youth. Some progress has been made on youth education for HIV/AIDS prevention. PMTCT support was the most problematic area, with only one of the six indicator targets being achieved. This is in part the consequence of shortages of health personnel.

ANNEX III

KENYA

OVERVIEW OF HEALTH SITUATION

All the major health indicators declined in the 1990s and health indicators continued to show a downward trend under the first national health sector strategic plan (1999–2004). Thus, there was an increase in under-five mortality from 11,2 % to 11,5 %. While it is difficult to establish the maternal mortality ratio, indicators do not point to an improvement. The only area of clear improvement was in HIV prevalence, which fell from 13 % in 1994 to 6 % in 2005.

The deterioration in major health indicators reflects declining use of services in public health facilities, shortages of health workers and their uneven distribution between urban and rural areas and public and private sectors, as well as stagnating contributions from the national budget to health. The second national health sector strategic plan (2005–10), supported by donors through a 'joint planning of work and funding', is attempting to reverse this decline.

GENERAL BUDGET SUPPORT

In view of the still relatively low expenditure on health, weaknesses in health and general public finance management systems, and the fact that only one of the four performance indicator targets was achieved, General Budget Support cannot be considered to have been very effective in Kenya in improving health services.

EDF PROJECTS

The eighth EDF project 'District health services and systems development programme' (DHSSDP) has made a significant contribution in the central and eastern regions to improving the access and quality of the public and non-public services, with a particular focus on the people more at risk and on the communities. However, had the project timeframe been longer than the three years foreseen and not reduced by delays, results would have been still better.

GENERAL BUDGET LINE PROJECTS

Adolescent sexual and reproductive health (ASRH) initiative

This project was making significant progress in improving the access to HIV/AIDS prevention and care services for the most vulnerable and marginalised youth by the use of youth-friendly mobile VCT service delivery and increasing community awareness about this initiative.

Access to and use of quality basic and comprehensive obstetric care services

The project seeks to improve access for women and children to obstetric and neonatal care in 10 target districts. Project indicators point to increases in the proportion of direct birth complications in the target districts being treated at emergency obstetric facilities and an increase in the proportion of deliveries attended by midwives.

Comprehensive approach to reaching those most at risk from and affected by HIV/AIDS

The project seeks to build the capacity of Marie Stopes Kenya to contribute to the Kenya national AIDS strategic plan (2005–10). Initial progress has been good.

Uzazi Bora — Mother and infant services — HIV activities

The aim of the project was to improve PMTCT, antenatal, intra-partum and postnatal care services in two districts. The project objectives were partially achieved, the main shortfall being in relation to postnatal services.

GLOBAL FUND

Although Kenya is a major beneficiary of the Global Fund, grants have been implemented with serious delays, with the result that the most targets will not be reached and budgets have been reduced after Phase I.

MALAWI

OVERVIEW OF HEALTH SITUATION

Malawi has one of the highest HIV/AIDS prevalence rates (approximately 14 %) in the world. The high HIV/AIDS prevalence rate has led to a major increase in tuberculosis, the number of cases doubling from 1994 to 2004. It also suffers greatly from malaria, it being the most commonly reported cause of mortality both in adults and children. Even if there has been an improvement since 2000, Malawi still also has one of the highest maternal mortality rates in the world at 984 per 100 000 live births. Similarly while some progress has been made in relation to child mortality, which has fallen to 76 per 1 000 live births, this too remains a major area of concern. Malawi health services have been grossly under-resourced to cope with these problems, with the very limited number of health staff heavily concentrated in urban areas.

GENERAL BUDGET SUPPORT

General Budget Support was not considered to have had a significant effect on improving health services by mid-2007. Since 2005, when General Budget Support was restarted, the government had focused on using budgetary support to help build up a sound track record in fiscal management rather than expanding pro-poor budgetary expenditure. However, through the leverage of General Budget Support, the Commission has contributed to ensuring that the government maintains its health budget allocation at a minimum of 10,7 % of the overall national budget. With the HIPC completion point now reached, greater discretionary expenditure, including for health, will become possible.

EDF PROJECTS

The eighth EDF project had created a national blood transfusion service which was covering between a third and a half of national needs. While this was less than what was specified in the financing agreement, it still represented considerable progress given the difficult cultural, as well as organisational, challenges which have had to be overcome by the project.

GENERAL BUDGET LINE PROJECTS

Scaling up of sexual and reproductive health (SRH) and HIV/AIDS services for young people

The project aims to increase the utilisation of youth-friendly SRH services and the adoption of safer sex practices by working through NGOs and youth clubs. Given initial delays, it may not be possible to achieve all project objectives.

Promotion of behaviour change and increase of access to SRH services in Thyolo district

The project was making a valuable contribution, particularly in improving access to a continuum of HIV care, support and treatment, PMTCT services and VCT services in this poor district of southern Malawi.

Youth and children's health in the central and southern regions of Malawi

The project is producing good results, with an increase in the number of youth undergoing VCT in the targeted youth and health centres and a decrease in pregnancies among school girls.

GLOBAL FUND

Overall, the Global Fund is producing significant results, most notably in enabling a huge scaling-up of ARV provision, from just a few thousand in 2004 to 110 000 by mid-2007. Most other components of the Round 1 HIV/AIDS project, after some delays, were on their way to important achievements, including the health systems support component, which was assisting in training large numbers of personnel, particularly at the level of community health workers. The main problem area was the PMTCT component.

ANNEX III

MALI

OVERVIEW OF HEALTH SITUATION

Mali has a very high maternal mortality ratio (1 200 per 100 000 live births) and child mortality rate (219 per 1 000 in 2004). The HIV/AIDS prevalence rate is relatively low (1,9 %) but tuberculosis is widespread (578 cases per 100 000 population) and malaria continues to be one of the main causes of child mortality. Other major illnesses include acute respiratory infections, diarrhoea, Guinea worm, schistosomiasis as well as growing problems with chronic illnesses such as diabetes and heart disease.

While significant investments have been made in health infrastructure and access to health services has globally improved, serious problems remain. There is no adequate human resource policy, resulting in low availability, inappropriate geographical allocation, and inadequate skills, motivation and ethical standards of staff. The decentralisation process has not been accompanied by a sufficient transfer of human and financial resources. Overall, the quality of health services remains low and health services are unaffordable for the poorest.

GENERAL BUDGET SUPPORT

Contrary to the commitment made in the General Budget Support financing agreement, the government did not increase the share of the health budget, while public funds continue to be inequitably allocated between regions. In addition, public finance management remains weak, with a high fiduciary risk and low efficiency and effectiveness of public spending.

EDF PROJECTS

The eighth EDF PASS project has contributed to its objective of strengthening the capacity of the Ministry of Health but not to its other objective of improving the quality of health services. The project was not in a position to bring about such improvements since this required the adoption of major structural reforms.

GENERAL BUDGET LINE PROJECTS

Improvement of women's reproductive health in northern Mali

The project contributed significantly to improving training of health workers and providing equipment but the project was too short to make a real impact on maternal mortality.

Action Biomali

This project to improve the detection of HIV/AIDS, TB and malaria in Mali has led to the setting up of a network of laboratories although there were delays in training personnel on how to use the equipment supplied. Monitoring of the increase in detection rates was problematic.

Participatory approach to improving access to healthcare for TB patients

This regional project, also covering Benin, Burkina Faso and Senegal, was contributing to an improvement in the detection of TB and subsequent follow-up.

Strengthening local capacity to fight HIV/AIDS

This project, which is still at an early stage, aims to reduce sexual and mother-to-child transmission in poorer regions of northern Mali through greater involvement of civil society and by improving the quality of health services.

GLOBAL FUND

The malaria grant had contributed to the supply of bednets and training to health personnel. The HIV/AIDS grant contributed to the number of people on ARVs increasing from 600 to 12 800 over the period 2005–07. For the TB grant, the treatment component was more successful than the prevention one. The health systems strengthening component was experiencing some difficulties, notably in relation to the construction and equipping of the national laboratory.

ANNEX IV

LIST OF PROJECTS EXAMINED

Country	Project title	Project amount	Rating
EDF PROJECTS			
Angola	Support programme to the health sector	25,0	Unsatisfactory
Benin	Support to the health sector	10,2	Partially satisfactory
Burundi	Transitional support to the health sector (PATSBU)	4,1	Unsatisfactory
Chad	Support to health policy	42,0	Unsatisfactory
Côte d'Ivoire	Emergency and rehabilitation programme Phase 1	34,0	Satisfactory
Kenya	District health services and systems development	15,0	Satisfactory
Lesotho	Support to the health sector reform	1,8	Partially satisfactory
Malawi	Malawi blood transfusion service	9,4	Partially satisfactory
Mali	Support programme to the health sector	10,5	Partially satisfactory
Sierra Leone	Health sector support programme	28,0	Unsatisfactory
Swaziland	HIV/AIDS prevention and care programme	4,3	Partially satisfactory
Uganda	Development of human resources for health	17,0	Satisfactory
INTRA-ACP PROJECTS			
8 countries	EC/ACP/WHO partnership on health MDGs	25,0	Partially satisfactory
14 countries	WHO polio eradication programme	26,8	Partially satisfactory
41 countries	EC/ACP/WHO partnership on pharmaceutical policy	24,6	Unsatisfactory
22 countries	EC/ACP/UNFPA/IPPF sexual and reproductive health	32,0	Satisfactory
3 countries	Development of malaria vaccine multi- centre trials	7,0	Unsatisfactory

ANNEX IV

Country	Project title	Project amount	Rating
HEALTH GENERAL BUDGET LINE PROJECTS			
Kenya	Adolescent sexual and reproductive health initiative	2,6	Partially satisfactory
Kenya	Increased access to and use of quality basic and comprehensive obstetric care services	2,2	Satisfactory
Kenya	Comprehensive approach to reaching those most at risk and affected by HIV/AIDS	4,4	Partially satisfactory
Kenya	Uzazi Bora — Mother and infant services — HIV activities	1,3	Partially satisfactory
Malawi	Scaling up sexual and reproductive health and HIV/AIDS services for young people	2,25	Partially satisfactory
Malawi	Promotion of behaviour change and increased access to sexual and reproductive health services	1,35	Satisfactory
Mali	Improving reproductive health services in northern Mali	1,6	Satisfactory
Mali	'Action BioMali'	3,6	Partially satisfactory
Mali	Participatory approach for improving the quality and access to health care for TB patients	4,5	Partially satisfactory
Burundi, Kenya, Mozambique	Fight against AIDS programme	2,0	Unsatisfactory
Burundi, Guinea, Haiti	Mutual strengthening of front line private and public players in the fields of protection of rights, prevention of infections and provision of complete healthcare for people living with HIV/AIDS	3,9	Partially satisfactory
Benin, Dem. Rep. of the Congo	Programme to develop integrated HIV care for TB patients living with HIV/AIDS	4,3	Unsatisfactory
Zambia, South Africa	Building local capacity and ownership of HIV vaccines in southern Africa	3,0	Unsatisfactory
Malawi, South Africa	Increasing prevention and treatment of TB	4,5	Partially satisfactory
NGO CO-FINANCED BUDGET LINE HEALTH-RELATED PROJECTS			
Lesotho	Home-based care for people living with HIV/AIDS or terminal illnesses and for orphans	0,7	Partially satisfactory
Mali	Strengthening local capacity to fight HIV/AIDS	1,0	Partially satisfactory
Malawi	Youth and children's health in the central and southern regions of Malawi	0,75	Satisfactory
Swaziland	Integrated HIV/AIDS and livelihood project	0,75	Partially satisfactory

REPLY OF THE COMMISSION

EXECUTIVE SUMMARY

I.
The Commission thanks the European Court of Auditors for its work on the EC development assistance to health services in sub-Saharan Africa (SSA). It provides an interesting analysis with findings and lessons learnt that gives an opportunity for the Commission to clarify a number of issues stemming from the Court audit work.

II.
The Commission policy recognises that supporting progress towards better health outcomes calls for a comprehensive strategy tackling existing constraints through the most appropriate instruments and division of labour with other donors. Thus 'at country level the Community will employ a range of complementary interventions including: macroeconomic support linked to improved health outcomes; support to sectors that have a wider impact on health outcomes and direct support to the health sector' (health and poverty reduction communication).

In line with its policy commitments the Commission has remained sensitive to the importance of health systems strengthening by maintainingd its direct financing to health at country level, increased general budget support and its contribution to global initiatives.

Health expertise in the Commission is kept within the limits of resource allocation decisions. However, mechanisms such as, at country level, the 'Technical cooperation fund' (TCF) or, more specifically at Headquarters level, 'external technical expertise' (ETE) might, for specific tasks, provide technical support to the Commission services.

III.

The Commission continues its effort to improve the speed and the predictability of its assistance to the health sector: this includes privileging sector-wide approach (SWAp), Sector Budget Support (SBS) where conditions allow but also a more predictable longer-term type of General Budget Support (GBS) ('MDG Contract') in performing countries.

IV.

The Commission shares the Court's view on the potential role of SBS, a relatively new aid modality of which the Commission is the largest user in Africa, according to available evidence. The Commission has already used SBS to support health sectors in Mozambique, Zambia and South Africa.

The Commission views GBS as a complement to health focal or non-focal interventions and is committed to further enhance this tool's effectiveness in general and in relation to sectoral issues. However, the Commission notes that the effectiveness of general budget support is better assessed in the longer term since progress in outcomes at national level takes time as it requires improvements in large systems and thus cannot be compared to progress in outputs in smaller and targeted groups of the population.

V.

In a country strategy paper related to a country in which health is supported, the Commission articulates different types of support, foreseen in its policy to improve health outcomes, in response to country specificities. The Commission will continue to strengthen synergies between different interventions at country level.

The health policy / strategy framework has improved a lot in SSA countries over the last decade, with the support of the WHO (World Health Organization) and of all other major development partners (Commission included). However, these policies need to be constantly reviewed and improved. As an example, joint annual health sector reviews in which the Commission is often involved, is an exercise which brings new developments to the policy.

VI.

The Commission will consider sectoral allocations according to the guidelines to be established for the 10th EDF mid-term review. These will stress country-level objectives, results achieved and the principles of country ownership and division of labour. They will also take into account the fact that results on the health MDGs can be attained through various ways, including investments outside the health sector (water and sanitation, education, rural development, governance) and not solely through direct support to health services.

The Commission will continue to support health systems, where possible with support to sector programmes. Development and retention of 'human resources for health' (HRH) as well as health system financing are issues that the Commission will follow carefully and assist.

— The Commission agrees that adequate expertise is important for those delegations which have an active donor role in the health sector. Where health is a focal sector, the Commission will explore ways to provide the delegation with the adequate expertise. In other cases, including for general budget support, silent partnerships and delegation of responsibilities to other donors could be envisaged in the context of the division of labour. Pragmatic ways such as EU pooling of experts might also be considered.

— SBS will increase from nearly 9% under the ninth EDF to 16% under 10th EDF across all sectors of cooperation. When conditions are satisfied it will be the preferred modality in countries that have programmed support to the health sector. The Commission will continue to strive to make its GBS instrument more effective in its achieving its goals, including through the launch of the MDG Contract.

— The Commission will continue to use projects in order to develop and strengthen health systems, especially in countries affected by situations of fragility.

In countries with a SWAp environment, support to policy development is also given through sector policy dialogue (involvement in specific working groups; participation in joint government–donor health sector reviews) as well as projects.

Capacity building, according to the 'Accra Agenda for Action' (September 2008), should increasingly be implemented through pooled funds to strengthen national capacities, maximising the use of local expertise.

— Following the Court's audit a specific Inter Service Group has been established to define what the Commission should do at country level to ensure a more efficient use of the Global Fund's financial resources.

— This guidance on the specific use of the various instruments in relation to the health sector, including on their use in combination, will be reviewed in the 'health programming guidelines' which are currently being updated to better take into account broader developments of EC instruments (e.g. MDG Contract).

— The Commission agrees and is convinced that a sound health policy and strategy framework is highly desirable for effective health system development. It will continue to promote the development and adoption of well-defined health policies with all the complementary interventions foreseen by its policy.

INTRODUCTION

1.
Sub-Saharan Africa lags behind in the achievement of most MDGs and notably of health-related ones.

Progress on health-related MDGs is linked to improvements on various fronts (education, water and sanitation, food security, etc.). Hence, supporting progress towards better health outcomes calls for a comprehensive strategy tackling existing constraints through the most appropriate instruments and through division of labour with other donors.

OBSERVATIONS ON ALLOCATION AND DISBURSEMENT OF RESOURCES TO THE HEALTH SECTOR

7.
The Commission wishes to put the audit of EC development assistance to health services in sub-Saharan Africa into the perspective of its overall approach to development assistance.

The Commission policy recognises that supporting progress towards better health outcomes calls for a comprehensive strategy tackling existing constraints through the most appropriate instruments and division of labour with other donors. Thus 'at country level the Community will employ a range of complementary interventions including: macroeconomic support linked to improved health outcomes; support to sectors that have a wider impact on health outcomes and direct support to the health sector' (health and poverty reduction communication).

While the Commission has indeed made strong commitments on health, it has never formally set a target in term of percentage of resources allocated to health for the EDF. Moreover, the Commission is of the opinion that targets based on financial inputs are increasingly ill-suited to reflect the current commitments within the framework of the aid effectiveness agenda and the real impact the Commission has on policies of partner countries.

The Commission's basic development approach focuses on poverty alleviation and, within this context, on improvements within the social sectors. Thus, the Commission concentrates on achieving development results as measured by performance indicators. Whether these results/indicators are reached with higher or lower, direct or indirect financial inputs is secondary.

The Commission agrees that there is no recognised method for attributing GBS assistance to specific sectors. Accordingly, the Commission takes note of the audit's methodology and its ensuing results. The Commission, however, would like to underline that because of fungibility of funds, both targeted and untargeted budget support contributes to financing the entire budget and not solely a part of it. Their imputed contribution to health sector financing should therefore be the same. Given the absence of an internationally recognised method for attributing GBS assistance to specific sectors, the Commission does not address specific findings on financial resources but intends to work towards a reporting methodology which would focus on performance indicators and aid effectiveness in line with Accra Agenda for Action and the Paris principles (ownership, alignment, harmonisation, managing for development results and mutual accountability).

12.

(b)

The Commission notes that the '70%' share the Court extracts from the IEO (Independent Evaluation Office)/IMF study only refers to the utilisation of additional aid but regardless of modalities and sectors. This share therefore does not relate to the total amount of budget aid or total aid flows. Budget support is always taken into account when determining public expenditures, including for health, and their optimal financing. When this implies reducing public debt or increasing reserves, the aid which is not immediately spent raises future spending capacity including in the health sector.

15.

The Commission notes that there is a shortage of international assistance for developing countries, in particular sub-Saharan Africa. This affects all areas, including health systems.

Donors' programming choices increasingly reflect internationally agreed principles of aid effectiveness such as country ownership and division of labour among donors. Excessive fragmentation of aid increases administrative costs by making the management of aid particularly complex and undermines partner country systems.

The Commission and the Member States have taken a strong policy commitment on division of labour, reflected in the 2007 EU Code of Conduct on Complementarity and the Division of Labour in Development Policy.

Programming of EDF funds is done jointly with the partner country and in consultation with the Member States: country strategies for the 10th EDF were presented to the EDF committee and considered by the Member States relevant responses to the problems of the partner countries in consideration of support provided by other development partners. Furthermore, in the context of the 24 June 2008 European Council conclusions on the EU agenda on MDGs, the EU collectively has committed to increase — in relation to the prospects of increased EU ODA — the EU support to health (8 billion euro by 2010, 6 billion euro for sub-Saharan Africa). In this respect, the convening role of the EC in the division of labour applied to health will play a key role.

16.

The Commission will provide direct support to the health sector under the 10th EDF to 15 SSA countries of which eight are affected by situations of fragility. The number of such countries which receive direct support from the Commission to their health sector has slightly increased from seven in the ninth to eight in the 10th EDF.

17.

The global partnerships (e.g. Global Fund, GAVI / Global Alliance for Vaccines and Immunization) have indeed attracted significant funding, sometimes at the expense of national health systems strengthening (HSS).

It has nevertheless contributed to a massive supply of medicines, vaccines and other preventive / curative commodities to fight AIDS as well as highly prevalent diseases such as, for example, malaria, tuberculosis or measles.

In addition to its contribution to the Global Fund, the Commission has also supported HSS, through various actions to lessen the HRH crisis, to improve the availability and affordability of essential medicines or to enhance health financing. In the countries in which 'health' is a sector supported by the national indicative programme, HSS is of course the central objective of EC support, preferably through a SWAp.

18.
Where the Commission is indirectly involved in the health sector, notably through GBS linked to the social sectors or budget lines and intra-ACP funding, silent partnerships have to be agreed with other (EU) donors in the spirit of the code of conduct on complementarity and division of labour, and coordination within the budget support donor group ensured.

Delegations may also be supported by headquarters (HQ). The Relex family services have regrouped its health expertise around health teams in DG Development and the EuropeAid Co-operation Office. This has substantially contributed to improved technical support to delegations, in the policy dialogue with partner countries as well as in the identification / formulation / implementation of health interventions.

(a)
Not only to support Global Fund 'operations' but also to exhort the Fund to integrate its activities into national policies and to strengthen health systems.

(d)
In countries where the HIV infection is highly prevalent, delegations are taking measures to ensure that all professionals dealing with any project / programme, are able to 'mainstream' HIV/AIDS in his/her area of expertise, even if he/she is not a health specialist. As an example, the EC Delegations in southern Africa are completing a guide on 'Mainstreaming HIV and AIDS in sectors and programmes'. Several delegations (e.g. Botswana) have already carried out specific training for their staff on mainstreaming HIV/AIDS.

20.
The Commission explores to what extent the division of labour will give opportunities for joint utilisation of expertise. The problem is that EU Member States are also reducing their sectoral expertise and that they might be reluctant to enter into formal and binding agreements.

Whereas an increased cooperation with ECHO health advisors is desirable, there are limits to their utilisation in policy development, because their professional profile usually requires them to manage humanitarian aid in emergencies, which is different from the professional profile of a health policy analyst and advisor to support health systems strengthening.

24.
The Commission welcomes the Court's remark on the speed and predictability of GBS funding under the ninth EDF. It notes that under the 10th EDF, it is planning to further improve the predictability of its GBS instrument through the provision of 'MDG Contracts' where conditions allow.

25.

(a)

The Commission will continue to strengthen health information systems in partner countries (e.g. Zambia) to increase their capacities in collecting data linked to result-based disbursements.

(b)

Eligibility conditions can affect the predictability of budget support but offer fundamental guarantees in terms of the effectiveness of budget support. Disbursement of SBS funds when a GBS programme is delayed or temporarily suspended is only possible when a deterioration of the macroeconomic framework constitutes a breach of GBS eligibility but is not viewed by the Commission as putting sector objectives at risk.

Finally out of 26 GBS programmes financed under the ninth EDF, 19% were affected by delays or suspensions.

29.

The fact that only a minority of applications submitted to the Global Fund are selected, does not facilitate coordination of the assistance provided by the donor community. As the Court noticed in Lesotho, the Global Fund granted, on its seventh round, USD 33 million to assist OVC (orphans and vulnerable children) while the Lesotho country strategy paper had already earmarked a significant support to them (at a time when there was no guarantee that the application to the Fund would be successful).

31.

The Commission welcomes the Court acknowledgement that budget support has the potential to play a key role in improving health services.

The differences between GBS and SBS are clearly identified in the existing international definition given by the OECD (Office for Economic Cooperation and Development) / DAC (Development Assistance Committee). While this definition is not always applied consistently by everyone everywhere[1], EC guidelines and practice are fully in line with it.

32.

A relatively new aid modality, SBS started under the ninth EDF, with first commitments in 2003, after the publication of guidelines on GBS (2002) and on support to sector programmes (2003). While it is true that so far health Sector Budget Support is limited to a small number of countries, available evidence for Africa[2] shows that the Commission is the largest user of Sector Budget Support across all sectors.

Given the deep technical engagement in sector policy design and implementation within a focused dialogue with a broad range of stakeholders required by SBS, the Commission believes that focal sectors are the ones where such a demanding effort to use SBS should focus. Where, however, resources were available, SBS has also already been used in non-focal sectors (Ghana, Mozambique).

33.

GBS can be additional to the focal sectors because it provides a unique opportunity to have a dialogue on the overall policy priorities of the partner country. SBS is a modality for the implementation of a focal or non-focal sector support.

[1] Strategic partnership with Africa, Survey of budget support 2007.

[2] Ibid.

34.
There is one clear Commission view (and practice) on the relation between GBS and social sector support. This is clearly stated in the current guidelines which do not lessen the relevance of social sector dimensions[3]. The Commission is promoting increased staff awareness about the link between budget support and social services.

35.
Having contributed to the evaluation approach conceived and used for the DAC joint evaluation (2006), the Commission is now working with other budget support donors within the DAC to develop an improved methodology that takes into account lessons learned.

[3] 'In a GBS programme designed to support a national policy and strategy, there will nevertheless be key sectors or areas where particular attention will be given. These sectors will be those judged to be of particular importance to the support to the national strategy. In those countries where support is being given to PRSPs (poverty reduction strategy paper) it is normal to focus on the social sectors of education and health as being key elements in reducing income and non-income poverty' (Guidelines page 50/51).

36.
In any given year, budgetary decisions in terms of total expenditures, their sector allocation, the level of the deficit and the composition of its financing take into account current and future macroeconomic constraints and the expected level and distribution of all flows of aid. Normally, therefore, there neither will nor should be a one-to-one relation between increased budget support and increased health expenditures in any given year. With time, however, budget grants support the creation of the fiscal space necessary for increased expenditures. Through its dialogue and conditions, EC budget support has also often pushed for higher budget allocation towards health. This, however, was not always regarded as the most urgent priority as when budget execution problems would impair the impact of higher allocations. For reasons like this, the Commission generally prefers to focus on outcome indicators that capture improvements at the level of beneficiaries.

37.
By fostering the strengthening of public financial management systems, the Commission 'dynamic interpretation' of eligibility which applies to both GBS and SBS supports local efforts to improve the effective use of budgetary funding. In this way GBS supports a sustainable answer to inefficient and ineffective public spending (in health as elsewhere) that will benefit all aid modalities used in the partner country.

Public expenditure tracking surveys are very illustrative but have proved to be of limited use as tools to engage country authorities' in a programme of PFM reform.

38.
GBS programmes address the risks mentioned by the Court in several ways.

The first is the regular implementation of PEFA (public expenditure and financial accountability) diagnostics that comprises indicators on primary level expenditure in health and education (Performance indicator No 23). The second is the progressive inclusion of decentralised and deconcentrated expenditure in the programmes of reform of public financial management. In agreement with other budget support donors, the Commission is ready to use financial audits and compliance tests when these are regarded as the most useful tools to spur the process of public finance management (PFM) reform.

In any case, the ways in which the Commission manages these risks must be compatible with the fact that once transferred to the national treasury, Commission funds are mixed with national resources, cannot be specifically traced and audited. This is true for both GBS and SBS which are both untargeted.

In SBS attention is given to the entire result-chain and to the allocation and execution of the sector budget. This can be supported by dialogue or conditionality according to the context and the specific objectives of a given SBS programme.

39.
GBS supports the strengthening of the global policy and institutional framework necessary for a sustainable and comprehensive improvement in the provision of health services. The Commission agrees that the existence of well-defined health policies increases the effectiveness of all types of aid to the sector and has actively supported the establishment of health policies since the 1990s (Senegal, Zambia, Ghana, etc.).

However, SWAps, national health policies and their relation with GBS should not be confused. Swaps are arrangements that harmonise donors support to an existing health policy. Although usually not fully aligned to country systems as budget support, Swaps are a positive development but should not be a pre-condition for GBS. As a matter of fact, when matched with adequate policy dialogue, the former can trigger the establishment of SWAPs (e.g. Madagascar).

Finally, by focusing at PRSP (poverty reduction strategy paper) level, GBS also promotes progress towards the MDGs by creating a demand for better defined sector policies. Out of the 22 SSA countries that have regularly implemented EC GBS under the ninth EDF, as many as 14 carry out regular joint health sector reviews whose results are then taken into account during the GBS joint annual review. In the remaining countries these are progressively being developed.

40.
The 2007 GBS guidelines do not prohibit the use of GBS capacity development funds to support sectoral ministries. However, in order to avoid excessive fragmentation, GBS capacity development funds are mainly used to strengthen PFM systems and PRSP monitoring frameworks. Importantly, however, this can include decentralised public financial management systems, in many countries directly relevant for health service delivery.

Broader technical assistance to the health sector is delivered in the frame of sector programmes by the donors active in the sector.

41.

The Commission welcomes the Court finding that the large majority of delegations directly participate in health sector dialogue.

(a)

Where the Commission is indirectly involved in the health sector, notably through GBS linked to the social sectors, silent partnerships have to be agreed with other (EU) donors in the spirit of the code of conduct on complementarity and division of labour, and coordination within the budget support donor group ensured. Delegations may also be supported by the health experts available at HQ.

(b)

An increasing number of countries manage GBS through performance assessment frameworks (eight in 2006, 12 in 2008). These jointly agreed matrices clearly define the benchmarks used to assess country performance, including in the health sector. It is for each delegation to decide the depth and extent of its involvement in sector policy dialogue. See also paragraph 39 above for articulation between GBS and sectoral reviews.

(c)

The value added of GBS is in encouraging sector dialogue to link policy, technical and financial inputs to critical sector outcomes. Accordingly, the Commission will continue its efforts to ensure that GBS outcome indicators are properly integrated into sector dialogue and processes. However, discussions on actual outcomes need to balance this objective with the need to ensure an exhaustive verification of disbursement conditions.

43.

According to the Commission's data on 138 scored health targets covering disbursement decisions over 2003–07, 83 targets were fully achieved (i.e. 60%).

In addition, in a further 15% of cases targets were partially met.

Overambitious targets may also have contributed to these results.

44.

(a)

The financial weight attached to individual targets is only one of the ways through which budget supports aims to foster improved performance, others being monitoring, policy dialogue and domestic accountability.

(b)

The Commission uses some input indicators (typically financial allocation and execution) but mainly focuses on outcome indicators (assisted deliveries).

While these are not under direct government control, they are still under indirect government control. Unlike input or output indicators (number of hospitals), they capture the objectives of government policies and their effects on beneficiary populations.

(c)

Although data reliability is a constraint, by using existing data the Commission promotes and supports their improvement.

(d)
The identification of ambitious and realistic targets is difficult and can only be satisfactorily achieved after several years of practice in management by results when sector processes are properly mastered. Improving partner countries capacity to manage by developing results is one of the objectives of the Commission approach to budget support.

(e)
Efforts are being made to better take quality of care into consideration. As an example, the indicator on delivery attendance has progressively evolved from 'institutional' deliveries (while not everyone in a health centre has been trained to attend deliveries) towards 'skilled' attendance.

45.
Although the Court is correct in stating that indicators do not directly target the poorest of the poor, it should be noted that:
— the definition of some indicators reflects a poverty dimension (e.g. assisted deliveries in basic health centres);
— poverty rates in countries beneficiary of budget support range between 30 and 60% of the population: targets for most indicators have overtaken the share of non-poor population.

In addition there is an increasing tendency to use indicators disaggregated at the level of the poorest regions, marginal areas or by gender.

46.
It should be noted that other GBS objectives can have a positive indirect influence on the health sector.

47.
Although the project (as an approach or as an implementation modality of a Sector Policy Support programme) is not the EC preferred form of aid implementation, it is clear that projects still remain a major instrument to carry out our development assistance.

For example, a first assessment of the initial allocations to the 10th EDF national indicative programmes / Envelope A of SSA countries (South Africa excluded) shows that Budget Support (including GBS and SBS) represent approximately 48% of the amounts so far allocated. The remaining 52% are then going to be spent mostly through projects.

48.
In order to monitor and draw lessons from the projects it funds and in addition to mid-term and final evaluations, the Commission has established a results-oriented monitoring (ROM) system covering all regions and sectors of Community aid. The ROM system mainly focuses on quality of design, efficiency and effectiveness to date, impact prospects and potential sustainability. The results obtained through ROM for EDF health interventions for the years 2001–07, indeed show an insufficient sustainability.

49.
(a)
The situation is now improving as the Commission endeavours to improve the 'link (between) relieve, rehabilitation and development' (LRRD).

(c)
Following the Court's special report on the 'Effectiveness of the TA in the context of capacity development' (2007), the Commission will finalise by the end of November 2008 its new 'Guidelines on technical cooperation and programme implementation arrangements'; the aim being to provide quality technical cooperation that supports country-led programmes as well as support through partner-owned project implementation arrangements, with a substantial reduction in the use of parallel project implementation units. This should contribute to better quality of the technical cooperation, ownership and strengthened capacity.

(e)
Most countries in SSA have developed national health policies with the support of the WHO and of the whole donor community, the EC included. However, often there needs to be a better fit between policies and resources (budget allocated to health, human resources for health, etc.).

The Commission contributes to the improvement of these health policies through projects (e.g. the EUR 25 million '*Programme de soutien au secteur de la santé*' in Angola), 'Sector Policy Support programmes' (e.g. health Sector Budget support in Zambia and Mozambique) or even through its participation in 'joint annual health sector reviews' (e.g. Benin, Madagascar, Mozambique, Zambia).

(f)
See replies to paragraphs VI (third indent) and 18.

50.
(b)
The delegations are kept informed about the centralised projects that are affecting their countries. It is useful in view of streamlining the EC interventions and avoiding possible overlaps between actions implemented at country or regional level and those implemented at intra-ACP level. In addition, EC delegations are regularly informed of centrally managed programmes when regional seminars are held. For more information, they also have access to CRIS (EuropeAid information system) and to the EuropeAid intranet.

(c)
The UN–EC joint guidelines on reporting are intended to overcome these difficulties.

53.
(a)
Usually, these general budget lines health projects proposed and implemented by NGOs and other non-state actors are funded by the Commission only if they are sufficiently compatible with the health policies and plans of the countries in which they are implemented. These projects are often carried out in cooperation with the local health system.

(b)
Between 2004 and 2005, the Commission held four thematic seminars (Addis Ababa, Dakar, Maputo and Bangkok) with contract beneficiaries, civil society organisations and other partners such as the WHO, to discuss and share lessons learned from the actions financed under the thematic health budget lines.

(c)
The innovative nature and the potential for scale-up interventions, applies not only to the national health programmes in the given country but also other countries facing similar challenges and global initiatives financing health interventions in those areas.

54.
The calls for proposals (CfP) under health thematic budget lines are targeted at least developed, other low and lower middle income countries and, within these countries, at the most disadvantaged population groups. It is recognised that poor and marginalised population groups even in more advanced developing countries need support; this particularly applies to HIV/AIDS and reproductive health needs of groups such as injecting drug users, migrants workers, refugees, sex workers, men having sex with men, etc. Furthermore, the CfP evaluation process takes into account the relevance of the action proposed to the needs and constraints of the country / region / population concerned.

58.
Following the Court's audit, the Commission has decided to establish a specific Inter Service Group with the following tasks:
- to define the role and responsibilities an EC delegation should have in relation to the Global Fund (e.g. participation in the CCM, reporting, etc.). Different types of delegations could be identified according to criteria such as, for example, the level of HIV prevalence in the country, the fact that 'health' is or not a focal sector in the CSP, etc.;
- find out how delegations will fulfil their new tasks taking their limited resources into account and;
- determine how delegations may be supported by HQ and how both Development DG and EuropeAid Co-operation Office will cooperate to carry out their assistance to the delegations.

(c)
The capacity of countries to prepare good quality proposals is generally improving. The last round of CfP (launched on 1 March 2008) has seen the highest amount requested so far (USD 6,1 billion), but it has also the highest ever rate of proposals recommended by the technical review panel: 54%.

The Commission is currently exploring with UNAIDS the ways to build capacity of countries in the fight against AIDS (development and implementation of a 'capacity building' plan of action).

60.
Efficient health systems are able to convert Global Fund and PEPFAR (US President's Emergency Plan for AIDS Relief) support into health services to the population affected by HIV/AIDS, tuberculosis and malaria.

The Commission also supports health system main elements such as human resources for health (HRH). The DCI / 'Investing in people' has earmarked EUR 40 million for HRH in the period 2007–13. The EDF supports HRH activities and programmes in Angola, Mozambique, Uganda, Zambia and Zimbabwe and HRH indicators are now used in GBS and health SBS variables tranches. The Commission also works with the WHO in supporting pharmaceutical policies (EUR 25 million) and improved health planning and budgeting (EUR 25 million) in ACP countries.

62.
The Commission is aware that significant disease specific programmes such as the Global Fund need efficient health systems to be productive. In order to better understand this relationship, Development DG is currently working on strategic and technical guidelines on how such disease specific programmes could strengthen health systems.

64.
The Commission notes that the issue may be first and foremost when a combination of GBS and a **health focal sector** is required and only secondly when SBS is an appropriate implementation tool for the health focal (or non-focal) sector.

The Commission considers that a well-defined health policy and a health sector programme supported by donors, not necessarily a Commission financed SBS, are desirable to improve the effectiveness of GBS contribution to health outcomes.

65.
In line with its belief concerning instruments complementarity, the Commission agrees with the Court that projects can reinforce budget support but notes that the opposite is also very much true.

66.
Complementarity is not easy with the Global Fund. The predictability is weak (according to the Court, only 39% of proposals for rounds 1–7 CfP have been granted by the Fund). In addition the time scale to plan and prepare an intervention for both the Commission and the Global Fund is completely different.

67.
The Commission agrees that there are potential synergies that could be better exploited by both budget support donors and the Global Fund.

68.
As a rule, if there is a sector programme[4] in a country and if the Commission is involved in the health sector of this country, the Commission will support its implementation.

[4] As a result of following a SWAp, a government progressively develops a **sector programme**. A sector programme has three components: **a sector policy and strategy**, a sector budget and its medium-term perspective and a sector coordination mechanism.

To reaffirm its position, the Commission signed in September 2007 the 'international health partnership' (IHP) which relaunched the sector wide approach in the health sector. Following this, the Commission delegations of Ethiopia and Mozambique have recently co-signed with governments and development partners, an 'IHP compact' (modalities to apply IHP in a specific country).

69.
The Commission actively promotes the development and implementation of a sector programme, through a SWAp, mainly in the countries in which it supports the health sector. So far, the Commission has been involved in several sector programmes (e.g. Ghana, Mozambique, Senegal, Uganda, and Zambia).

70.
In order to provide SBS to the health sector, the following criteria have to be satisfied:
1. the inclusion of support to health in the CSP, as focal or non-focal sectors in the context of country ownership and division of labour;
2. SBS eligibility conditions are satisfied (well-defined sector policy, sector coordination mechanism, macroeconomic stability and PFM improvement).

However, in many sub-Saharan Africa countries these conditions are not currently met.

72.
The policy / strategy frameworks have improved a lot in SSA countries over the last decade, with the support of the WHO and of all other major development partners. However, these policies need to be constantly improved (for example, better links between health needs and resources). Joint annual health sector reviews in which the Commission is often involved, is an exercise which often result in new developments in the health policy / strategy frameworks.

CONCLUSIONS AND RECOMMENDATIONS

73.
In line with its policy commitments the Commission has maintained its direct financing to health at country level, increased general budget support and its contribution to global initiatives.

The 20% commitment ('The Commission will endeavour to ensure that a benchmark of 20% of its allocated assistance under country programmes covered by the DCI will be dedicated, by 2009, to basic and secondary education and basic health, through project, programme **or budget support linked to these sectors**, taking an average across all geographical areas…' Article 5 of the Development Cooperation Instrument) does not apply to ACP countries.

74.
Efficient health systems are able to convert Global Fund and PEPFAR support into health services to the population affected by HIV/AIDS, tuberculosis and malaria.

The Commission also supports health system main elements such as human resources for health (HRH). The DCI / 'Investing in people' has earmarked EUR 40 million for HRH in the period 2007–13. EDF supports HRH activities and programmes in Angola, Mozambique, Uganda, Zambia and Zimbabwe. HRH indicators are now used in GBS and health SBS variables tranches. The Commission also works with the WHO in supporting pharmaceutical policies (EUR 25 million) and improved health planning and budgeting (EUR 25 million) in ACP countries.

75.
The observation of the Court is noted by the Commission which will try to find solutions in view of having additional expertise, either in-house or through agreements, for example, with Member States aid offices present in the countries.

RECOMMENDATIONS ON RESOURCE ALLOCATIONS

No 1: The Commission will consider sectoral allocations according to the guidelines to be established for the 10th EDF mid-term review. These are likely to stress country-level objectives, results achieved and the principles of country ownership and division of labour. They will also take into account the fact that results on the health MDGs can be attained through various ways, including investments outside the health sector (water and sanitation, education, rural development, governance, etc.) and not solely through direct suport to health services.

(a) While recognising the scope to expand the attention to health in fragile States, often health donor orphans, the Commission already provides or will provide direct support to the health sector under the 10th EDF to 15 SSA countries of which eight are affected by situations of fragility (Burundi, Chad, Congo, Democratic Republic of the Congo, Guinea, Côte d'Ivoire, Liberia and Zimbabwe). The number of countries affected by situations of fragility whose health sector is supported by the Commission has increased from seven in the ninth to eight in the 10th EDF.

No 2: During the mid-term review of the 10th EDF, the Commission will review the balance of its funding to best reflect its policy priorities in health as in other sectors in the light of the first years of implementation of the 10th EDF. Health system strengthening (HSS) is indeed among its priorities.

No 3: Though acknowledging the limits of resource allocation decision as concerns overall staff, the Commission is exploring ways to ensure a better access to public health expertise in delegations. Where the Commission is indirectly involved in the health sector, notably through GBS linked to the social sectors or budget lines and intra-ACP funding, silent partnerships have to be agreed with other (EU) donors in the spirit of the code of conduct on complementarity and division of labour, and coordination within the budget support donor group ensured. Where health is a focal sector, the Commission will look into ways to provide the delegation with the adequate expertise.

(a) The possibility of establishing health expertise in regional delegations has been under consideration for some time. There is a need for the Commission to better balance the advantages and disadvantages of such a recommendation before reaching any decision.

(c) Cooperation with the WHO, which is already important, could indeed be reinforced with its country offices whenever this is possible.

76.

The Commission welcomes the Court's observation on the improved speed of implementation of EDF health interventions, under the ninth EDF, and agrees with the Court that this is partly due to devolution.

77.

The results of the first five-year ongoing evaluation of the Global Fund will be available by the end of this year. They will provide detailed information and analysis on the actual implementation of proposals funded by the Fund. The Commission carefully follows this evaluation and will take into consideration its conclusions. The Commission will also follow up on the conclusions of the Court's audit.

78.

The Commission agrees that greater predictability of funding would increase the effectiveness of aid. Accordingly, starting with the 10th EDF, the EC has developed the MDG Contract precisely to increase predictability of budget support in performing partner countries. The Commission notes, however, that volatility in aid is justified when the preconditions for aid effectiveness are no longer present as when budget support eligibility elapses.

RECOMMENDATIONS ON SPEED AND PREDICTABILITY

No 4: The Commission is currently exploring with UNAIDS the ways to build capacity of countries in the fight against AIDS (development and implementation of a 'capacity building' plan of action).

No 5: Under the 10th EDF, the Commission is seeking to make its GBS more predictable through the launch of MDG Contract in performing countries. The Commission believes that the threat of suspending payments is an incentive to preserve eligibility: this would be undermined if the recourse to alternative instruments to preserve the flow of funds was automatic. The need to avoid unnecessarily punishing the poor, however, is one of the key factors determining Commission's decisions under this case-by-case approach.

79.
The Commission welcomes the Court's acknowledgement that GBS can be an important instrument to support better health policies. Nevertheless, the Commission underlines that the effectiveness of general budget support is better assessed in the longer term since progress in outcomes at national level takes time as it requires improvements in large systems and thus cannot be compared to progress in outputs in smaller and targeted groups of the population. Further improvements are targeted during the 10th EDF implementation, thanks to the introduction of MDG Contract and the preferred use of SBS for the implementation of programmed sector support. The Commission continues its efforts to increase the effectiveness of its BS instruments (including through increased used of indicators disaggregated at the level of the poorest regions, marginal areas or gender).

80.
The project approach — as stand alone project or as implementing modality of a SPSP — will continue to be an important element of EC support to the health sector. The Commission continuously tries to improve the selection of multi-country projects.

81.
The implication of the delegations also depends on their capacity in sectoral matters.

Following the Court's report, a specific Inter Service Group has been established to define what the Commission should do at country level to ensure a more efficient use of the Global Fund's financial resources.

RECOMMENDATIONS ON MANAGEMENT AND EFFECTIVENESS OF INSTRUMENTS

No 6: The Commission is committed to make the greatest use possible of SBS for focal and non-focal sector health interventions when conditions allow it. As per its programming guidelines, the Commission regards GBS as complementary to focal sector interventions, including when these are implemented through SBS.

No 7 (a): The Commission will continue its efforts to use GBS performance indicators and the linkages between GBS and sectoral dialogue (including joint sector reviews and ongoing dialogue where there is a SWAP) so as to encourage countries to achieve their health MDGs and other targets in a sustainable manner. This will imply using what in each individual country case is regarded as the most appropriate mix of outcome and input indicators (such as budget shares and execution rates). A technical assistance facility could be included in General Budget Support operations to respond to specific needs regarding sectors with GBS indicators (e.g. health information systems).

(b) At sector level annual reviews typically focus on the implementation of the sector policy and the execution of the sector budget. Results of public expenditure reviews and expenditure tracking surveys are also taken into account when available. Out of the 22 SSA countries that have regularly implemented EC GBS under the ninth EDF, as many as 14 carry out regular joint health sector reviews whose results are then taken into account during the GBS joint annual review. In the remaining countries these are progressively being developed and encouraged in the context of GBS dialogue. Howevers the Commission will generally prefer to use GBS and any attached safeguard as a means to strengthen more systemic components of partner public financial management and also build capacities in the area of management of human resources. Thus it would prefer to strengthen domestic accountability bodies' capacities to carry out reviews like the ones suggested rather than carrying them out directly. Such an approach has the potential to maximise the impact of GBS, reduces the risks of overburdening the tool and embodies a design more proportionate to the multiple objectives of GBS.

(c) See above (point b of this box).

(d) Within the overall limits of its human resource budget and the evolving status of division of labour exercises, the Commission will do its utmost to improve the quality of input into health sector dialogue as suggested above.

(e) The improvement of the indicators utilised in its budget support operations is a continuous preoccupation of the Commission.

No 8: The Commission has decided to establish a specific Inter Service Group, with the following tasks:

(1) to define the role and responsibilities an EC delegation should have in relation to the Global Fund (e.g. participation in the country coordinating mechanism, reporting, etc.). Different types of delegations could be identified according to criteria such as, for example, the level of HIV prevalence in the country, the fact that health is or not a focal sector in the CSP, etc.;

(2) find out how delegations will fulfil their new tasks taking their limited resources into account;

(3) determine how delegations may be supported by HQ and how both Development DG and EuropeAid Co-operation Office will cooperate to carry out their assistance to the delegations.

In addition, The Commission is currently examining with UNAIDS the ways to build capacity of countries in the fight against AIDS (development and implementation of a 'capacity building' plan of action).

No 9: Although the project (as an approach or as an implementation modality of a sector policy support programme) is not the EC preferred form of aid implementation, it is clear that projects still remain a major instrument to carry out our development assistance. For example, a first assessment of the initial allocations to the 10th EDF national indicative programmes / Envelope A of SSA countries (South Africa excluded) shows that budget support (including GBS and SBS) represent approximately 48% of the amounts so far allocated. The remaining 52% are then going to be spent mostly through projects and earmarked programmes. However, the Commission cannot agree with the recommendation to use project support 'to provide healthcare in poorer regions not adequately covered by health care services' since in at least 30 developing countries, access to health services is limited; but the adequate response to the challenge is sufficient, predictable and aligned health ODA; rather then the proposed NGO financing.

82.
The Commission will further improve the way in which it seeks to exploit synergies between its interventions, starting with the ongoing review of health guidance.

83.
To support the implementation of sectoral programmes, the Commission in 2007 updated its 2003 guidelines on EC support to sector programmes and organised a whole series of trainings related to this implementation modality. It has also launched and managed together with Denmark and the Netherlands the joint learning programme on sector-wide approaches, an initiative highly regarded by the donor community. The Commission will continue to support the establishment and implementation of sector programmes, directly in the countries where health is part of its cooperation strategy, and indirectly through GBS performance assessment and joint review processes elsewhere.

RECOMMENDATIONS ON COHERENT USE OF INSTRUMENTS

No 10 (a): In the light of accumulating experience, the Commission will assess whether there is need to review the indications about when to use GBS and SBS, and how best to use the two together, which are currently contained in the Commission's guidelines for programming, GBS and SBS.

(b) The guidance on the specific use of the various instruments in relation to the health sector (including projects), as well as on their use in combination, will be reviewed in the 'health programming guidelines' which are currently being updated to better take into account broader developments of EC instruments (e.g. MDG Contract).

(c) The Commission's new Interservice group on cooperation with the Global Fund will address ways to achieve greater complementarity with Global Fund taking into account predictability issues in relation to Global Fund operations and the different timeframes for Commission and Global Fund operations.

No 11: The Commission is committed to use SBS as its preferred implementation modality for health interventions whenever conditions such as, among the others, the existence of a well-defined sector policy.

No 12: The EC will continue to support the establishment and implementation of sector programmes, directly in the countries where health is part of its cooperation strategy, and indirectly through GBS performance assessment and joint review processes elsewhere.

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SPECIAL REPORT 'EC DEVELOPMENT ASSISTANCE TO HEALTH SERVICES IN SUB-SAHARAN AFRICA' EXAMINES WHETHER THE FINANCIAL AND HUMAN RESOURCES ALLOCATED TO THE HEALTH SECTOR REFLECTED THE EC'S POLICY COMMITMENTS, AND WHETHER THE COMMISSION HAS SPEEDED UP THE IMPLEMENTATION OF THIS AID AND USED THE VARIOUS TYPES OF FINANCING EFFECTIVELY. THE REPORT MAKES A SERIES OF RECOMMENDATIONS AIMED AT IMPROVING THE EFFECTIVENESS OF EC ASSISTANCE IN CONTRIBUTING TO IMPROVING HEALTH SERVICES IN SUB-SAHARAN AFRICA.

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