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Evaluatie-studies uitgebracht door de IOS ontwikkelingssamenwerking en beleidsev

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250 1990 **Volkshuisvesting Curaçao.** *Een evaluatie van het huisvestingsprogramma van de Fundashon Kas Popular (FKP), 1979-1989*

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269 1998 **Bangladesh.** *Evaluation of the Netherlands Development Programme with Bangladesh, 1972-1996 (Volume 2 - Main Report)*

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Preface

Health is both a human right and a vital condition for development. These are the guiding principles of Dutch international co-operation in the field of health, nutrition and population. Over the last two decades, Dutch support in this field has increased, totalling € 650 million over the period 1995-1999.

The Policy and Operations Evaluation Department (IOB) has carried out an independent evaluation of Dutch health, nutrition and population support in Burkina Faso, Mozambique and Yemen over the period 1995-1999. These countries were selected because of their long standing co-operation with the Netherlands in the health sector, involving a substantial Dutch financial contribution to a variety of programmes. The major objective of the evaluation was to determine how far health programmes have contributed, directly or indirectly, to the reduction of morbidity and mortality, especially among the poor. Therefore, a methodology was developed that emphasises access to and the quality and use of health services, assuming that good health care contributes to better health behaviour and to better health. These issues were addressed in a field study in the three countries, including both the health services and the household level.

The evaluation results show a mixed picture. In all cases, positive effects have been achieved in the field of infrastructure and training. The quality of care improved in some settings, but in others much remains to be done. Among the negative findings are the neglect of the community level and the lack of affordable essential drugs in remote areas. We hope that the evaluation results will provide a basis for discussions on future health sector support.

The evaluation was carried out by inspector Marijke Stegeman, in close collaboration with Anita Hardon and Trudie Gerrits from the medical anthropological unit of the University of Amsterdam. The country studies were carried out mainly by teams of locally based experts. IOB is grateful to all who contributed by sharing their knowledge, experience and comments. IOB, however, bears sole responsibility for the contents of this report.

Rob D. van den Berg
Director, Policy and Operations Evaluation Department

Contents

1. Main findings and issues for the future

1.1 Introduction

Health is both a fundamental human right and a vital condition for development. These are the basic principles of Dutch international policy in the field of health, nutrition and population. The major variances in morbidity and mortality, between poor and rich countries and between the poor and the rich in the individual countries themselves, clearly show the linkage between poverty and health. A sufficient and balanced diet, safe drinking water, adequate sanitary facilities and education are all preconditions for good health. Action is required in a variety of fields if death and disease are to be reduced. Good quality health care delivery plays a modest but essential role in the improvement of health status, and thus contributes to poverty reduction.

The overall goal of the evaluation was to determine to what extent activities in the field of health, nutrition and population have contributed, directly or indirectly, to combating disease and death, especially among the poor.

Morbidity and mortality are determined by a complex array of factors which make the impact of health programmes on health status hard to measure. In this evaluation, three assumptions are made. Firstly, that health programmes lead to an improvement in the structure and performance of the health system, including health promotion, disease prevention and curative care. Secondly, that these improvements lead to better health behaviour. Thirdly, that better health behaviour contributes to better health status. Assessing these factors required the implementation of a field study and the collection of data from both health services and individual households.

The focus of the evaluation was at country level. For logistical reasons, the number of countries was limited to three and the evaluation period to the years 1995-1999. The criteria for country selection were the volume and the duration of Dutch support, as well as the variation in the health programmes. Mozambique, Yemen and Burkina Faso were the countries selected and they all fall into the low-income category. The whole range of programmes and projects supported by the Netherlands in each country was evaluated,

provided that the budget exceeded 50.000 Euros and the duration was at least two years. The main findings, except for the first one, relate solely to the health programmes in these countries.

The evaluation started in March 2000 with a preparatory document study, followed by three country studies over the period October 2000-June 2001. In each country, the evaluation was carried out in two phases. During the first phase, all programmes and projects included in the evaluation were analysed in terms of relevance, effectiveness, efficiency and sustainability. This was done on the basis of document review, key person interviewing and site visits. During the second phase, a field study was then carried out in a chosen district. There, for a limited number of programmes, the impact of programmes was assessed in terms of the improvement in the structure and performance of the health system, as well as the improvement in health behaviour.

Health, nutrition and population are important components of Dutch development co-operation. During the 1980's and 1990's, Dutch policy followed international developments. It included support for primary health care, disease control, essential drugs, HIV/AIDS prevention and control, reproductive health, nutrition and health system support. The total volume of Dutch aid to these policy areas during the period 1995-1999 was about 650 million Euros. The country allocations for social development accounted for over half of total expenditure. Contributions to multilateral organisations totalled about 40 percent. Altogether, the health programmes in Mozambique, Yemen and Burkina Faso accounted for about 15 percent of the overall country allocations for health, nutrition and population, with Mozambique and Yemen among the highest receivers.

Taken together, the primary health care programmes evaluated account for 36 percent of the total bilateral budget for primary health care in the years 1995–1999; the ones included in the field study account for 16 percent of that budget. The essential drugs programmes evaluated in the country studies together account for 43 percent of the total country programme budget for essential drugs during the same period. Other programmes, such as disease control, HIV/AIDS prevention or reproductive health, accounted for only a small percentage of the total health expenditure in the policy areas concerned.

The relationship between health care, health behaviour and health status is complex and data on health status in the field study areas was not available. Furthermore, the evalua-

tion results of the different programmes varied substantially and it was not always possible to directly attribute the results to Dutch support. These factors ultimately limited the possibility of determining the programmes' contribution to combating death and disease among the poor. Where appropriate, the findings are related to the health status of the poor and to poverty reduction.

1.2 Main findings

1. *Since the early1980's, Dutch international policy in the field of health, nutrition and population has followed international developments.*

Dutch policy gradually shifted from support for comprehensive primary health programmes to support for health organisation and health sector reform. The sector-wide approach became the guiding principle. In addition a number of priorities were defined, such as nutrition, reproductive health and HIV/AIDS prevention and control. No guidelines were given on how these Dutch priorities could or should guide the Dutch participation in sector wide approaches.

2. *The programmes and projects are generally in line both with health policy in the countries and with Dutch policy. They are not, however, based on an in-depth needs analysis nor on a specific co-operation policy between the Netherlands and the country concerned.*

Almost all programmes and projects in Mozambique, Yemen and Burkina Faso are in direct response to important public health problems. Millennium development goals also include the reduction of several of these problems. These findings are hardly surprising, as needs are numerous and policies broadly defined. Moreover, the choice of specific areas of health support has predominantly been based on international policy developments in the field of health, nutrition and population, and not on a needs analysis nor on a specific co-operation policy between the Netherlands and the country concerned.

3. *In primary health programmes, the shift towards institutional support has led to insufficient support for community health.*

During the 1980's, both international and Dutch policy focussed on primary health care support, emphasising health promotion and community health. The institutional level was neglected. In the 1990's policy changed and gradually more attention was given to the quality of care at services level and to health system organisation and health finance.

This development led in turn to the community level being neglected, both in national health policies in the recipient countries and with regards to international and Dutch policy. With the move to an approach of sector-wide support, even more emphasis is given to the institutional aspects of the health system. Both in Burkina Faso and in Mozambique, the field study revealed that community health workers and community midwives lack the means to provide adequate services. In both field studies, the population generally expressed its appreciation for the community health workers, but cited their lack of capacity to provide curative care. As health services are located far away and means of transport are virtually non-existent, this is a serious problem. In Yemen, the field study was carried out in a city. There, home-based community health is still an integral part of the health system, though to a lesser extent than when the programme was being funded by Dutch aid. The insufficient attention paid to community health limits the health programmes' contribution to poverty alleviation.

4. *The structure of the health system in all three countries has been improved by Dutch support for the construction and rehabilitation of infrastructure and for human resources training.*

The number of services per head of population increased and thus, too, the accessibility of those services. The services are also better equipped, though in some programmes maintenance proved to be insufficient. In almost all primary health programmes, training was an important component and a substantial number of health professionals and community health workers have been trained.

5. *In most primary health programmes, the institutional strengthening of the public system was included in the objectives, but only two programmes attained this objective.*

In six of the seven primary health programmes, institutional strengthening was an important objective, either at the outset or subsequent to a mid-term evaluation. In three programmes, serious efforts have been made to realise this objective. The primary health care programme in Kaya in Burkina Faso succeeded in improving the organisation and planning of health services. The Hodeidah urban programme in Yemen also did, but the efforts proved unsustainable. The support for the provincial health office in Nampula, Mozambique, was only successful in some respects, such as the realisation of participatory planning. The other three primary health programmes achieved negligible strengthening of the public system.

6. *The quality and the utilisation of the health services varied substantially among the settings in the three countries.*

In Burkina Faso, the field study revealed that Dutch support has led to better preventive and curative services in the health centres. However, the utilisation of the services is far lower than expected given the population size in the target area of the health facilities. This can partially be explained by the fact that large numbers of the target population live in remote areas. In Yemen, the Hodeidah field study revealed that Dutch support led to better preventive services, which are much utilised by the population. The programme led to the introduction of the 'murshidat', a new type of female health worker, who quickly became key players in health promotion and preventive service delivery. Curative services have also improved in Hodeidah, but are not much used by the general public. In cases of illness and disease, people give preference to the readily-available private services. In Mozambique it was found that the quality of most services was sub-standard. However, service utilisation by the population is high, which indicates that, unlike in Hodeidah, no other services are available. The two programmes that were successful in improving the quality of care were the same as those that were effective in terms of institutional strengthening.

7. *The fairness of the health systems is a matter of concern. No proper exemption rules are being applied for poor people who cannot afford to pay fees for services and drugs, leading to inequity in access to health.*

In all three countries included in the evaluation, a 'fee for services' system is being applied. In Burkina Faso, no exemption rules have been established for those who cannot afford to pay for services or drugs. In both Yemen and Mozambique an exemption policy has been established, though, in Yemen, it is only partially being implemented. In Mozambique the fees for services and drugs are very low but the lack of drugs in health centre pharmacies forces people to buy them at high market prices. No mechanisms exist to assist those who cannot afford these prices. In all three settings, poor people do not have access to insurance systems. These findings reveal inequities in access to health care, which decrease the potential to combat disease and death among the poor and limit the programmes' contribution to poverty alleviation.

8. *Essential drugs programmes were effective in the procurement of drugs and in the amendment of drug legislation, but often failed to guarantee the availability of drugs in peripheral health services.*

In Mozambique and Yemen, the procurement and purchase of drugs with Dutch support were met with success, though some delay. In Burkina Faso, other donors financed the procurement and purchase. In all three countries, amendments to drug legislation were included in the programmes and successfully implemented. The field studies revealed that in two of the three settings, the programmes failed to guarantee the availability of essential drugs in peripheral health services. As drugs are still scarce and relatively expensive, the risk of corruption and other illegal practices is high. In Mozambique, the field study revealed that pharmacies were almost empty. In Yemen, the situation was somewhat better but still far from acceptable in some centres. Here, doctors appeared both reluctant to prescribe essential drugs and under some pressure from the pharmaceutical industry to prescribe brand products. In Burkina Faso, the drugs were available in the services but high prices hampered their utilisation. In all three countries, few efforts have been made to guarantee proper prescription and rational drug use. This seriously limits the likelihood of essential drugs programmes having a positive effect on health outcomes.

9. *The integration of nutrition in health programmes is inadequate.*

Malnutrition is a serious problem in the three countries included in the evaluation. In spite of this, prevention of malnutrition and treatment of malnourished children is insufficiently addressed in the basic health services. The field studies revealed that, despite the routine weighing of all children by the health services, mothers are generally not adequately informed about the nutritional status of their children. No proper nutritional education is given and malnourished children do not receive special attention. Dutch policy has formulated clear guidelines for confronting the problem of malnutrition in the context of basic health services. These have not been translated into practice in the three programmes included in the field study.

10. *In the countries studied, a reproductive health policy has been formulated but is only partially being implemented.*

The field studies revealed that reproductive health had not been fully integrated into the health services. On the positive side, contraceptives are available in health services.

On the negative side, an unmet need was detected and reproductive rights were not always respected. Reports from both Yemen and Burkina Faso indicated that contraceptives are not provided to women without their husband's consent. Projects in Mozambique and Yemen, which focussed specifically on reproductive health and were supported by the Netherlands, did not form part of a comprehensive national reproductive health policy. Evaluation results varied. The census project in Mozambique attained its objective fully and the midwife training project in Yemen did so partially. In Burkina Faso, a more comprehensive reproductive health programme was financed but was not successful. In this instance, the lack of a properly defined national reproductive health policy hampered full implementation.

11. *Disease control programmes that aim at the detection of patients in health centres are not effective in a setting where the health system is under-utilised.*

The national tuberculosis control programme in Burkina Faso follows international guidelines. Tuberculosis patients are not actively approached but are detected when they visit a health centre (passive case finding). However, despite the clear contribution Dutch support made to the improvement of infrastructure, equipment and supplies, the number of cases detected and then treated properly barely increased. The leprosy control programme in Mozambique was effective in case detection and proper treatment. Here, the level of integration of Dutch support in the national health system can be questioned, as aid only covers the leprosy components of the national Tuberculosis and Leprosy control programme.

1.3 Issues for the future

Since 1999 the push towards the sector-wide approach has been intensified. In this framework, it is a challenge to include the major evaluation findings in discussions on health policy and on poverty reduction strategy papers in countries. This is especially the case for those findings that relate to the policy shift.

1. *Confronting the neglect of community health*: in the 1980's all efforts were directed at primary health care at community level. Isolated primary health care projects proved to be ineffective and unsustainable if not bolstered by a well functioning health system. As a result, policy shifted to supporting the health system at district or national level, ideally by means of direct budgetary support. Nowadays, all efforts are directed at institutional support with the community level receiving much less attention, both in

national health policies and in donor policy. However, since people living in remote areas do not have access to health services, the challenge remains to retain those elements of the primary health approach which function well, including community health, and to integrate these within the health system.

2 *Confronting regressive financing systems*: the field studies documented that in the three settings patients have to pay user fees for services and/or for the drugs. User fees were introduced in many developing countries in the 1980's as a way to mobilise additional resources at the local level of health care and in response to inefficiencies in health care systems. Those systems provided free health care within a publicly financed health care system. Exemption policies were seen to resolve the equity concerns raised by the change in health care financing systems. The field-studies pointed to a general lack of existence and/or implementation of such exemption policies. Findings from health financing systems have shown that user-fee systems tend to be regressive and often impede access to health care.[1] Prepayment through insurance systems can be used to pool and share risks across the population and thus lead to greater fairness. It is a challenge to develop insurance schemes which broaden participation to allow inclusion of the poor, who generally do not have regular jobs and income.[2]

3 *Confronting the unavailability of drugs and irrational drug use in the periphery*: the availability of affordable essential drugs at service level is an absolute condition for a health system that functions well. Drug unavailability is caused by an array of factors, including an absolute shortage, inadequate distribution, leakage and corruption. Corruption is closely related to the other three factors. Irrational drug use also has multiple causes, such as inadequate prescription, the pressure of private drug companies, and lack of information on drugs. It is a challenge to establish a proper balance between the various elements of a national drug programme. This implies: a sufficient supply; appropriate legislation and regulation relating to quality control; enforcement of the foregoing; and the use of generic drugs. It also implies a good monitoring system to control distribution to the periphery and efforts to enhance rational drug use. These efforts must include the provision of adequate information to both drug prescribers and to the general public. Only then will

1 *World Health Organisation 2000.*
2 *Kutzin 1996.*

successes in the field of procurement and legislation have a positive impact on health status.

4 *Considering nutrition and reproductive health*: nutrition and reproductive health are important health policy areas which need to be addressed from both inside and outside the health system. It is a challenge to enhance the prevention and treatment of malnourished children in the public system by transforming the routine weighing of under-fives into a consultation process in which: children are weighed; mothers are informed about their children's nutritional status and advised appropriately; and where, if necessary, malnourished children are treated. With regards to reproductive health, progress has been made in the fields of mother and child care and the availability of contraceptives. Here too, the challenge exists to address issues such as sexual health, adolescent health and reproductive rights e.g., the freedom to decide on the use of contraceptives. It is also a challenge to include nutrition and reproductive health in other non-health sectors.

2 Objectives and approach

2.1 Justification

Since the 1970's, health, nutrition and population (HNP) have become important components of Dutch development co-operation. In 1998, health was defined as a priority sector in more than half of the countries that were selected for bilateral development co-operation. Over the period 1995-1999 HNP expenditure totalled 650 million Euros. However, since the late 1980's there has only been limited evaluation carried out in this area by the Policy and Operations Evaluation Department (IOB).[3] A combination of these factors led to the decision to carry out this evaluation in the field of health, nutrition and population.

Over half of Dutch HNP support during the second half of the 1990's was channelled through the budget category 'country programme for social development'. At present, Dutch bilateral policy has a strong country focus in all sectors and areas. These two factors led to the choice of an evaluation at country level. An additional argument for excluding the multilateral channel is that multilateral organisations are already being evaluated on a regular basis, with the participation of several contributors.[4] The health component of the MFO programme has also been evaluated recently.

2.2 Objective and key questions

The overall goal of the evaluation of the country programmes is to determine to what extent HNP activities have contributed directly or indirectly to combating disease and death, especially among the poor. The key questions relate to:

- the basis and the coherence of the country programme;
- the policy context;
- the relevance, effectiveness, efficiency and sustainability of the programmes and projects[5] in the countries. For a limited number of programmes, efforts

3 IOV evaluated the health co-operation from 1975-1984. Findings are summarised in two reports: IOV 1987 and IOV 1988. Health was included in the country evaluations in Egypt (1998) and Bangladesh (1998). Reproductive health was part of the evaluation women and development (1998).

4 At present, UNAIDS is being evaluated. Preparations are made for a multi-donor evaluation of UNFPA.

5 We use the term programme to refer to aid which aims at strengthening an existing recipient country structure, such as a district health care programme, or an essential drugs programme, and at improving its performance. We use the term project, to refer a set of activities which take place in a defined place and time period.

have also been made to assess the impact in terms of the improvement of health status.

Basis and coherence of the programme refers to the considerations that influenced the decision to support a programme or project.

Policy context refers to the priorities in national policy, as well as to health care organisation, planning and finance in the countries included in the evaluation. The evaluation includes a description of Dutch policy in the field of health, nutrition and population over the last two decades, as well as an inventory of money flows in the period 1995-1999.

Re*levance* refers to the extent to which the programme/project addresses the health problems in the country concerned. It also refers to the degree to which the programme/project reflects the priorities formulated in the national health policy and in Dutch policy in the field of HNP.

Effectiveness concerns the extent to which the programme/project objectives have been realised. The timelines and adequacy of changes of original objectives on the basis of monitoring and evaluation results is included.

Efficiency concerns the way in which the programme/project uses the funds to reach its objectives. In assessing cost-effectiveness, the evaluators specifically made an assessment of the costs of expatriate technical staff as compared to the alternative of hiring local expertise at much lower cost. Efficiency requires adequate management, adequate monitoring and an adequate and transparent accounting system in order to monitor expenditures, allow for timely adjustments and avoid leakage of funds and fraud. These issues were also assessed.

Sustainability refers to the potential to retain the achievements of health aid after major technical, managerial and financial assistance from the donor has ended. In this evaluation it includes an assessment of the extent to which the externally funded activities are embedded in the health system (institutional sustainability); an assessment of the extent to which policy issues have been incorporated in national health policy (sustainability in policy terms) and the extent to which programmes have been continued after withdrawal of funds, including the risk of 'brain-drain' of trained health staff (financial sustainability).

Impact refers to improvement of health status. An assessment of impact, in terms of *health outcomes*[6] of health programmes, is a methodological challenge. Impact is hard to measure for programmes with a broad range of health objectives and a variety of actors, including the recipient country government. Programmes can be judged as effective and efficient in terms of the objectives set and the resources utilised, without in fact contributing to improved health. Moreover, morbidity and mortality are determined by a complex array of factors in addition to health services. The most important are income, nutritional status, education, the status of women, and the quality of the environment, particularly access to safe water and sanitation. Changes in income, education, or access to transport and communications can alter attitudes towards health (e.g. breast-feeding, smoking, alcohol consumption, diet, exercise routines) and thereby influence health status even in the absence of health interventions. Furthermore, changes in the macro-economic environment can influence changes in demands for health goods and services, independent of any change in the health system itself. [7] As a result, evaluations can usually not prove a causal relation between health programme/project efforts and health outcomes.

This evaluation aimed to resolve this methodological challenge by assessing the effect of the health programmes on three types of intermediate factors:

- structure of the health system;
- performance of the health care system; and
- health seeking behaviour of the target population.

The assumption is that an improved health system structure contributes to a better performance of the health system; that improved performance contributes to better health behaviour; and that better health behaviour contributes to better health. For example, improved drug supply – an effect of the Dutch funded essential drugs programmes – will only lead to better health, if an appropriate drug distribution system exists, if drugs are available at an affordable price, if health workers prescribe the drugs properly and if patients use the drugs as prescribed.

Structure of the health system relates to infrastructure, supply and organisation of services.

6 Impact in this evaluation is measured in terms of a better health status. In public health terminology the term 'health outcome' is used for 'improved health status'. Therefore, in this evaluation, the term 'outcome' is used in a different way as it is in the evaluation terminology.
7 Stout 1997.

Performance of the health system is assessed on the basis of the following criteria:

- are interventions of proven clinical effectiveness;
- is the health care system responsive to client needs;
- is the financing system fair[8].

If health care is clinically effective, responsive and fair, it is likely to lead to increased utilisation by the population. Below the three aspects of performance are further operationalised for the purpose of this evaluation.

Clinical effectiveness involves how effectively and how appropriately health care providers administer medical or preventive procedures and advice. To ensure an appropriate level of clinical effectiveness, the health system should provide the most cost-effective clinical and public health interventions. These are defined as interventions with a large potential impact on health outcomes.[9] For this evaluation we will focus on the following key interventions.

KEY INTERVENTIONS[10]	ELEMENTS OF INTERVENTIONS TO BE ASSESSED[11]
Immunisation	• BCG at birth • OPV at birth • DPT at 6,10 and 14 weeks • Measles at 9 months • TT for women of child-bearing age
Maternal health and safe motherhood interventions	• pre-natal and delivery care
Family Planning	• a range of contraceptive methods available • information and education • correct use of contraceptives
Integrated management of childhood illness	• case-management of acute respiratory infections • case-management of diarrhoea • feeding/breast-feeding counselling • monitoring of nutritional status, feeding advice/supplementary feeding for malnourished children

8 *These criteria are put forward in World Health Organisation 2000.*
9 *World Health Organisation 2000.*
10 *These cost-effectiveness interventions was first calculated in the 1993 World Development report; the list in this table was derived from the above cited World Health Report (WHO 2000).*
11 *Adapted for each country field study depending on activities of projects evaluated*

- IEC on the need for immunisation, good nutrition, appropriate self-treatment, and adequate hygiene

Responsiveness of the health care system to clients' needs is a measure of how the system responds to *perceived* health needs including meeting or not meeting a population's expectations of how it should be treated by health staff. [12] Responsiveness is an important determinant of the degree of the health services' utilisation. Health care can be of excellent technical quality, but if interpersonal communication between patients and health workers fails, the clinically effective care has little impact on health. Health-seeking behaviour studies have shown that people avoid health services where they are treated rudely by health staff. Responsiveness includes respect for human beings as persons, and more objective elements related to how a system meets certain commonly expressed concerns of patients. Responsiveness can only exist when the health care providers are aware of the target audience's perceived health needs, local terms they use for common health conditions, cultural notions of aetiology and efficacy of treatments. Community participation in health care is a strategy that has proven to be effective in enhancing such responsiveness of the health system. Community participation requires and ensures that the target audience participates in information, education and communication activities, as well as in formulation, implementation and evaluation of the health care programmes.

Fairness. Fair financing in health systems means that the risks each household faces due to the costs of the health system are distributed according to ability to pay rather than to the risk of illness: a fair financed system ensures financial protection for everyone. There should be no discrimination by ethnicity, class, gender, age or marital status. A health system in which individuals or households are forced into poverty through their purchase of needed care is unfair. Paying for health can be unfair because families have to pay unexpected costs, such as the costs of gloves when in hospital to deliver a baby; or because payments are regressive, in that the least able to pay contribute proportionally more than the better-off. It is now generally accepted that fairness is greater in pre-payment financing systems, such as through taxes, social or voluntary insurance. The reality, however, in most developing countries is that patients pay out-of-pocket when making use of the health system. In fact, this is increasingly so due to the introduction of user-fees in many public health systems, even though there are usually attempts in such

12 *In defining this criterion we deviate slightly from the definition given by the WHO (2000). We have added the extent to which the health care meets perceived health needs; the extent to which it enhances community participation as key elements of responsiveness.*

systems to protect the poor by exempting them from payment. In this evaluation, the extent to which patients pay for services and for drugs was used to assess the fairness of the health system.

Ultimately health outcomes are determined by *behaviours* of individuals and families. Clinically effective, responsive and fair health care can be expected to enhance demand for services and improve compliance with medical regimes thus contributing to better health. This is only the case if the health care services, which are strengthened by the programme/project efforts, are indeed perceived to be of better quality of care and seen as meeting people's health needs. Most project/programmes aim to strengthen *public* health care services. These services have, in many developing countries, been in bad shape for a long time. Studies on people's health behaviours in developing countries show that they frequently self-medicate using medicines from informal drug providers, and that they value the quality of care provided in the private sector where business interests enhance the responsiveness of providers to clients' needs. The poor are less able to resort to the private sector than the rich, and thus more likely to self-medicate conditions of ill health. Good health care should ideally not only increase the utilisation of health services, but also encourages healthy behaviour, which prevents ill health, and ensure that people practice self-care appropriately. An increase in immunisation is an easily measurable indicator for health behaviour. It is also an important one. As immunised children are protected against disease, a positive health outcome is likely.

Poverty constrains people's capacity to behave in a healthy manner. If people lack resources for food, transport to health facilities and medicines, then even fair, responsive and clinically effective health care has little impact on health. Such situations occur in times of ethnic conflicts, war, drought, and among segments of the population which are severely impoverished. Ethnic tensions and civil wars not only affect health behaviour, but also negatively impact the structure and performance of the health services. Economic crises affecting many African countries widen the gap between the rich and the poor, leaving the poor more at risk for ill health and less able to pay for care.

This evaluation aimed ultimately to link the intermediate factors, as described, to positive *health outcomes* using a number of key health indicators, for which information is routinely collected in the health services. The relevant indicators were[13]:

13 Evaluators judged the value of the data available. Unfortunately the reliable data collected for Demographic and Health Surveys were not of use for this evaluation as the DHS data are not collected often enough to allow for the measurement of change related to the programme efforts.

- Under five and infant mortality rates. Decreases in under-five and infant mortality can reflect improved prevention, including immunisation coverage, and better treatment of predominant childhood disorders. It also can reflect better nutritional practices, including breast-feeding.
- Maternal mortality. Decreases in maternal mortality can reflect improved antenatal care, prompt attention in cases of obstructed labour and other delivery-related emergencies.

2.3 Scope

For logistical reasons, the number of countries included in the evaluation is limited to three. Mozambique, Yemen and Burkina Faso were selected on the basis of the following criteria: volume of money flow, range of programmes and avoidance of duplication of recent evaluations. Together, in the period 1995-1999, these countries consumed about 15 % of Dutch bilateral HNP support. In these countries the entire range of health, nutrition and population projects and programmes supported through the bilateral and multi-bilateral channel have been included in the evaluation, excepting a few projects which were either completed too long ago, were too small (< 50.000 Euros) or were terminated due to external events such as civil unrest. Table 1 gives an overview of the programmes and projects included in the evaluation.

In each of the three countries, a field study was carried out in one of the districts where a PHC programme operates, enabling focused data collection. Given the time-consuming character of this kind of research, it was decided that in each country only one PHC programme could be included in the field study: the Angoche programme in Mozambique, the Hodeidah urban PHC programme in Yemen and the Kaya PHC programme in Burkina Faso.

The choice of a focus on three countries implies that the evaluation results reflect the programmes and projects of those countries. The table shows that in all three countries, district level PHC programmes and a range of nation-wide health support programmes, including essential drugs, disease control and reproductive health programmes have been funded. These programmes are implemented in a general public health framework, enabling comparisons to be made.

The primary health care programmes included in the evaluation represent 36 % of total expenditure in this area; the ones included in the field studies account for 16 % of that

Table 1 Overview of the scope of the evaluation by type of programme/project

Country	PHC Programmes which strengthen district health structure and performance	Nation-wide health support programmes	Other health projects
Mozambique	Nampula health sector support (1997-2001)	Essential drugs programme (1994-2001)	Probeira local production of weaning food (1991-1998)
	Memisa primary health care project (1997-1999)	HIV/AIDS control (1995-2001)	Census Mozambique (1996-2000)
	Health care support programme in Angoche (1995-2001)	Leprosy control in Northern Mozambique (1995-1997)	
		Pooling agreement for technical assistance in the health sector in Mozambique (1995-2000)	
Yemen	Hodeidah urban PHC project (1993-2000)	Yemen drug action programme (1996-2001)	Mentally ill patients kept in Yemeni prisons (1996-2000)
	Aden Urban PHC project (1997-2002)	Community midwife training (1997-2001)	
	Dhamar rural PHC project (1993-1998)		
Burkina Faso	PHC project in Kaya sanitary region (1995-2000)	Central agency of essential drugs purchase (CAMEG) (1995-1998)	Study into sexual health needs (1996-1998)
		National tuberculosis control programme (1995-2000)	
		UNFPA reproductive health projects (1993-1997)	
		Integration of reproductive health in the curriculum of the national school of public health (1997-2000)	

expenditure. The essential drugs programmes account for 43 % of total expenditure in this health policy area. The other policy areas represent a much smaller part of total expenditure and results cannot be generalised.

2.4 Methods

In each country, the evaluation has been carried out in two phases. The *first or appraisal phase* included a description of national health policy and a description of the origins of the Dutch programmes and projects in the field of health, nutrition and population. Then, all the above programmes and projects were assessed in terms of their policy relevance, effectiveness, efficiency and sustainability. Methods used were document review and key informant interviews.

The contribution of these projects and programmes in terms of combating disease and death among the poor required a further assessment in terms of their so-called impact, that is health outcomes. This, in turn, required a population-based study and an assessment of the quality of health care provision, which was done during the *second phase* of the evaluation. The implementation of nation-wide essential drugs programmes in the areas concerned was also assessed in the field study.

2.4.1 *Methods for the first phase*

Methods used in the appraisals included:

- A review of policy documents. This review included documents on the health situation and on policy developments over the last decade.
- A desk review of all project/programme documents. For each of the projects and programmes, timelines were developed, and overviews of available project memoranda, proposals, and reports. The evaluation teams analysed these documents using the criteria mentioned above.
- Interviews with key informants were done to further evaluate donor support and programme and project efforts, in terms of effectiveness, efficiency and sustainability, and congruence with national and donor policy. Key informants were technical experts and administrators in the Dutch embassy, relevant health staff in the Ministry of Health of the recipient country, other health and development agencies including local UN offices, staff involved in the implementation of the project/programme, and experts in the field of health and health care working in Universities and NGOs, as well as organisations which represent the interests of the target populations of the projects/programmes.

- Review of secondary literature on the health-seeking behaviour and health status of the population. The key informants were asked if they have access to any relevant unpublished research, situation analysis and evaluation reports.

2.4.2 *Framework for the first phase*

The following table summarises the evaluation framework for the assessment of programmes and projects on the basis of documents and key person interviewing.

Table 2 Framework for the assessment of the entire range of health, nutrition and population programmes/projects supported in three selected countries

Evaluation Criteria	Issues	Methods
Relevance	• Extent to which programme/project addresses major health problems in the country • Coherence with national health policy • Coherence with Netherlands donor policy	Review of documents Review of secondary literature Key informant interviews
Effectiveness	• Extent to which programme/project objectives are realised • Adequacy of adaptations of objectives on the basis of monitoring and evaluation	
Efficiency	• Cost-effectiveness of programme/project, considering staff costs • Adequacy of management and transparency of accounting system • Adequacy of monitoring system	
Sustainability	• Likelihood that the initiated activities will continue when donor support ends (financial sustainability) • Likelihood that improvements in health care system are sustained (sustainability in institutional and policy terms)	

2.4.3 *Methods used in the field studies*

The following methods were used to collect information on the structure and performance of the health system, on health behaviour and health outcomes.

- Key informant interviews with district health planners, staff of health centres and hospitals, community leaders, and leaders of community organisations and NGOs.
- Focus group discussions with mothers of pre-school children and other relevant population groups (depending on the interventions to be evaluated), such as adolescents.

- Structured observations in the health centres to assess health system structure and performance.
- Client exit interviews on responsiveness and fairness.
- Review of health outcome indicators measured in the health information system.
- A general health survey, including focused recalls on the occurrence and treatment of target health conditions (ARI, diarrhoea) occurring in the past week. The focused recalls contributed information on actual health behaviour, including the use of medicines, and the utilisation of public health services.

2.4.4 *Evaluation Framework for the field studies*

The framework for the evaluation of the likelihood of impact used in the field studies is summarised in the table on page 22.

Table 3 Evaluation framework for the field study[14]

Criteria	Indicators	Methods
Improved health system structure (intermediate factor)	• adequacy of facilities and equipment • adequacy of health worker skills • appropriateness of manuals/training materials • availability of essential drugs, contraceptives and vaccines • adequacy of health information system	Key informant interviews Observations
Improved health system performance (intermediate factor)		Key informant interviews Observations Client exit interviews
Clinical effectiveness	• rational prescription of essential drugs • adequacy of antenatal and delivery care • adequacy of weight monitoring and nutritional advice • adequacy of immunisation services • adequacy of family planning services	Focus group discussions with clients
Responsiveness	• health workers show respect for clients • clean/private amenities • adequacy of IEC activities • adequate mechanisms for community participation	
Fairness	• charges for drugs/services affordable • implementation of exemption policies	
Improved health behaviour of target population (intermediate factor)	• increased utilisation of health services • perceived quality of care improved • adequate knowledge on nutrition • adequate treatment of common childhood disorders • decreased unmet need for family planning methods • increased percentage of immunised children • increased use of condoms	Household health survey Focus group discussions
Improvements in health outcomes	• decreased infant mortality rate • decreased under-five mortality rate • decreased maternal mortality rate	Health statistics Demographic health surveys

14 *This evaluation framework is inspired by the framework presented in Stout 1997.*

2.5 Limitations of the evaluation

2.5.1 *Attribution*

During the appraisal phase, it generally proved feasible to assess the effectiveness of national programmes. In most cases, it was not possible to relate the findings to the Dutch donor support provided.

In the field studies, it proved feasible to measure the intermediate factors: health system structure, health system performance and health behaviour. It proved impossible to measure changes in these factors and to relate them to changes in health outcome because:

- No baseline data existed for most health care performance and health behaviour indicators. We could only measure changes in the utilisation of health services.
- Infant mortality, under-five child mortality and maternal mortality rates had not been documented systematically over time in the districts studied.

These limitations demonstrate the difficulty in measuring changes in health outcomes and relating them to donor inputs, which aim at strengthening health system structure and performance.

2.5.2 *Representativeness*

The field study in Hodeidah covers all the health centres and is considered representative for the city. It is important to note here that, for pragmatic reasons, the field studies in the other two countries could not cover all of the programme areas. In Burkina Faso, the field study was carried out in one of the four districts of the sanitary region of Kaya. Here, one third of the health centres, selected at random, were included in the study. In Angoche, one of the four districts where the programme was carried out was included in the field study. The health centres were selected on a weighted basis of geographical distribution and levels of health facilities provided. In the selection of households though, random selection procedures were followed in all three studies.

3 Dutch policy in the field of health, nutrition and population 1980-2000

3.1 Introduction

This chapter contains an overview of Dutch policy and budget allocations in the field of health, nutrition and population. Policy memoranda, parliamentary documents, ministerial speeches, Budgets[15], instructions for conferences, additional literature and the ministerial management and information system have provided the background information. Paragraph two outlines a succinct history of international and Dutch health policy since the 1980's. Paragraph three describes Dutch policy guidelines for the major health policy areas and is followed, in paragraph four, by an overview of money flows in the period 1995–1999. Paragraph five describes the decision-making process at the Ministry of Foreign Affairs with respect to health programme support. The chapter concludes with a critical analysis of Dutch policy and money flows.

3.2 History

3.2.1 International policy

In the 1970's, the awareness was growing that health and disease were related to living conditions. Many of the poor, especially in remote rural areas, did not, and still do not, have access to food, education, safe drinking water and adequate sanitation and health facilities. As a consequence, they suffer from diseases that could have been prevented or treated at an early stage.[16] International aid and the national health budget in developing countries went mainly to fund hospital care and were not beneficial to the poor.
The international WHO/UNICEF health conference in Alma Ata in 1979 was a turning point and 'Health for All by the year 2000' became the objective. Based on experiences with village health workers in China and Latin America, a strategy was developed to reach

15 *Each year, the Budget is accompanied by informative memorandums (memorie van toelichting).*
16 *Bergstrom, S. 1994: 3-13.*

this target: the primary health care (PHC) strategy. This aimed at providing preventive and elementary curative services in those areas where the poor were living. The overall strategy was elaborated in the declaration of Alma Ata.[17]

By the late 1980's, international health policy started to change, with more emphasis being given to the organisation and financing of the health system. Several factors contributed to this shift, but at its source lay a number of studies showing that public resources in health were not used efficiently.[18] Primary health care proved to be not as cost-effective as initially foreseen. The programmes were donor-driven and not sustainable. In 1987, a WHO/UNICEF conference in Bamako determined that health systems, in order to be sustainable, should introduce cost-recovery mechanisms. The organisation of health care soon came to mean the re-organisation of the system, with health reform the watchword. The World Bank played an important role in this process and donors were henceforth encouraged to support Health Ministries in developing countries carry out health reform.

In 1993 the World Bank issued the World Development Report 'Investing in Health'.[19] This report introduced the concept of 'disability adjusted life years' (Daly), which enabled the different health burdens exacted by various diseases and disorders to be calculated and the cost-effectiveness of curative and preventive interventions to be assessed. It thus provided important criteria for priority setting in public health. This also marked the introduction of the 'minimal package of essential care' concept, which defined a minimum number of cost-effective services that public health authorities should guarantee to the poor. Other services could be delivered through private care providers, with health care involving both public and private sectors. The sector-wide approach was introduced as the organising principle.

In addition to these developments, a number of important conferences which took place during the 1990's also influenced international policy in the HNP field. The World Summit for Children in 1990 reiterated the need for child survival and development. The International Conference on Nutrition (ICN) in 1992 made clear that malnutrition was still a major problem, and that a multisectoral approach was needed to tackle the

17 *World Health Organisation 1981.*
18 *Stout 1997: 32-33.*
19 *The World Bank 1993.*

problem. In 1994, the International Conference on Population and Development (ICPD) pointed to the need to include reproductive health and gender equality in international health policy. The Social Summit in 1995 stressed the importance of basic social services for the well-being and development of the poor. In addition to these high level events, ministerial conferences were convened on malaria, tuberculosis and HIV/AIDS. All these summits and conferences concluded with declarations, listing numerous priorities and providing guidelines for their implementation.

3.2.2 *Dutch policy*

Dutch HNP policy also followed these trends, with primary health care becoming the guiding principle in the 1980's. A policy memorandum was drafted in 1986, providing guidelines for the implementation of health programmes and projects.[20] Though it was acknowledged that there was no blueprint for implementation, to be eligible for support a programme had to include the basic principles and components of primary health care, with due attention to intersectoral issues, like nutrition, hygiene and reproductive health. The 1991 general policy memorandum, 'A World of Difference', endorsed the emphasis on PHC and at the same time recognised the importance of health care organisation and the need for cost-recovery. It was explicitly stated that the introduction of cost-recovery should be accompanied by exemption mechanisms for the poor.[21] Gradually a tendency developed towards district level support for the health system, which included the institutional strengthening of public institutions. This focus on the district level was a logical step in countries where a decentralisation process was underway. Indeed, sectoral decentralisation often paved the way for political and administrative decentralisation. As from 1997, succeeding Budgets give informative indications of these changes. In that very year, a speech given by the Minister for Development Co-operation included programme support for Ministries of Health as one of the options in international health co-operation.[22]

In 1998, following new overall policy guidelines in Dutch bilateral co-operation, the sector-wide approach started to predominate. With its emphasis on the appropriate budgetary support of the recipient Ministry of Health, this approach responded both to the lack of ownership of the recipient country and to the problems posed by different individual donor regulations.

20 *Notitie gezondheidszorg 1986-1987.*
21 *Nieuwe kaders voor ontwikkelingssamenwerking: Een wereld van verschil 1990-1991: 195-203.*
22 *Ministry of Foreign Affairs 1997.*

A general policy memorandum was then drafted, pointing to the need for ownership, policy coherence and donor co-ordination. Though it did not contain specific health issues as such, it nonetheless encouraged responsible health programme officers into making efforts to reschedule previous projects and programmes within a framework of sector-wide support.[23] Zambia and Ghana provided successful illustrations of this process and served as examples as the approach became a part of overall Dutch policy. Key persons reported that the Netherlands also very actively promoted the sector-wide approach in international health fora. In the 1999 Budget, the emphasis on preventive and curative basic health care was reiterated, and sector support and donor co-ordination were mentioned as important contributions.

Some of the international summits and conferences which took place in the 1990's were followed by specific Dutch policy memoranda; these will be listed and summarised in the next paragraph. The ICPD was followed by a parliamentary decision to allocate 4 % of the budget to reproductive health. The Social Summit was followed by a policy decision to earmark 20 % of the budget for basic social services. From 1990-1999, these themes are mentioned as a priority in most Budgets.

3.3 Major health policy areas

3.3.1 Primary health care (PHC)

The principles and components of PHC are summarised in box 1. Equity is a key component of overall PHC strategy and, as diseases are caused by many factors outside the health system, emphasis was given to prevention and to intersectoral co-operation. Appropriate technology was another requirement, given the importance of community involvement in the provision of primary health care. Village health committees were considered an important vehicle to communicate health problems to the health authorities, and village health workers, persons living in the community who had received some elementary health training, were considered key players in the provision of PHC services. Ideally they were to be selected and remunerated by the community itself, and for people living in remote areas, they were indeed the first resort when health problems arose.

23 *Ministry of Foreign Affairs 2000.*

Box 1 Primary Health Care

Basic principles

- *Equity*
- *Community participation*
- *Prevention*
- *Appropriate technology*
- *Inter-sectoral approach*

Key components

- *Mother and child care, including nutrition and family planning*
- *Essential drugs*
- *Water and sanitation*
- *Immunisation*
- *Health promotion*
- *Elementary curative care*

Soon after the PHC programmes started to get underway, opinions began to differ as to how to implement the strategy: comprehensively or selectively. The comprehensive approach includes all components of primary health care, whereas the selective approach promotes intervention in one area, such as vaccination or family planning.

These principles were endorsed in a Dutch policy memorandum issued in 1986 and led to the comprehensive PHC approach being adopted. The importance of women as health care providers, both in the family and in the community, was also emphasised, especially as the inferior status of women in many societies negatively influences health and hampers development. Primary health care activities tended to either be implemented as separate projects or as components of integrated rural development projects. In the 1990 Budget however, the instruction came for PHC programmes to be increasingly supported independently, separate from rural development programmes. Over the period 1995-1999, all PHC programmes and projects were financed through the bilateral channel.

During the implementation of some PHC projects, a number of major problems occurred.[24] The community sometimes seemed to have less confidence in village health workers than did the donors giving financial support. The essential precondition for health promotion, namely good quality curative care at services level and preventive services at village level, was sometimes forgotten in the first burst of enthusiasm over the new health strategy.

24 *Examples provided in: Streefland & Chabot 1990.*

3.3.2 Disease control

Support for disease control programmes has a long history, both in bilateral and in multilateral co-operation. The most important programmes relate to the development, supply and distribution of vaccines, tuberculosis control, malaria control and river blindness control. With the exception of malaria control, no special guidelines have been drafted for disease control programmes.[25] In general, the recommendation is to integrate disease control within basic health services, though implicitly it is recognised that vertical structures are justified when the health services are weak.[26]

Within the framework of bilateral co-operation, tuberculosis control receives most support. These programmes follow international WHO guidelines concerning directly observed treatment with short course therapy (DOTS). For the other disease control programmes, support includes research into vaccines and drugs. From 1995-1999, this support was financed both through multilateral organisations and the country programme for social development. Instructions for the board meetings of research programmes contain statements on the need for research results to be beneficial to the poor and for products to be available at affordable prices. They also include a plea for operational and applied research.

3.3.3 Essential drugs programmes

Over the past twenty years, providing support to essential drugs programmes has been an important component of Dutch development aid. There are, however, no specific policy guidelines. In general policy documents and in speeches given by the Minister for Development Co-operation, it has been emphasised that the availability and rational use of essential drugs is a prerequisite for a well-functioning health system. Assistance has been provided for both commodity supply and for the implementation of an essential drugs policy. The Essential Drugs Policy programme of WHO (EDM) provides countries with the necessary technical support to implement these policies. Box 2 shows the various components of a national essential drugs policy.

In the implementation of essential drugs programmes, there has to be a balance between various components. In practice, the emphasis is often placed on procurement and sup-

25 *Notitie malaria, 1992-1993.*
26 *Nieuwe kaders voor ontwikkelingssamenwerking: Een wereld van verschil, 1990-1991: 202.*

ply; and yet without training in the rational use of drugs, the programmes are not likely to have positive health outcomes.

In international fora, the Netherlands has always argued in favour of the essential drugs concept, including the promotion of legal procedures to prohibit unfair drug advertising. Safeguarding the quality of drug donations has also been a policy issue since 1996. In 1999, the Minister for Development Co-operation made a plea for better private and public sector co-operation in the twin fields of vaccine and drug research and product distribution with a view to affordable pricing.[27]

Financial support is mainly channelled through the country programme for social development and to a lesser extent through multilateral organisations. The WHO essential drugs programme has received both a core contribution and a contribution earmarked for specific countries.

Box 2 National essential drugs policy

- *Legislation, regulation and guidelines for the pharmaceutical sector as regulatory framework.*
- *Selection of essential drugs, defined as those which satisfy the needs of the majority of the population and therefore should be available at all times, in adequate amounts and in the appropriate dosage forms. The list of essential medicine is generally published in a national essential drugs list and used for drug procurement in the public sector.*
- *Supply mechanisms, including procurement, storage and distribution of essential drugs to hospitals and health centres.*
- *Pharmaceutical quality assurance, which covers all the activities intended to ensure that the user of a drug receives a product that meets established specifications and standards.*
- *Rational use of drugs, which includes mechanisms to ensure that patients receive medications appropriate to their needs.*
- *Sustainable financing, including choosing the most appropriate financing mechanisms to ensure access to essential drugs.*

27 *Ministry of Foreign Affairs 1999b.*

3.3.4 *HIV/AIDS prevention and control*

Since the mid-1980's, the HIV/AIDS epidemic has expanded dramatically and this has led to HIV/AIDS prevention and control being included in Dutch development policy. 1993 saw the issue of the policy memorandum 'AIDS and Development Co-operation'[28], where AIDS is considered a development problem with poverty being the major cause. Dutch policy is aimed at both preventing the spread of the virus, and at non-discrimination and respect for the human rights of AIDS victims. The memorandum points to the dramatic effects of the epidemic for developing countries. The decrease in the number of productive survivors leads to lower food production, which can be the start of a vicious circle of malnutrition, disease and even lower food production. It is self-evident that the consequences of the epidemic for health expenditure are also disastrous.

Policy measures aim at the emancipation of the poor, with special attention for women. A multi-sector approach is encouraged in the policy memorandum, including awareness raising, education and promotion of condom use. Support for biomedical and social science research is also recommended. Other components of AIDS prevention and control are: capacity building in developing countries and care for people with AIDS and AIDS orphans. A pragmatic approach is advocated, including the utilisation of existing structures, both governmental and non-governmental.

Progress relating to HIV/AIDS prevention and control, including the financial flows to these areas, has been reported to Parliament on a number of occasions. The budget has increased substantially since 1995 and is channelled both through bilateral co-operation and through multilateral organisations. The Netherlands has been the major donor to UNAIDS, which was set up in 1996. In instructions for board meetings, it has been constantly emphasised that AIDS is not a health problem but a development problem.

3.3.5 *Reproductive health*

During the 1970's and 1980's, Dutch co-operation in the field of reproductive health was only channelled through multilateral organisations, specifically in the form of support to family planning programmes. The policy memorandum, 'A World of Difference', encouraged bilateral population and family planning programmes for the first time, with the Minister for Development Co-operation confirming the importance of these programmes

28 *Aids en ontwikkelingssamenwerking, 1992-1993.*

in a speech in 1992.[29] During the preparations of the International Conference on Population and Development in Cairo in 1994, the Netherlands played a very active role in the negotiations on the final declaration. Prior to the conference a policy memorandum was drafted, pointing to the objectives of Dutch policy in the field of reproductive health and providing guidelines for their implementation.[30]

The most important objective of Dutch population policy is to make population issues and reproductive health an integral part of Dutch development efforts and to help developing countries better understand the effects of population factors on the development process. A number of underlying principles have been formulated, such as the recognition of men and women's basic human right to decide how many children to have and when to have them, the importance of women's education and the recognition of women's physical, economic, cultural and social autonomy.

The memorandum also outlines which programmes are eligible for support. These include: activities to reinforce basic health care- of which family planning and reproductive health should be an integral part; programmes for those groups that are neglected in regular health services; information, education and communication activities; activities aimed at improving safe motherhood; prevention and control of sexually transmitted diseases; and supply and production of contraceptives. Training and research programmes also qualify for support.

In 1999, the Minister for Development Co-operation addressed 'The Hague Forum', organised five years after the ICPD, in order to review what had been accomplished and how to move forward. She mentioned several successes but warned that, though progress had been made, the implementation of the action plan of was still lagging behind. In her own words: "Women's and girls' right to health is still flagrantly disregarded from the cradle to the grave". The Minister confirmed that reproductive health would continue to be an important part of Dutch policy and indicated that she considered the role of non-governmental organisations especially important when it came to advocacy and reaching young people. Parliamentarians were encouraged to bring sexual and reproductive health issues into the public debate and to fight for proper legislation to give women access to land, economic resources and protection against violence.[31]

29 Ministry of Foreign Affairs 1992.
30 Ministry of Foreign Affairs 1994.
31 Ministry of Foreign Affairs 1999a.

Box 3 Reproductive health, ICPD 1994

Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirm in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child-birth and provide couples with the best chance of having a healthy infant.

The overwhelming majority of the reproductive health budget is made up of a contribution to UNFPA. Less than 20 % spent through the bilateral channel.

3.3.6 Nutrition

The International Conference on Nutrition (ICN) in 1992 made clear that malnutrition is still a major problem; 20% of the world's children under five are malnourished. Malnutrition is caused by a complex array of factors, such as deficient food production or access to food, unequal distribution of available food at household level, poor food quality and inadequate (health) care. These multiple causes make nutrition everybody's concern and yet nobody's responsibility.

The ICN gave a new input to the development of a policy on nutrition in the Netherlands, which was formalised in the 1995 policy memorandum 'Nutrition: Interaction of Food, Health and Care'.[32] The title already points to the fact that an adequate nutrition policy includes interventions in several areas and, indeed, to ensure good nutritional status, three conditions do have to be fulfilled: food, health and care. The most important objectives are: improving food security, particularly at household level; improving the total range of food produced for consumption; improving the quality of (emergency) food aid; promoting breast-feeding; promoting the local production of weaning food and; devoting increased attention to nutrition in health care. Health care should, of itself, promote breast-feeding, infant and child nutrition, nutrition during and after sickness, micronutrients, women's nutrition, reproductive health, and education and information.

32 *Ministry of Foreign Affairs 1995.*

The memorandum provides guidelines for programme implementation. Informed knowledge of both the local food and nutrition situation and national food and nutrition policies is required before the choice of a particular intervention can be made and programme support start. The recommended approach is a flexible one, which takes both short and long term effects into consideration. Carefully planned and implemented interventions will contribute to make nutrition everybody's responsibility.

Support is channelled both through bilateral co-operation and to an increasing extent through multilateral organisations. Internationally, the Netherlands has strongly promoted and supported breast-feeding and sought to prevent the advertising of breast-milk substitutes.

3.3.7 Health policy, basket funding and budget support

The policy memorandum 'A World of Difference' noted that results of primary health care programmes were disappointing. Bad economic conditions and low health budgets in developing countries were considered a major root cause of this disappointment and accordingly, a differentiated approach was recommended which took cultural aspects into consideration. The document endorsed the primary health care principles, but emphasised the need to invest in the improvement of the quality of care. As a consequence, recommendations were made to include training, health management and finance, logistics and the monitoring of services in future health support.

In the 1990's, health system organisation and health reform were given increased importance in Dutch policy. The 1993 World Development Report gave a further impetus in the same direction. In 1998, with the formalisation of the sectoral approach in bilateral co-operation, ownership, policy coherence and donor co-ordination became the watchwords, implicitly denying the need for specific Dutch HNP policy guidelines in bilateral co-operation. In 1999 at a meeting with health experts and programme officers responsible for health programmes at Dutch Embassies, the introduction of the sector-wide approach was discussed. This meeting was followed by a publication that elaborated the concepts used in this approach and presented the state of the art in the countries receiving Dutch support for health, nutrition and population.[33] Though this was not an official policy memorandum, it nonetheless became an important policy reference. The bilateral

33 *Dubbeldam & Bijlmakers 1999.*

channel accounts for almost all budgetary spending for health policy, basket funding and budget support.

3.4 Money flows 1995 -1999

Total HNP expenditure was 650 million Euros.[34] Over half was spent in the budget category 'country programme for social development' that mainly relates to bilateral co-operation. About 40 % went to multilateral organisations and the remainder to various other budgetary lines. Table 4 summarises the expenditure per policy area and per budget category. Activities on health, nutrition and population that are an integrated part of other programmes, such as rural development programmes, are not included in the table.

Table 4 Distribution of HNP budget (million Euros) 1995-1999 per policy area and budget category

Policy area/ Budget category	Country programme social development	Multilateral organisations*	Other**	Total
Primary health care	57.2	–	2.7	59.9
Disease control	55.8	20.4	0.5	76.7
Essential drugs	63.5	10.9	6.8	81.2
HIV/AIDS	36.8	25.4	4.1	66.3
Reproductive health	61.7	206.5	5.9	274.1
Nutrition	20.4	5.0	0.5	25.9
Health policy; basket funding; budget support	21.8	1.4	0.9	24.1
Other	24.1	0.9	17.7	42.7
Total	**341.3**	**270.5**	**39.1**	**650.9**

* *Mainly special programmes WHO and contribution UNFPA and UNAIDS*
** *Includes support for Surinam, subsidies to organisations and a number of activities in other budget categories selected on the basis of CRS codes (medical training; medical research)*

Source: MIDAS

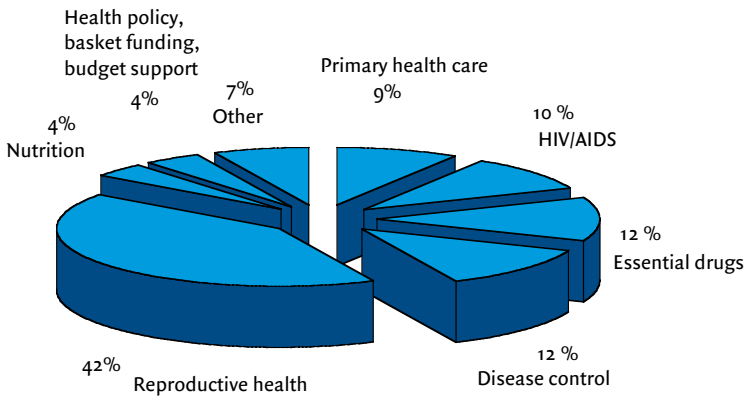
34 *All information in this paragraph is based on the management and information system of the Ministry of Foreign Affairs (MIDAS). Annex four provides information on data selection and processing and presents more details.*

The table shows that for all policy areas but one, the bilateral co-operation channel predominates. The exception is reproductive health, where the budget is largely spent on a core contribution to UNFPA (1995-1999 = 192.4 million Euros.) For the HIV/AIDS policy area, the multilateral channel is also important with UNAIDS receiving 21.8 million Euros in the period 1996-1999.

The policy area 'other' includes research and training that is not related to another policy area, for example support for a research institute. In the policy area 'disease control' 17 % of the budget was spent on research and in HIV/AIDS 23 %. In all other policy areas, only a minor percentage of the budget was spent on research. For all policy areas, training as a separate activity accounted for less than 5 % of the budget.

Expenditure in the budget category "other" goes mainly to the health programme in Surinam. The policy area 'other' accounts for a large part of this category. The reason is that the programme in Surinam has a special character, as costs for the treatment of patients with severe diseases as well as hospitals investments are included.[35] Figure 1 and 2 illustrate the relative importance of the respective policy areas for the overall budget and for the country programme for social development.

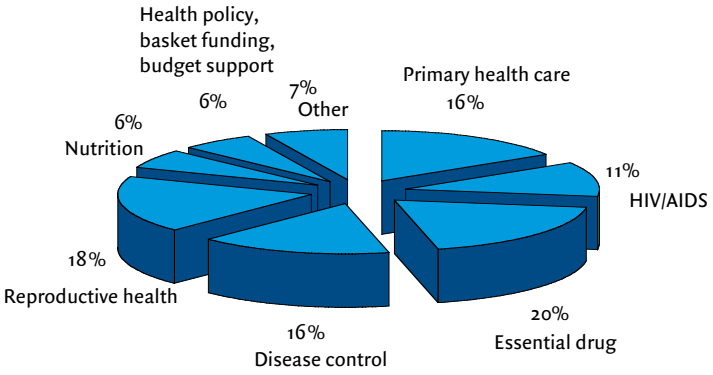
Figure 1 Total HNP expenditure per policy area 1995-1999



Source: MIDAS

35 The so called RLA procedure. Details on the budget categories, including the health support for Surinam, are presented in annex 4.

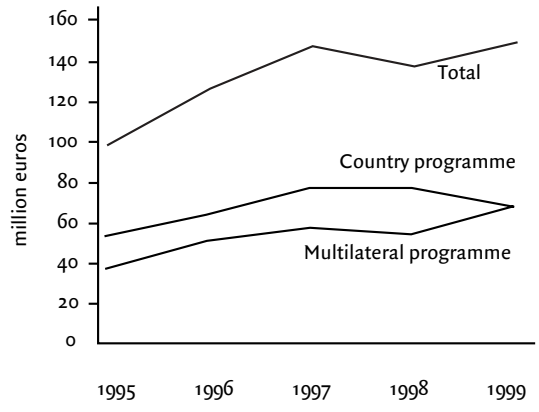
Figure 2 Country programme social development; HNP expenditure per policy area; 1995–1999



Source: MIDAS

The figures again show that reproductive health is by far the largest budget category and the major part of this budget is channelled through multilateral organisations. In the bilateral country programme on social development, the major policy areas of primary health care, disease control, essential drugs and reproductive health are almost equally represented, with 15-20 % of overall expenditure. The policy area HIV/AIDS accounts for 11 %. The two remaining areas, nutrition and the cluster 'health policy, basket funding and budget support' each account for 6%.

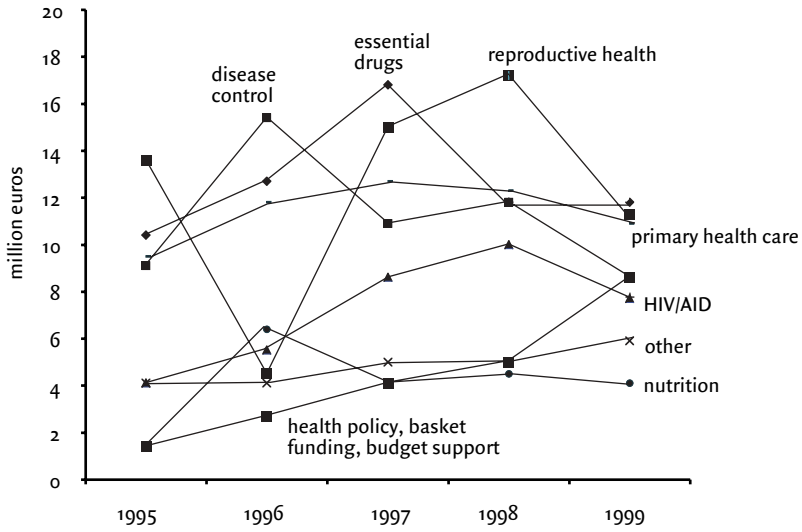
Figure 3 HNP expenditure; changes from 1995-1999



Source: MIDAS

Figure 3 shows the developments over the years. From 1995-1999 total expenditure increased by about one third. From 1995-1997 there was a steady increase, followed by a dip in 1998 and then by 1999 the budget had once again reached the 1997 level. If inflation over the years is taken into account, the budget has decreased in real terms in the three year period ending in 1999. The figure shows that since 1997 the relative importance of the multilateral channel has increased, whereas the relative importance of the country programme for social development has decreased.

Figure 4 Total expenditure in country programme social development per policy area; changes over the period 1995-1999

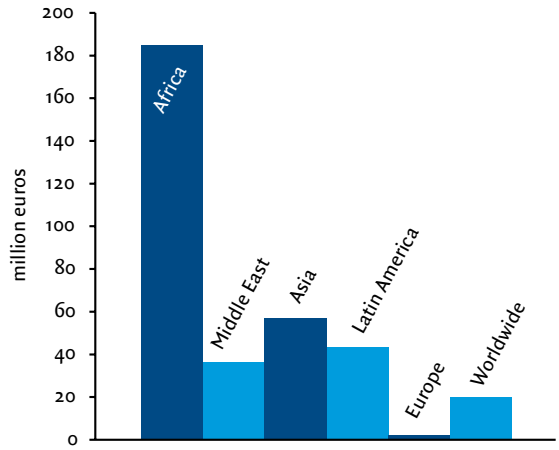


Source: MIDAS

Figure 4 shows expenditure changes for the different policy areas in country programme social development. The lines reveal that expenditure may vary considerably from year to year. Primary health care is rather stable and expenditure follows the general pattern shown in figure 3. Most other policy areas follow the general pattern, but show greater ups and downs and dips in years where expenditure is very low. Essential drugs expenditure increased from 1995 to 1997 and has dropped since 1997. The overall budgetary increase over the period 1995-1999 was mainly allocated to the policy areas 'health policy, basket funding and budget support', nutrition and HIV/AIDS. Expenditure in the field of reproductive health showed a slight decrease. For other categories, expenditure in 1999 was broadly equivalent to 1995.

Figure 5 shows the regional distribution.[36] Over half of the expenditure in health, nutrition and population went to sub-Saharan Africa.

Figure 5 HNP expenditure country programme social development; regional division; 1995-1999

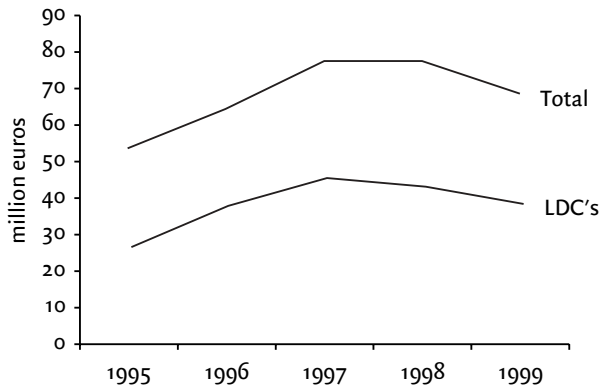


Source: MIDAS

Figure 6 shows the money flow over time to the least developed countries, compared to the general pattern. Of total HNP expenditure in the budget category 'country programme for social development', 204.2 million Euros went to the least developed countries. From 1995-1999, health support to these countries increased but not at a steady rate. A sharp increase from 1995 to 1997 was followed by a decrease in 1998 and 1999.

36 Clarification of the classification: Africa = sub-Sahara Africa; the Middle East = Egypt, the Palestinian areas and Yemen; Asia = Asia with the exception of Yemen and the category Latin America also includes the Caribbean.

Figure 6 Country programme social development; total HNP expenditure and HNP expenditure for the least developed countries; changes in the period 1995-1999



Source: MIDAS

3.5 Decision process

General policy guidelines stipulate that the support for programmes and projects should be demand driven. Previous to the reorganisation within the Dutch Ministry of Foreign Affairs in 1996 ("Herijking"), the decision-making power was at country desk level in The Hague, where the regional desk officers were responsible for bilateral support programmes. They were supported by an independent Technical Advice Unit, which included health expertise. Usually at the request of the Embassy in the countries concerned, a country desk commissioned missions to identify support areas, to formulate proposals for support and monitor and review implementation.

In order to be better able to respond to the demand and needs in developing countries, health experts were hired to reinforce Embassy staff, with the first health expert taking up his post in 1990 in the south of Africa. As from 1992, the number has gradually increased and by the end of the 1990's, almost all countries receiving health sector support had a health expert in the Dutch Embassy.

As from 1991, the Technical Advice Unit in the Hague was extended to include health, nutrition, reproductive health and AIDS expertise. They had an independent advisory role in the identification and formulation phase and an –obligatory – say in the approval

phase. Decision-making power for multilateral contributions in the field of HNP was at the level of the multilateral desk, with HNP experts in an advisory role.

In 1997 the situation changed and the Embassies were made responsible for the process of identification and approval of bilateral support programmes. Overall approval of yearly plans and budget allocation remained in the hands of the Ministry in The Hague. The independent Technical Advice Unit was abolished and the HNP experts transferred to a social policy division, which was responsible for, inter alia, health, nutrition, reproductive health, water/sanitation and AIDS. This division originally had the power to take decisions vis-à-vis the total thematic budget allocations and the overall process of year plan approval. The HNP experts remained as advisors, if asked, and as 'sparring-partners' for the health experts at the Embassies on the one hand, and for the multilateral desk officers on the other.

3.6 Analysis

Dutch HNP policy has followed in the footsteps of international policy, with the relevant health policy areas addressing the major public health problems of poor countries. For a number of health policy areas, policy memoranda have been drafted which include implementation guidelines. However, there are no decisions on how to assess the relative importance of one area in relation to another and only two written statements were found on money flows to the different areas. In the first, Parliament required that 4 % of development aid be spent on reproductive health; in the second, the Social Summit was followed by a decision to spend 20 % on basic social services. Since 1998 there has been an overall policy decision to either go for a sector-wide approach and budget support in bilateral co-operation provided certain conditions are met. This decision has not been translated in financial terms.

The impact of the 1986 PHC policy memorandum was considerable. Over the period 1995-1999 primary health care, and the closely-related area of essential drugs, continued to receive more bilateral funds than any other health policy area. Over the years, the focus of PHC programmes tended to shift towards the institutional level, including health system organisation and finance, and away from the provision of assistance in remote areas. This change has been referred to on occasion in a ministerial speech and in the relevant Budget, but no new guidelines have been developed for its implementation nor have previous guidelines been revised or renounced. The 1990 general policy memorandum is the only one to contain some remarks on this development, which include a clear statement

about cost recovery and the need for exemption rules for the poor. This policy has never been made operational.

The importance of the disease control and essential drugs programmes was described in the 1990 general policy memoranda and reiterated in later Budgets and ministerial speeches. No separate guidelines exist for them, with the sole exception of a 1992 policy paper on malaria, though implicitly, general WHO policy guidelines are followed. The money flow to disease control in bilateral co-operation has decreased since 1996.
The money flow to essential drugs increased from 1995 to 1997 and has dropped since 1997.

Most international HNP conferences held during the 1990's were either accompanied, or followed, by Dutch policy memoranda; and they all point to the importance of this health policy area. In the memoranda on nutrition and reproductive health, encouragement is given to both the integration of these areas within general health programmes and to the support for separate activities. The HIV/AIDS memoranda advocate a practical approach, using the channels most appropriate to the circumstances. Expenditure on nutrition and HIV/AIDS increased over the period 1995-1999, though the budget on nutrition remains low. From 1995-1999 reproductive health expenditure varied considerably on a year-to-year basis. No explanation could be found for this variation.

The money flow to the cluster 'health policy issues, basket funding and budget support' shows a steady increase from 1995-1998, followed by a rapid increase in 1999. This was due to the general policy decision to concentrate bilateral co-operation to a limited number of countries and to a limited number of sectors within these countries. In 1999 the figure was still low, with only 13 % of overall HNP expenditure in bilateral co-operation.

The general policy changes of 1998 were accompanied by two further changes in money flows to HNP programmes. Firstly, the budget for multilateral organisations increased at the expense of the bilateral co-operation budget. Secondly, health expenditure in the least developed countries decreased.

The 2000 general policy memorandum on the sector-wide approach provides general guidelines that also relate to health. This memorandum does not contain any information on the content of health programmes and was not accompanied by new health policy guidelines. The former guidelines were not retracted and no directives exist concerning

the integration of priority areas such as primary health care, reproductive health and nutrition in the sector-wide approach.

Emphasis is given to form and process, highlighting the importance of ownership, policy coherence and donor co-ordination. The understanding is implicit that, in the countries concerned, government policy should be followed, though the precise meaning of 'coherence' in health policy is not explicitly documented. Neither is it clear to what extent policy areas, such as nutrition, reproductive health and HIV/AIDS, should be integrated into the national health policies in developing countries as a yardstick for 'coherence' .

Summarising the findings, this review of policy documents and financial flows highlights the following:

- Dutch HNP policy documents address the major public health problems of the poor. From the mid-1980's to the late 1990's a gradual policy shift has been observed. The content of health policy and service accessibility were prominent in the 1980's, while the institutional level was neglected. The late 1990's, in contrast, saw greater emphasis given to the institutional level and the introduction of the sector-wide approach as a guiding principle.
- Policy guidelines on newly-introduced health policy areas have been added to existing ones, without clear guidance either on priority setting or on how to integrate them into existing policy. As the priority of any given health policy area varies substantially according to the circumstances, it is obvious that no specific financial directives are made. However, guidelines on how to weigh circumstances and priorities would facilitate choices.
- With respect to the country programme for social development, the budget allocation to most health policy areas shows considerable variations over the period 1995-1999. Except for the budgetary increase for the cluster 'health policy, basket funding and budget support' from 1998-1999, no explanations for these variations can be found in policy memoranda.

4 Mozambique

4.1 Health situation and health policy

Mozambique is a country that, since its civil war ended in 1992, has received relatively large amounts of support from a wide range of donors, including the Netherlands. The country is located in the south-eastern part of Africa and has about 17 million inhabitants, 60 % living in rural areas. It has a tropical climate. In 1999 and 2000 extreme rainfall caused severe floods that seriously damaged the country's infrastructure. In the post-war years after 1992, the peace process has brought stability and economic growth. The country experienced major changes, such as a process of liberalisation and, following general elections, the establishment of a democratic government.

On the human development index, Mozambique is located in the group of countries with low human development. It ranks number 157 on a list of 162 countries. The GDP per capita is US$ 230 per year, with an estimated 70 % of the population living in extreme poverty. The literacy rate is about 25 % for women and 50 % for men. About 60 % of the population use an improved drinking water source and 43 % have access to adequate sanitary facilities. Life expectancy is only 43 years. The major health indicators, summarised in table 5, are extremely unfavourable.[37]

Table 5 Health indicators in Mozambique

Indicator	Mozambique	Year
Infant mortality rate (/1000 live births)	127	1999
Under five mortality rate(/1000 live births)	203	1999
Maternal mortality rate (/100.000 live births)	1100	1996
Total fertility rate (amount of children per women)	6.1	1999
Percentage under-fives with underweight (< 2 SD median)	26%	1995-2000
Percentage infants with low birth weight	12%	1995-2000
Annual population growth	3.4%	1990-1999
Contraceptive prevalence rate	10%	1999

Source: UNICEF, The state of the world's children, 2001

37 UNDP 2001, UNICEF 2001.

Upon independence in 1975, the health system was in deplorable shape and health care in rural areas almost non-existent. The government then defined a health policy based on primary health care(PHC) principles; health services were expanded and special emphasis given to health promotion and prevention, including a number of vaccination campaigns. The control of endemic diseases became a priority and to counter the woeful state of the health system, particular attention was given to human resources development. The health system was nationalised and as a result, the planning and administration of services became highly centralised. Private practice and traditional medicine were forbidden by law.

The civil war in the 1980's forced many people to leave their homes and destroyed much of the health system. After 1992, displaced people were resettled and the soldiers demobilised. Since then, much of the health service has been rehabilitated, mainly with external financial support, and now an estimated 50% of the population has access to the health system. The aim has been to increase access to basic facilities to 70% by 2002, but achieving this target has been hampered by a shortage of well-trained staff, low salaries and unfavourable working conditions.

The period of general economic liberalisation which took place in the 1990's also affected the health system, with both the private sector and civil society coming to play a role. In rural areas though, it is the public health system which still remains by far the most important provider. A process of health sector reform was subsequently initiated to improve the quality of care and rationalise available means. The policies and strategies are developed at central level and their implementation at district level is supported by the provincial health offices. However, the role of community health has not been subject to policy definition. A 'fee for services' system has been established with very low fees. Traditional medicine is no longer forbidden and clients consider it important.

Many external agencies were involved in the rehabilitation of the health system when the civil war ended. The World Bank, the ADB and the Islamic Bank provided loans for the rehabilitation of the infrastructure and the training of human resources. Several bilateral donors also support the health sector: Switzerland, Norway, Finland, Denmark, Italy, the United Kingdom, Ireland, Canada, Japan and the Netherlands. USAID mainly provides support through international NGOs. The European Union is a major donor as well. WHO, UNICEF and UNFPA also provide assistance. In the period 1997-2001, the aggregate donor contribution to the health sector totalled almost US$ 300 billion. Co-opera-

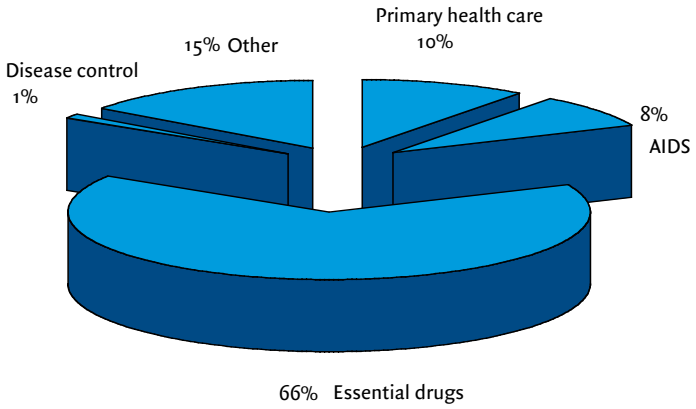
tion with some donor countries has been going on a long time, resulting in the co-financing of a number of programmes, such as the essential drugs programme and the pooling of technical assistance. About hundred NGOs, both international and national, are also active in the field of health, nutrition and population (HNP).

In the 1990's it was decided that, over and above providing support for national programmes, each of the major donor agencies should also be active in a different province of the country. By the end of the decade, this policy had changed and at present, most bilateral donors are moving in the direction of sector-wide support, with basket funding for several programmes. This support is channelled through the Ministry of Health, with whom donors meet on a regular basis.

4.2 Dutch support for health, nutrition and population

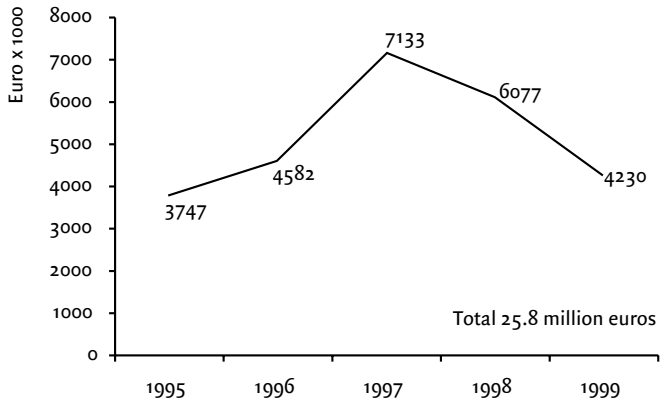
With the success of the peace process, Dutch support in the field of health moved from humanitarian assistance to the strengthening of the health system. In the period covered by the evaluation, 25.8 million Euros were spent on HNP. The Netherlands were the fifth largest donor in the period 1997-2001. Figure 7 shows the distribution of the budget among the main areas of support and figure 8 shows the expenditure changes over the years.

Figure 7 Mozambique; HNP expenditure; distribution over main areas of support



Source: MIDAS

Figure 8 Mozambique; HNP expenditure; timeline 1995 – 1999



Source: MIDAS

Two remnants of the post-war emergency consumed a large part of the budget during the period 1995-1999. The first of these was drug supply- in response to the drug shortage- and accounted for almost two thirds of the budget. This programme, though changed, is still ongoing and receives support from various other donors. It aims at improving the availability of essential drugs in Mozambique health services. The second remnant was the pooling agreement for technical assistance- in response to the severe staff shortage- and this accounts for slightly over 10% of the budget. This budgetary line has financed the salaries and related costs of foreign doctors and paramedical staff as well as a certain amount of training.

In addition to these post-emergency programmes, 8% of the budget has gone to a national HIV/AIDS prevention and control programme which has received support since 1994. HIV/AIDS awareness and increased availability and use of condoms are the major objectives of this programme. The implementing agency formulated a proposal on the request of the Ministry of Health and submitted it, among others, to the Netherlands.

At national level, support was also given to the census. As the reliable population data needed for proper planning were not available in the post-war period, Mozambique requested support for a census. The national statistical institute carried out the census in 1997 and UNFPA managed the funds.

Early on in the 1990's, Mozambican foreign aid policy was to concentrate the support of each of the major donors in different provinces in the country. The Netherlands started a programme in Nampula province aimed at poverty alleviation, which included rural development, drinking water and sanitation, urban development and health. Other bilateral donors and a considerable number of national and international NGO's also provided support in this province and co-ordinated their efforts on an ad-hoc basis.

The health component of the Nampula programme started with the support of several NGO's and technical assistance. As from 1996, preparations were made for long-term support and since absorption capacity was felt to be limited, the choice was made for a slow start and a gradual expansion. The idea was that the institutional strengthening of the provincial health office should be the core of the programme and that ownership of the programme should increasingly devolve to Mozambique.

In the evaluation, we have included four health programmes and projects implemented in Nampula province. Prindesa aimed mainly at institutional strengthening and was implemented by the provincial health office and DGIS, with the latter being responsible for the administration of funds.

The health programme in Angoche, implemented by Health Net International, was a follow-up to emergency assistance by MSF in the same area. The implementing agency submitted a request for funding. The Memisa project and the leprosy control programme for the Northern Region were also submitted by the implementing agencies. The budget for these four programmes accounted for about 10% of the 1995-1999 budget.

One project included in the evaluation, the Probeira weaning food production, is a bit an outsider. It has been carried out in Beira. It was a response to the high percentage of malnutrition and it has a long history of deliberations on the need of a local production of weaning food. The initiative was Dutch. Table 6 summarises the projects and programmes included in the evaluation. It could not be ascertained whether other, different, areas of support might have been initially considered as an alternative to the package that received support in the end.

Since 1998, policy changes in the Netherlands in favour of sector-wide approach have led to a policy of direct budgetary support for the Ministry of Health's health sector reform programme. This support is channelled through several pooling mechanisms; the drug

Table 6 Programmes and projects included in the evaluation

Policy area	Programmes and projects	Objectives	Budget (x million Euros)	Duration	Implementing agency
Primary health care	Nampula health sector support (Prindesa)	Improvement basic health care Institutional strengthening	2.5	02-1997 – 01-2001	Provincial health office DGIS
	Health Care Support Programme in Angoche Region (Angoche)	Strengthening health system	2.0	07-1995 – 05-2001	Health Net International
	Primary health Care in Erati, Memba and Nacaroa districts in Nampula province (Memisa)	Physical and functional rehabilitation of health care	0.4	11.1997 – 03.1999	Memisa
Disease control	Assistance to the leprosy component of the NTLCP (Lepra)	Decrease of leprosy prevalence and incidence	0.3	09.1995 – 12.1997	Netherlands' leprosy control foundation (NSL)
Essential drugs	Drug supply (Medicamentos)	Increase of drug availability Improved drug management	15.2	08.1994 – 03.2000	Ministry of health SGS[38] NIC[39]
HIV/AIDS	Communication and social marketing for AIDS prevention (PSI)	Increased availability and access to condoms	1.5	12.1994 – 12.1999	Population Services International
Reproductive health	Census Mozambique	Ensuring availability of demographic and socio-economic data	0.9	01.1996 – 06.2000	UNFPA
Nutrition	Local production of weaning food (Probeira)	Availability of affordable weaning food	0.5	07.1991 – 06.1998	Ministry of industry Royal tropical Institute
Other	WOZ Doctors Pooling agreement for medical and non-medical assistance (PATA)	Temporary fulfilment crucial medical vacancies Capacity building	2.8	01-1993 – 03-2000	Ministry of Health UNDP

Source: Documents and MIDAS.[40]

38 Societé General de Segurance
39 Nederlands inkoopcentrale (Dutch agency for purchase of goods)
40 The total amount is similar to the budget 1995-1999 in figure. In the table, expenditure before 1995 and after 1999 is included. In the figure expenditure of projects that did not meet the evaluation criteria is included. Coincidentally, the amounts involved are almost equal.

supply and HIV/AIDS programmes however, will continue to receive targeted support. The plan is for the Ministry of Health to continue receiving support in 2002.[41] It should be pointed out that since, over the period 1995-1999, less then 1% of funding went to budget support, it did not meet the criteria to be included in this evaluation. Despite the initial long-term plans for Nampula, at the time of the evaluation support for the Nampula programmes had either ended, or was about to end after the conclusion of ongoing activities. Further support for the province is foreseen, but it will take a different form and as yet, this has not been determined.

In conclusion, the programmes and projects are either targeted at directly improving the performance of the health system or at creating the necessary conditions for good performance. Thus the programmes and projects are complementary and make up a coherent package of health system support, when the input of other actors is taken into consideration. The implementation of such a package has the real potential to contribute to poverty alleviation.

4.3 Relevance

Programmes are considered relevant if they meet the needs defined in Mozambique's health policy. In general terms, all the programmes and projects were responses to the most urgent prevailing health problems and most were initiated at the request of the Mozambican authorities. The drug supply programme, the pooling for technical assistance, the census and the Nampula health support programme were all integrated into already defined government development plans. None of these programmes though, were directly administrated through government structures. The AIDS prevention and control programme was an initiative of the implementing agency (HIV/AIDS prevention is defined as a priority in the national health agenda).

The national programmes also received financial support from other donors and/or international agencies. The leprosy control programme in the northern region and the two PHC projects in Nampula were implemented by international NGOs. Though they were conceived and carried out in a cadre defined by the Mozambican health authorities. However, the degree to which the leprosy control programme is integrated within the national health system can be questioned, as support covers only the leprosy component of the national tuberculosis and leprosy control programme.

41 *Ministry of Foreign Affairs 2001, Yearplan Mozambique.*

The weaning food production was relevant at the time it was conceived. However, as both the socio-economic situation and Mozambican policy changed over time, this activity no longer corresponded to the new situation and lost its relevance.

Eight of the nine programmes and projects responded to priority needs and plans, as defined by the Mozambican government; hence they were relevant. Most programmes were also in line with Dutch HNP aid policy, with the exception of the pooling agreement for technical assistance. Here, most of the experts work at hospital level, which is no longer a priority in Dutch co-operation. Support has nonetheless been maintained over a long period at the request of the Mozambican authorities.

4.4 Effectiveness

Effectiveness was assessed by analysing to what extent the programmes' and projects' objectives have been realised. Where necessary, the feasibility of the objectives and the way in which they changed over time was also assessed. Lack of baseline data, the fact that the objectives were not always measurable and that result indicators were not specified, limited the possibility to assess effectiveness. Further constraints included weak or non-existent progress monitoring. Only some programmes and projects were independently evaluated.

Most programmes also received support from other donors. In such cases it is hard to assess the specific effectiveness of the Dutch support component.

In principle, the three PHC projects in Nampula province which received Dutch support were complementary; one (Prindesa) directed at institutional development at provincial level and the other two (Angoche and Memisa) directed at care quality improvement at district and community level. The Memisa project which aimed at providing technical assistance at district hospital level and implementing mother and child care, was terminated far ahead of plans, mainly due to management problems at the implementing agency. The objectives were not achieved; the project was not effective.

Prindesa, which aimed at the institutional strengthening of the Nampula health office (HO), started in 1998. At that time, the plan was for long-term assistance to the province with direct support to the provincial HO at the core of the programme. However, the programme had a separate staff. By 1999, after a delay in implementation that led to underexpenditure, and subsequent to a Dutch policy shift in favour of the sectoral approach, the first signs started to appear that the whole continuation of the programme was in doubt. A period of uncertainty followed, finally leading to a decision by the Netherlands at the end of 2000 to not continue the programme. This uncertainty and the later change of plan both negatively impacted the programme's effectiveness. A number of studies were carried out in the field of human resources, infrastructure, gender and community participation and their quality is good. However, the atmosphere of doubt and the false expectations of the district HO hampered the utilisation of their results. Several missions were also commissioned to discuss the future of the programme; as there was no future, these missions came to nought.

Other activities within the Prindesa programme *are* considered to have contributed in a positive way to the functioning of the health system. The provincial HO received assistance in planning and supervision, which resulted in a system of integrated supervision being set up and implemented. A strategic health plan was formulated. Several training courses, both at management level and at elementary health worker level, were carried out with funds from the project. The purchase of 19 cars and 20 motor vehicles greatly improved the transportation system.

To sum up: some improvements were achieved in the health system, such as better planning and the implementation of integrated supervision. Though the studies were of high

quality, they were less effective because of lack of follow-up. Neither the missions, nor the frequent discussions, managed to lead to acceptable proposals in favour of continuing the programme. But they did raise expectations at the Provincial Health Office that support would be continued.

The overall effectiveness of the Angoche health programme was limited. In the first phase the objectives were too ambitious and too broadly defined; they included improving both the health management and the planning and resolving capacity of the health services. These objectives were not achieved. The most positive results were in the area of training. The training of health workers at elementary and community level was carried out according to plan and key informants expressed their satisfaction with it. Data on the performance of the trainees is not however available. Health committees were also set up with support from the project, though only one is still functioning. During the first phase, health system research activities were carried out but with no tangible results.

After a mid term review in 1997, the objectives were more clearly defined and their number reduced. Infrastructure improvements have been successfully achieved and training activities continued. The effectiveness of the village health workers' and traditional birth attendants' training was hampered by the lack of a clear national policy on community health. During the second phase of the programme, an emergency fund for unforeseen activities was established. This has been used by the district health authorities to resolve urgent problems such as guaranteeing vaccine supply in times of shortage. Key informants expressed their satisfaction about the fund. An initiative was also taken to establish community health committees.

To sum up: with the exception of the training component, only a few tangible effects are visible. The results of the field study, summarised under the item 'impact', confirm these findings. Given that the health services are still sub-standard, it is clear that the major objective of the programme to improve the quality of care has not been obtained.

The leprosy control programme in the northern region was effective. It is a relatively small programme with well-defined aims that did not change over time. The detection of leprosy patients, their treatment with multi-drug therapy and the cure rate increased. But, lack of an adequate information system prevented us from verifying whether the 75% percent treatment compliance objective had been reached by 1997. It was found in the

field study that leprosy drugs were always available even in the health services which generally lacked supplies of essential drugs.

The effectiveness of the national programmes varied. The drugs supply programme, the pooling agreement for medical technical assistance, the AIDS prevention programme and the census project all responded to urgent needs. Of these programmes, the census and the AIDS prevention programme are the most effective. The drug supply programme and the technical assistance programme all made some positive contributions, in spite of the major shortcomings which were identified.

The drugs supply programme made funds available for the purchase of essential drugs (defined by the government). In 1999 the Netherlands financed around 10% of government drug expenditure and thus contributed to the potential availability of drugs for the general population. Another positive effect was the strengthening of institutional capacity at both the Health Ministry and the distribution agency, where procedures were improved and a management and audit system set up. On the downside, the availability of essential drugs in the periphery was, and still is, far from adequate. Systematic research into the availability of drugs throughout the country could not be done for logistical reasons, though the findings of the Angoche district field study, presented in the paragraph on impact, are illustrative. There are problems with the distribution system and leakage at different levels. Another weakness in the drug supply programme was the lack of attention paid to rational drug use. Prindesa organised a course targeting this issue.

The AIDS prevention programme succeeded in increasing the availability, sale and use of condoms at national level; in Angoche, however, usage still remained low. A practical plan of work was developed and carried out as scheduled and training, promotion and research activities implemented according to plan. The programme developed a monitoring system, with statistical data on the distribution and sale of condoms compiled in monthly and three-monthly reports. The household survey in Angoche did not confirm an increase of condom use at national level; although awareness of HIV/AIDS and the ways to prevent it was high, condom use was still very low.

The census data were summarised in readily accessible documents and distributed to the provinces. This census led to an improvement in the capacity of the executing agency (INE) as well as meeting the clearly defined, gender-related, objective of involving women in the process and giving them training.

The pooling agreement for medical and non-medical technical assistance was successful in the sense that the provincial reference hospitals had medical teams at their disposal in order to meet local needs. However a further programme objective, aimed at increasing local capacity through training, was not achieved. After identifying some major problems in the course of implementation, the objectives were adapted and appropriations changed to include the salaries of national and provincial health managers. However, the programme did not manage to increase institutional capacity at the Ministry of Health, nor to achieve proper planning of human resources utilisation. For these reasons, support has been discontinued.

The objectives of the local weaning food production project, known as Probeira, were formulated in a socio-economic context different to the one prevailing at the time of implementation. In spite of this, the objectives were not changed. As a result, there were no buyers for the food finally produced and at a certain stage severe problems and misunderstandings occurred between the project and the Ministry of Health. This project was ineffective.

In conclusion, the effectiveness of the programmes varied. In the census project and the HIV/AIDS programme the objectives were attained. In most other programmes, the objectives have been partially attained. In two projects, the objectives have not been attained.

4.5 Efficiency

The efficiency of the programmes and projects have been assessed using three main criteria: cost-effectiveness, programme management and the transparency of the financial administration. One of the items under the cost-effectiveness heading concerns how adequately expatriate personnel were used. The objectives and the scope of the projects and programmes vary substantially and as a consequence the comparison of expenditure in the different budgetary lines also shows great variations.

Looking first at the programmes implemented in Nampula, and starting with Prindesa, a relatively large part of their budget was spent on personnel, infrastructure and vehicles. The programme had a Dutch co-director and employed two foreign architects and a training advisor. It is not clear if the project tried to find Mozambican staff for other vacancies, but it did try in vain to employ Mozambican architects. Staff at the national health institute complained that an expatriate was selected for a training consultant vacancy. Besides international staff, the project also employed Mozambican technical and support

personnel. The justification for such a high number of project staff was the lack of institutional capacity at the health office, a situation that was supposed to change in the course of the programme. As there will be no follow-up phase, the employment of such a high number of persons has not been cost-effective. This is even more the case for several international missions that were specifically commissioned to formulate the follow-up phase. Delays in implementation, especially at the start of the programme, also negatively influenced overall efficiency. The financial administration is transparent and no serious cases of abuse have been detected.

The health programme in Angoche had only limited tangible results and thus low cost-effectiveness. A relatively large part of the budget (40 %) was spent on expatriate staff. Problems with the recruitment of staff, both international and national, occurred during the first phase. As a consequence the staff changed frequently, which further influenced the cost-effectiveness in a negative way. During the first phase the project had two offices, one in Nampula and one in Angoche. Considering the scope of the programme, this was not necessary and therefore not efficient. The financial administration is transparent and no irregularities have been detected.

The district health project in Erati, Memba and Nacaroa came to a close far earlier than planned, due mainly to serious management problems at the Memisa office. The initial investments did thus not bear fruit and the project was not cost-effective. Some technical experts continued working for the district after the project was closed down, and they were financed directly by the Netherlands. The financial administration was transparent and no major problems were revealed.

With a relatively limited amount of money, the leprosy programme succeeded in increasing the detection and treatment of leprosy patients; it is therefore cost-effective. The financial administration is transparent, providing regular financial reports. However, Mozambican counterparts mentioned a lack of transparency. At local level, there was a report of funds being abused but this could not be verified. Monitoring is done via the yearly visit of a representative from the Dutch implementing NGO- NSL – and a representative of the national tuberculosis and leprosy control programme. Health workers perceived this supervision as very supportive.

In the drug supply programme, international companies were used for procurement and quality control. We were unable to make a comparison between the costs involved in

using these companies and those that would have resulted from following mechanisms already established in Mozambique and accepted by other donors. At the start of the programme institutional capacity building was not incorporated in the programme and this had negative consequences in terms of efficiency. However, at a later stage this component *was* introduced successfully. Serious cases of abuse were detected in 1997, especially concerning the distribution of drugs that are not distributed in kits, the so-called 'via classica'. A portion of these drugs, which were intended for use in the public sector, ended up in the private sector. In 2000 serious problems with drug distribution in Nampula were detected and staff had to be changed as a consequence. The field study in Angoche showed that essential drugs are not available at health centre level. Abuse still clearly exists, although the evaluation could not assess at what scale it took place on a national level.

The AIDS prevention programme succeeded in gradually decreasing indirect costs for personnel from 50% in the pilot phase to somewhat less than 40% by 1999. By then, only one expatriate staff member was employed. As condoms are free and do not figure in the budget, it is not possible to estimate the real percentage of personnel costs. The stock and sale of condoms are monitored on a regular basis. The financial administration is transparent and yearly audit reports are available. In 1997 a serious case of fraud was detected by the implementing agency PSI, involving employees of the implementing agency and bank personnel. Adequate measures were taken to avoid repetition.

The census project attained its objectives with the funds available. In the provinces reports came in that funds had been used for activities other than planned. An audit report, issued in May 1999, considered these expenses justified.

As the weaning food production programme was not effective, it was not cost-effective either. A large amount of the budget was spent on technical assistance. Various missions were commissioned to modify the plans but failed to take into sufficient consideration the changing political environment. No problems were apparently detected in the financial administration.

The pooling agreement for technical assistance also faced efficiency problems, though of a different order. As the important human resources development component of the programme was never realised, cost-effectiveness was perforce limited. Although a trust fund account existed, UNDP reported separately to the different donors, as per donor require-

ments. This is not an efficient procedure. No irregularities were detected in the financial administration.

In conclusion, only a few general observations can be made on the efficiency of the programmes due to their great variation. Three programmes were efficient. Most other programmes and projects showed weaknesses either in cost-effectiveness, management, financial administration transparency or in all of these elements. In some cases the mere lack of results influenced the cost-effectiveness. The budget of the programmes and projects was generally sufficient for the activities planned; but these same activities were not always actualised. In some programmes/projects, funds were made available after a long delay with negative consequences for cost-effectiveness. In some programmes serious management problems occurred and in others abuse of funds was detected.

4.6 Sustainability

Sustainability has been defined as the potential to retain what has been achieved in the projects and programmes after withdrawal of the donor's technical and financial assistance. In order to be sustainable, a programme should be integrated into the health system, be viable and also contribute to the improvement of the system. However, taking the socio-economic situation of the country into consideration, it is not realistic to expect that the health system to function without external support in the near future. So, one has to distinguish between financial sustainability, institutional sustainability and sustainability in terms of long term viability. What was remarkable, was that none of the programmes/projects included a strategy for phasing out after the withdrawal of external funds.

Only two of the nine programmes and projects included in the evaluation were still being implemented when the evaluation was carried out: the drug supply programme and the AIDS prevention programme. Changes in Dutch development co-operation in favour of a sector-wide approach influenced the decision not to continue support for the Prindesa, Angoche and the leprosy control programmes. Support for the pooling for technical assistance was supposed to be integrated in the sector-wide approach, but at the time of the evaluation this had not yet been realised. Support for the census was temporary by definition and stopped when the census had been concluded. Lack of results led to the termination of two projects: the Memisa district health programme and the local production of weaning food.

The sustainability of the basic health programmes and the leprosy programme in Nampula was limited. Prindesa aimed at the institutional strengthening of the health office and attained some sustainable results, such as the realisation of integrated supervision and the development of participatory planning. On the other hand, in spite of the first phase initially being seen as a preparatory one, many investments were not subsequently given any follow-up. As expectations had been raised that this was a programme of long-term support to the health sector, no other funding had been sought and no exit strategy included in the proposal. The financial sustainability: low.

The health programme in Angoche faced a similar situation. When it became clear that the programme would not be continued, the implementing agency started to look for other funding- without success. In institutional terms, sustainability varied. The professional capacity of health workers improved; yet lack of a clear Ministry of Health policy on community health prevented the best use being made of village health workers' knowledge. Drug supply is inadequate and no proper remuneration is provided to the village health workers, which limits their role in community health. These factors led to a decrease in sustainability. For traditional birth attendants the situation is somewhat different, as they are able to apply the knowledge acquired during training. Some of the programme activities have been incorporated into the district health system or at community level. Others have not, as they were not defined as priorities by the community or by health workers. An example of this is health system research. The Memisa district health project ended long ago. Some elements are reported to be integrated in the health system. The overall sustainability though is very low.

The leprosy programme contributed to the implementation of a national health programme and in that sense, sustainability at policy level is guaranteed. It also increased the institutional capacity of the health services. In financial terms though, the programme is not sustainable. After withdrawal of Dutch bilateral funding, the implementing agency continued its support to the national programme with its own funds.

Given the socio-economic situation, it is not realistic to foresee an adequate drug supply without external funding. However, the Mozambican government has increased its participation in the procurement and purchase of drugs. In other words the financial sustainability of the programme has improved. Attention has been paid to the improvement of procedures and mechanisms for administration in the later stages of the programme, contributing to institutional sustainability.

The AIDS prevention programme has contributed to increase the importance of HIV/AIDS in the health and development agenda. The programme is part of the national strategy for AIDS prevention and control. From a financial point of view though, the programme is not, and does not aim to be sustainable.

As the census is an event that will not be repeated over the short term, financial sustainability is not an issue. Mozambique contributed about 10% to the whole exercise. A large number of technicians have been trained and they carry out surveys on more specific issues: institutional sustainability is therefore high. For the pooling agreement the situation is less positive. A human resources development plan has never been made and consequently the institutional sustainability is low. As yet there has been no transition of funds for technical assistance into the sector-wide approach.

4.7 Impact

In this evaluation, impact is defined in terms of likely impact. It is assumed that improvements in the structure and performance of the health system, as well as in the health behaviour of the population concerned, will lead to a better health status. Health system structure is measured by: infrastructure, supplies and the organisation of health care. Health system performance is measured by: the clinical effectiveness of the interventions, the responsiveness of the system and the fairness of the system. Health behaviour is measured by: service utilisation and health practises.

For a limited number of programmes included in the evaluation, these issues have been researched in a field study in the Angoche district. Here the international NGO, Health Net International (HNI), has been implementing a health programme at both services and community level over the last five years aimed at improving the quality of care. The Aids prevention programme, the national drug supply programme, the regional leprosy control programme and the Nampula health support programme have also been assessed in the field study. Given that those programmes are of a much wider scope, the results of the field study are only illustrative for the findings of the document appraisal and key person interviews. As was pointed out before, hardly any baseline data exists and it was therefore difficult to trace changes.
The field study is based on:

- the inspection of the health services
- interviews with the staff of five health centres and posts
- interviews with community health workers

- 61 client exit interviews
- a survey among 101 households.

Infrastructure, equipment and organisation of services

In very general terms, the structure of the health system in Angoche has been improved over the last five years. As HNI supported the rehabilitation of some of the health centres and also supplied equipment and means of transport, some of these improvements are due to their input. However, inspections of the health centres showed that no systematic maintenance activities are being carried out. Part of the equipment was not functional and the cleanliness of most centres was found to be sub-standard. The programme's contribution of one car and two motorbikes has slightly improved the transport picture, but taken overall, the situation is still far from desirable. Maintenance is insufficient and, given the distances that need to be travelled in the district, lack of means of transport and communication remains a serious problem.

Drug supply at the health centre and community health worker level is weak. On paper, a well-defined system has been worked out for the distribution from the port to Nampula, from Nampula to the districts and from the districts to the health centres and community health workers. However, this is theory and in reality the system is far from working smoothly. At health centre level most pharmacies were empty, with even aspirin and chloroquine not being available. Vaccine availability was also inadequate.

The following findings are illustrative:

- Provision of drugs at Nacala harbour (a coastal town in Nampula province where drugs arrive by boat from Maputo) is rarely on time – this is the first delay in drug provision to the districts, with further delays occurring at each step in the system. Systematic delay in provision makes control and planning all the more difficult.
- The quantity of drugs provided is always insufficient; 'reserve' stocks hardly exist at any level of health care.
- The distribution of drugs to the districts does not function well – mainly due to transport problems. There is only one vehicle available for this and it is also used for other purposes. This explains the irregular distribution of drugs from the district centre to peripheral health units. When drugs are not supplied, health workers at times take private transport to the district town to fetch the drugs.
- Recently, a batch of kits was withdrawn because drug quality had deteriorated during transport: Kanamicina with fungus contamination was detected; and the medicines

were delivered in different dosages to those specified by the Mozambican health system. The fact that this failure was detected in timely fashion points to good quality control. However, the consequences were severe, as kit distribution was suspended.

Due to the problems in drug supply and quality, there have been regular interruptions in drug availability over the past four years. During the period of field observation (30 May- 5 June 2001), all the health centre pharmacies were virtually empty; even chloroquine and aspirin were not available. The following matrix summarises the observations made.

Box 4 Availability of drugs in health centres

Rural Hospital of Angoche	*In April/May 2001, there were ruptures in drug supply lasting at least one week for chloroquine, aspirin, paracetamol and penicillin*
Health Centre Namitoria	*In April/May 2001, the health centre only had aspirin and choroquine available, nothing else*
Health Centre Inguri	*In February/May 2001 and April/May 2001, for periods of one to two months, only vitamins and ORS were available*
Health Centre Namaponde	*In April/May 2001, for the period of two months, only ORS and ferrous sulphate was available*

The drug supply situation in Angoche seemed to worsen rather than improve over the period 1998-2001; the timeframe during which the Mozambique Essential Drugs programme received support from Dutch Development co-operation. Community health workers reported that on average they received six to eight kits in 1998; only three kits in 1999; and only one kit in 2000 and another one in 2001. The last kit supplied in 2001 was empty after 45 days.

A substantial number of training courses for health professionals and community health workers were organised with the support of HNI, Prindesa and the leprosy control programme. The training materials were adapted to the local situation and made available in the health facilities; apparently they were barely used. An integrated supervision system has been established and some supervision carried out during the last year, though to a lesser extent than planned. Health workers appreciate the training and the supervision and are of the opinion that both their motivation and the quality of their work has

improved. However, the lack of equipment, drugs and transport means that they are not getting the most out of their training.

The number of consultations and the vaccination coverage are registered at health services level. Data is provided to the district office but is not used for monitoring.

Clinical effectiveness of interventions

In the health centres there is hardly any health promotion material available. Preventive services for antenatal care and childcare are provided, but as only a few of their clients were interviewed, the quality of these services could not be assessed. The quality of curative services could be assessed. As a general rule, health workers follow the treatment norms and prescribe essential drugs. However, clinical effectiveness is dramatically lessened by the frequent unavailability of these drugs. Lack of transport hamstrings adequate and timely reactions to obstetric urgencies. Data from a previous survey was used to assess the village health workers' performance at community level. In general terms this study revealed that village health workers do indeed implement the knowledge obtained during training and that their role in the community is much appreciated. At the time of the evaluation, the absence of a community health policy coupled with a lack of supplies hampered their performance.

Responsiveness of the system

Clients reported that health workers both approached and treated them with respect. Half of the clients said that they had to wait less than half an hour before being attended to. The evaluation team had their doubts about these positive results, feeling that an element of bias might have been introduced by conducting the client interviews at the health centres.

Fairness of the system

Fairness was assessed looking into the prices clients have to pay for consultation and for drugs. Preventive consultations are free; for curative consultations a symbolic fee has to be paid. Drugs should be sold at low, established and uniform prices. In general, the field study revealed that if drugs were available, they could be obtained at the fixed price. However, as drugs hardly ever were available at the health centres, they had to be obtained elsewhere at high cost, either from private pharmacies or on the black market. There are no exemption mechanisms for those who cannot afford to pay the high market prices.

Health behaviour

The household survey revealed that the utilisation of public health services among the population is high, a finding that has been confirmed during the visits to the centres. One major reason for this is the relative absence of private sector health care facilities in rural areas of Nampula province. As compiled data was not available, changes over time could not be ascertained.

The majority of women interviewed had their last delivery in a health centre, assisted by a trained midwife. About 40% of the mothers (40/101) expressed the wish for birth spacing and half of them (21/40) used modern contraceptives.

Mothers exclusively breastfed their babies until the age of four months, in line with national guidelines. They take their children to the centres for vaccination. However, except for BCG, a large number of children were not completely immunised.

In 75 of the 101 household interviews, at least one of the under-fives was found to have been ill in the month preceding the interview. Malaria, cough and diarrhoea were most frequently mentioned and some children had more than one illness. The aggregate total was 115 episodes of illness.

For all children, treatment was sought at the health centre and 73 children received a prescription. For two thirds of the children drugs were purchased; only 21 of the 53 households that bought drugs for their children could buy them in the health unit. For adults the numbers are somewhat different. Twenty-three adults had been ill during the month before the interview, 22 received a prescription; 21 bought drugs, ten at the health unit.

The data on health behaviour confirms the findings of the exit interviews. The population frequents both the health units and the village health workers. Weaknesses in the health system though, especially the lack of drugs and equipment, prevent the provision of proper quality care. Despite this people continue to visit the health services. The advice given is apparently valued and they have few other options.

Box 5 Health care utilisation, drugs prescription and drug consumption in 101 households

	Under-fives	Adults
Sick	75	23
Health centre consulted	75	22
Prescription	73	22
Drugs bought	53	21
Drugs bought in health centre	22	10

Turning to HIV/AIDS, Angoche has been one of the priority areas of the Population Services International (PSI) programme. The extent of preventive knowledge and practice was assessed in the household survey.

Almost all persons interviewed had heard about HIV/AIDS, mostly by radio. Only one person interviewed had actually attended the theatre play promoted by PSI as an advocacy tool. Knowledge about ways to prevent the disease was rather limited. Slightly more than half the people interviewed recalled preventive means; of which condom use and staying with only one partner were most frequently mentioned. Out of the 101 persons interviewed, 76 had heard about condoms, 46 knew where to obtain them and 5 had condoms at home at the time of the interview. Focus group discussions confirmed the two elements of widespread knowledge about HIV prevention and low use of condoms. Men said that women did not want to use condoms and women said the opposite. Utilisation among the young is somewhat higher than among older people.

Data on health outcomes are not available. Failures in the health system structure, such as lack of drugs and vaccines at services level, hamper the clinical effectiveness of the interventions and thus the entire performance of the Angoche health system. Given the generally weak performance of the health system, it is not likely that programme efforts have led to much progress in this field.

4.8 Conclusion

The overall picture of this evaluation is a diverse one. Almost all the programmes met the health needs defined by Mozambique and thus potentially contribute to poverty reduction. At the time of their conception, the programmes were also in line with Mozambican

health policy and therefore relevant. With regard to effectiveness, most programmes and programmes showed both weaknesses and positive results.

Highlights of the national health programmes are:
- the improved drug management capacity at national level
- a growing awareness of HIV/AIDS and increased availability of condoms
- the publication of census results.

Highlights in Nampula province are:
- the improved planning capacity at the provincial health office
- the improved case management of leprosy patients.

Weak points in the national health programmes are: drug leakage in the distribution pipeline and the absence of a human resource development plan. The most important weakness in the Nampula programmes was that despite serious efforts to improve them, the quality of services still leaves a great deal to be desired.

With regard to efficiency, a number of programmes showed but little cost-effectiveness and a few had problems with transparency. As far as sustainability was concerned, some programmes- such as the drug supply programme and the Nampula health support programme- contributed to improved institutional capacity and are considered sustainable in institutional terms. In financial terms, due to the socio-economic situation in the country, the situation is less positive.

The findings on likely impact, as measured by changes in the structure and performance of the health system performance together with health behaviour, showed some positive results. However the health system is still weak, both at services and community level, with lack of drugs remaining the major problem. Impact in terms of improved health outcomes is likely to be very limited. The evaluation results are summarised in the following table.

Table 7 Summary of evaluation results in Mozambique

Programme	Highlights and weak points	Relevance	Effectiveness	Efficiency	Sustainability	Impact
Nampula health support	s Availability institutional assessment s Improved planning capacity t Study results hardly utilised	++	±	±	–	–**
Health care support in Angoche	s Training of health staff and community health workers t Low quality of care t Inappropriate community health	++	±	–	–	–
Primary health care in Erati, Memba and Nacaroa	t Serious management problems	++	–	––	NA	NA
Leprosy control	s Increased case finding and treatment	±	+	++	±	NA
Drug supply	s Increased drug supply and improved management capacity t Inadequate drug distribution and unavailability of drugs at health services level	++	±	±*	±	–**
HIV/AIDS control	s Increased awareness on HIV/AIDS s Increased condom supply	++	++	+	±	±**
Pooling agreement on technical assistance	s Medical staff available in post -war situation t Human resources development plan not realised	++	±	±	–	NA
Census	s Availability of demographic and socio-economic data	++	++	++	NA	NA
Weaning food production	t Inadequate reaction on policy changes	±	–	–	***	NA

* Could only partially be assessed at national level. In Nampula, efficiency was low.
** Impact only measured in Angoche district
*** Could not be assessed.
NA: not applicable

5 Yemen

5.1 Health situation and health policy

Located in the southern part of the Arabic peninsula, Yemen has a long-standing history of international co-operation with the Netherlands. The Republic of Yemen, as it is known today, was founded in 1990 after the re-unification of the southern and northern parts of the country. After a rapid population increase in the early 1990's due to the forced return of many Yemeni, the country now has about 17 million inhabitants with 75 % of them living in rural areas. In 1994, a period of civil unrest wrought serious damage on economic and social development nation-wide. After a reconciliation, various administrative, economic and political reforms were introduced, resulting inter alia in a process of decentralisation.

On the human development index, Yemen is number 133 on a list of 162 countries. In other words, it has a low level of human development. GDP per capita is 350 US$ per year and over the 1990's, the number of people living in poverty has increased. The literacy rate is about one third for women and two thirds for men. Slightly over two thirds of the population uses an improved drinking water source and 45 % has access to adequate sanitary facilities.[42] The major health indicators, summarised in table 8, are unfavourable. Life expectancy is 57 years.

Yemen adopted the primary health care approach in 1978, though at the time the country was still divided into South Yemen and North Yemen. In the South, the public health system was important, whereas in the North, the state was less present in the health sector and private health providers played an important role. After re-unification in 1990, the primary health strategy remained in place for several years, however the results it obtained were less than expected. In the 1990's, following the trend in international health, the need for health sector reform was discussed and in 1998 a health sector reform strategy was accepted.

The health sector document reported a gradual expansion of nation-wide health service coverage from 10 % in 1970 to 50 % in 1998. This was accompanied by a proportional

42 UNDP 2001.

Table 8 Health indicators Yemen

Indicator	Yemen	Year
Infant mortality rate (/1000 live births)	86	1999
Under five mortality rate(/1000 live births)	119	1999
Maternal mortality rate (/100.000 live births)	350*	1996
Total fertility rate (amount of children per women)	7,3	1999
Percentage under-fives with underweight (< 2 SD median)	46%	1995-2000
Percentage infants with low birth weight	19%	1995-2000
Annual population growth	4,6%	1990-1999
Contraceptive prevalence rate	21%	1999

* Data on maternal mortality vary substantially in different sources.

Source: UNICEF, The state of the world's children

increase in health manpower. However, a number of major problems were observed: deficient service quality, low utilisation of services, low staff morale, lack of essential drugs, lack of equity in the distribution of health resources and poor efficiency of organisational and managerial structures.[43]

Health sector reform takes place within the overall context of government reform, including democratisation, decentralisation, civil service reform and financial restructuring. This process will support, and in turn be supported by the health sector reform. The long term objectives of health sector reform are: universal access to health services, equity in both the delivery and financing of health care, improved technical efficiency of the service delivery system, improved quality of health services and the future sustainability of the system.
Key elements of health sector reform include:

- decentralisation
- redefining the public sector's role in a health system environment where the private sector is an important player
- a district health system approach
- community co-management of the health system
- cost sharing
- an essential drugs policy

43 *Ministry of Public Health Yemen 1998.*

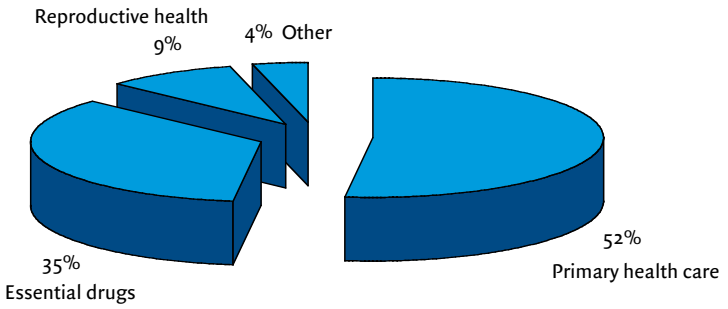
- inter-sectoral collaboration
- a sector-wide approach to donor funding and programming, with a strong role for the Ministry of Public Health in co-ordinating donor assistance.[44]

Only a few bilateral donors actively support the Yemeni Ministry of Public Health. Multilateral agencies specialising in health and the World Bank are also present in Yemen, together with numerous private organisations, both international and domestic. These NGOs are active at local level in the HNP field and include both profit and non-profit models. Their co-ordination apparently takes place on an ad hoc basis.

5.2 Dutch support for health, nutrition and population

The Netherlands' support to health, nutrition and population in Yemen has a long history, starting in 1978 with the construction of a hospital in Dhamar. Over the period 1995-1999, total aid expenditure amounted to 21.1 million Euros. The Netherlands is among the three largest bilateral donors in the field of health, nutrition and population. The policy area distribution and the timeline are shown in figures 9 and 10 respectively.

Figure 9 Yemen; health, nutrition and population expenditure; distribution over health policy areas

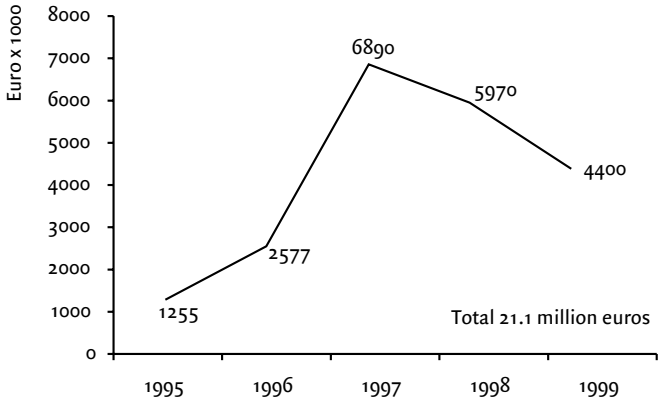


Source: MIDAS

Primary health care consumes the major part of the aid budget. Since the late 1970's, various health programmes have been supported in rural areas of what was formerly North Yemen, which aim at increasing both the access to and the quality of the health

44 *Ministry of Public Health Yemen 1998.*

Figure 10 Yemen; health, nutrition and population expenditure; timeline 1995-1999



Source: MIDAS

services. Neither the key person interviews nor the document review allowed for systematic retrospective analysis of the extent to which the Yemeni authorities were involved in developing the programmes' objectives and activity plans. Most programmes were initiated more than two years before the evaluation and the responsible public health officials have since changed jobs. Long negotiations took place prior to most programmes and these were mainly related to procedures. Consequently, it was not possible to analyse if support to other health policy areas or health related areas had been considered as an alternative.

Three primary health programmes, two urban and one rural, were implemented in the period 1995-1999 and thus met the criteria for inclusion in the evaluation. The major objective of these programmes was to improve the health system, with a special emphasis on mother and child care. Activities included the construction and rehabilitation of health infrastructure, mother and child care, the training of health workers and the institutional strengthening of the Health Office. The programmes in Hodeidah and Dhamar were a follow-up of previous programmes. In the period that these programmes were conceived, Dutch policy strongly emphasised the need for comprehensive primary health care projects in remote areas. A key informant suggested that a health expert of the Ministry of Foreign Affairs take the initiative for these programmes. With respect to the third programme, the primary health project in Aden, documents on the yearly bilateral negotiations between Yemen and the Netherlands indicate that health support for this city had

been under consideration since 1994. However, it was only actually started in 1996. The implementing agency submitted a proposal for funding.

Since 1996, the Yemen drug action programme (YEMDAP) has received both technical and financial support, aimed at increasing the availability and rational use of essential drugs. To attain these objectives, interventions included the purchase and distribution of drugs as well as a revision of legal procedures relating to drug supply and consumption. The Yemeni Ministry of Public Health requested Dutch support for the pharmaceutical sector. A long period of negotiations and preparations preceded the actual start-up of the programme and its subsequent implementation led to a rapid increase in Dutch aid expenditure in 1997. GTZ and the World Bank are the other donors to YEMDAP.

Since late 1997, a midwife training programme implemented by UNFPA has received Dutch support. The programme has a clear objective, the increase of the number of trained midwifes. Activities include the development of training material and the training itself.

Among the other programmes, only one met the criteria for inclusion in the evaluation, namely the support given to mentally ill kept in Yemeni prisons. The objective is the improvement of their living conditions. Interventions include the rehabilitation of premises and the assistance and treatment of patients. Faced with the very poor circumstances in which the mentally ill are detained in Yemeni prisons, the implementing agency submitted a proposal for funding.

None of the programmes and projects included in the evaluation have been implemented under the complete and sole responsibility of the Yemeni authorities. With the exception of the midwife training project, there is a strong presence of expatriate technical assistance in all programmes and projects. The Hodeidah urban primary health project is a follow-up of a previous project that had been implemented directly by the Dutch bilateral development co-operation and the same modality was chosen for the second phase. Selection of the private company that has implemented the Dhamar rural health project was the result of a bidding procedure. In the Aden urban primary health project, the implementing agency Médecins sans Frontières (Doctors without Borders) was already in the area and requested funding. The selection of the private company that is the implementing agency in the drug action programme is also the result of a bidding procedure. Long discussions preceded the selection of this procedure, as in 1993 the World Health

Organisation had already presented a project proposal, including the formulation of a national essential drugs policy, to the Yemeni authorities, the World Bank and the Netherlands. Back then, the Netherlands had expressed their willingness to support it on the condition that the policy was adopted. However, after a period of negotiations it was finally decided not to support the WHO project, but to start a bidding procedure. Eurohealth subsequently became the implementing agency. The midwife training project is being implemented by UNFPA and the support for the mentally ill prison detainees by the ICRC.

Table 9 summarises the description of the programmes and projects included in the evaluation.

Table 9 Yemen: programmes and projects included in the evaluation

Policy area	Programmes and projects	Objectives	Budget (x million Euro)	Duration	Implementing agency
Primary health care	Hodeidah urban primary health care project II (Hodeidah)	Improvement of the health system, emphasising mother and child care Institutional strengthening	3.9	01-1993 – 02-2000	DGIS Ministry of Public Health
	Dhamar rural primary health project (Dhamar)	Improvement of rural health care, emphasising reproductive health	7.0	05-1993 – 06-1999	Intervision Ministry of Public Health
	Aden urban primary health care project (Aden)	Improvement health system Institutional strengthening	2.2	10-1997 – 10-2002	Médecins sans Frontières
Essential drugs	Yemen drug action programme (YEMDAP)	Increased availability and rational use of essential drugs	10.3	03–1996 – 09-2001	Eurohealth
Reproductive health	Support to community based reproductive health through training of midwives	Increasing the number of trained midwifes	5.2	11-1997 – 11-2001	UNFPA
Other	Support for mentally ill patients kept in Yemeni prisons	Improving the living conditions of the mentally ill	0.6	01-1996 – 03-2000	ICRC

Source: MIDAS and documents[45]

5.3 Relevance

All programmes, with the exception of the support for mentally ill detainees in Yemeni prisons, are congruent with the Yemen national health policy in terms of their objectives. They are also congruent with Dutch development co-operation policy in the field of health, nutrition and population. This finding is not surprising, as both policies are very comprehensive. A change in focus can be observed, which follows policy trends at both Dutch and at international levels. Examples of this are: the importance of cost recovery in

45 *The budget is 8 million Euros higher than the amount mentioned in figure 10. In the table expenditure in 1993, 1994 and 2000 is included.*

primary health programmes and the emphasis placed on reproductive health. With Dutch development policy moving in the direction of a sector-wide approach, PHC programmes have been encouraged to integrate their activities within the relevant government health offices.

The Hodeidah project is a follow-up to a previous project of limited scope, which had been implemented in two neighbourhoods only. Its extension to the whole city was a response to the dramatic population increase in Hodeidah, due to the forced re-migration of Yemenis living abroad. The Dhamar project is also a follow-up to a prior Dutch programme supporting the Governorate. Informants related that the Yemeni Health Office request to include support to the hospital had been denied as this was no longer in line with Dutch policy. The Aden project was a response to the worsened health structure in Aden after the civil unrest in 1994. It was assumed that the project would follow the Hodeidah example.

YEMDAP was established to address high drug expenditure and the programme integrated into the Yemeni public health care system from the start. Co-operation with other donors has been problematic, with each agency using its own drug supply mechanism.

The Community Midwives project was also integrated into the Yemeni public health system from the outset. It meets health needs defined as a priority in the national health policy. The project reflects Dutch commitment to supporting reproductive health care programmes. The PHC programmes have also contributed to the improvement of the position of women and children, in line with Dutch policy on women and development.

5.4 Effectiveness

The primary health care programmes had ambitious objectives, which are not easy to implement in the public health system of a newly-formed State. All programmes are well documented with progress reports that could have allowed for adjustments. However, the objectives were only changed into more feasible ones after an external evaluation had been carried out.

The urban PHC project in Hodeidah City has a long history and here the programme has proved to be very effective in increasing access to both basic mother and child care and curative services. Infrastructure has been upgraded according to plan. Curative services

have been introduced, efforts to make essential drugs available were partially successful and a cost recovery system was put in place. Through the programme a new type of health worker has been introduced in the health system: the Murshidat, a female health worker with elementary training. They deliver MCH services at the health centres and pay home visits to families defined as risk groups. The programme has contributed to the training of the Murshidat and, in general terms, the employment of the Murshidat has in turn contributed to the improvement of the quality of services. The efforts to integrate the programme in the Hodeidah Health Office met with some success, at least during the period of implementation. The HHO was given support for the introduction of planning tools, such as a health information system. Overall the effectiveness of the Hodeidah programme was good. The details on health system performance presented in the paragraph on impact confirm this finding.

The other two PHC programmes have been less successful in terms of strengthening the health system. In Dhamar, the programme did not result in the improvement of the rural health system, its major objective. Various factors impeded the realisation of the objectives and the implementation of planned activities. In 1994, not long after the effective start of the programme, civil unrest hampered further implementation and only after reconciliation could the activities start anew. During the first phase, too much emphasis was placed on applied research and on the introduction of new concepts with the result that service quality did not much improve. After a midterm evaluation in 1996, it was decided to reduce the number of districts and to focus on more tangible health interventions, including the introduction of a 'fee for services' system at local level. Support for reproductive health was also strengthened by a series of measures which included the construction and fitting-out of a centre for reproductive health and a Women's Union centre in Dhamar City.

Document review, key person interviewing, a visit to a rural health centre, a rural health post, the Dhamar reproductive health centre and the Women's Centre in Dhamar revealed a mixed picture. On the positive side, a substantial number of female health workers (Murshidat) and other health professionals have been trained. The reproductive health centre is working very well and, with about 300 clients per day, utilisation is high. The political participation of women has increased. The Women's Union centre receives over one hundred women per day for training activities. The major weakness is the inadequate quality of care in rural areas and the failure of efforts to co-operate with the Health Office. Clients' utilisation of rural health centres is very low, with a mean of three persons per

day per centre. The local 'fee for services' system is not functioning as it should, nor is the national drug policy yet being properly implemented in the health centres.

In conclusion, the overall effectiveness of the Dhamar rural health programme is low, with some important positive exceptions. The major objective of the programme, the improvement of the health system in rural areas, has not been attained. However, in the twin fields of reproductive health and the empowerment of women, important results have been obtained in Dhamar city.

In Aden the programme has completed the rehabilitation of all but two health centres according to plan. All polyclinics and health centres are functioning normally. An exemption system has been established and is functioning effectively. However, key person interviews revealed that the foregoing efforts have not been adequately co-ordinated with existing health care structures and this hampers overall effectiveness. For example, the implementing agency is providing drugs through its own mechanism, which impedes a proper implementation of the drug policy established at national level. This lack of integration in the health system is all the more noteworthy given that it occurred at a time when Dutch health and development policy had already shifted towards a sector-wide approach. In conclusion, the effectiveness of the Aden programme is limited.

Other programmes and projects supported by the Netherlands include YEMDAP, the training of community midwives, and the assisting of mentally ill detainees in prisons. Generally the overall objectives were too ambitious. All programmes and projects are well documented with progress reports allowing for plan adjustment.

In the Yemen Drug Action Programme (YEMDAP), there was a lack of balance in the objectives, with too much emphasis on drug procurement, legislation and distribution and too little on rational drug use. A national drug policy has since been formulated and an essential drugs list and treatment guidelines published and distributed. In January 1999 three key decrees were adopted relating to the drug fund, cost sharing and hospital autonomy. A mechanism for drug procurement was set up and a first batch of drugs worth 4.1 million Euros distributed to regional warehouses. However, problems then occurred further down the line which led to inadequate distribution to the health centres themselves. In part, this was due to implementation delays and to a budgetary reduction in the World Bank contribution.

The evaluation team was unable to systematically verify the proper and successful distribution of drugs to the periphery. The field study in Hodeidah however, revealed that the availability of essential drugs in the main centres was good but inadequate in the sub-centres. In the rural health centre visited in Dhamar, the pharmacy was not well-organised nor was the national essential drugs policy being implemented properly.

A second batch of drugs also worth 4.1 million Euros was used as start-up 'capital' for the newly established revolving drug fund. This fund decentralises the overall drugs budget and specifies the budget for each level of care by region. Health centres are then able to use their budget to buy drugs which they then sell on to recover the costs. Key person interviewing revealed that the successful implementation of the drug fund will be a difficult process.

Relatively little attention has been paid to rational drug use activities. Educational interventions included a course on rational pharmaceutical therapy for university staff. Schoolbooks on rational drug use were published and public information materials developed on drug use in pregnancy. Despite these efforts, inadequate drug prescription among health providers and over-spending on non-essential drugs, especially in the private sector, are still common.

To summarise the findings: in the area of procurement and legislation YEMDAP has been effective; in the area of distribution and rational drug use, the effectiveness has been limited.

With respect to the community midwives, by February 2001 all the curricula had been prepared and 724 midwives were undergoing training. Specific training material had been developed for both the teachers and the trainees, though a midterm evaluation revealed some weaknesses in it. It was considered too complex and too theoretical and a revision of the content was recommended. Another weakness of the programme resided in the fact that the newly-trained midwives are not guaranteed employment. Only one third of the midwives trained in 1999 subsequently found a job in the public sector. Finally, the project would have been more effective had it included the strengthening of national institutions in charge of health professionals' training. In conclusion, the effectiveness of the project varied.

The project aiming at the improvement of living conditions for mentally ill patients kept in the Yemeni prisons of Sana'a, Taiz and Ibbs had well defined objectives, which have generally been attained. Document review, key person interviewing and a visit to Sana'a prison revealed that the living conditions in the wards for mentally ill detainees had indeed improved. A number of Red Crescent volunteers are accompanying the mentally ill and providing care on a daily basis. Most patients receive medical treatment, though not always with the drugs best suited to their individual condition, and most of them have re-established contact with their families. As the project largely achieved its objectives, it was considered effective.

Summarising the findings: in the urban primary health care programme in Hodeidah and in the project for the mentally ill detainees in prison, most objectives were attained. These programmes have thus been effective. The Yemen Drug Action Programme achieved considerable results. However, due to the difficult political environment created by the importance of the private sector, the objective of rational drug use was far from being met. The other three programmes have shown some positive results and some major weaknesses.

5.5 Efficiency

Efficiency is to be understood on the basis of three criteria: cost-effectiveness, management and the transparency of the financial administration. Included in the assessment of cost-effectiveness are the budgetary lines allocated to cover expatriate and national projects staff costs.

The Hodeidah programme has led to a sustainable upgrading of the primary health care system at a cost of about 2.5 US$ per person per year, if the whole population is taken as beneficiaries. About 20 % of the budget was spent on expatriate staff and about 4 % on local staff. No major problems have been reported regarding programme management. The financial administration was transparent and no irregularities were detected. The Hodeidah programme can thus be seen to have been efficient.

The Dhamar health programme had work plans that were neither feasible nor directly targeted at the major objectives of the programme. This can partly be explained by the more difficult rural environment in which this programme operated. In comparison with the Hodeidah and Aden programmes, a higher proportion of the budget was spent on staff and missions in this programme: 40-50 % during the first phase of implementation

and 30% during the second phase. Considerable difficulties were reported in programme management, including high staff turnover and a serious problem was detected in the financial administration during the first phase of implementation. This led to staff being replaced. Adding up these factors, the Dhamar programme was found to be inefficient.

The Aden PHC programme appeared to have missed opportunities to build on experience and expertise in the existing health system, thus limiting the cost-effectiveness. 20 % of the budget was spent on expatriate staff. Greater use of local resources would have enhanced the efficiency of the programme. The financial administration was transparent and no irregularities were revealed. Overall, a programme of limited efficiency.

The budget for YEMDAP can be split into two parts: work programme (20%) and drug purchase (80%). The funds earmarked for the work programme have been used for a wide range of activities that by and large were carried out according to plan. The remainder of the budget was spent buying two batches of drugs.

YEMDAP documents do not provide information on the efficiency of drug distribution. Key informants suggested that there were logistical problems. The second batch of drugs was used as an initial investment in the newly created revolving drug fund, which has the potential to encourage a more efficient use of donor support. As the fund has only recently started, its efficiency could not be assessed. Expatriate staff and related costs account for approximately 60 % of the budget for the work programme. This relatively high proportion is felt to be justified, given that the implementation of an essential drugs programme is a complex and difficult undertaking, with many stakeholders in the pharmaceutical sector having a material interest in impeding the prescription and use of essential drugs. In the words of one key informant: “Many people are working hard to get the drug fund functioning, and as many are working hard to impede its implementation”. Programme management was good and the financial administration transparent. In conclusion, though weaknesses in cost-effectiveness were revealed, the programme is considered efficient.

In the Community Midwife Training programme the funds have been used to implement the planned activities. However, past experience acquired in the field of midwife training was not sufficiently taken into consideration. Objective and adequate analysis of that experience could have led to a different approach that would have strengthened the

capacities in the national Health Manpower Institutes. Such an approach would have been more efficient. Management and supervision guidelines have been prepared and a successful monitoring system has been established. The financial administration was well organised and did not reveal problems. In conclusion, the efficiency of this programme is limited.

The budget for the project to support mentally ill detainees in Yemeni prisons was also spent according to plan. Project management was good, the financial administration transparent and no problems were revealed. The project was efficient.

In summary, three programmes- the Hodeidah urban primary health programme, the drug action programme and the mentally ill support programme- were seen to be efficient. The Dhamar rural health programme was judged inefficient and the efficiency of the Aden primary health programme and the midwife training programme was felt to be limited.

5.6 Sustainability

The Hodeidah urban primary health care project ended in September 2000. Evaluation is thus revelatory of how sustainable project-initiated improvements in the health system were, eight months after the withdrawal of external funding. In general, health improvements in the functioning of the health system are still visible, though the budget for running costs has diminished rapidly. The programme had theoretically developed a good 'exit strategy' involving the integration of the programme into Hodeidah Health Office (HHO). However, most of the well-paid staff moved to other jobs when this planned integration actually took place. At present, a new project is being implemented by a private company that was selected after a bidding procedure. This project aims at health improvement in the rural environment. Key persons are of the opinion that the project does not sufficiently build upon the experience acquired in the Hodeidah urban programme. In summary, the sustainability at institutional and financial level is limited. In terms of service delivery, sustainability at policy level is high.

The Dhamar programme had also ended by the time of this evaluation. At present the health office in the Governorate is receiving budgetary support. The sustainability of the programme varies by component. New elements introduced by the programme have barely proved sustainable, even if introduced within the framework of health reforms. On the other hand, the empowerment of women and their increased participation in

public services and local policy have proved to be sustainable, though only in policy and institutional terms, not in financial terms.

The Aden PHC programme is still ongoing. It has contributed to a better organisation of the health system, ensuring sustainability. On the other hand, key informants reveal a lack of co-ordination with the Aden Health Office, thus reducing sustainability. A recent mid-term evaluation recommended better integration within the AHO.

YEMDAP's financial sustainability depends on the effective operations of the drug fund and the enhanced training of health workers. It cannot therefore be assessed. The introduction of reforms in drug legislation point to sustainability at policy and institutional level.

The midwife training programme has opted for rural training centres attached to community health centres. These training facilities are not formally recognised by the Yemen health care system. As long as these centres are not linked to the Health Manpower Institutes, the sustainability of the programme has to be questioned.

After its conclusion, the mentally ill Yemeni prison detainees project has received other external funding. The involvement of the Yemeni authorities in the improvement of the detainees' living conditions is still rather limited, which reduces sustainability at policy and institutional level.

Summarising the findings, none of the programmes or projects that have come to an end are felt to be fully sustainable either in institutional or financial terms. In policy terms though, Hodeidah has been sustainable. YEMDAP is potentially sustainable, both in institutional and financial terms. The ADEN primary health programme and the midwife training programme at present do not have potential to become sustainable in institutional or financial terms. However, the implementation of recent midterm evaluation recommendations might make them more sustainable.

5.7 Impact

As health is defined by an array of different factors, it is not possible to precisely determine the impact of the health programmes and projects in terms of the prevention and decline of morbidity and mortality. Therefore, for the purposes of this evaluation, their likely impact is being interpreted through intermediate and associated factors: the effects

on the structure and the performance of the health system and the effects on health behaviour. A field study to this end was carried out in Hodeidah. Results refer only to the Hodeidah Urban Primary Health Project and to the Yemen Drug Action Programme. The findings though, be they positive or negative, may not necessarily be directly due to the programmes/projects. Other players in the health system doubtless exert an influence, such as the private sector that plays such a dominant role.

The study is based on inspection and interviews with the staff of thirteen of Hodeidah's fifteen health centres, 140 client exit interviews and consultation observations, and a survey among 120 households.

Infrastructure, equipment and organisation of services

Primary health care in Hodeidah City is provided through a network of fifteen health centres, with this study dealing with thirteen of them (three main and ten sub-centres). These centres cover the entire city and they were all upgraded during phase II of the programme, which targeted the setting-up of this city-wide health service coverage. Two to four sub-centres are linked to each main centre, which provides supervision and technical support to the sub-centres and act as a referral point for them. The total population of Hodeidah City – over 330 thousand inhabitants – is the catchment population for this network of health centres.

The overall hygienic and physical conditions of the health centres are adequate. Basic medical equipment and furniture, fans and air conditions are available and well maintained. Almost all clients have expressed their satisfaction with cleanliness and ventilation. All health centres are sufficiently equipped with refrigerators for the storage of vaccine as well as iceboxes. Vaccination protocols, cards and records are available in all centres and have been adequately used in all observed consultations. Essential drugs are available in the main health centres. In general, drug availability is inadequate in the sub-centres the (see box 6 on essential drugs).

The impact of efforts to establish a health information system was reflected in the well-structured system of data recording, processing and reporting that is still functioning in all health centres. However, inadequacy and inaccuracy in reporting and feed back have been observed.

Clinical effectiveness of interventions

The services provided by the health centres cover health promotion and preventive and curative services. Female health workers, trained by the project, are the main providers of PHC in health centres and at the same time provide a link between the health system and the community. A total of 132 Murshidat have been trained throughout the period of the programme.

Home visiting is a unique feature of the Hodeidah urban PHC project. A monthly schedule is planned for home visits in the catchment area around each health centre. During the visit, the Murshidat give information to the family about the health services provided at the health centre and encourage them to appropriately utilise the available services. At the same time they identify families at risk according to specified criteria and provide suitable advice. Visiting has continued after the end of the project, though not as regularly as before.

Observations revealed that all children under five are weighed at every visit. However, growth monitoring cards are often not available and the nutritional status of the child and its implications are not sufficiently well explained to the mother. Observations of consultations also revealed that protocols for treatment are available, but that they are not used. Though essential drugs are available in the main health centres, these drugs are not much prescribed. Trade marks are much more used than generic drugs. The findings on essential drugs are summarised in box 6.

Box 6 Essential drugs

Availability essential drugs

Essential drug	Main	Sub
	n=3	n=10
Acetylsalicylic acid	3	3
Paracetamol	3	8
ORS	2	2
Chloroquine	3	9
Ferrous Sulphate	3	8
Folic acid	2	8
Phenoxymethyl Penicillin	2	6
Co-Trimoxazole	3	4
Mebendazole	3	3

Drug prescription

Name	Frequency	Percentage
Trade	58	85.3
Generic	10	14.7
Total	68	100

Responsiveness of the system

Exit interview findings showed that 139 out of 140 (99.3%) of the study population expressed their satisfaction with the way in which the health worker listened to them. 93.6 % of respondents also reported that they were given the opportunity to ask questions at the same time. 90% stated that the consultation took place in a private room and that they were treated with dignity. However, patient observations revealed that many health workers lack communication skills.

Key person interviewing revealed that contraceptives are only given to women accompanied by their husbands. This behaviour on the part of health workers is not in line with the concept of reproductive rights, as defined at the International Conference on Population and Development.

Fairness of the system

Community participation in the management of health resources is an important contribution of the Hodeidah urban PHC project. It started in 1995 through the formation of Local Health Committees (LHCs). At present, the LHCs are actively involved in the management of fee-for-service revenues in all health centres and finance around 75 % of the running costs, with the exception of the salary costs of the professional and technical staff. The remaining 25 % are covered by the health office. All clients have to pay fees for services, as well as the cost of drugs and laboratory tests, irrespective of their socio-economic status. The absence of an exemption system constitutes a real threat for many households and restricts their access to primary health care. This situation deteriorated after the programme ended. With decreasing home visits by the murshidat, there was correspondingly less detection of families at risk.

Health behaviour

Breastfeeding is a common practice among mothers in Hodeidah and it is encouraged by the health education programme. There are various supplementary or weaning foods available in Hodeidah, with most women choosing to give additional liquids to their children in the form of juices, soup and/or yoghurt. The household survey indicated the popularity of health centre services among mothers of pre-school children. Weighing and vaccination are usually provided in the same visit, showing similar utilisation figures (94%) for the youngest child in the household. In general, people's attitude towards vaccination is positive, and not one mother was found who did not have her child vaccinated against the major preventable child diseases. Even if she was afraid of injections, and may

Table 10 Vaccination coverage 1996-2000

Years	BCG		DPT/Polio		Measles	
	Absolute	%	Absolute	%	Absolute	%
1996	7450	47	7242	45	4054	25
1997	9903	62	7737	48	7076	44
1998	9268	58	7859	49	7986	50
1999	9731	58	8012	48	7246	43
2000	10286	60	8723	51	7123	41

Source: HHO, statistics department, 2000

thus choose to forego a TT vaccination for herself, she still brought her child to the health centre for immunisation. The household survey revealed very high vaccination coverage among children under five, ranging from 82 to 100 %.

Table 10 shows the vaccination coverage in the period of implementation of the second phase of the Hodeidah programme. Vaccination coverage had increased substantially during the first phase. The levels have been sustained and even somewhat improved during the second phase.

Of the respondent mothers, 100 out of 120 (84 %) had been to the health centres for antenatal care during their last pregnancy; and 104 (87 %) of them have had tetanus toxoid vaccine. The majority of the mothers (98/120) expressed the wish for birth spacing and about one third of these women (31/98) used modern contraceptives. The health centres are the main source for contraceptive methods with 27 out of 31 (87 %) women who used contraceptives obtaining them from the health centres.

In contrast to the high utilisation of preventive services, the utilisation of curative services is rather low. Most respondents in the household survey perceived public services as inferior in this respect. Furthermore, mothers often did not follow the health worker's advice. Box 7 presents an overview of the health seeking behaviour of the mothers included in the household survey.

Box 7 Health seeking behaviour in Hodeidah City: public health centres are one of several treatment options

Most commonly reported childhood illnesses in the household studies were respiratory infections/cough (34 percent of total episodes reported in the past two weeks), diarrhoea (28 percent of episodes), and malaria (6 percent of episodes). Women rated the condition as being severe/dangerous or not severe, and described their health seeking behaviour. From their illness recalls, various treatment choices manifest themselves and were categorised. In below table the percentage episodes treated using the different treatment options are summarised for the most common childhood disorders: malaria, diarrhoea, and ARI.

Reported health-seeking behaviour in common childhood health problems

Health problem	**N**	**No action with home remedies**		**Self-care**		**Self-care with pharmaceutical**		**Consultation at public health centre**		**Consultation with Private health provider**	
		abs.	*%*	*abs.*	*%*	*abs.*	*%*	*abs.*	*%*	*abs.*	*%*
ARI	41	6	15	22	53	21	51	6	15	6	15
Diarrhoea	34	6	9	26	76	4	12	7	20	8	21
Malaria	7	1	14	2	28	1	14	2	28	4	57
Total	82	10	12	50	60	26	31	15	18	18	21

In severe episodes more than one option tends to be used. The table shows that overall self-care is the predominant form of treatment. Home remedies are often used. Public health centres are visited in about the same percentage of the episodes as private health providers. There are differences in treatment seeking behaviour for the different types of illness problems. To assess impact of improved quality of care on public health centres on health seeking behaviour it is useful to present the observed patterns in detail:

Sixteen of the above recorded 34 diarrhoea cases were perceived to be non-severe by the mothers; the studies showed that non-pharmaceutical, non-medical home treatment consisting of specific foods (starch or rice with yoghurt or water), and an increase in liquids and/or breast feeding are common treatments for these non-severe diarrhoea cases. The mothers do not mention pre-packaged ORS as therapy. Only one out of 16 respondents whose child reportedly had non-severe diarrhoea went to see the doctor of the public health centre. The doctor did not prescribe ORS, and requested a stool test for amoeba.

Serious cases of diarrhoea show an even wider array of home treatments (variety of juices, teas, cumin, mareimara against fever), along with pharmaceuticals (including ready-made ORS and antibiotics). It is popular to have some pharmaceuticals at home for the treatment of diarrhoea. These are obtained without prescription from local groceries. They are taken according to perceived need unrelated to visiting professional health care providers. In cases perceived serious, people tend to visit both public health centres and private providers and spend an additional amount in buying pharmaceuticals, generally from private pharmacies, costing YER 600-1000.

For cough cases home treatments are plenty, ranging from warmth therapy (wax cream/henna on hair, additional clothing, covering child, hot drinks) to specific drink and balm treatments (tamr hindi, murr, sesame syrup). Home treatment with pharmaceuticals is used in severe and non-severe cases.

A variety of pharmaceutical cough drugs are stocked in most households (vicks balm, cough drops, cough syrup, analgesic syrup). They are obtained from local pharmacies or they are leftovers of an earlier prescription. Cough symptoms (continuos cough, sound coming from chest) are a trigger for mothers to seek help of professional health providers. Treatment choice in these severe cases include visiting the public health centre and paying a maximum of YER450 for drugs (purchased from a private pharmacy), and visiting hospitals and private providers with a drug expenditure of YER 150-2000.

The seven recorded cases of Malaria, were all perceived serious; four were brought to public health centres or private practitioners at an early stage for a confirmation of diagnosis (malaria test). Drug treatment is relatively cheaper than for other predominant child diseases (350-500 YER), because of the low cost of chloroquine, the preferred treatment.

Waiting to see if the condition persisted is another type of health seeking behaviour. In FGD they explained that, at times, children get better without any treatment (including home treatment), and that in general people have little money to afford expensive treatment (professional health care). If the financial situation is very poor, and their health seeking behaviour is limited to free or inexpensive treatment options, it occurs that children die from untreated complications of the condition. Early treatment is one of the health efforts specified by mothers, yet it is also dependent on the accessibility of health care providers. Poor people perceive themselves as being excluded from care at the health centres, because they cannot afford the user-fees.

Rational drug use is indeed impeded by the general poor economic situation in the area. Given rational drug prescriptions, the clients may decide to purchase only some of the drugs on the prescription,

depending on their resources. There is not enough understanding among consumers that rational therapy may necessitate the combination of drugs prescribed, and their use according to prescription. Informal observation confirmed the practice that mothers did not comply to the health provider's advice to e.g. finish the prescribed amount of drugs even if symptoms disappear meanwhile, or to administer the drugs at times specified. Rational drug use also involves good communication between health provider and client which, as shown throughout the Hodeidah field study, is not always the case.

The afternoon curative sessions in the public health centres denote an improvement for patients, and an additional option for treatment. However, in case of emergency, health centres are of limited accessibility. Nowadays, health centres are considered a first stop for treatment, compared to other health options they are still perceived of inferior quality. In spite of the health centre's accessibility and their expertise on MCH services, people tend to seek the (additional) advice of paediatricians, or other private health providers. Going to a private health provider or hospital denotes greater effort and cost, and is particularly set out in severe cases requiring immediate action. General customer satisfaction also is higher after such visit as most recall that the child recovered shortly after the therapy, while visiting public health centre did not show an immediate, significant change in the child condition.

Health outcomes

Data on health outcomes are not available. It is likely that the improved use of preventive services have had some positive effects.

Summarising the findings from the field study: positive results were observed in terms of the strengthening of the health system structure. The performance of the system, measured by the criteria of clinical effectiveness, responsiveness and fairness, varies. The clinical effectiveness of preventive services is satisfactory but that of the curative services is not. Responsiveness is good. Fairness was felt to be adequate during the implementation of the programme but was not sustained. Health behaviour also varies. Mothers undertake considerable efforts to prevent death and disease among their young children. However, once these children do fall ill, their subsequent treatment is not adequate.

5.8 Conclusion

The overall picture of the relevance, effectiveness, efficiency and sustainability of the programmes and projects included in the evaluation is mixed. The Hodeidah urban health project had positive results on almost all criteria. However, the institutional strengthening of the health office proved not to be sustainable. The support for mentally ill patients

kept in Yemeni prisons, a bit of an outsider compared to the other programmes, also showed good results. The other projects and programmes varied. YEMDAP was very successful in the procurement of drugs and in the adaptation of drug legislation. The distribution of drugs though was much less successful and rational drug use was not adequately addressed. Dhamar was neither effective, efficient nor sustainable. However, some very positive results were obtained in the fields of reproductive health and empowerment of women. The Aden urban primary health project and the midwife training project both lacked good integration with existing structures, limiting their effectiveness, efficiency and sustainability. Health impact has been only assessed in Hodeidah, and this through a number of intermediate factors. In the areas of health promotion, prevention and community participation, major positive results have been obtained. Curative care though is not adequately provided in the public system and drugs are not used rationally. The overall conclusion is summarised in the following table.

Table 11 Summary of evaluation results in Yemen

Programme	Highlights and weak points	Relevance	Effectiveness	Efficiency	Sustainability	Impact
Hodeidah urban health project	s Increased access to and use of preventive MCH services s Introduction of female community health worker t Institutional strengthening not sustained	++	++	+	±	±
Dhamar rural primary health project	s Construction of reproductive health centre t Inadequate quality of care in rural areas t Inadequate integration in health office	++	–	– –	–	NA
Aden urban primary health care project	s Rehabilitation of infrastructure t Co-ordination with public health authorities	++	±	±	?*	NA
Yemen drug action programme	s Drug supply and legislation t Inadequate drug distribution and irrational drug use	++	±	+	?**	±***
Community midwife training	s Midwives trained t Training material too theoretical	++	±	±	±	NA
Support for mentally ill in Yemeni prisons	s Living conditions and treatment improved t No institutional support	– –	++	++	±	NA

* The rating is a question mark because it depends on the implementation of the results of a recent mid-term evaluation
** The rating is a question mark, because it depends on the functioning of the recently installed drug fund
*** Impact only measured in Hodeidah
NA: not applicable

6 Burkina Faso

6.1 Health situation and health policy

Burkina Faso is located in the Sahel zone. The country has about 10 million inhabitants, with over 80% living in rural areas. The climate is unfavourable and the recurrent periods of severe drought seriously hamper agricultural production.

On the human development index, Burkina Faso ranks number 159 on a list of 162 countries. GDP per capita is US$ 240 per year and an estimated 60% of the population live in extreme poverty. The literacy rate for men is 34% and for women only 10%. Data is lacking on what percentage of the population have access to an improved drinking water source in rural areas. About 33% of the population have adequate sanitary facilities. Average life expectancy is 54 years. The most important health indicators, summarised below in table 12, are unfavourable.

Table 12 Health indicators, Burkina Faso

Indicator	Burkina Faso	Year
Infant mortality rate (/1000 live births)	106	1999
Under five mortality rate (/1000 live births)	199	1999
Maternal mortality rate (/100.000 live births)	930	1996
Total fertility rate (number of children per woman)	6.4	1999
Percentage under-fives with underweight (< 2 SD median)	37%	1995-2000
Percentage infants with low birth weight	21%	1995-2000
Annual population growth	2.8%	1990-1999
Contraceptive prevalence rate	12%	1999

Source: UNICEF, The State of the World's Children 2001.

Since 1979, primary health care (PHC) has been the cornerstone of the national health policy. A ten year plan (1980-1990) was drawn up to develop a network of facilities, but it faced numerous problems during implementation, such as: the identification of village health workers to staff the health posts in the periphery (PSP), a lack of essential drugs and difficulties with the integration of vertical health programmes in the basic health service.

In 1992 a number of health reforms were introduced and, as of 1993, emphasis was placed on decentralised district health care. By 1996, fifty-three sanitary districts had been established around a hospital or a health centre with surgical facilities. The overall process of health reform aimed at strengthening the peripheral health services and involving the community in their management. To this end, the necessary legal procedures were adopted to allow for the districts' autonomy in planning and management. At the same time, considerable efforts have been undertaken to improve general health service performance. A list of drugs was established that should normally be available at each health service level. Clients were to pay fees for services and for essential drugs. The primary health posts were no longer considered part of the health system.

In 1998 the Ministry of Health launched a process which sought to formulate a national health policy. By the end of 2000, two health policy documents were completed, defining the priorities for 2001-2003: disease control, improvement of the quality of care and institutional strengthening of the Ministry of Health. By mid 2001, these documents were adopted.[46]

The budget of the Ministry of Health, including external financing, accounts for about 10% of total public expenditure.[47] The most important external donors in the area of health, nutrition and population (HNP) are the European Union, France, Belgium, Germany and the Netherlands. The World Bank supports a HIV/AIDS programme and WHO, UNICEF and UNFPA are also represented. In addition, a number of international NGOs are active in the field of health or related areas. At national level, co-ordination mechanisms have been established, such as the yearly conference for the health partners of the Ministry of Health. Bilateral donors are active in different regions. Some national programmes, such as the tuberculosis control programme, receive support from various donors.

6.2 Dutch support fot health, nutrition and population

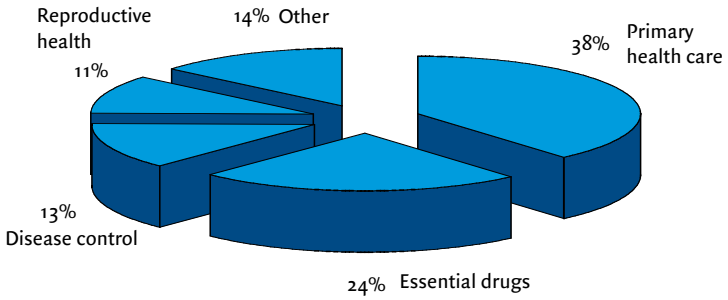
Dutch bilateral development co-operation in Burkina Faso has a 25-year history. Until recently, integrated rural development in several areas of the country formed the cornerstone of this co-operation. At present, bilateral co-operation is concentrated in three areas: rural development, basic education and health.

46 Ministère de la Santé Burkina Faso 2001.
47 Ministère de la Santé Burkina Faso 2001.

Specific support for health, nutrition and population started with selective primary health care interventions implemented by NGOs. There were no formal co-ordination mechanisms between the programmes that received support. During the 1990's, the basic health interventions became more comprehensive and increasingly integrated in governmental structures. Since 1998, a sector-wide approach has become the guiding principle for bilateral co-operation. At the time of the evaluation, Dutch support for the Kaya programme was coming to an end and it had not yet been decided if, and in which form, support should be continued. A number of national health programmes also received support.

In the period covered by this evaluation, 5.8 million Euros was spent. The Netherlands are among the three most important bilateral donors. Figures 11 and 12 show the distribution among the different policy areas and the changes over time.

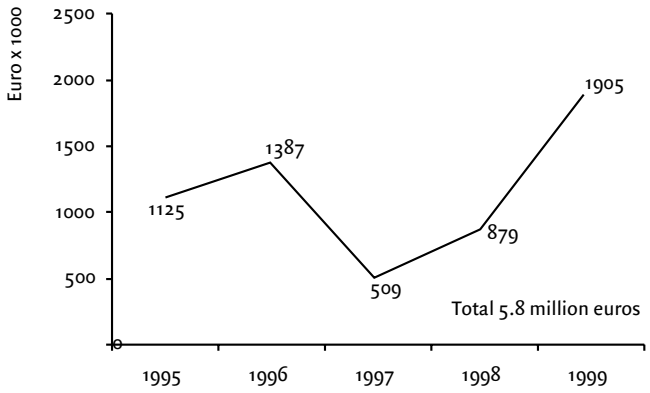
Figure 11 Burkina Faso; HNP expenditure; distribution of Dutch bilateral aid over policy areas, 1995-1999



Source: Midas

A basic health programme in Kaya (PASSK), implemented by a Dutch NGO, accounts for 40% of the budget. This programme started in the 1980's as a small project aimed at increasing vaccination coverage in three districts (Bam, Yatenga and Sanmantenga). A key informant suggested that the choice of these districts was probably not a coincidence, because at the time, a Dutch priest was running a number of small social development projects in the area.

Figure 12 Burkina Faso; HNP expenditure; timeline 1995-1999



Source MIDAS

Gradually the project expanded to become a basic health programme for the whole Kaya sanitary region and the focus took on a more institutional nature, aiming at both the strengthening of planning and management at district level, and community participation in periphery health centre management. Some elements of the programme, such as community involvement in services management, have set an example for national health reform. Special attention is given to mother and childcare.

The Dutch NGO started as the implementing agency and it now provides technical assistance when so requested by the district health authorities. The NGO still administrates the project budget.

The national tuberculosis programme (PNLT) has been receiving Dutch financial support since 1995. France is another donor to the programme. Its twofold aim is to increase tuberculosis case finding and directly observed multi-drug treatment (DOTS). It should be recalled that in 1994, the Ministry of Health was confronted with a situation analysis that pointed to inadequate detection and treatment of the disease. This was a threatening situation- as the tuberculosis prevalence was itself due to an increase in HIV infections- and thus led to the Ministry of Health requesting support for the programme. At the time of the evaluation preparations were underway for its continuation.

Dutch support for the central agency for the purchase of drugs (CAMEG) started in 1995, also at the request of the Ministry of Health. In addition to Dutch support, it has received financial contributions from the World Bank, the European Union and France. Burkina Faso contributed in kind. The programme aims at increasing the availability of essential drugs in the periphery at a reasonable price. As the availability of drugs is a necessary condition for basic health care to function properly, this programme tends to support the Kaya initiative.

In the field of reproductive health, three programmes met the criteria for inclusion in the evaluation. Two are smaller projects, implemented by NGOs. One of these projects was a study in reproductive health needs and the executing agency, a Burkinabé NGO linked to IPPF, requested the funding. The other project aimed at introducing reproductive health into the curriculum of the National School of Public Health. Document review and key person interviewing could not reveal who took the initiative for this project. The third programme relates to the national UNFPA programme and is more comprehensive. Starting in 1993, it included three different projects aimed respectively at: the decentralisation of reproductive health services, the promotion of socio-sanitary activities, and information, education and communication. This was a follow-up to previous support given to UNFPA.

In meetings with the Ministry of Health, the Netherlands expressed a strong interest to continue support in the field of reproductive health. At the time of the evaluation, preparations were being made to support an HIV/AIDS prevention and control programme.

The programmes included in the evaluation were conceived and initiated several years before this evaluation. Document review and key person interviewing were unable to reveal whether consideration had ever been given to provide support to alternative health policy or related areas. Table13 summarises the programmes and projects included in the evaluation.

Table 13 Burkina Faso, programmes and projects included in the evaluation

Policy area	Programmes and projects	Objectives	Budget (x million Euros)	Duration	Implementing agency
Primary health care	Programme for the development of primary health care in the Kaya region[48] (PASSPK)	Improved access to and quality of health services	2.5	01.1995 – 12.2000	Save the Children Netherlands
Essential drugs	Support to the essential drugs purchase agency (CAMEG)[49]	Improved availability of essential drugs	1.2	08.1995 – 05.1998	CAMEG
Disease control	National tuberculosis control programme (PNLT)	Increased case finding and treatment	0.8	03.1995 – 09.2000	Ministry of health
Reproductive health	Contribution to the United Nations Fund for Population Affairs (UNFPA)	Increased utilisation of antenatal care and family planning Improvement of women's position Health promotion	1.5	01.1993 – 03.1997	Ministry of health UNFPA World Population Foundation
	Study in sexual health needs satisfaction in urban and rural environments (ABBEF)	Development of a model for service delivery in the field of sexual health	0.4	07.1996 – 03.1998	ABBEF[50]
	Integration of reproductive health in the curriculum of health workers of the National School of Public Health (ENSP)	Improvement of training and including reproductive health in the ENSP curriculum	0.1	10.1997 – 08.2000	ENSP Family Care International

Source: Documents, MIDAS[51]

48 *Programme d'appui au développement au développement de soins de santé primaires à la région sanitaire de Kaya.*
49 *Support pour la centrale d'achat des médicaments essentiels génériques (CAMEG).*
50 *Association Burkinabé pour le bien-être Familial/Burkinabé association for family well-being.*
51 *The total budget is 6.5 million Euros, 0.7 million more than the total in the figure. The contribution to UNFPA in 1993 and 1994 is included in the table; support to activities that did not meet the criteria to be included in the evaluation is excluded from the table.*

6.3 Relevance

All programmes and projects included in the evaluation are related to the priorities listed in the national health policy. They are also in ine with Dutch international co-operation policy in the field of HNP. This finding should not surprise, as both policies are very comprehensive. Each programme is assessed to the extent in which it relates to Burkina Faso health policy.

The support for basic health care in Kaya has been instrumental to the development of the district health concept throughout the whole country. Important principles, such as decentralisation, the autonomy of health districts, community participation and cost-recovery, have all been applied in the Kaya programme. Over time, the programme has smoothly adapted to changes in the administrative organisation of the country. Key informants reported that Kaya serves as an example to other health regions.

Both the tuberculosis control programme and the support given to the central agency for drug supply are national programmes- and as such in line with national policy.

Reproductive health is also listed as a priority in the national health policy. However, when Dutch support for UNFPA started in 1992, a strategy for reproductive health had not yet been determined; UNFPA was a major contributor to its development when the time came. A key informant at the Ministry of Health subsequently told us that though several strategies for policy implementation had been defined, they had never led to proper implementation.

The two smaller reproductive health projects relate to research and training and hence are potentially supportive of policy implementation at national level. However, we were unable to verify if this really was the case or not. Several key informants reported a lack of communication between the public sector and private organisations in the field of reproductive health.

6.4 Effectiveness

Effectiveness was assessed by analysing to what extent the objectives of the programmes and projects were attained. The support to the Kaya primary health programme (PASSK) led to a considerable improvement in accessibility to, and in the quality of, the health services. However, client utilisation of these services is still very low.

Due to the construction and the rehabilitation of infrastructure, more people have access to health services. Health facilities increased from one per 16 thousand inhabitants in 1995 to one per 13 thousand inhabitants in 1999. The Kaya programme has also contributed to a better organisation of the health system. At district level, operational plans are made every four months and generally the activities have been carried out according to plan. A minimal packet of basic health services has been defined and treatment guidelines distributed. Monitoring and supervision of the health services is done on a regular basis. At health centre level, a structure has been established for community involvement in health facility management.

Despite all these improvements, observations indicated only a slight increase in take-up of the health facilities (CSPS) by the local population. When one takes into consideration the target population of a health care facility and the expected morbidity, client utilisation is seen to be very low. The household survey revealed that people in remote villages were satisfied with the quality of the health services. However, due to the long distances involved and lack of means of transport, the truth is that they hardly ever use them. In the villages, a village health worker is generally available and sometimes a peripheral health post (PSP). These structures are remnants from the previous health policy and no longer part of the official health system. The Kaya programme does not provide support to these structures and the quality of care is very low. The paragraph about impact will provide more details.

By the distribution of proper technical guidelines and the training of personnel, the NPLT programme contributed to tuberculosis control becoming better organised. However it did not lead to the expected increase in case finding and treatment. The original objective in 1995 was to increase case finding from 25% to 50% by 1997. This objective proved too ambitious and was reduced several times. Currently, for the period 2000-2004, the aim is a yearly increase of 10%. From 1996-1999, case detection showed only a slight increase, from 26.8% to 28.2%. The target for directly observed case treatment (DOTS) was (and still is) 75%, somewhat lower than the 85% recommended by WHO. From 1998-1999 no improvement was found in this area.

These results are disappointing, because NPLT is well-organised and uses the proper guidelines. The technical guidelines used for laboratory research and for case management, including the drug treatment schedule, are coherent with international recommen-

dations. Several technicians underwent training and a monitoring and information system was set up.

Two major causes for the disappointing results could be identified: The first was coincidental and linked to a severe meningitis epidemic that broke out in 1996. This resulted in an emergency drain on available health personnel and frustrated the proper implementation of foreseen NPLT activities. The second cause was structural in nature. In line with WHO recommendations, this programme relies on passive case finding. However, because the utilisation of the public health services is so very low all over the country (a fact confirmed in the Kaya region), few tuberculosis patients will ever reach the health facilities.

The support to the central agency for essential drugs supply (CAMEG) has fully attained its objectives. It contributed to the availability of reasonably priced essential drugs in the health facilities, and to the implementation of a drug cost-recovery system. However, although drugs are available, their use is limited for two reasons. Firstly, the health facilities are under-utilised, and secondly, drug prices are high compared to other countries in West Africa. The Ministry of Health has implemented a system of decentralised distribution and quality control, which appears to be functioning adequately. In 1999, there were hardly any reports of stocks running out, a finding that the Kaya field study confirmed. However, these positive results were not achieved overnight. In the first years of its existence CAMEG faced considerable problems and stock ruptures occurred regularly.

The three programmes in the field of reproductive health did not all have the same level of effectiveness. The support to the UNFPA programme did not lead to tangible results. Document review revealed that, the lack of success relating to the UNFPA three project programme, was mainly due to the absence of an institutional cadre. In addition, serious management problems hampered the proper implementation of the programme. This will be further discussed in paragraph 6.5.

The study on sexual health needs in a rural environment carried out by ABBEF met its objectives. The quality of the study was good and the results have been used for the design of a follow-up project, that aims at meeting the needs identified. This project had just started at the time of the evaluation and so was not included in it.

The national School of Public Health (ENSP) has introduced the subject of reproductive health into its curriculum and the work plan has been adapted in order to include practical experience. The quality of the training programme is good. The project's objective has been realised.

To sum up: the findings on effectiveness give a varied picture. With one exception, all the programmes managed positive results in terms of the realisation of their objectives. The objectives of the programmes and projects range from broadly defined and ambitious, to well defined and limited.

- The health support to the Kaya region is comprehensive and its broadly defined objectives were partially achieved.
- The tuberculosis control programme had clearly defined objectives that were only very partially achieved.
- The support for the essential drugs programme had clearly defined objectives that were almost fully realised. However, during the first years the programme faced a number of problems.
- The two small projects in the field of reproductive health had clearly defined objectives and attained them.
- The support for the UNFPA programme was not successful. Hardly any tangible results could be found.

6.5 Efficiency

To assess efficiency, three criteria are taken into consideration: cost-effectiveness, the quality of programme management, and the transparency of the financial administration.

The support given to the Kaya health region succeeded in bringing about considerable positive changes to the health system for a budget of about 2200 Francs CFA (3.18 Euros) per person per year. Compared to other interventions, this is considered efficient. However, when one takes into consideration the low level of health facility utilisation, it is clear that the number of beneficiaries was considerable lower than the number of inhabitants in the region.

Technical assistance consumed 12% of the budget and overhead costs another 12%. The programme management has changed over time. At the beginning, the implementing agency took the initiative for carrying out activities; whereas at present, its role is that

of an advisor to the health authorities. Key persons expressed their satisfaction with this move. A system for the financial administration was set up and responsible administrators have been trained to use it. However, high personnel turnover made it necessary to hire external audit companies. In the financial administration department, several errors were reported, but no major irregularities.

The tuberculosis programme was not cost-effective. During the period 1996-1999, average costs per person treated were about 108.9 Euros, twice the amount recommended by WHO. One reason for this is that considerable investment was necessary before the programme could take off and expand. Another reason is that administrative procedures, concerning both the transfer of the budget and the purchase of necessary equipment, caused serious delays in the implementation of the programme. The programme is adequately managed. The financial administration of PNLT is transparent and no irregularities were found.

For CAMEG, the situation is the other way around. Here, the programme was cost-effective but irregularities were revealed in the financial administration. Dutch support of 1.2 million Euros contributed substantially to the availability of drugs all over the country. However, in 1995 and 1996 serious problems were detected in both the stock management and in the financial administration. Bad selection of suppliers, stock rupture and excessive drug prices are all documented in reports from the administrative board. Key informants from CAMEG however tell a different story and relate these problems to difficulties with complicated donor procedures. The situation finally got to the point where the funds were blocked. In 1996 an outside company drew up a list of the problems and at that juncture, serious measures for improvement were introduced.

The support for the UNFPA was not efficient at all. The budget was sufficient to implement the activities planned, however only a few of them were actually carried out and so the budget absorption rate was low. There are many reasons to explain this, including lack of clarity in responsibilities and complex administrative procedures.

The decentralisation of the maternal and child services project was implemented by the Ministry of Health; the social action project by the Ministry of Social Affairs. It was foreseen that these two projects would eventually be integrated, but this never happened. The information, education and communication project had a late start and only carried out a few of its intended activities. Lack of proper communication between the ministries

involved, the NGO providing technical assistance, the UNFPA, and the Dutch Embassy also thwarted proper implementation. As support to UNFPA had stopped almost three years before the present evaluation, it was not possible to verify these findings during key person interviews. The administrative procedures were opaque and there was no adequate budget control. The administrative capacity of the implementing agencies at national and district level was also inadequate.

The cost-effectiveness of the ABBEF study relates to the utilisation of the study results, an issue that could not be evaluated. The ENSP project is considered to be cost-effective in that the planned integration of reproductive health within the curriculum has been achieved with a limited budget. Document review of both of these projects did not reveal any problems or irregularities in management or financial administration.

Summarising the findings: the efficiency of the programmes varied, with most having both strong and weak points. Overall, the Kaya programme was efficient, but it had some administrative problems. The NTLP was not that cost-effective, though on the positive side, the financial administration was very transparent. For CAMEG, the reverse was true; it was very cost-effective, but some irregularities in the financial administration were detected at the start of the programme.

6.6 Sustainability

To assess sustainability a distinction has been made between financial sustainability, institutional sustainability and sustainability in terms of policy.

In the Kaya programme, a number of planning and cost-recovery measures were introduced that are now part and parcel of the national health policy, making the programme highly sustainable in policy and institutional terms. However, key informants reported that the financial input from the implementing agency is still very important to sustain some of these measures. So there is some question about the programme's financial sustainability.

The tuberculosis control programme is a national health programme and thus sustainable in policy and institutional terms. In financial terms the programme is not (yet) sustainable. Withdrawal of external finance would decrease training, supervision and laboratory tests, and consequently influence case finding and treatment negatively. Therefore Dutch support for NLTP has been continued.

The support to CAMEG was highly sustainable. CAMEG has become an association that does not receive any external support. The findings from the field study (see paragraph 6.7) point to a programme that is still functioning well.

The sustainability of the support for UNFPA is difficult to assess. In policy and institutional terms, the projects contributed to the awareness of the need for a national reproductive health policy to be formulated. However, reproductive health policy is still a long way from being implemented. The continuity of the special project activities after the withdrawal of Dutch financial support could not be assessed.

For the study in reproductive rights, the sustainability criterion is not applicable.
The introduction of reproductive health in the ENSP curriculum is sustainable in institutional and financial terms.

Summarising the findings:

- The support for the Kaya region, the tuberculosis control and the central agency for essential drugs are all sustainable in policy and institutional terms.
- The support for CAMEG has proved to be sustainable in financial terms, the other programmes not.
- The sustainability of support for UNFPA could not be assessed.
- The criterion sustainability is not applicable to the ABBEF study.
- The ENSP project is sustainable.

6.7 Impact

In Kaya district, one of the four districts of the Kaya region, a field study has been carried out to assess the intermediate factors defined as preconditions for the impact of the health programmes. These are the improvements in the structure and performance of the health system and changes in health behaviour. The results of the field study are related to the Kaya PHC programme and to the support for CAMEG. The study design did not allow for the results of the tuberculosis programme to be measured.

With respect to reproductive health, various issues were assessed. These relate to national reproductive health guidelines and not to Dutch support for the programmes included in the evaluation, as these were implemented in another geographical area.

Visits were carried out to nine randomly selected health facilities (CSPS). Among the villages covered by the health centre visited, four were selected following a stratified sampling procedure. Two villages were randomly selected among those situated less than five kilometres from the CSPS; and two villages among those situated more than five kilometres from the CSPS.

Field study results are based on:

- key informant interviews with health workers and village leaders
- a hundred consultation observations and exit interviews
- a household survey among 100 households, including interviews with the head of the household and with the mother of a young child
- five focus group discussions.

The findings give a general picture of the health system and health behaviour. Only some of the findings can be directly related to Dutch support to the Kaya region.

Infrastructure, equipment and organisation of services

Health infrastructure and equipment have been improved thanks to the Kaya programme. All centres have access to radio equipment and in most, an ambulance is available for emergency cases. All centres were clean. Part of the medical-technical equipment was not functional and consumables such as disposable needles were almost non-existent. Only two out of the nine health centres heads had put in a request for the replacement of non-functional equipment. Recently the Burkinabé authorities allocated funds for maintenance. However procedures for their use had not yet been established at the time of the evaluation.

Drug supply was adequate in all health centres (CSPS). The pharmacies were well organised and stocks were well documented. In eight of the nine centres no stock rupture had occurred in the year previous to the evaluation. At village level, the opposite was found. There, hardly any drugs are available. The village health workers are supposed to buy drugs at the CSPS and resell them to clients in the villages. Interviews in the villages revealed that this system did not function.

Vaccines were not always available in the CSPS. In only one centre had all necessary vaccines been available throughout the entire year previous to the evaluation. Shortages of vaccines against tuberculosis, tetanus and yellow fever were reported from time to time in the other centres.

Almost all CSPS health workers reported that facilities provided through the Kaya programme had increased their motivation to work in the area. Among the advantages mentioned were: training, supervision, better equipment and housing, and transportation facilities. The programme facilitated numerous training courses in a variety of areas, such as nutrition, disease prevention and management and information. Almost all health workers, including the persons responsible for the pharmacies, stated that they had attended several of these courses. At village level, most health workers had received basic training but hardly any follow-up to it.

In a CSPS the services are well organised and planned. Curative care and emergency care is provided every day and preventive services on specific days only. A community health committee (COGES) is involved in the management of a CSPS, including the use of the budget. Though this committee should represent the target population of a CSPS, key informants in remote villages were not even informed about its existence let alone its role. Data on health care utilisation is collected and sent to the district health office and since 1997, the health information system has been improved. In many health centres, informative graphs were shown, for example about the population size in the target area and on vaccination coverage over time.

Clinical effectiveness of interventions

Health promotion has been reinforced over the last three years. Health education materials and the choice of issues are defined at central level. Prevention of HIV/AIDS is an important theme. The household survey revealed that 60% of women and 50% of heads of household had attended at least once a health information session. The material is adequate. The quality of the sessions could not be assessed.

Preventive consultation for under-fives and antenatal care are given during special sessions, twice or three times a week. Under-fives are weighed and the health worker notes the weight on the growth monitoring chart. Only very general advice on feeding is given to the mothers. Consultation observations and exit interviews revealed that none of the undernourished children received any special attention or treatment. Previously, a food provision programme had been running in the area, but as, apparently, the food did not go to the children in need, the programme was stopped. It was never subsequently replaced by better-targeted measures for undernourished children. Generally, antenatal care was carried out according the guidelines. All pregnant women received proper anti-malaria prophylactics.

Concerning curative care, therapy guidelines for the most important diseases are available in all the CSPS but these instruments are not used on a regular basis. Nonetheless, client observations and exit interviews revealed that most drug prescriptions (26 out of 33) were rational.

Responsiveness of the system

Client exit interviews revealed that most people were satisfied with the health workers' performance. Clients reported that they were treated with respect and that the health worker carefully listened to them. The majority of the health workers explained what they were doing. However, only once was the patient's opinion asked for. Consultation observations confirm these positive findings.

Fairness of the system

Fairness is inadequate as fees are charged and there are no formal exemption mechanisms. In four of the nine CSPS, a 'fee for services system' is applied and in all nine, essential drugs are being sold. At national level, no guidelines exist for exemption from payment for those who cannot afford to pay. At local level, several informal mechanisms do exist, such as the provision of donated drugs, or drugs on credit, which are reimbursed

in instalments. At village level, people often help one another, collecting money in order to provide the poor with the necessary treatment.

Health behaviour

Vaccination coverage in the Kaya district increased from 1997-1999. Despite the considerable increase, it is still very low. Table 14 shows the findings.

Table 14 Evolution of vaccination coverage of under ones given in percentages; 1994-1999

Year	BCG	DTP Polio3	Measles	Yellow fever
1994	64	41	45	45
1995	74	47	56	56
1996	53	37	55	28
1997	46	28	33	27
1998	52	31	38	33
1999	60	42	53	50
2000	79	56	58	55

Obstetric care has increased substantially. Health office data reveal that despite a reduction in trained personnel, deliveries assisted by health workers or trained village midwifes increased from 13% of expected deliveries in 1997 to 40% by 1999. For contraceptive prevalence, only national data is available. It increased slightly from 8% in 1993 to 12% in 1999. Midwives in the health services and in the villages indicated that more and more women are using contraceptives. From 1997-1999, health services utilisation for curative care in the Kaya district increased from 0.12 to 0.22 new contacts per person per year. This number is still very low, compared with an estimated 'need' of at least two new contacts per person per year.

Findings from the household survey revealed that, during their last pregnancy, more than half of the mothers visited a CSPS for antenatal care. Three-quarters had their baby accompanied by a village midwife and about a quarter had their baby at the CSPS. These numbers are substantially higher than the data from the health office. The discrepancy can be explained by the fact that not all the midwives, mentioned by the mothers, were trained midwifes. These 'untrained' midwives do not report to the health office.

Almost three-quarters of the mothers (72/104) expressed the wish for birth spacing and

28 mothers used modern contraceptives. About 70% of the under-fives were brought at least once a year to a CSPS for preventive consultation.

In case of sickness, 40% of the mothers went to a CSPS during the last illness episode of a child. Rational drug use could not be assessed in the household interviews, although it could in the exit interviews, where it proved to be low. Out of 33 clients receiving a prescription, only 14 could explain how to use the drugs. In other words, though the health workers explained what they were doing, the patients did not retain the information that they received about drugs.

Key informants in two health centres attributed the increase of curative consultations to the availability of drugs at a reduced price, to intensified promotion and to improved quality of care. Nonetheless, in their view several factors impeded a further increase. In the rainy season health centres are not accessible, and even in the dry season access is difficult due to lack of transport. Though available at a reduced price, many people still cannot afford to pay for drugs. Health workers are relatively young, there is a high turnover amongst them and hardly any women work in the CSPS. None the above factors build confidence among the population. Finally many patients practice self-treatment or go to traditional healers.

Interviews with community leaders and the household survey confirmed these findings. Most people in the households expressed their appreciation for the health services (CSPS) and only a few voiced complaints, such as long waiting times or absence of a water source in the CSPS. Most people felt that the distance to the centre was too great, especially in the rainy season. The great majority of the villagers interviewed were of the opinion that the health post (PSP) in their village was not functioning well. The health worker did not have the necessary drugs nor sufficient training. This explains why traditional healers are widely consulted as a first resort. People consider them as the only ones able to heal certain diseases, such as epilepsy, impotency and sickness caused by the 'evil eye'. Their treatment is not considered adequate for other diseases, such as meningitis, tetanus or AIDS. The healers themselves confirmed these attitudes. Out of 20 traditional healers interviewed, 15 stated that people consulted them first. All healers indicated that sometimes they refer the patient, either to a CSPS or to a colleague.

Health outcome

Due to lack of data on child and maternal mortality at district level, health outcome could

not be measured. Improved vaccination coverage makes a slight improvement likely. At national level, a decrease in maternal mortality has been observed in the period 1997-1999.

Summarising the findings: the field study identified strengths and weaknesses in both the health system and health behaviour. The support to the Kaya health region has thus potentially made a positive impact on the health situation, though on a limited scale.

6.8 Conclusion

The overall evaluation results give a varied picture. Highlights are the Kaya primary health programme, CAMEG and the two smaller projects in the field of reproductive health. The tuberculosis programme had limited results. The UNFPA projects were not successful.

- The Kaya primary health programme obtained important improvements in the organisation of the health system. Major weaknesses are the continuing low service utilisation at CSPS level, the low level of fairness in the system and the low quality of care in the villages.
- CAMEG led to the increased availability of essential drugs in the periphery. However, due to the low utilisation of services, these drugs are not always used. In addition, CAMEG initially faced major problems in stock rupture and financial administration.
- Major investments were made through the tuberculosis control programme, which aimed at better case detection and treatment. However, the number of patients detected and treated properly hardly increased and remained well below target.
- In the field of reproductive health, the evaluation could not reveal any tangible results of the projects supported through UNFPA.
- The ABBEF study into sexual and reproductive health needs was carried out properly and the study results have been used in the design of a project in the field of reproductive health.
- The project aimed at the incorporation of reproductive health in the curriculum of the National School of Public Health and has reached its objective.

The support to the Kaya sanitary region, CAMEG, ENSP and the ABBEF study are judged efficient. The efficiency of the other programmes was limited. Except for the UNFPA projects, all programmes were sustainable at institutional and policy level. CAMEG also proved sustainable in financial terms.

With respect to health outcome in Kaya district, lack of data makes judgement difficult. The increased immunisation coverage has potentially led to a slight improvement in health outcome.

The overall conclusion is summarised in the following table.

Table 15 Summary of evaluation results in Burkina Faso

Programme	Highlights and weak points	Relevance	Effectiveness	Efficiency	Sustainability	Impact
Support for primary health care in the Kaya region	s Increased access to, and quality use of, MCH services s Improved planning and organisation of the health system t Neglect of community health	++	+	+	+	±
Essential drugs programme	s Availability of essential drugs in peripheral health centres t Serious management problems in the first years	++	++	+	++	±*
National tuberculosis control programme	s Improved organisation of tuberculosis control t Hardly any increase in case finding and treatment	++	±	±	±	NA
Support to UNFPA	s Contribution to the formulation of a national reproductive health policy t Lack of institutional cadre t Complex administrative procedures	±	–	– –	?**	NA
ABBEF study in sexual health needs	s Utilisation of study results	±	++	+	NA	NA
Introduction of reproductive health in the Public Health School curriculum	s Good quality training programme	±	++	+	++	NA

* Impact only measured in Kaya
** Could not be assessed.
NA: not applicable

7 Synthesis of findings and emerging issues

7.1 Comparative assessment of the Primary Health Care (PHC) programmes

7.1.1 Introduction

This evaluation included seven PHC programmes, implemented in the period from 1995 to 1999: three in Mozambique (Angoche, Prindesa and Memisa), three in Yemen (Hodeidah, Aden and Dhamar) and one in Burkina Faso (PASSPK Kaya). In total almost 40% (20.4 of 52.6 million Euros) of total Dutch development co-operation in the area of health in the three countries has been spent on these PHC programmes. On the basis of document review, key person interviewing and site visits, all these programmes have been assessed in terms of policy relevance, effectiveness, efficiency and sustainability.

In addition, in each country one of the PHC programmes has been assessed in more detail in a field study: Angoche in Mozambique; Hodeidah in Yemen; and Kaya in Burkina Faso. These studies focused on the structure and performance of the health system, as well as on the health behaviour of the population. As explained in chapter 2, the assumption is that positive effects in these areas together will be likely to have a positive impact in terms of a better health status of the population.

The primary health care approach is an essential component of the respective health policies of the three receiving countries and of development co-operation in the Netherlands. Generally speaking the seven PHC programmes aim to improve access to, and the quality of, primary health care. With the move of Dutch development policy towards a sector-wide approach, the emphasis has shifted gradually from community health to institutional strengthening. As we have seen in the previous chapters, specific objectives and the scope of the various programmes differ substantially. In the country chapters we have also seen that the PHC programmes differ in terms of results obtained. We now turn to a comparative assessment of the programmes in terms of effectiveness and efficiency. For the programmes assessed in the field studies, the effects on the structure and performance of the health system and on health behaviour are also compared.

7.1.2 *Effectiveness*

Effectiveness in this evaluation is assessed by analysing to what extent the programmes' and projects' objectives have been realised. In the preceding chapters, we have seen that effectiveness of two PHC programmes (PASSPK Kaya and Hodeidah) is evaluated as good; the effectiveness of three other PHC programmes (Aden, Prindesa and Angoche) is found to be limited; and the effectiveness of the two remaining PHC programmes (Dhamar and Memisa) is judged weak. A comparison of the effectiveness of these programmes resulted in the following key-findings:

Ambitious objectives: A frequent conclusion in the country evaluations is "the initial objectives were too ambitious". This was the evaluation teams' conclusion with particular regard to the PHC programmes in Yemen and the two programmes in Mozambique (Angoche and Prindesa). In the three Yemen programmes and in the programme in Angoche, the objectives *were* changed over time into more feasible ones and the strategies were adapted too. The Angoche programme for example focused more directly on improving basic health services, including community based health care. And the Dhamar programme limited the number of districts. The fact that these changes were made after a midterm review or evaluation, underlines the importance of timely assessments.

Focus on hardware: The current evaluation findings show that most of the PHC programmes evaluated have been successful in achieving objectives which improve the health system structure, such as: the building of new health centres and the rehabilitation of existing facilities; improvements in equipment and transport; and strengthening the supply of essential medicines. Training activities were also successfully accomplished. Fewer results were obtained in the areas of care quality enhancement, equity, community participation, and inter-sectoral collaboration. This was also found in the evaluation of Dutch PHC programmes in 1988.[52]

Improvements in infrastructure form an essential part of efforts to improve health and health care. However, without improvements in the quality of care, these investments are not likely to have any impact on health outcome. There are, though, some positive findings in this area. A highlight is the introduction and training of murshidat by the health programmes in Dhamar and Hodeidah. The murshidat is a female health worker who

52 *IOV 1988.*

provides preventive services both in health facilities and at community level. The introduction of these health workers enhanced the accessibility to, and the quality of, mother and child care and reproductive health. Another positive example is the inter-sectoral collaboration in Hodeidah and Dhamar. PHC programmes here have been successfully working together with a non-health organisation, the Yemenite Women's Union. Many women were found to be participating in various training activities, and the political participation of women has increased.

Varied success in institutional strengthening: Institutional strengthening is considered a precondition for improving both the health system structure and the quality of care. It was an objective of all but one of the PHC programmes. The extent to which this objective has been achieved, varied substantially among the programmes. The Prindesa programme in Nampula (Mozambique) had an institutional focus from the very start. It carried out some very good studies at provincial level, whose results could have been applied to improve planning. At the time of the evaluation this had not yet happened. Angoche, the other programme in Mozambique, only very partially succeeded in the strengthening of the district health offices. In Yemen, the picture is varied. In Hodeidah, the co-operation with the health office was good and led to improvements in the organisation of the services and in the health information system. However, the successes proved not to be sustained after external financing was withdrawn. In Aden, successes were negligible and in Dhamar, hardly any results were observed. In the Kaya programme in Burkina Faso, various mechanisms for improved planning of services were put in place, and here the institutional strengthening is considered successful.

7.1.3 *Efficiency*

Efficiency in this evaluation has been considered in terms of both cost-effectiveness and appropriate management (which is taken to include a good monitoring system and transparent financial administration). Ideally, efficiency means making an assessment of the costs of alternative approaches, and then taking an informed decision based on the most cost-effective of these. This has, however, not been the case for any of the PHC programmes.

In general terms, the efficiency of the evaluated PHC programmes varies widely. The PASSPK in Burkina Faso and the Hodeidah programme in Yemen are found to be the most efficient, though even these two programmes reveal failures in efficiency. Three of the PHC programmes – Angoche, Memisa and Dhamar – were found to be lacking in efficien-

cy. In Dhamar, Angoche and Memisa, the objectives could not be achieved and activities were not implemented according to plan, hence these programmes were not cost-effective. The Aden and Prindesa programmes can be placed somewhere in between the two extremes. The limited efficiency of the Prindesa programme is mainly due to external factors, i.e. the fact that the planned second phase will not be carried out, makes some of the implemented programme activities inefficient.

The two most effective programmes are found to be the most efficient as well. Both the Hodeidah programme and the PASSPK have been able to achieve their main objectives – increasing access to, and quality of, PHC services – within their allocated budget. A combination of the appropriate technical approach allied to adequately functioning managerial mechanisms plays an important role in these successes. In Hodeidah, for example, the training of the female health workers is considered to have been a very cost-effective approach. Training of higher-level health professionals would have taken much more time, and hence would have been much more expensive.

Comparison resulted in the following key-findings:

Huge variations in appropriateness of management: In Hodeidah, project management was appropriate. However, two managerial mechanisms were identified, which clearly diminished the efficiency of the programme. These were: the requirement for the RNE to tender internationally for building activities; and the difficulties involved in accessing money recovered through a cost-sharing policy. According to some informants, money disappeared as a consequence of this.

In the case of PASSPK, in Burkina Faso, the management of the project was adequate. A high organisational level allowed the programme to discover its own limited financial management capability, and to find a solution for this in the form of contracting an external office for its financial administration.

Weak programme cost-effectiveness was found to be associated with two factors: organisational and managerial problems within the project; and problems in the articulation of the projects with existing state health care institutions in the area.

All Mozambican programmes and projects suffered from managerial problems. The Memisa project in Mozambique was even ended early because of management

problems within the implementing agency. And for the Angoche programme in Mozambique, late availability of funds in the first phase of the programme, and difficulties in recruiting personnel (local and foreign) were important factors limiting programme implementation. The limited efficiency of the Prindesa programme in Mozambique is related to discontinuities in donor support. The Prindesa programme was defined as a preparatory phase to be followed by a comprehensive co-operation programme. But the decision process on the continuation of the programme took so long that it led to uncertainties, which influenced efficiency in a negative way.

In Yemen, mismanagement was reported in the Dhamar PHC programme, resulting in a failure to implement the rural primary health programme. In both the Aden and Dhamar programmes in Yemen, insufficient co-ordination with the public health office was found to be a major factor impeding the execution of planned activities.

Limited adequacy of monitoring systems: The evaluated PHC programmes had different monitoring systems and approaches, and most of them did not function very adequately. The PASSPK in Burkina Faso forms a positive exception to this general statement. This programme was also subject to an external evaluation, which led to the work programme being adapted.

In Yemen all programmes are well documented with progress reports, which in principal allow for both plan adjustment and accountability to the donor. However, these progress reports were superfluous and descriptive, and did not lead to modifications in the work plans. The same goes for the progress reports of the three Mozambican PHC programmes.

Midterm evaluations though *did* lead to major adaptations in the objectives and the work plans of the three programmes in Yemen and in Angoche. Two programmes were never evaluated: Prindesa's request to have a final evaluation was not approved by the RNE in Mozambique; Memisa stopped long before planned.

Programmes predominantly transparent: Efficient programme implementation requires an adequate accounting system to monitor expenditure and to avoid fund leakage and fraud. Five of the seven PHC programmes (the three Mozambican, PASSPK and Aden) were found to be transparent and no irregularities were detected. In the Hodeidah programme, some problems occurred regarding the management of the drug fund,

but besides this, the general accountability of the programme was found to be good. In the Dhamar programme, a serious case of fraud was detected in 1995 and staff changed as a consequence. The financial administration has not been sufficiently transparent. In 1999, a new audit revealed that some procedures were still not appropriate.

7.1.4 Impact

Impact has been studied in the following areas only: in the city of Hodeidah in Yemen; in the Kaya district in Burkina Faso; and in the Angoche district in Mozambique. At the time of the evaluation, the primary health programmes with Dutch support had been implemented in these locations for at least four years. As explained previously, impact in this study has to be understood to mean 'likely impact'. It is measured by an appraisal of the following intermediate factors: improvements in the structure and performance of the health system and in the health behaviour of the population. The health system has been assessed using observation and interviewing at services level. A household survey and focus group discussions aimed at gathering information on health behaviour. In addition, health statistics have been researched to check health services utilisation and health status. However, it transpired that reliable statistics on health outcome at district level were not available. Below we review the results of the field studies for each of the intermediate factors.

Effects on structure of the health care system

All PHC programmes aimed at improving the health system structure. In the field studies, the following improvements were reported:

Successful rehabilitation of facilities, equipment, and means of transport: In all three PHC programmes, improvements were achieved in infrastructure, equipment, means of transport and in maintenance. Between the three programmes, there is a huge variation in the level that has been reached. This is understandable given the very different individual situations which prevailed at the beginning of the respective programmes. The situation in Angoche is the least favoured all round, with lack of transport and communications facilities posing major problems, especially in the case of (obstetric) emergencies. In Kaya district, the health posts in the villages were found to not be equipped; they were therefore not functional either.

Successful training of health workers and/or community health workers: Training was an important element of all three programmes and it led to the improvement of service delivery. In Hodeidah and Angoche, the training of (female) community-based health workers contributed to increasing access to basic health services in peripheral zones. However, in neither Mozambique nor Yemen is the national policy on community health workers properly defined. Community health workers, in practice, are not remunerated properly and do not have the basic means to provide adequate services. This seriously limits the effectiveness, and subsequently the sustainability, of training efforts. In the Kaya programme, training of community-based health workers has been neglected. This reflects national policy in Burkina Faso, where services at community level are no longer part of the public health system.

Supervision improved: All three PHC programmes have introduced or reintroduced a supervision schedule. In Kaya, the village health committee has come to play an important role in the supervision; in Angoche, 'integrated supervision' has been introduced; in Hodeidah an elaborate system for quality assurance was set up. After the programmes ended, supervision in the Hodeidah and Angoche programmes deteriorated, due to lack of money to pay related costs.

Motivation of staff generally improved: The variation in motivation level in the three programme areas and among different types of health workers, clearly reflects the 'incentives' they received. When working and living conditions are substantially improved – as was the case for the health staff in Burkina Faso and for the murshidat in Hodeidah – health workers are motivated. When this is not the case, or barely so – as for the community-based health workers in Kaya and most of the health staff, village health workers (VHW) and traditional birth attendants (TBA) in Angoche – health workers are less motivated. In these latter examples, it is vital that appreciation for their work be expressed, either by the population or by senior staff during supervision, in order to prevent a state of complete de-motivation.

Inadequate supply of drugs and vaccines: The supply of drugs at district level is found to be irregular across the board in Angoche and Hodeidah, and almost non-existent at the health posts in Kaya (reflecting Kaya's neglect for this lowest level of health care). Vaccine supply is irregular in Kaya and Angoche and stock ruptures were reported. The supply in Hodeidah is regular. Details on drug availability, drug funds and rational drug use are provided in next paragraph, which deals with the essential drugs programmes.

Results relating to health services management varied: In Kaya district, adequate management procedures and tools are in place and are reasonably used. In Hodeidah, this has only partially been achieved. In the Angoche programme, this objective was not systematically pursued, although some of the Angoche health staff followed management-training courses facilitated by Prindesa.

In Kaya, Hodeidah and Angoche, community health committees have been set up to assist in the management of the health centres. In Kaya and Hodeidah, these committees were given responsibility in planning and (financial) management. An important task of these village health committees is the management of revolving drug funds. However, not everything is functioning smoothly. In Burkina Faso, village health committee members all lived locally and thus were unrepresentative of the Kaya health centres' catchment area population. In Hodeidah, the committees were found to be limited by administrative procedures in their capacity to use the funds, and there was an apparent unwillingness, on the part of the finance officers responsible, to make the resources available to the community. In Angoche district, community committees no longer existed by the time the evaluation was carried out.

Health information system improved: In Kaya and Hodeidah, the health information system (HIS) has been improved. This is not the case in Mozambique. In Kaya, the information has been used for improved planning in the field of drugs. In Hodeidah, the improved HIS has not been used either for monitoring or for evaluation.

Effects in terms of performance of the health system

The performance of the health system was assessed by looking into the clinical effectiveness, the responsiveness and the fairness of the system.

Clinical effectiveness in this evaluation refers to how appropriately health care providers administer health promotion and preventive and curative care. Curative care has been measured by the way health workers use curative guidelines and prescribe essential drugs for predominant health conditions.

Neglect of nutrition: All three programmes have almost fully neglected the nutrition issue. Weight control of children under the age of five is commonly done in all health centres. However, growth-monitoring cards are often not available, and if they are available, they

are not properly used. The growth curve is often not completed. Feedback and advice given to mothers is minimal and very general. Health workers do not inform mothers about vaccination. No clear policy guidelines exist on how to treat undernourished children.

Quality of curative care varied. In all three PHC programmes therapeutic guidelines had been developed or adapted. Quality of curative care was studied in the health centres by looking to see whether these guidelines were applied in the treatment of diarrhoea and acute respiratory infections. Observations and interviews revealed a different picture among the three PHC settings. In Kaya and Angoche it was found that the treatment guidelines were hardly ever used, but, in spite of this, drug prescription still remained predominantly in line with clinical guidelines. In Hodeidah, the reverse was true: guidelines were used and essential drugs were available, but prescription of drugs was by trade name, which led to unnecessary extra costs for the patients.

Responsiveness of the health system to clients is a measure of how the system responds to perceived health needs, including needs at the interpersonal and communicational level. Responsiveness is an important determinant of health services utilisation. If people do not feel well treated, they will be reluctant to return.

Responsiveness good: In all three settings, the majority of clients expressed their satisfaction – in exit interviews – with the way they were treated by health personnel. The latter show respect and adequate concern for their clients; they listen well and give opportunities to ask questions. Consultations (with the exception of the weighing sessions) are said to take place in private and clean places, and adequate information is provided about treatment. In Kaya, the evaluation team confirmed these findings: relational skills were found to be rather good. In Hodeidah however, the evaluation team – in a finding also based on consultation observation – gave a negative judgement on the inter-relational and communication skills of the health staff. In Angoche, the health centres were found to not be clean, and even though no consultation observations were carried out, the evaluation team questioned the accuracy of the rather too positive judgement of the health staff's inter-relational skills.[53] Waiting time, another indicator for respect, was short in Hodeidah and Kaya (hardly ever more than 30 minutes), and reasonable in Angoche (about one third of the clients waited more than an hour).

53 *Both the Mozambican and Yemen evaluation teams note that clients – when answering these questions – might be influenced by the interview setting (close to the health centres) and feel inclined not to speak negatively about the health workers.*

Another element of responsiveness is that there should be no discrimination on the grounds of ethnicity, class, gender, age or marital status. In Yemen and Burkina Faso, health workers indicated that they do not provide contraception to women without their husband's consent.

Fairness of the health system means that the risks each household faces, due to the costs of the health system, should be distributed according to the ability to pay rather than to the risk of illness. The introduction of user fees and fees for drugs in public health systems can make the system less fair. Exemption policies and the correct implementation of such policies have the potential to restore the fairness of the system and protect the poor. A fair finance system ensures financial protection for everyone.

Fairness varied but generally low: In all three countries, fees for both services and for drugs were introduced in the 1990's. However, *equity* concerns were dealt with differently. In Kaya, no exemption policy has been defined. In Hodeidah, an exemption policy with a set of indicators has been developed and implemented during the project period; this identifies risk families who are then exempted from paying for services and drugs. At the time of the evaluation however, these criteria were no longer in use. In Mozambique, people can get an exemption if they show an '*atestado de pobreza*'(statement of poverty), a document which can be obtained from the local administration. In practice however, health personnel in all three settings act in a very similar way when confronted with patients who cannot pay the 'doctor's bill': they search for an ad hoc solution. Though this is a very friendly gesture to the individual patient who profits from it, such ad hoc solutions create a situation of dependence on the good will of health personnel, and cannot be considered fair. It might be suspected – though this has not been systematically studied in this evaluation– that people do not visit the public health centres because they cannot afford to. If this is true, user fees may increase inequity in access to health.

Health behaviour

Ultimately, health is determined by the health behaviour of individuals and families. Good health care – clinically effective, responsive, and fair – should lead to increased utilisation of the health services and encourage healthy behaviour to prevent ill-health. This evaluation has studied how people use the health services and what they do to prevent disease.

Utilisation of health services varied: Data was collected on the utilisation of immunisation, family planning, antenatal care, curative services and delivery care, which are key areas of PHC. Utilisation of the public health services differs among the three evaluation settings. In Angoche, almost all the women interviewed in the household survey visited the nearest public health centre for curative and/or preventive services, both for themselves and for their children. For the population in Angoche, few alternative health care facilities are available besides traditional healers, who are also popular.

In Hodeidah, there *are* alternative health facilities available in addition to the public health centres: private clinics, hospitals, charity clinics, and a range of traditional healers. In the majority of the households, the public services – which have been strengthened with Dutch support – are used by mothers and their children for preventive care. For curative care, however, they hardly ever visit public health centres. Especially in cases of serious childhood illness, mothers prefer to take their children to the private health care sector. When they are themselves ill, women rarely seek any professional help, opting instead for home treatment and self-medication.

In Kaya, most women use the preventive services of the public health centres. Utilisation of public services for curative reasons is low: only 39% of women interviewed visited the health centre for the last episode of illness in their family. One reason mentioned for not using the centres was the long distances that had to be travelled to get to them. The general preference was for self-care and traditional medicine.

In all three settings mothers highly appreciate vaccinations as a preventive health service. Vaccinations are nearly always obtained from the public health system and not from private services. Still, coverage levels are not uniformly high in the three settings. The Hodeidah household survey shows very good coverage; data that is not confirmed by health office statistics. In Angoche, the picture is different and vaccination coverage is low. Strikingly, seven recently-born children had not received any vaccination whatsoever. Their mothers claimed that they *had* visited the health centres, but that at the time vaccines were not available. This story was later confirmed by other sources. In Kaya, statistics indicated that coverage had increased over the last five years, but was still low. This finding was subsequently confirmed in the household survey.

The household surveys also collected data about women's wishes regarding *birth spacing and use of contraceptives* (table 16).

Table 16 Birth spacing and use of contraceptives

Contraceptive demand/use	Yemen (%)	Bukina Faso (%)	Mozambique (%)
Demand for birth spacing	81.7 (n=120)	69.2 (n=104)	39.6 (n=101)
Actual contraceptive use (% of demand)	31.6 (n=98)	38.9 (n=72)	52.5 (n=40)

The number of women who do not want to become pregnant during the next two-year period is highest in Hodeidah, followed respectively by Kaya and Angoche. Use of contraceptives varies considerably among the three study settings: in Angoche, half the women who do not want to become pregnant use modern contraceptives; while in Kaya and Hodeidah the percentage is considerably lower. In other words, in these locations there is a high unmet need for contraceptives.

In all settings, contraceptives are generally obtained from the public health centres. In Hodeidah, the women give several reasons to explain the 'unmet need': natural spacing applied (breastfeeding, menstruation not yet returned), non-approval of husband, religious objections, and/or perceived side effects. In Kaya, some VHWs say that the demand for contraceptives has increased, but that contraceptive use is still low. As reasons for this low use, they cite: the husband's resistance (marital consent is required by health workers); the lack of female staff at the health centres; and the frequent presence there of local dignitaries, which hinders health staff in communicating freely with their clients. In Angoche, some women used 'natural spacing' and others said that they needed the permission of their husband (and in some cases of another relative, as well) to use modern contraceptives.

The proportion of women who reported *visiting antenatal care services* in a public health centre at least once during their last pregnancy is high: Angoche 99%, Hodeidah 84 % and Kaya 62%. Information on where and with whom the last delivery took place gives a different picture. In Kaya 75% of women delivered with the assistance of a TBA, and 25% in a health centre. In Hodeidah home-delivery is also the rule: 78% of women delivered at home, assisted in almost half of the cases by a community midwife. The murshidat rarely assist deliveries. In Angoche, women usually deliver in a health unit (reported by 70 out of

101 deliveries), 8 (of 101) women delivered with a TBA. Almost one quarter of the women delivered at home without trained assistance.

7.1.5 *Concluding remarks*

Seven programmes were assessed on the basis of documents, key person interviewing and sight visits. Three of these programmes were studied in more detail, on the basis of a health services inspection and a household survey. The structure of the public health system and the capacity of public health staff has improved due to programme intervention. In terms of strengthening the public health institutions, only two programmes obtained good results and only one good and sustainable results.

The quality of care could be measured for the three programmes studied in detail. Two of these programmes have contributed to better health system performance. The clinical effectiveness of the interventions is generally good for most preventive programmes. It is also these programmes which are most used by the population. However, nutrition is not adequately addressed in the preventive services for the under-fives. Responsiveness is generally good. Fairness is a problem in all programmes and leads to the conclusion that the PHC programmes have not specifically focused on improving the situation of the poorest in the programme areas.

Health system performance is better in Yemen and Burkina Faso, but health care utilisation is highest in Mozambique. This is partly explained by the fact that, in Burkina Faso and Yemen, people can go to the private sector for what is generally believed to be better health care. In the Angoche district in Mozambique, this is hardly an option. People depend on the public sector and seem to value whatever it has to offer. In all field study areas, preventive services utilisation has increased.

By implementing primary health care in a distinct geographical area, the PHC programmes not only reinforced existing PHC policies, they also provided lessons to the respective Ministries of Health, which inform and influence future health policies and strategies in the receiving countries. In Yemen, the Hodeidah programme contributed to the formulation of the Yemen health reform policy regarding cost-sharing mechanisms, the home visiting strategy of the *murshidat* and the Essential Drugs Programme. In Burkina Faso, a number of mechanisms for planning and cost control, as implemented by the PASSPK, are nowadays integrated elements of the national health policy. In Mozambique, the Provincial Strategic Health Plan, formulated by the Nampula health

directorate and Prindesa, is referred to as an example of how a 'swap' can be prepared at provincial level.

This move to strengthen the health system is considered a necessary condition to improve its structure and performance, and thus promote better health behaviour too. However, the downside was that it went hand-in-hand with a neglect of community health. As a major part of the population, especially those living in rural areas, does not have access to public health facilities, this neglect of the community level is a policy failure.

7.2 Review of country level support to Essential Drugs Programmes

7.2.1 *Introduction*

Support to essential drugs programmes has been an important component of Dutch Development Aid over the past ten years. Though, as we have seen, there are no separate policy guidelines on support in this sub-sector, those guidelines developed by WHO are followed.

As described in chapter 2, a national drug policy (NDP) includes: legislation, regulation and guidelines for the pharmaceutical sector; selection of essential drugs; supply mechanisms; pharmaceutical quality assurance; rational use of drugs; and sustainable financing. In the implementation of essential drugs programmes, there has to be a balance between these various components. In practice, it is often procurement and supply that are emphasised. However, without training in the rational use of drugs, the programmes are not likely to have positive health outcomes.

Support for essential drugs differs in the countries included in this evaluation. In Yemen, support is given to the implementation of the Yemen National Drug Policy, including all the NDP components mentioned above. The NDP is implemented by the Yemen Drug Action Programme (YEMDAP). In Mozambique, the support is mainly for the purchasing of essential drugs. Other major donors include Ireland, Denmark, Switzerland, United Kingdom and Norway. The bulk of Dutch funding is used to buy drug kits, which are directly distributed to peripheral health units. Another part is used to supply drugs (not in kits) to referral health centres and hospitals. Institutional strengthening is also included in the programme's objectives. In Burkina Faso support has been given to CAMEG (la Centrale d'Achat de Médicaments Essentiels Génériques). CAMEG is an autonomous agency that aims at making essential generic drugs accessible at 'social'

prices and guaranteeing the availability of high quality drugs. It has been operating as a non profit-making company since 1998. Support to CAMEG was not for drugs, in contrast to that in the other countries.

Support to essential drugs programmes accounts for around 50% of total Dutch health-related development co-operation support to the three countries (52.6 million Euros in the period 1995-1999). Most of this money has been spent on drugs – only around 10% on capacity building to strengthen supply systems and encourage rational use of drugs.

Support for essential drugs is congruent with the aim to strengthen basic health services. Health services without drugs are not likely to be used by the population. The support is also congruent with the national essential drugs policies in the three countries. The findings are based on document review and key person interviewing. The field study allowed for assessing the availability of drugs in health services and their rational use among the population in the districts where the study was carried out.

7.2.2 *Effectiveness*

Within the pharmaceutical sub-sector, effectiveness of the Dutch Development Co-operation support is greatest in Burkina Faso. Here, focused support to capacity building has contributed to a well-run, autonomous agency which ensures a regular supply of affordable essential drugs in the country. The objectives of the Dutch-funded work programme were realistic and have been met. In Yemen and Mozambique, the bulk of the funds was spent on the procurement of essential drugs. Procurement support has proved effective in both countries. The effectiveness of the capacity building components of these programmes is also good. The capacity of health administrators in the different Health Ministries has improved; legislative amendments and procedures have been put in place; and monitoring and evaluation systems have been improved. The distribution of drugs to health centres in the periphery in these two countries, however, proved to be problematic. And, in all countries included in the evaluation, the issue of rational drug use was not adequately addressed.

The field study in Burkina Faso revealed that in peripheral health centres, generic drugs are generally available at fixed prices. However, prices are high compared to other countries in the region. The supply of essential drugs was regular during the past 12 months in 8 out of the 9 health centres included in the Kaya district study. Manuals on how to treat predominant diseases, such as malaria, diarrhoea, ARI and sexually trans-

mitted diseases, are available in nearly all health centres, and 26 out of 33 curative consultations observed were treated in accordance with the guidelines. Exit interviews indicated however, that only 14 of the 33 patients bought medicines in compliance with the prescription, indicating possibly that the costs of the medicines were too high. In Burkina Faso, people pay a fee for each medicine obtained in the health centres. Household interviews demonstrate that people value the availability of essential drugs in the health centres at affordable prices; however only 39% of respondents answered that they would go to the health centre as a first resort in case of illness.

In Mozambique, the multi-donor support programme has contributed to improving drug logistics. The planning of drug supply for the districts is based on recent consumption of medicines. The provincial drug store is supposed to supply drugs to the districts every three months. Drugs are then supplied to the different health centres in the district by the district drug store. The drugs are supplied in kits, whose contents depend on the level of the health centre/community health worker. There is a control system for stocks of drugs and vaccines, which, though simple and manual, seems to be effective.

Despite the improvements in planning and the existence of a control system, drug distribution to the periphery is still a major problem. The Mozambique team reported that most essential drugs were not available in the health centres. Partly this is caused by the shortfalls in the overall budget for drugs: only 50%of the drug requirements are covered by the budget.

The field study in the Angoche district in Mozambique revealed how the drug supply system works in practice: delays in provision, insufficient quantities supplied, transport problems, and problems with drug quality are reported. Due to the problems in drug supply and quality, there have been regular ruptures in supply in the past four years. During the period of field observation, all health centre pharmacies were almost empty; even chloroquine and aspirin were not available.

Observations of drug prescription practices indicate that when the drugs are available, the quality of prescribing is relatively good.

Regarding the implementation of the essential drugs programme in Yemen, YEMDAP, progress has been made in the drafting of legislation, contributing to the setting up of a drug fund which will operate as a semi-autonomous revolving drug fund. A national drug

policy has been formulated and essential drugs lists and treatment guides published and distributed. A mechanism for procuring drugs has been set up, and a first batch of drugs worth 4.1 million Euros distributed to regional warehouses. However, here too, problems occurred further down the pipeline. Key persons indicated that it was unlikely that these drugs ever reached the health centres. The second batch of drugs, also worth 4.1 million Euros, served as the start-up 'capital' for the Drug Fund. At the time of the evaluation, it was impossible to judge to what extent these drug had reached peripheral health centres. The field study revealed that most essential drugs were available in the main centres, but not in the sub-centres. Even when available, essential drugs were not prescribed by health workers, indicating a degree of neglect in the training of health workers on rational drug use in the essential drugs programme.

The main problem concerning the rational use of drugs in the health centres in Hodeidah, was that the physicians on duty during the curative service hours, distrust the essential drugs supplied to the health centres by generic name. Physicians tend to prescribe pharmaceuticals by trade names. Private pharmacists around the health centre, and pharmaceutical representatives visiting physicians on duty, encourage this practice. Physicians sometimes even instruct patients to go to the pharmacy to buy a specific trade name, and to return to them in order to check whether this has happened. This practice contradicts their protocols. As a consequence, people are paying unnecessarily high prices for drugs which can also be obtained as generics from health centres.

The negative findings on rational drug prescription in the field studies in Hodeidah and Kaya, can be explained in part by the fact that the national essential drugs programmes have neglected this issue. Some educational initiatives were developed in Yemen, where YEMDAP included a course on teaching rational pharmacotherapy for teaching staff at universities and health manpower institutes. Also, public information materials have been developed on drug use during pregnancy and schoolbooks published on the rational use of drugs. However, in terms of reaching out to the prescribing health worker and the general public, coverage of this issue is limited. Thus, while overall the supply of essential drugs has improved, the positive effects of the intervention are likely to be limited due to problems linked to distribution and the irrational use of drugs.

7.2.3 *Efficiency*

The efficiency of Dutch development co-operation support to CAMEG in Burkina Faso is judged to be good. With a relatively small amount of support, the institution was

strengthened and it is now a self-financing NGO. However, efficiency problems were reported at the beginning of the programme. An audit identified the following problems in the management of the drug supply: delays in the supply of drugs, expiry of drugs and inadequate amounts supplied. In Yemen and Mozambique, 80% and 90% respectively of the funds are spent on drug procurement. In Yemen, procurement is conducted efficiently by the Ministry of Health; in the Mozambique programme, drug procurement was implemented by the Dutch company "Nederlands Inkoop Centrum". This is surprising, as the other donors who have pooled their contributions for drugs, have assigned this responsibility to the Mozambique Ministry of Health, which has set up an autonomous agency to deal with procurement (CMAM). It seems inefficient to utilise two different procurement mechanisms to provide support to the Mozambique essential drugs programme.

In both Yemen and Mozambique, problems are reported in the drug distribution system. In Mozambique, drugs are distributed to the peripheral level in drug kits. A kit-related efficiency problem is that drugs differ from kit to kit, and shortages of some drugs can occur before the next batch of kits arrive, as illustrated by the data from the Angoche field study and presented above. In 1997, an external evaluation revealed that only a fraction of the drugs that are not distributed as kits reached the districts.

In Yemen, there is no data from YEMDAP on the efficiency of supply of the first batch of drugs sent to the health centres. Key informants suggested that there were distribution problems, as the logistical system of the essential drugs programme still needed to be strengthened. This is partly due to delays in implementation and partly to reductions in budget (from US$9 million to US$2 million) of the World Bank programme for improving the storage and supply of drugs.

The use of the second batch of drugs as starting capital in the newly set up revolving drug fund, can potentially encourage a more efficient use of donor support. The policy of this new Drug Fund, consistent with the Health Reform policy of the Ministry of Health, entails health centres receiving a budget for drugs, that they then purchase from regional warehouses. The health centres then have to sell these drugs, in order to have resources available for the next supply of drugs. The Drug Fund has only started and its efficiency will need to be monitored and evaluated.

For logistical reasons, the evaluation teams could not collect primary data on the drug distribution system in the whole country. Key informant interviews, and the field-observa-

tions presented above, point to the following efficiency problems in the drug distribution system:

- delays in the supply of drugs; these are reported in Angoche district. Delays occur at every step in the drug distribution system.
- poor storage and management of drug inventories, leading to expiry of drugs or quality deterioration. Expired drugs were reported in the Nampula store in Mozambique and observed in the Hodeidah health centres.
- theft of drugs during transport to health centres. It is very hard to find proof of such practices. Key informant interviews in Mozambique and Yemen indicated that this might be a problem. Moreover the 1996/7 external evaluation report on the distribution of drugs (not kits) in Mozambique determined that drugs 'disappear'.
- lack of appropriate estimates of drug requirements leading to shortages of some drugs and excesses of others. This is likely to occur in Yemen where no system to estimate drug requirements has yet been set up.
- drug kits do not meet the drug needs in the district; as a result shortages of some drugs occur before the next kit arrives.

In all three countries studied, patients pay user-fees to the health services. In Mozambique, patients pay a fixed fee for treatment, which is very low and is unlikely to limit poor people's access to treatment. In Burkina Faso and Yemen, people pay a fixed fee for the consultation and a variable fee for drugs. The more drugs required, the more they pay. In such schemes, problems occur regarding regime compliance because of people's (in)capacity to pay.

To be successful, user fee mechanisms must generally be accompanied by perceived improvements in the quality of services. This implies that improved supply mechanisms for drugs are simultaneously prerequisites *and* outputs of successful programmes. A recent review of experiences with revolving drug funds and community drug schemes, concluded that the following factors are necessary to improve drug availability, equity of access and efficiency. These include:

- local retention and control of revenue (as is planned in the Drug Fund programme in Yemen)
- reliable supply of low-cost, good quality drugs
- continued public subsidy for the poor and other target groups
- a businesslike orientation to personnel, financial and supply management

Assessments of the efficiency of drug supply should take the private sector into consideration as well. In Yemen and Burkina Faso, the fact is that people mostly buy drugs from the private sector (accounting for 90 and 80% respectively of expenditures on pharmaceuticals.) They pay relatively large amounts of money out of pocket, in comparison to what they would pay in the public sector for essential drugs. A good deal of this unnecessary expenditure could be prevented, if people understood (via education on rational drug use) that the generics supplied in the public sector offer better value for money. As we have seen above, public health workers in Yemen continue to prescribe brand name drugs despite the availability of essential drugs in their health centres. The efficiency of essential drugs programmes could be greatly enhanced, were more attention to be paid to training and educating health workers and consumers on rational drug use.

7.2.4 *Concluding remarks*

The evaluation results confirm that implementation of a comprehensive, essential drugs programme is not an easy task. The programmes included in the evaluation in the three countries all still have difficulties in ensuring a regular supply of drugs to health facilities. In Burkina Faso drug supply functions relatively well, but in Mozambique and Yemen it is deficient.

The drug supply system is managed differently in the three countries. In Mozambique and Yemen, it is still a purely public sector responsibility. But in Burkina Faso, an autonomous non-profit agency has been set up, whose main objective is to increase the population's access to affordable generic drugs. The advantages of this kind autonomous supply system over a central medical store in the Ministry of Health are as follows:

- flexible management of resources and personnel
- the supply system is easily monitored
- the agency can operate a revolving fund mechanism
- the non-profit status of the organisation means that it can concentrate on promoting 'social' equity in access to drugs, rather than pursuing commercial aims

A disadvantage, compared to the private sector, is that there is no competition. The agency is the sole provider of essential drugs to the public sector. It operates as a monopoly.

Revolving drug funds that rely on systems of user fees are being implemented in Yemen and Burkina Faso. While increasing the sustainability of the essential drugs programmes,

a problem with user fees is that they are unaccompanied by exemption mechanisms for the poorest. This compromises equity. Both systems are decentralised, with revenues collected at the local level, and this allows the management of both funds and drugs to take place closer to the end-users. Strong supervisory mechanisms and other forms of accountability, such as community health committees, are essential to prevent efficiency problems.

Rational drug use education in all countries has not been implemented well, severely limiting the effectiveness of the essential drugs programmes in making drugs accessible to people who need them. Access to essential drugs has become an important issue in the global health policy arena in response to the problems identified in the treatment of major infectious diseases: malaria, TB and HIV/AIDS. To control these infectious diseases new medicines are needed, which are often still too expensive to be included in essential drugs programmes, as they are still covered by patent protection and the manufacturers can set the price. Since the late 1990's, various global public-private partnerships have been set up with an aim increasing access to these newer types of drugs and making them accessible to populations in need. Strong essential drugs programmes, integrated in the public health system, are needed to make such drugs accessible to people in countries like Yemen, Burkina Faso and Mozambique. With the lion's share of attention being devoted to the drug access issue in the global health arena, there is a risk that the rational use of drugs will continue to receive too little attention in the implementation of essential drugs programmes. In providing support to essential drugs programmes, an appropriate balance between supply activities, and training to enhance the rational use of drugs, is essential.

7.3 Support to disease control programmes

7.3.1 Introduction

Dutch health-related development co-operation has been used to support two national disease control programmes in the three countries selected for the evaluation. These are: assistance to the leprosy component of the National Tuberculosis and Leprosy Control (NTLC) programme in Mozambique, and support to the National Tuberculosis Control Programme in Burkina Faso.

The programme in Mozambique aims at supporting the NTLC programme in the reduction of leprosy prevalence and incidence. The short-term objective is to provide multi-

drug treatment to all registered leprosy patients. The programme is carried out in three provinces in the northern region: Nampula, Niassa and Cabo Delgado, where 80% of the leprosy patients live. The implementing agency is a Dutch NGO, the Netherlands Leprosy Control Society. Dutch support is primarily for technical assistance and improved case detection and treatment.

In Burkina Faso, the tuberculosis control programme has nation-wide coverage and is implemented by the Ministry of Health. Support to the programme responded to the re-emergence of TB related to the AIDS epidemic. The programme aims at the detection and proper treatment of tuberculosis cases. It involves the training of personnel, structural improvements in the health services including support for diagnostic equipment, and the implementation of direct observed treatment with short course treatment scheme (DOTS).

Both these programmes are set up as vertical programmes. They are relevant in terms of targeting diseases that are prevalent in Mozambique and Burkina Faso. The respective Ministries of Health have developed national policies and programmes. Dutch Development Co-operation does not have a specific policy for the control of these infectious diseases. The main policy aim is towards integration of such 'vertical' programmes in PHC.

In line with health reform policies, integration tends to be sought at the district levels of health care. A fully integrated programme at this level means that district health teams plan, implement and co-ordinate all health programmes. This is not the case for the TB and leprosy programmes evaluated, which have separate resource flows, objectives and work plans. Here, integration takes place at the level of the public health centres, where health staff carry out the case-detection and treatment of leprosy (in Mozambique) and TB (in Burkina Faso), in addition to their other health-related tasks. In Mozambique, the level to which Dutch support is integrated in the national health system is open to question, as it only covers the leprosy component of the NTLC programme.

7.3.2 Effectiveness

For both leprosy and TB control, the problem is that good case-detection is a prerequisite for control. Without that, transmission continues in households and communities. Passive case-detection, where patients are diagnosed when they come to clinics, is not efficient in health systems where the public health services are under-utilised. Active case

finding however, is expensive. For both infectious diseases, multi-drug treatment regimes exist which are highly effective if taken appropriately. The treatment has to be taken over a period of six months for leprosy in Mozambique, and eight months for Tuberculosis in Burkina Faso. Health services need to ensure compliance with such long treatment regimes. For TB, DOTS has been introduced to enhance compliance. Patients have to come to the health centre to obtain their medicines.

In Burkina Faso, the National Tuberculosis Control Programme has contributed to an increased recognition of the number of TB patients, and adequate treatment practices using the DOTS regime. However, the planned objectives were not realistic. The aim to double the detection-rate of TB patients, from 25% to 50% in the period 1995-1997, was not achieved. The objective was subsequently reformulated to target a 20% annual increase in cases detected. Low detection rates are caused by the low utilisation of the health services by the population. It must also be admitted that the programme did not sufficiently realise how much time would be needed to strengthen the capacity of the TB control staff. The eight months treatment method selected in the programme is highly effective. However, the number of TB patients who actually complete the treatment is still relatively low. During the period 1996–1999, only about one quarter of the estimated population of TB patients were detected and started treatment.

In Mozambique, the leprosy programme is relatively small and it has well-defined aims and activities that did not change over time. Hence the original plans were realistic. The detection and cure rates increased, but lack of an adequate information system makes it hard to verify if the aim of 75% treatment compliance had been reached in 1997, when the programme ended. In the field study, it was found that in the health centres which generally lacked supplies of essential drugs, leprosy drugs were always available.

In conclusion, the effectiveness of the disease control programmes varies with health facility utilisation. In Burkina Faso, utilisation is low, and thus the TB control programme did not succeed in its objectives. In Mozambique, utilisation is higher and the leprosy control programme increased case detection and treatment.

7.3.3 Efficiency

The targeted nature of vertical disease control programmes enhances their effectiveness, because a relatively large amount of technical support and resources are given to meet clearly-defined objectives. However, efficiency and sustainability can be compromised as

compared to a more integrated implementation of the programme. The limited efficiency of the Burkina Faso programme is due to the low number of patients treated. In Mozambique, support for the leprosy programme is relatively limited, and the programme is judged as cost-effective. The administration of both programmes was transparent, and no irregularities in fund use were detected.

7.3.4 *Concluding remarks*

Development co-operation donors increasingly intend to support integrated health programmes rather than focused disease control programmes. The results of the evaluation show that with targeted support, short term objectives can be met. But, as was the case in Burkina Faso, programme effectiveness is highly dependent on the extent to which people utilise the health services, participate in public health campaigns and comply with treatment regimes. A well-functioning public health system, with strong mechanisms for community participation, and a regular supply of essential drugs, is a prerequisite for sustainable disease control programmes.

Efficiency issues, related to the targeted disease control programmes, need to be viewed in the context of other major diseases suffered by the population. There are serious dilemmas here which have to be faced. Can paying 97US$ per case of TB cured, be justified in a context where children die unnecessarily of diarrhoea and pneumonia? One must take into consideration that diseases like leprosy and TB are infectious, and untreated cases lead to increased transmission. Treatment not only benefits the individuals who are cured, it also limits the further spread of the disease. In health reform programmes, priority setting in public health is decentralised. Ideally, such planning allows for priorities to be set in line with the local needs of the population. With limited resources, choices need to be made.

7.4 Comparative assessment of support to reproductive health programmes, including HIV/AIDS

7.4.1 *Introduction*

The country studies included an evaluation of six different reproductive health programmes. Their objectives, activities, and scope vary strongly. All programmes concentrate on a more or less specific activity or area: census, reproductive health study, curriculum development, MCH/FP, HIV/AIDS, and training of community midwives.

Reproductive health is a priority of both Dutch development co-operation in the area of Health, Women and Development, and of the three countries involved. The principles adopted at the 1994 International Conference on Population and Development have been underlined in Dutch policy, but no operational guidelines nor common framework exist on how to implement reproductive health care programmes at national level. The diversity in objectives and scope of the programmes found in the country studies reflects this.

All three countries adhered to the principles of, and the rights to, reproductive health care. However, it seems that plans to integrate reproductive health into the primary health care systems have not yet been formulated, and that reproductive health programmes are not – explicitly – connected to PHC programmes. The identification and formulation of Reproductive Health Programmes, with support funded from the Dutch Health, Nutrition and Population budgets, was not based on a comprehensive analysis of reproductive health problems and subsequent priority setting in the three countries.

7.4.2 *Effectiveness*

Four of the six reproductive health programmes have been rather successful in achieving their objectives. Three of these programmes had clearly-defined objectives, and a relatively short period to attain them. These are: the census-project in Mozambique; the reproductive health study in Burkina Faso; and the development of a reproductive health curriculum for the public health training institute (ENSP) in the same country. The fourth effective programme (AIDS/PSI in Mozambique) also has clearly defined objectives, but it is not short term. Document review and key person interviewing revealed that the programme improved awareness on HIV/AIDS and increased condom use. In the field study in Angoche, the increased awareness on HIV/AIDS was confirmed. However, condom use was very low. The effectiveness of the midwife training programme in Yemen was limited, as training materials were considered too theoretical. The UNFPA projects in Burkina Faso were not effective.

7.4.3 *Efficiency*

The four reproductive health programmes that were most effective, were also efficient. These four programmes had/have good monitoring systems in common, which allowed for objectives and work plans to be adapted to the reality on the ground. The least effective programme, the UNFPA programme in Burkina Faso, was also very inefficient. A number of management problems were reported. An inadequate institutional frame-

work, communication problems between the donor, the executing agency and local partners, and inappropriately functioning monitoring systems (internal and external) compounded the difficulties. In the community midwife training programme, past experiences were insufficiently taken into consideration.

7.4.4 *Concluding remarks*

The reproductive health programmes cannot be compared, because there is no common framework to them. In the evaluation, it became clear that the Dutch policy of support for reproductive health is reflected in the support given to a variety of reproductive health programmes. The main problem is, that the identification of support is not based on a good analysis of the reproductive health problems in the country, nor on appropriate priority settings at national level. There is also no framework for integrating the concept of reproductive health in existing primary health care programmes.

Despite these limitations in relevance of the projects, the assessment makes clear that the effectiveness and efficiency of the projects that have been supported, *is* relatively good. Four of the six projects appear to be achieving the objectives that were set in a relatively efficient way.

Annex 1 Policy and Operations Evaluation Department

The Policy and Operations Evaluation Department, in Dutch the Inspectie Ontwikkelingssamenwerking en Beleidsevaluatie (IOB), is responsible for conducting evaluations of Dutch foreign policy.

IOB is part of the Ministry of Foreign Affairs. It is an independent unit which reports directly either to the Ministry of Foreign Affairs or the Minister of Development Co-operation. The Minister concerned submits IOB reports to Parliament, where they are discussed by the Permanent Committee on Foreign Affairs with respect to follow up actions.

IOB was established in 1977 with a mandate that was restricted to the evaluation of aid programmes. Following the reassessment of Dutch foreign policy in 1996, IOB's mandate was broadened to include other fields of foreign policy.

From 1977 to mid-1980s, IOB's emphasis was on individual project evaluations, the status of which was then confidential. Since the mid-1980s, emphasis has shifted to comprehensive thematic studies, focusing on policies and modalities of implementation and covering sectors, themes or programmes. External independent experts participate in the various phases of the research, under responsibility of IOB. Increasingly, institutions or experts in recipient countries are invited to participate in the fieldwork. A reference group consisting of independent experts and Ministry staff is appointed for each study to advise on the methodology and approach of the evaluation.

The final reports, based on various field and desk studies, are written by IOB's own staff and published under its responsibility. Examples of recent studies include PalestinianTerritories, Hulp door Handel (Aid through trade), Oret/Miliev review 1994-1999, Institutional Development, Revue de la coopération entre le Mali et Les Pays-Bas (review of the co-operation between Mali and the Netherlands), and De Kunst van het Internationaal Cultuurbeleid (International Policy on Culture).

IOB also participates in multi-donor evaluations. Examples of this include the evaluation of: the World Food Programme, the European Union Food Aid Programme, Emergency Assistance to Rwanda, European Union Aid: ACP, MED, ALA Programmes and Humanitarian Aid, and the United Nations Capital Development Fund (UNCDF).

Annex 2 Terms of Reference for the evaluation of health, nutrition and population 28 July 2000

1 Introduction

The Policy and Operations Evaluation Department (IOB)'s programme for 2000 includes an evaluation of Dutch co-operation in the field of health, nutrition and population, within the poverty reduction cluster. Evaluations in this cluster should focus more than in the past on the perspective and situation of the poor themselves when addressing the relevance, effectiveness, efficiency and impact of interventions. The approach will involve: preliminary studies in the countries selected for evaluation and input from investigating teams to help provide a basis for the methodology of the investigations. This means that, following extensive preliminary studies, separate terms of reference will be drawn up for each country evaluation. These general terms of reference will contain background information, objectives, general issues to be addressed, the plan of action, a definition of the scope of the investigation, a general methodological framework and information about the way the activities will be organised, the expected product and the budget. They will also define and delimit the scope of the evaluation.

2 Rationale

Health has been an important element of Dutch development co-operation since the 1970s. Thanks in part to international trends, a policy on health emerged and was adapted over time. At first, the emphasis was on improving curative treatment in hospitals. Later, it shifted to prevention and primary health care. During the 1990s, the organisation and financing of health care came into the foreground. In addition, Dutch policy began to devote more attention to nutrition and reproductive health. Since 1998, policy has aimed at a sector-wide approach that in the long run will ideally lead to sectoral budget support. In more than half of the countries in which multi-sectoral bilateral co-operation is to continue, health has been chosen as a priority sector.

IOV, IOB's forerunner, evaluated health care co-operation in the period from 1975 to 1984. The results are contained in a 1987 report on hospital care and a 1988 report on primary health care. Health was also one topic covered in 1998 country evaluations of Egypt and Bangladesh. Reproductive health figured in the 1998 evaluation on women and development.

The above-mentioned changes in policy, the fact that the last programme evaluation in the health field took place over ten years ago, the importance of health within development co-operation and a request from the relevant policy theme department form the rationale for evaluating the programme.

3 Background

3.1 Health and poverty

Morbidity and mortality rates in poor countries have fallen dramatically in the past thirty years, thanks in part to economic growth and improved basic services. However, the divide between rich and poor countries and between rich and poor social groups within countries remains enormous. For instance, in the least developed countries child mortality is twenty times as high as in the industrial world and maternal mortality almost eighty times as high (according to the 1999 HDR).

Poverty, in the form of inadequate income and inadequate access to important services like drinking water, sanitary facilities, education and health care, is at the root of many diseases, infectious or otherwise, and is therefore to blame for the deaths that these diseases cause. However, it is not possible to indicate exactly how much influence each aspect of poverty has on health and disease. This is first of all because the terms health and disease cover a wide range of phenomena and have different meanings in relation to different age groups. Still, the main underlying cause of a specific disease often can be traced. Secondly, the above-mentioned aspects of poverty are interconnected. This makes it difficult to determine the role of individual factors, such as health care. Nonetheless, it has been clearly shown that poor people are more often sick, that they die earlier and that the quality of health care is a factor.

Disease stands in the way of productivity and thereby perpetuates poverty. Disease can sap a household's budget and leave inadequate resources to meet other basic needs. It can also lead to debt, which can in turn plunge people into a lifetime of crushing poverty

at the minimum subsistence level. So, investment in health means investment in poverty reduction. *Investing in health*, a 1993 World Bank report, considers at length the link between disease and poverty. However, because poverty itself is caused by the interplay of many factors, the extent to which disease leads to poverty cannot be determined precisely. Accordingly, it is impossible to say just how much disease prevention contributes to poverty reduction.

In short, good health care contributes to good health and good health contributes to poverty reduction. Still, the extent of the contribution and the exact role of health care are not entirely clear.

3.2 Development policy in the field of health, nutrition and population

Dutch policy on health, nutrition and population has evolved more or less in step with international trends. In the 1960s and 1970s, aid went largely to hospital construction, equipment, medicine, staff and support for vertical programmes. At that time the World Bank mainly provided loans for vertical family planning programmes. Co-operation efforts did not take sufficient account of the morbidity pattern among the bulk of the population in poor countries.

The international WHO conference in Alma-Ata in 1978 was a turning point. Universal access to health care became the rallying cry and attention shifted towards primary health care. Prevention, participation by the recipient population and co-operation with other sectors, such as water and sanitation, became key notions. According to this new perspective, village health workers were to take responsibility for a large share of preventive and simple curative medical care. In the Netherlands, this policy was set down in 1986 in a policy memorandum on health care. In 1991, the policy document "*Een wereld van verschil*" (A world of difference) and a speech by the Minister for Development Co-operation confirmed this stance.

The emphasis on access to health care pushed quality of care out of the spotlight. Slowly but surely, it became clear that this was a mistake. Awareness grew that prevention could only succeed when complemented by good curative care. Health care financing also began to receive more attention. The starting point was UNICEF's Bamako initiative, in which the recipient population contributed to the cost of medicine. The result is that the focus of the international donor community has shifted to the organisation of health care. This generally includes support for health care reform initiatives, often as part of

more general public sector reform. The World Bank is instrumental in this process. In the Netherlands, the new focus on the organisation of health care was confirmed in 1997 in a speech by the Minister for Development Co-operation. Since 1998, policy has aimed at a sector-wide approach, ideally leading to sectoral budget support.

Along with this new focus on organisation and reorganisation, a series of conferences in which the Netherlands participated in the 1990s raised new issues. The World Summit for Children breathed new life into mother and childcare programmes. The International Conference on Nutrition and the World Food Summit drew attention to the importance of nutrition. The International Conference on Population and Development introduced the term reproductive health and the International Conference on Women and Development confirmed its importance. At the same time, it was recognised that women's health is dependent on women's social status. Specific diseases such as tuberculosis, malaria and later AIDS continued to receive attention throughout this period. In a number of memoranda (on nutrition, family planning and reproductive health, malaria, HIV/AIDS, and children) the Netherlands set out its policy in specific fields and provided guidelines for its implementation.

3.3 *Inventory of activities in the field of health, nutrition and population*

Table 1 Expenditures on health, nutrition and population 1995-1999

Health policy area	Sub-area	Number of activities	Expenditure per sub-area (x 1000) NLG	Euro	Expenditure per health policy area (x 1000) NLG	Euro	%
Basic health services					131.376	59.616	9.2
	General	93	126.057	5720			
	Research	3	2026	919			
	Training	9	3393	1494			
Disease control					168.933	76.659	11.8
	General	58	139.013	63.081			
	Research	27	28.433	12.902			
	Training	4	1487	675			
AIDS prevention and control				145.190	65.884	10.1	
	General	124	112.421	51.014			
	Research	21	32.584	14.786			
	Training	2	185	84			

Annex 2

Health policy area	Sub-area	Number of activities	Expenditure per sub-policy area (x 1000) NLG	Euro	Expenditure per health area (x 1000) NLG	Euro	%
Essential drugs					178.561	81.028	12.5
	General	65	178.225	80.875			
	Research	2	336	153			
	Training						
Reproductive health					604.546	274.331	42.2
	General	123	587.624	265.291			
	Research	18	4318	1959			
	Training	11	12.604	5720			
Nutrition					56.795	25.773	4.0
	General	57	51.617	23.423			
	Research	6	2833	1286			
	Training	5	2345	1064			
Health policy					16.912	7674	1.2
	General	22	11.040	5010			
	Research	7	2916	1323			
	Training	4	2956	1341			
Sector-wide support	1.0	8			14.292	6485	
Budget support		5			21.365	9695	1.5
Miscellaneous					95.271	43.232	6.5
	General	110	85.257	38.688			
	Research-general	9	1845	837			
	Training-general	25	8169	3707			
Total		818			1.433.241	650.376	100

Source: MIDAS KBE (smallest administrative unit) 737, 803, 804, 805, 917 and 782 (relevant activities) as well as CRS 93108, 93109, 93210 and 93350 (relevant activities that do not fall under the above-mentioned KBEs).

4 Goal of the evaluation and key questions

The overall goal of the evaluation is to determine how much activities in the field of health, nutrition and population have contributed, directly or indirectly, to combating disease and death, especially among the poor.

As section 3.1 explains, health and disease are consequences of many related factors. The role of health care and improvements in it cannot be quantified. Nor is it usually possible to quantify the extent to which the activities supported by the Netherlands improve health care. However, figures can be given for certain indicators, both in the field of health, nutrition and population and in service provision. If an activity takes place in a limited geographical area and has a clearly defined target group, several of these indicators can be used to estimate the extent to which it contributes to the general goal. The potential contribution of other activities to reducing morbidity and mortality rates will have to be determined on the basis of their compatibility with policy and their effectiveness.

Key questions are classified by theme below. Note that they are not presented in order of priority.

I *Basis and coherence of the programme*

- What considerations led to the current programme of activities in the field of health, nutrition and population and where did the initiative come from?
- How do the activities compare to efforts in other sectors by the Netherlands and other actors, particularly in areas that have a strong impact on health (often stronger than the influence of health care), such as water and sanitation, income improvement and education?
- What considerations led to the selection of specific activities within the programme? In the light of other actors' efforts, is the programme coherent?

II *Policy context*

- How is national health policy, including the allocation of the budget, determined? Key issues: drafting, planning and participation.
- Policy priorities: are the health problems of the poor a policy priority? If so, in what way do they receive priority? Key issues: prevention and education, nutrition, infectious disease, reproductive health, women's issues and budget allocation.

- Organisation of health care: Do the poor have access to health services? Key issues: reorganisation, decentralisation, the role of the private sector, the insurance system and safety nets.
- How do national authorities in public health and other areas co-ordinate international co-operation in the field of health, nutrition and population?

III *Compatibility with policy, effectiveness, efficiency, sustainability and impact*

Compatibility with policy

- To what extent is the programme of activities supported by the Netherlands compatible with national health policy?
- What are the similarities or differences between national health policy and Dutch development policy in the field of health, nutrition and population?

Effectiveness

- Were the objectives feasible and workable?
- How much did potential clients use the services provided via the activity? Key issues: accessibility, in both the physical and the social/cultural sense, and the quality of service.

Efficiency

- How much of the Dutch budget, the recipient country's budget and the implementing partner's budget was spent on a given activity?
- Did the activity proceed as planned? Key issues: sources of delay and overheads.
- Did monitoring take place? Key issues: quality of monitoring and changes made in response to monitoring.

Sustainability

- How deeply is a given activity embedded in the health care system? Key issues: sustainability within national policy (coverage of costs and financing), capacity building, percentage of people trained staying in health care jobs.

Impact (case studies)

- What changes have there been in key health and health care indicators? Key issues: child mortality, malnourished children under five, the incidence of common diseases, vaccination rate and use of health services.

- Are there indications that interventions financed by the Netherlands have contributed to any changes noted?
- How does the public rate health services? Key issues: satisfaction, frequency of use and reasons given.

Side effects

- What side effects has a given activity or package of activities had? Key issues: personnel diverted from health care system, funding diverted from national budget and vertical programmes.

5 Scope of the investigation

The range of activities in the field of health, nutrition and population is so wide that it is impossible to analyse all of them. A selection has thus been made. The evaluation will be limited to three countries.

The first criterion for selection is that the country must be one of the 17+ 4 (seventeen plus four) countries and it must have chosen the health sector as a priority. Other criteria are the total amount of aid to the sector in the past five years, the amount of aid per capita, whether the programme is varied, whether it is possible to carry out a case study and whether an evaluation has taken place recently or is scheduled to take place in the near future. Ethiopia has been excluded because it has not been decided whether co-operation will continue. Ghana because the relationship has not existed long enough to be evaluated.

Table 2 Overview of countries and selection criteria

Country	Total amount of Dutch aid in the health sector 1995-1999 (x 1.000.000)			Annual per capita aid			Evaluated recently?	Varied programme?	Case study possible?
	NLG	Euro		NLG	Euro				
Bangladesh	38.7	17.6	+	0.07	0.03				
Burkina Faso	10.0	4.5		0.22	0.1	+		+	++
Mali	16.7	7.6		0.38	0.17	+	–	+	++
Mozambique	48.5	22.0	++	0.71	0.32	++	–	+	+
Nicaragua	9.0	4.1		0.45	0.2	++			++
Tanzania	32.0	14.5	+	0.21	0.1	+	–	+	+
Vietnam	21.0	9.5	+	0.07	0.03			+	
Yemen	41.5	18.8	++	0.65	0.29	++		+	++
Zambia	39.5	17.9	+	0.99	0.45	++	– –	+	++

Annex 2

Key to the table

Total amount of Dutch aid:
++ more than NLG 40 million (Euro 18,2 million) in the period 1995-1999
+ NLG 20-40 million (Euro 9-18 million) in the period 1995-1999

Per capita aid:
++ more than NLG 0.40 (Euro 0.18)
+ NLG 0.20-0.40 (Euro 0.09-0.18)

Evaluated recently:
- field work carried out for an IOB evaluation in 1998 or 1999 (Mali, Mozambique) or another major evaluation involving health authorities in progress (Tanzania)
— non-IOB evaluation in progress, focusing on activities in the field of health, nutrition and population, with bilateral Dutch involvement (multi-donor evaluation in Zambia; the ministry's Social Policy Division (DSI/SB) has asked Zambia not to be included in the evaluation)

Varied programme:
+ activities in progress in at least three of the health policy areas listed in Table 1 (with the exception of the category "miscellaneous")

Case study:
++ basic health care activity located in a clearly delimited geographical area, in progress for at least five years
+ basic health care activity located in a clearly delimited geographical area, in progress for at least three years

Appendix 1 gives an overview of countries with which a bilateral aid relationship in the field of health, nutrition and population will be continued. This overview includes some general information about population, the health situation and health care, as well as a brief description of the programme receiving Dutch aid.

On the basis of the above criteria, Yemen, Mozambique and Burkina Faso have been selected. The entire range of health, nutrition and population activities in these countries will be evaluated. This means that the programme will be described, and

activities that ended in the period 1995-1999 and current activities that have been in progress for at least two years will be evaluated. Furthermore, an in-depth case study of a single district health care or primary health care programme will be carried out in each country.

Finally, projects in the countries selected that receive Dutch financing but fall outside the bilateral programme will also be included in the evaluation. The chief activities in this category are those of the co-financing organisations and the SNV (the Netherlands Development Organisation), as well as personnel services. Evaluations of these activities will mainly be based on their compatibility with national health policy and the extent to which they supplement the bilateral programme. The effectiveness and efficiency of these programmes will not be considered in the evaluation.

The International Education programme (which includes scholarships and regional education programmes) and all activities with a total expenditure of less than NLG 100.000 (45.378 Euros) will not be included in the evaluation. The duration of the evaluation will be one and a half years. Fieldwork will take two months in each country.

6 Approach and methodology

6.1 Approach

The evaluation will take place in four stages. The first stage, in which relevant policy documents were analysed and the activities were inventoried, is now complete. The terms of reference are partly based on the findings of this exploratory stage.

The second stage involves a large-scale preliminary investigation of the countries selected. This investigation will:

- describe the health situation and health policy in each country;
- analyse files (activity numbers) in the field of health, nutrition and population;
- identify evaluation teams;
- inventory the evaluations carried out by other organisations or donors in the countries selected; and
- develop a detailed methodological proposal for the studies within each country.

At the end of this stage, the evaluation teams will meet to finalise the methodology they are to apply. Specific terms of reference for the evaluations within each country will be based on the results of this meeting.

The third stage comprises fieldwork, which will lead to individual country reports.

The fourth and final stage comprises:
- the revision of the country reports;
- the drafting of a comprehensive report; and

the presentation of the results.

6.2 Methodology

To answer the key questions of the evaluation, a variety of strategies and methods will be needed. A brief description of these methods follows, arranged by theme. Preliminary studies will result in specific methodological proposals for each country evaluation, including the methods of compiling data.

6.3 Basis of policy

The evaluation will take the form of a situation analysis. The role of each partner in decision-making will be investigated. Data will be compiled by means of a literature review (including unofficial sources), an examination of the files and interviews with key figures.

6.4 Policy context

This part of the evaluation involves reconstructing policy. Most of the data will be compiled by means of a literature review (including unofficial sources). Interviews with key figures will provide supplementary information.

6.5 Policy relevance, effectiveness, efficiency, sustainability and impact

A logical framework analysis will be employed for this part of the evaluation. Case studies (of district programmes) will examine indicators of impact, such as child mortality and vaccination rates, and use of services. Data will be compiled by means of a semi-structured survey of a random sample of the population. Other methods will include observation of health services and interviews with health workers. More detailed information about indicators, sources and methods of compiling data will be incorporated into the terms of reference of the individual country evaluations.

For the other activities, indicators of use and quality of services will be examined. Data will be compiled by means of a literature review, observation of health services and interviews with health workers using a structured questionnaire. Where possible, these activities will be incorporated into the questionnaires for the case studies. More detailed information about indicators, sources and methods of compiling data for each activity will be incorporated into the terms of reference of the individual country evaluations.

7 Organisation

IOB inspector Marijke Stegeman is responsible for organising and co-ordinating the implementation of the evaluation. In stage 2, junior investigator Sabine Ravestijn will be involved in the inventory of activities and examination of the files in preparation for the fieldwork. The medical anthropology unit at the University of Amsterdam (UvA) will assist with stages 2, 3 and 4, with Anita Hardon heading the investigation. This department, in collaboration with the IOB, will produce a methodological proposal and organise a training seminar on methods of investigation. It will also supervise fieldwork, draft country reports and produce a comprehensive report based on the country reports, together with the inspector. If necessary, other outside experts will be called in.

Investigating teams from the recipient countries will carry out the fieldwork (stage 3), after taking part in the methodological seminar (stage 2). An internal focus group will be assembled. This group will comprise the relevant country desks and the Ministry's divisions concerned with poverty reduction and social policy. Other outside experts, at national and international level, will be asked to submit written suggestions concerning the terms of reference of the country evaluations and, if desired, on the progress of the evaluation as a whole.

8 Products

The following publications are anticipated:

- a discussion paper on methodology for the evaluation of health programmes
- a report on the Burkina Faso country evaluation
- a report on the Yemen country evaluation
- a report on the Mozambique country evaluation
- a comprehensive final report

9 Schedule

Stage 1 complete (January-April 2000)
Stage 2 May-October 2000
Stage 3 October 2000-April 2001
Stage 4 April-August 2001

10 Budget

		NLG	Euro
1.	staff		
	senior investigators (UvA)		
	stage 2 (25-day preliminary investigation)	30.000	13.613
	(3-day seminar)	5.000	2.269
	stage 3 (3 x 40 days)	80.000	36.302
	stage 4 (25 days)	30.000	13.613
	junior investigator (stage 1 en 2)	60.000	27.227
	country teams (stage 3)	240.000	108.907
	(2 senior or 1 senior plus 2 junior investigators per team; in total, NLG 2000 (Euro 908) per day x 40 days x 3 countries)		
	other outside expertise to be determined		
2.	travel expenses		
	stage 2	24.000	10.890
	(estimate based on 9 x NLG 2000 (Euro 908) for seminar plus 3 x NLG 2000 (Euro 908) for junior investigators)		
	stage 3	18.000	8.168
	(estimate, 3 x NLG 6000 (Euro 2.723) for senior investigators)		
	DSA (Daily Subsistence Allowance)		
	stage 2	16.000	7.260
	stage 3	48.000	21.782
	(based on NLG 400 (Euro 182) per day plus		

	seminar (9 x NLG 400 (Euro 182)) plus junior investigators (30 x NLG 400 (Euro 182)) plus senior investigators (120 x NLG 400 (Euro182))		
3.	seminar in the Netherlands (estimate)	20.000	9.076
4.	local expenses		
	workshops in countries selected	45.000	20.420
	local transport; administration	30.000	13.613
5.	production costs for country reports and final report (incl. translation)	100.000	45.378
6.	incidental expenses (5%)	35.000	15.882
		781.000	354.402

July 2000

Annex 3 Organisation of the study

1 Preparations

The first step was to create an inventory of relevant policy documents and money flows. Then, after the country selection, all files of aid activities in the field of health, nutrition and population in Mozambique, Yemen and Burkina Faso both at the department and in the embassies, were scrutinised. Important documents with respect to programme and project objectives and implementation were summarised and copied. This work was carried out by Ms Sabine Ravestijn, MA, in the period February through August 2000. In addition, the medical anthropological of the University of Amsterdam reviewed relevant health evaluation literature.

2 Country studies

Ms Prof. Dr. Anita Hardon, head of the medical anthropological unit of the University of Amsterdam, elaborated an evaluation framework for the country studies. This model was discussed and finalised at a seminar with the country evaluation teams in October 2000.

The country study in Burkina Faso was carried out from November 2000 until January 2001 by Prof. Dr. Blaise Sondo (University of Ouagadougou, team leader), Dr. Dominique Kyelem and Ms Dr. Suzanne Sobela. A team of four interviewers and one supervisor assisted in carrying out the field study. At a seminar in Kaya, Ms Jeanet van de Korput, MA, (University of Amsterdam) trained the field team in the use of the data collection methods. These were also pre-tested. During the evaluation, Jeanet van de Korput and Ms Dr. Marijke Stegeman (IOB) provided technical assistance.

The country study in Yemen was conducted from March 2001 until May 2001 by Dr. Ali Mohamed Assabri (University of Sana'a) and Prof. Dr. Abdulla Saeed Hattab (University of Aden). A field team of four interviewers, a statistician and a supervisor assisted in carrying out the field study. They were trained at a seminar in Hodeidah by Ms Elisabetta El-Karimy, MA, (University of Amsterdam), who co-ordinated and supervised the fieldwork. Anita Hardon and Marijke Stegeman provided technical assistance.

Ms Irae Lundin, MA, Ms Fernanda Farinha, MA, Dr. Jorge de Barreto and Dr. Ricardo Barradas (consultants) conducted the country study in Mozambique from April 2001 until June 2001. A team of one supervisor and two interviewers assisted in carrying out the field study. Irae Lundin trained the team in the use of the data collection methods at a seminar in Nampula. Ms Trudie Gerrits, MA, (University of Amsterdam) and Marijke Stegeman provided technical assistance.

Country study reports were submitted to relevant stakeholders in the countries concerned, to the desk officers and technical experts at the department and to some external advisors. Comments were analysed and, if applicable, incorporated in the final version of the country studies.

3 Synthesis report

The final report was written by Marijke Stegeman, Anita Hardon and Trudie Gerrits. A draft version of the report was discussed with relevant stakeholders at the department and sent to relevant stakeholders in the countries concerned, for written comments. The comments, if applicable, were incorporated in the final version. Ms Helene Pulles, MA, assisted in the finalisation of the report and Mr. Jeff Lewis edited the report.

4 Co-ordination

The study has been co-ordinated by Marijke Stegeman of the Policy and Operations Evaluation Department of the Ministry of Foreign Affairs. Anita Hardon, Trudie Gerrits and Jeanet van de Korput of the medical anthropological unit of the University of Amsterdam provided technical assistance. An internal advisory group composed of the desk officer of the Yemen desk, (Ir. Dick van Ginhoven), head of the social policy department (Ms Dr. Aagje Papineau Salm), experts of the social policy department (Dr. Harry van Schooten and Ms. Ir. Reina Buijs), deputy director IOB (Dr. Henri Jorritsma) and one inspector IOB (Dr. Alex Bartelink) commented on the terms of reference, the findings of the field studies and the final report. External advice was given by Mr Erik Heydelberg, MA.

Annex 4 Detailed information on money flows

1 Procedure

The inventory of money flows is based on the information system of the Ministry of Foreign Affairs. First, relevant budget categories were selected. These were:
Kbe 737, the country programme for social development.
Kbe 803 (support to UNAIDS), 804 (support to UNFPA) and 805 (special multilateral programmes).
Kbe 917, subsidies to organisations. This category exists only since 1998.
Kbe 782, aid to Surinam.

In addition, a number of CRS codes relating to health were reviewed. A small number of activities did not fall in the budget categories mentioned above. They were mainly related to medical research and training. For these activities, a budget category 'other' was created.

Then, a number of health policy areas were defined on the basis of major policy issues: primary health care, disease control, essential drugs, reproductive health, nutrition, an area including policy, basket funding and budget support and an area "other". For each health policy area two sub-areas were created: research and training. Then, two policy areas were added, research and training, for research and training activities that are not related to one of the major policy areas.

All activities in the budget categories mentioned were reviewed and on the basis of the title and the description of the objectives either skipped or placed in one of the health policy areas or sub-areas. If necessary, the project file was studied. To give some examples: a malaria research project was placed in the policy area disease control, sub-area research. An inventory of the institutional capacity of a Ministry of Health was placed in the area: policy, basket funding and budget support. A rural water project, financed through budget category 737, was skipped.

2 Details on money flows

Table 1 provides overall information on the distribution of money flows by budget category and by policy area.

Table 1 Distribution of HNP budget (million Euros) 1995-1999 per policy area and budget category

Policy area/ Budget category	Country programme social development	Multilateral organisations*	Other**	Total
Primary health care	57.2	–	2.7	59.9
Disease control	55.8	20.4	0.5	76.7
Essential drugs	63.5	10.9	6.8	81.2
HIV/AIDS	36.8	25.4	4.1	66.3
Reproductive health	61.7	206.5	5.9	274.1
Nutrition	20.4	5	0.5	25.9
Health policy; basket funding; budget support	21.8	1.4	0.9	24.1
Other	24.1	0.9	17.7	42.7
Total	**341.3**	**270.5**	**39.1**	**650.9**

* *Mainly special programmes WHO and contribution UNFPA and UNAIDS*
** *Includes support for Surinam, subsidies to organisations and a number of activities in other budget categories selected on the basis of CRS codes (medical training; medical research)*

Source: MIDAS

The following tables provide for each budget category detailed information per year on distribution of money flows among policy area and sub-areas. As the amounts in the table are MIDAS data, they are given still in Dutch guilders (1 Euro equals 2,20 guilders).

Annex 4

Table 2 Inventory MIDAS figures, **total** country programme social development (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total		%
PHC		10	89	20278	25560	27788	26338	23452	**123416**		
	Research	11	3	359	795	494	377	0	**2025**		
	Training	12	3	0	0	154	20	153	**327**		
										125768	16,7
Disease Control		20	45	16007	29797	21252	22602	17491	**107149**		
	Research	21	18	159	4258	2369	2791	1256	**10833**		
	Training	22	3	3518	5	600	209	450	**4782**		
										122764	16,3
HIV/AIDS		30	98	6077	7623	13726	15251	11534	**54211**		
	Research	31	17	3832	4847	5506	7004	5157	**26346**		
	Training	32	1	0	0	0	127	0	**127**		
										80684	10,7
Essential Drugs		40	55	23049	27935	36514	26348	25594	**139440**		
	Research	41	2	263	15	58	0	0	**336**		
	Training	42	0	0	0	0	0	0	**0**		
										139776	18,6
Reproductive Health		50	87	29519	8934	27037	34947	21330	**121767**		
	Research	51	7	387	622	318	434	1017	**2778**		
	Training	52	10	0	439	5664	2802	2854	**11759**		
										136304	18,1
Nutrition		60	47	2041	13715	8549	8153	7103	**39561**		
	Research	61	5	594	286	106	868	964	**2818**		
	Training	62	5	6	305	790	627	618	**2346**		
										44725	6,0
Health policy		70	16	2079	463	1097	614	2869	**7122**		
	Research	71	6	1124	144	453	593	107	**2421**		
	Training	72	4	0	2699	84	127	46	2956		
										12499	1,7
Basket funding		80	8	0	76	1272	2607	10337	**14292**		1,9
Budget Support		90	5	0	2750	5760	6795	6059	**21364**		2,8
Other		100	95	7359	8686	9401	9065	10907	**45418**		6,0
Research (general)		110	8	0	9	1	472	313	**795**		0,1
Training (general)		120	18	1373	713	1545	1787	1665	**7083**		0,9
Total			**655**	**118024**	**140676**	**170538**	**170958**	**151276**	**751472**		**99,8**

Annex 4

Table 3 Inventory MIDAS figures, **total** special multilateral programmes (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total		%
PHC		10	0	0	0	0	0	0	**0**		
	Research	11	0	0	0	0	0	0	**0**		
	Training	12	0	0	0	0	0	0	**0**		
										0	0
Disease		20	10	5835	5071	5194	4715	10730	**31545**		
Control	**Research**	21	3	2600	2541	2920	2500	2500	**13061**		
	Training	22	1	61	3	0	0	0	**64**		
										44670	35,7
HIV/AIDS		30	2	0	1438	1877	341	4342	**7998**		
	Research	31	0	0	0	0	0	0	**0**		
	Training	32	0	0	0	0	0	0	**0**		
										7998	6,4
Essential drugs		40	6	2000	6217	5980	5150	4900	**24247**		
	Research	41	0	0	0	0	0	0	**0**		
	Training	42	0	0	0	0	0	0	**0**		
										24247	19,4
Reproductive		50	14	2651	1977	3161	3528	18850	**30167**		
health	**Research**	51	1	152	0	0	187	0	**339**		
	Training	52	1	0	0	612	235	0	**847**		
										31353	25,1
Nutrition		60	9	707	2985	988	2431	4300	**11411**		
	Research	61	0	0	0	0	0	0	**0**		
	Training	62	0	0	0	0	0	0	**0**		
										11411	9,1
Health		70	2	0	993	1070	400	400	**2863**		
policy	**Research**	71	0	0	0	0	0	0	**0**		
	Training	72	0	0	0	0	0	0	**0**		
										2863	2,3
Basket funding		80	0	0	0	0	0	0	**0**		0
Budget Support		90	0	0	0	0	0	0	**0**		0
Other		100	4	250	131	200	1075	825	**2481**		2,0
Research (general)		110	0	0	0	0	0	0	**0**		0
Training (general)		120	0	0	0	0	0	0	0		0
Total			**53**						**125023**		**100**

Annex 4

Table 4 Inventory MIDAS figures, **total** support to UNAIDS (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total	%
HIV/AIDS		30	3	0	10000	11000	12000	15000	**48000**	100
	Research	31	0	0	0	0	0	0	**0**	
	Training	32	0	0	0	0	0	0	**0**	
Total			**3**						**48000**	**100**

Table 5 Inventory MIDAS figures, **total** support to UNFPA (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total	%
Reproductive **health**		50	6	69300	83500	95000	87500	88500	**423800**	100
	Research	51	0	0	0	0	0	0	**0**	
	Training	52	0	0	0	0	0	0	**0**	
Total			**6**	**69300**	**83500**	**95000**	**87500**	**88500**	**423800**	**100**

Table 6 Inventory MIDAS figures, **total** subsidies (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total		%
HIV/AIDS		30	0	0	0	0	0	0	**0**		
	Research	31	1	0	0	0	0	5000	**5000**		
	Training	32	0	0	0	0	0	0	**0**		
										5000	32,4
Essential drugs		40	1	0	0	0	0	515	**515**		
	Research	41	0	0	0	0	0	0	**0**		
	Training	42	0	0	0	0	0	0	**0**		
										515	3,3
Reproductive **health**		50	2	0	0	0	0	9006	**9006**		
	Research	51	1	0	0	0	0	256	**256**		
	Training	52	0	0	0	0	0	0	**0**		
										9262	60,1
Nutrition		60	1	0	0	0	0	646	**646**		
	Research	61	0	0	0	0	0	0	**0**		
	Training	62	0	0	0	0	0	0	**0**		
										646	4,2
Total			**6**						**15423**		**100**

Annex 4

Table 7 Inventory MIDAS figures, **total** aid to Surinam (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total		%
PHC		10	4	544	660	806	631	0	**2641**		
	Research	11	0	0	0	0	0	0	**0**		
	Training	12	0	0	0	0	0	0	**0**		
										2641	4,7
Disease control		20	3	5	41	76	101	96	**319**		
	Research	21	0	0	0	0	0	0	**0**		
	Training	22	0	0	0	0	0	0	**0**		
										319	0,56
HIV/AIDS		30	2	0	0	1	2	1	**4**		
	Research	31	0	0	0	0	0	0	**0**		
	Training	32	0	0	0	0	0	0	**0**		
										4	0,01
Essential drugs		40	3	2048	3939	5973	1935	127	**14022**		
	Research	41	0	0	0	0	0	0	**0**		
	Training	42	0	0	0	0	0	0	**0**		
										14022	24,8
Reproductive health		50	1	0	0	400	475	300	**1175**		
	Research	51	0	0	0	0	0	0	**0**		
	Training	52	0	0	0	0	0	0	**0**		
										1175	2,1
Nutrition		60	0	0	0	0	0	0	**0**		
	Research	61	1	0	0	0	14	2	**16**		
	Training	62	0	0	0	0	0	0	**0**		
										16	0,03
Health policy		70	4	341	154	225	66	269	**1055**		
	Research	71	0	0	0	0	0	0	**0**		
	Training	72	0	0	0	0	0	0	**0**		
										1055	1,8
Other		100	10	6791	11555	12029	3226	3741	**37342**		66,0
Total			28						**56574**		100

Annex 4

Table 8 Inventory MIDAS figures, **total** activities with CRS-Codes 93108, 93109, 93210 (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total		%
PHC		10	0	0	0	0	0	0	**0**		
	Research	11	0	0	0	0	0	0	**0**		
	Training	12	6	848	497	349	571	701	**2966**		
										2966	43,7
Disease		20	0	0	0	0	0	0	**0**		
control	**Research**	21	6	474	538	70	98	0	**1180**		
	Training	22	0	0	0	0	0	0	**0**		
										1180	17,4
Health policy		70	0	0	0	0	0	0	**0**		
	Research	71	1	450	44	0	0	0	**494**		
	Training	72	0	0	0	0	0	0	**0**		
										494	7,3
Other		100	1	0	0	16	0	0	**16**		0,2
Research (general)		110	1	350	350	350	0	0	**1050**		15,4
Training (general)		120	7	0	288	167	560	70	**1085**		16,0
Total			**22**						6791		**100**

Table 9 Inventory MIDAS figures, **total** CRS-Codes 93600 excluded Kbe 8030, 8040, 8041, 8050, 8161, 7370, 9170 and included Kbe 7391, 7392, 7500, 7630, 7890 (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total	%
Reproductive		50	10	648	535	179	312	35	**1708**	64,4
health	**Research**	51	5	620	259	67	0	0	**946**	35,6
	Training	52	0	0	0	0	0	0	**0**	0
Total			**15**						2654	**100**

Annex 4

Table 10 Inventory MIDAS figures, **total** CRS-Codes 93350 excluded Kbe 7370, 8030,8050, 9170 and included Kbe 7000, 7120, 7290, 7391, 7392, 7550, 7630, 7794, 7890, 7910 (x 1000 NLG)

Policy Area	Sub-area	Code	Nr. Activities	1995	1996	1997	1998	1999	Total	%
HIV/AIDS		30	19	265	281	412	1034	217	**2209**	63,0
	Research	31	3	19	371	480	367	0	**1237**	35,3
	Training	32	1	0	0	0	53	5	**58**	1,7
Total			**23**						**3504**	**100**

Annex 5 Evaluation questions and questionnaires

In this annex the specific research questions, elaborated for the first and the second phase of the country studies are presented. The annex includes also an example of a questionnaire. As the Burkina Faso and the Mozambique data collection tools are only available in French and Portuguese respectively, the choice is made to present a Yemen data collection tool that is bilingual. Many data collection tools were elaborated, including checklists for key person interviewing; checklists for focus group discussions; questionnaires for exit interviews; questionnaires for consultation observation; and questionnaires for the household survey. Here, the last one, as an example, will be presented.

Evaluation questions

The evaluation questions are given below for each of the six components in the evaluation framework. Note that only the questions related to components 1 and 2 were applied to all evaluated projects/programmes in the three countries. The questions for components 3-6 were only to be applied in the district field studies.

1 Donor health support

a What considerations led to the current programme of activities in the field of health, nutrition and population? What was the rationale for supporting the activities?
b To what extent is the Dutch support coherent with the health policy of the recipient country?
c To what extent is the Dutch support complementary to activities supported by other donors; Do mechanisms exist for co-ordination with other donors?
d Are there mechanisms to encourage multi-sectoral co-ordination with other health-related projects funded with Dutch Aid (for example with sanitation and income-generating projects)?

2 Programme/project efforts

a What is the justification for the project/programme and how is the situation analysed? Are the justification and situation analysis appropriate and relevant?
b Is the project/programme coherent with the health policy of the recipient country?

Describe how it supports the policy, or fails to do so? Is it compatible with the Dutch health-aid policy? Specifically, has health reform been initiated, and if yes, is the activity coherent with the changes in health care structure resulting from health reform?

c Were the objectives and work plans feasible? Did the objectives change over time? Were the changes justified?

d Were the activities implemented according to plan?

e Is an adequate monitoring system in place; is it used to adjust plans of activities?

f Has the Ministry of Health in the recipient country developed guidelines that are relevant for the intervention? Is the intervention in coherence with these guidelines? Is it likely to result in improved guidelines?

g Are funds efficiently used to meet the objectives? Specifically, is there an adequate balance between expatriate technical staff input and use of local expertise; and between investment costs and recurrent costs? Is an adequate accounting system in place? Have any problems in financial management been identified?

h Is the programme/project sustainable, as reflected in contributions of the recipient country/population? Does the programme/project strengthen the institutional capacity of the health services, and build capacity of staff. Are trained health workers likely to leave the health services?

3 Effects on structure of the health system

a Has the project/programme led to improvements in health facilities and equipment?

b Has the project/programme enhanced the technical skills and/or interpersonal skills of staff by means of training?

c Are training materials and methods appropriate? Do treatment guidelines exist in the health facilities on how to prescribe the essential drugs?

d Has the programme or project led to a regular supply of essential drugs and vaccines? Are essential drugs and vaccine-need calculated adequately? Have logistical problems, which cause shortages of drugs, been resolved? Does leakage of essential drugs occur?

e Has the programme /project improved motivation of staff? Are salaries paid regularly?

f Has the financial accountability of the health services been improved? Do managers have the flexibility to adjust budget if required?

g Does the programme /project result in an improved health information system? Does the information system capture at least immunisation coverage, contraceptive prevalence, and utilisation of health services by health condition?

4 Effects on performance of the health system

a Does health personnel prescribe adequately for childhood ARI and diarrhoea? Are prescriptions in accordance with treatment guidelines?

b Are there improvements in ante-natal care and delivery care?

c Did the project/programme lead to increased responsiveness:
- do health personnel show respect for dignity of the person?
- do they respect autonomy of the client to participate in choices about one's own health?
- are amenities of adequate quality, such as cleanliness, and is there private space for the consultation?
- are IEC activities strengthened?
- is community participation enhanced?

d Are mechanisms in place to ensure that the poor have access to services? If the government has implemented a system of user-fees, what are the exemption criteria? How are the criteria implemented in practice?

e Is there any evidence of discrimination on grounds of sex, age, marital status, ethnicity of class?

5 Changes in health behaviour

a Did the activities result in increased utilisation of services? What other factors have affected utilisation of services?

b Has perceived quality of care of the health services improved; how does it now compare with perceived quality of care in the private sector? Are the health premises perceived to be adequately clean? Is privacy sufficiently ensured? Are people's perceived health needs met?

c Has knowledge on good nutrition, appropriate treatment of childhood diseases and hygiene increased?

d Do patients use medicines in accordance with the advice given in the health services (special attention for ARI/Diarrhoea)? To what extent do people go to public health services for these conditions? What other factors influence the rational treatment of these predominant health conditions?

e Has the percentage of fully immunised children increased due to the improved responsiveness of the health services?

f Has unmet need for family planning services decreased due to the improved responsiveness of the health services? Has the use of contraceptives been affected negatively by changes in payment structure?

g Has the use of condoms increased due to IEC efforts?

6 Health outcomes

a Have under-five and infant mortality rates decreased? Which factors can be related to these changes? Has improved performance of the health services contributed to any change? What is the impact of AIDS on these mortality figures? Can changes in the macro-economic environment or other societal changes explain the changes in health outcomes?

b Has maternal mortality in the region decreased? What factors account for changes? Has improved performance of the health service contributed to any change?

c Has fertility in the region decreased? Is this related to increased contraceptive prevalence? Has improved performance of the health service contributed to any change? Have other factors, such as the AIDS epidemic, or changes in the economic environment influenced fertility patterns?

Annex 5

HOUSEHOLD INTERVIEW WITH MOTHERS
استمارة مقابلة المرأة بالمنزل

Interviewer: _____ الباحث
Date: __ __/ __ __/ __ __ التاريخ
Time:

Catchment area: _____ المركز منطقة
Block/No: _____ بلوك\رقم
Household number: __ __ __ رقم المنزل

Nr.	QUESTIONS	CODING CATEGORIES	SKIP
1.	Since when do you live here? (in years) كم سنة لكم تعيشون في هذا المنزل؟	in years __ __ بالسنة	
2.	How many people live in this house? كم عدد الساكنين في هذا الأسرة المعيشية ؟	__ __	
3.	How many children (female/male) do you have? كم عدد أطفالك(ذكور- إناث)؟	boys أولاد __ __ girls بنات __ __	
3a	How many children under five years of age do you have? كم عدد أطفالك الذين هم دون سن الخامسة؟	__ __	
3b	What are their names, sex and ages (in ascending order)? حسب العمر تصاعديا أمام الجدول التالي		بالترتيب

	Name	Sex	Age (months)
1			
2			
3			
4			
5			

Nr.	QUESTIONS	CODING CATEGORIES	SKIP
4.	What in your view should a mother do to keep her child healthy? في رأيك، ماذا يجب على المرأة عمله لتحافظ على صحة طفلها؟		
5.	Do/Did you breast-feed (youngest child)? هل ترضعين-أرضعت طفلك الأصغر؟	Yes.....نعم .....1 No.....لا 2	
6.	Did you start introducing additional fluids/weaning to your infant ? هل بدأت تعطين الرضيع سوائل/أطعمة إضافية؟	Yes.....نعم .....1 No.....لا 2	→Q.9
7.	If Yes, at what age? كان عمره ؟ كم	Age in months _____ العمر بالأشهر	

Annex 5

Nr.	QUESTIONS	CODING CATEGORIES	SKIP
8.	What kind of weaning food did you give? ماهي الأطعمة التي كنت تعطينها لطفلك إلى جانب الرضاعة؟	1- 2- 3-	
9.	Has your youngest child been weighed? هل قمت بوزن طفلك الأصغر؟	Yes..... ...نعم .....1 No..... ...ال 2	→Q.10
9a	Where did you go to weigh your child, the last time? أين تم وزن الطفل ؟	HC, Hospital Priv/Publ, Priv clinic, Other *1-المركز الصحي* *2- المستشفى خاص | عام* ***3-عيادة خاصة*** _____ ***4-غير ذلك***	
9b	Do you have the growth monitoring card yourself? هل تحتفظين ببطاقة مراقبة نمو طفلك لديك ؟	Yes.....نع م .....1 No.....ال 2	
9c	What did the health worker tell you about the weight of your child? ما ذا قال لك العامل الصحي عن وزن طفلك ؟	Normal..... 1 طبيعي Underweight..... ناقص الوزن2 Other(specify):..... غير ذلك 3 Says nothing.....4 لم يقل شيء Don't remember..... لا اذكر 5	
9d	Did the health worker give you advice? هل قدم لك العامل الصحي نصيحة ؟	Yes.....نع م .....1 No.....ال 2	→Q.10
9e	What was the advice? ما هي النصيحة التي قدمت إليك ؟		

Now, I would like to talk with you about common child illnesses.
الآن ، أود الحديث عن بعض الأمراض الشائعة بين الأطفال

Nr.	QUESTIONS	CODING CATEGORIES
11.	In the last two weeks, did one of your under-five children have diarrhoea? [If *more than one: ask about youngest*] في الأسبوعين الماضيين هل أصيب أحد أطفالك الذين هم دون سن الخامسة بالإسهال ؟ [إذا كانوا أكثر من واحد فاسأل عن أصغرهم]	

Annex 5

11a	What was his/her age then? كم كان عمره في ذلك الوقت	
11b	What were the signs or symptoms you noticed? [*write down exact wording of respondent*] ماذا كانت الأعراض الرئيسية ؟ [سجل بدقة كلمات الشخص الذي تجري معه المقابلة]	- - -
11c	How do assess the seriousness of the symptoms ? كيف تقدر خطورة تلك الأعراض: عادي (غير خطير) او غير عادي (خطير) ؟	Serious ..... خطير.....1 not serious..... غير خطير.....2
11d	What have you done for him/her? [*probe on all interventions; fill the table event by event*] What is the first thing that was done? ... What happened then? **كيف تصرفتم؟ ماذا عملتم للطفل؟ [المس الجدول التالي ، اسأل عن كل ما عمل للطفل، ثم ماذا عمل أولا ، ثم ماذا ، ثم ماذا؟]**	

TREATMENT العلاج	**1** (first action) ماذا عمل أولا؟	**2** (and then…) ثم ماذا ؟	**3** (and then…) ثم ماذا ؟	**4** (and then…) ثم ماذا ؟
11e. What did you do/ has been done? ماذا عمل ؟				
11f. Who gave you the advice? من قال لك ؟				
11g. What is the result? ما هي نتيجة الحادث/التصرف على حالته ؟				استاءت حالته 1 لم يتحسن 2 خفت 3 تماما 4
If medicine was not prescribed, go to Q.13..... في حالة عدم وصف دواء اذهب الى السؤال رقم 13				
11h. Where did you get the Medicine? من اين حصلت على العلاج ؟	1-من صيدلية المركز الصحي 2-من صيدلية خاصة 3- غير ذلك(حدد)			

Annex 5

11i. How much did it cost? كم كانت تكلفة الدواء(بالريال اليمني) ؟				

Nr.	QUESTIONS	CODING CATEGORIES
12.	In the last month, did one of your under-five children have cough? *[If more than one: ask about youngest]* في الأسبوعين الماضيين هل أصيب أحد أطفالك الذين هم دون سن الخامسة بالسعال ؟ [إذا كانوا أكثر من واحد فاسأل عن أصغرهم]	Yes.....1 No.....2 **→Q.13**
12a	What was his/her age then? كم كان عمره في ذلك الوقت ؟	age (months) _ _ شهر اذا كان العمر اقل من شهر دون:1)
12b	What were the signs or symptoms you noticed? *[write down exact wording of respondent]* ماذا كانت الأعراض الرئيسية ؟ سجل بدقة كلمات الشخص الذي تجري معه المقابلة	- - -
12c	How do assess the seriousness of the symptoms ? كيف تقدر خطورة تلك الأعراض: عادي (غير خطير) او غير عادي (خطير)؟	Serious ..... خطير.....1 not serious..... غير خطير 2
12d	What have you done for him/her? *[probe on all interventions; fill the table event by event]* What is the first thing that was done? ... What happened then? كيف تصرفتم؟ ما اذ عملتم للطفل؟ [ما الأول الذي تلى ، اسأل عن كل ما عمل للطفل ، ما اذ عمل أولا ، ثم اذا ، ثم ماذا؟]	

TREATMENT العلاج	1 (first action) ماذا عمل أولا؟	2 (and then...) ثم اذا ؟	3 (and then...) ثم اذا ؟	4 (and then...) ثم اذا ؟
12e. What did you do/ has been done? ما اذ عمل ؟				
12f. Who gave you the advice? من قال لك / كيف عرفت؟				

Annex 5

12g. What is the result? ما هي نتيجة الحادث/التصرف؟				
If medicine was not prescribed, go to Q.13..... في حالة عدم وصف دواء اذهب الى السؤال رقم 13				
12h. Where did you get the Medicine? من اين حصلت على العلاج ؟	1-من صيدلية المركز الصحي 2-من صيدلية خاصة 3- غير ذلك			
12i. How much did it cost? كم كانت تكلفة الدواء(بالريال اليمني) ؟				

Now I would like to ask you about other illnesses of children. الآن أود الاستفسار عن أمراض الأطفال الأخرى و		
Nr.	**QUESTIONS**	**CODING CATEGORIES**
13.	During the last two weeks, was any of your under-five children ill with another illness? *[If more than one: ask about youngest]* خلال الأسبوعين الماضيين :هل كان أحد أطفالك ممن هم دون سن الخامسة مريض بمرض اخر؟	Yes.....نعم.....1 No.....لا.....2 **→Q.14**
13a	If yes, what was the disease? ما هو المرض؟	
13b	What was his/her age then? كم كان عمره في ذلك الوقت ؟	العمر بالشهر __ __ (اذا كان العمر اقل من شهر دون(1

13c	What were the signs or symptoms you noticed? *[write down exact wording of respondent]* ماذا كانت الأعراض الرئيسية ؟ [سجل بدقة كلمات الشخص الذي تجري معه المقابلة	- - -
13d	How do assess the seriousness of the symptoms ? كيف تقدر خطورة تلك الأعراض: عادي (غير خطير) او غير عادي (خطير)؟	Serious ..... خطير.....1 not serious..... عادي.....2
13e	What have you done for him/her? *[probe on all interventions; fill the table event by event]* What is the first thing that was done? ... What happened then? كيف تصرفتم؟ ماذا عملتم للطفل؟ [اسأل عن الجدول التالي ، المألوف ، ثم ماذا ، ثم ماذا عملوا للطفل ، ماذا عمل لكل؟]	

Annex 5

TREATMENT العلاج	**1** (first action) ؟الوأ لمع اذام	**2** (and then…) ؟ اذام مث	**3** (and then…) ؟ اذام مث	**4** (and then…) ؟ اذام مث
13f. What did you do/ has been done? ؟ لمع اذ ام				
13g. Who gave you the advice? من قال لك/ كيف عرفت؟				
13h. What is the result? ما هي نتيجة الحادث/التصرف؟				
If medicine was not prescribed, go to Q.14..... في حالة عدم وصف دواء اذهب الى السؤال رقم 14				
13i. Where did you get the Medicine? من اين حصلت على العلاج ؟	1-من صيدلية المركز الصحي 2-من صيدلية خاصة 3- غير ذلك			
13j. How much did it cost? كم كانت تكلفة الدواء(بالريال اليمني)؟				

We have talked about your children, now some questions about what you do about your own health. والآن ، اسمحي لي بطرح بعض الأسئلة عن صحتك		
Nr.	**QUESTIONS**	**CODING CATEGORIES**
14.	Have you suffered from any illness in the last two weeks? هل عانيت من مشكلة صحية خلال الأسبوعين الماضيين؟	Yes.....نعم.....1 No.....لا.....2 →Q.15
14a	If yes, what was the disease? ما هو المرض؟	
14b	What were the signs or symptoms you noticed? [*write down exact wording of respondent*] ماذا كانت الأعراض الرئيسية ؟ سجلي بدقة كلمات الشخص الذي تجري معه المقابلة	- - -

Annex 5

14c	How do assess the seriousness of the symptoms ? كيف تقدر خطورة تلك الأعراض: عادي (غ ي خطير) او غير عادي (خطير) ؟	Serious ..... خطير.....1 not serious..... عادي.....2
14d	What have you done for him/her? *[probe on all interventions; fill the table event by event]* What is the first thing that was done? ... What happened then? كيف تصرفتم؟ ما ذا عملتم للطفل؟ [استعمل الجدول التالي ، اسأل عن كل ما عمل للطفل ، ما ذا عمل أولا ، ثم اذا ، ثم اذا؟]	

TREATMENT العلاج	**1** (first action) ماذا عمل أولا؟	**2** (and then...) ثم اذا ؟	**3** (and then...) ثم اذا ؟	**4** (and then...) ثم اذا ؟
14e. What did you do/ has been done? ما ذا عمل ؟				
14f. Who gave you the advice? من قال لك/ كيف عرفت؟				
14g. What is the result? ما هي نتيجة الحادث/ التصرف؟				
If medicine was not prescribed, go to Q.15..... 15 في حالة عدم وصف دواء اذهب الى السؤال رقم				
14h. Where did you get the Medicine? من اين حصلت على العلاج؟	1-من صيدلية المركز الصحي 2-من صيدلية خاصة 3- غير ذلك			
14i. How much did it cost? كم كانت تكلفة الدواء(بالريال اليمني) ؟				

Nr.	QUESTIONS	CODING CATEGORIES	SKIP
15.	Do you go to your (nearest health centre?) هل تذهبين إلى اقرب مركز صحي ؟(تأكدي)	Yes.....نعم.....1 No.....لا.....2	→ Q. 15b

Annex 5

15a	Why don't you go to the (name of nearest centre)? لماذا لا تذهبين إلى أقرب مركز صحي (أذكر اسم أقرب مركز الصحي [أكتب الأسباب ، ودون الملاحظات لكل حالة إذا كان ذلك ضروري]	1 2 3	
15b	When you go to the Health Centre, do you have to pay for the consultation? عندما تذهبين إلى المركز هل يتوجب عليك الدفع مقابل للخدمة ؟	Yes..... ...نعم.....1 No..... ...لا.....2	→ Q.15d
15c	How much did you pay last time you visited the centre? إذا كانت الإجابة بنعم فكم دفعتي آخر مرة ؟	Yemeni rial ريال يمني __ __ __	
15d	Do the centre provide medicines? هل يقوم المركز الصحي بصرف الأدوية؟	Yes..... ...نعم.....1 No..... ...لا.....2 DK..... أعرف لا 3	→ Q. 16 → Q. 16
15e	Do you have to pay for them? هل يتوجب الدفع مقابل الحصول على الأدوية؟	Yes..... ...نعم.....1 No..... ...لا.....2	
15f	Are they expensive in your view compared to medicines in the pharmacies in town? هل تعتقدين أنها ارخص أو أغلى أو بنفس الثمن مقارنة بالأدوية التي تباع في صيدليات المدينة؟	more expensive.....أغلى 1 cheaper.....ارخص 2 same price.....نفس السعر 3 DK.....8 لا أعرف	
15g	Are they good quality medicines in your view? هل الأدوية ذات نوعية جيدة؟	Yes..... ...نعم.....1 No..... ...لا.....2	
Now, I would like to ask you some questions about pregnancy. الآن اسمحي لي بطرح بعض الأسئلة عن الحمل			
16	When was your last pregnancy? متى كان آخر حمل لك ؟	حاملة حاليا .....99 من __ __ شهر	

Annex 5

17	Do/did you go to the health centre for ante-natal care? هل ذهبت /تذهبين إلى المركز الصحي للرعاية أثناء الحمل	Yes.....1 No.....2	→ Q. 17b
17a	Which center ? أي مركز ؟	_____ اسم المركز	→ Q. 17c
17b	Why not? لماذا لا تذهبين إلى المركز ؟		
17c	Have you had tetanus toxoid vaccination? هل أخذت لقاح الكزاز ؟	Yes..... ...نعم.....1 No..... ...لا.....2	
18	Where did you deliver last time? أين وضعت آخر مرة ؟	home ..... 1 في منزلي family's home..... عند أهلي(منزل الاسرة) 2 nearest center..... في المركز الأقرب 3 other: غير ذلك (حددي): 4	
18a	Who attended the delivery? ؟ أشرف على الوضع من	Trad. birth attendant.....1..... جدة trained midwife.....2.....قابلة doctor.....3..... طبيب nobody.....4..... لا احد someone else_____ شخص اخر 5	

Nr.	QUESTIONS	CODING CATEGORIES	SKIP
19	Do you want any more children in the coming two years? ؟ أكثر إنجاب أطفال العامين المقبلين هل ترغبين خلال	Yes..... ...نعم.....1 No..... ....لا.....2 n.a. .... لا ينطبق.....9	→Q.20
19a	Are you currently using family planning methods? هل تستعملين حاليا وسائل تنظيم الأسرة ؟ (لا تسأل إذا كانت حامل)	Yes..... ...نعم.....1 No..... ...لا.....2	→Q.20
19b	Why not? لما ذا لا ؟		→Q.20

Annex 5

19c	What kind of family planning methods? مامي الوسيلة التي تستخدمينها ؟	Condom.....1- الواقي الذكري oral contraceptive/ pill .....- الحبوب2 IUD..... - اللولب 3 calendar method.....- طريقة الحساب 4 coitus interruptus.....- الجماع المبتور 5 breastfeeding.....الرضاع طبيعي - 6 other:_____.....- غير ذلك (حدد)6	→Q.20 →Q.20 →Q.20
19d	Where did you get your family planning method from? من اين تحصلين على الوسيلة ؟	1 المركز الصحي 2 صيدلية خاصة _____ غير ذلك 3	
20	What is your age? ما عمرك ؟	___	
I would like to ask you some questions about the murshidat. Do you know who they are, what they do? **الآن ، أود الحديث عن المرشدات - هل تعرفي عن وجودهم؟ ماهي واجباتهم ؟**			
21.	Has your family been visited by the murshidat? هل زارت أسرتكم المرشدة ؟	Yes..... ...نعم.....1 No..... ...ال.....2	→Q. 21
21a	How often during the last year? كم زيارة خلال السنة الماضية ؟	No visit.....0 ولا مرة Once..... مرة1 Twice..... مرتين2 more than twice.....كثر من مرتين 3	
21b	What did she do? ما اذ عملت أثناء الزيارة ؟		
21c	What was her advice? ما هي النصيحة التي قدمتها المرشدة ؟		
21d	What is your opinion about the advice? ما رأيك في النصيحة ؟	Good/ useful..... جيدة-مفيدة 1 not good in my case/ impossible..... غير مناسبة لي- مستحيلة التطبيق 2 n.a. .... لا ينطبق.....9	

Annex 5

21e	Do you think home visits by the murshidat should continue? في رأيك ، هل ينبغي أن تستمر الزيارات المنزلية من قبل المرشدات ؟	Yes..... ...نعم.....1 No..... ...ال.....2	→Q. 21
21f	How often per year is best in your view? في رأيك ، كم زيارة في السنة سيكون الأفضل ؟	times per year __ __السنةامرة	
Now, I have some last questions on living conditions. الآن ، اسمحي لي بطرح بعض الأسئلة عن الأحوال المعيشية			
22	Is this your own house? or do you rent? هل هذا المنزل ملك لكم ، أم انتم مستأجرون ؟	Ownership ..... ملك1 Rent..... إيجار 2 Waqf.....وق ف 3	
22a	Interviewer: Observe type of house *لاحظي نوع المنزل ؟*	stones حجر 1 mud Brick لبن 2 cement bricks طوب واسمنت 3 Other غيرذلك 4	
22b	Do you have a 'safe' water tap in the house? هل تصل شبكة المياه إلى منزلكم ؟	Yes..... ...نعم.....1 No..... ...ال.....2	
22c	Are you connected to a sewage system? هل منزلكم موصل بشبكة مجاري ؟	Yes..... ...نعم.....1 No..... ...ال.....2	
22d	Do you have electricity? هل لديكم كهرباء ؟	Yes..... ...نعم.....1 No..... ...ال.....2	
22e	What electrical appliances do you have? (specify) ماهي الأجهزة الكهربائية التي لديكم ؟	TV Refrigerator Radio Video Fan satellite dish private telephone other: _____	

Annex 5

22f	What is your educational level? وصلتي إلى أي مستوى دراسي ؟ هل تقرئي و تكتبي ؟	Illiterate..... أمية 1 Writing and reading.....2 أقرا و اكتب Primary ..... ابتدائي \عدادي3 Secondary ..... ثانوي 4 University..... جامعي 5 Other?..... غير ذلك 6	
22g	Do you work? هل تعملي ؟	Yes..... نعم.....1 No..... لا.....2	→Q. 21 i
22h	If yes, what do you do? نوع العمل ؟		
22i	Does your husband work? هل زوجك يعمل ؟	Yes..... نعم.....1 No.....لا..... ...2 n.a. .... لا ينطبق.....9	→stop. →stop.
22 j	If yes, what does he do? نوع العمل ؟		
Interviewer: Give your opinion on the socio-economic level of the respondent. **للباحثة: في رايكي ما هي الحالة الاقتصادية الاجتماعية؟ :** **1- عالي 2- متوسط 3 - متدني**			
Thank you very much!! أشكرك جدا جدا			

ANNEX 6 SUMMARY OF THE FIELD STUDIES

Effects on structure of health care system, based on inspections of health centres and interviews with health workers

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Facilities, equipment, means of transport	+ improved health infrastructure + improved coverage level (health centres – CSPS) – health posts (PSP) and community health workers (VHWs/TBAs) not well equipped and not functional – equipment at CSPS not complete and not sufficiently maintained + maintenance funds recently set up by the state and the project	+ 3 main health centres and 10 sub-centres upgraded + adequate cleanliness and ventilation + improved physical access + basic medical equipment available + good maintenance	+ health centres rehabilitated + construction of maternity + staff houses built + limited improvement in transport (one car and two motors), entire district disposes one ambulance + limited improvement in equipment – no systematic maintenance, limited funds – no adequate communication mechanisms (telephone / radio) available
Staff skills / training	+ health workers skills improved by frequent training – VHWs and TBAs received limited training	+ training of health workers, in particular of 132 female village health workers (murshidat) + quality of training adequate for murshidat tasks + all trained murshidat are employed by Hodeidah Health office, and some even are managers + training integrated in Institute of Health Manpower	+ training of health staff in various topics (also with support of Prindesa) + training of community health workers (VHWs and TBAs) + training material of MoH adapted for training of VHWs and TBAs
Supervision	+ supervision and monitoring improved by involvement of COMEG	– no funds available for continuing supervision of murshidats.	+ integrated supervision improved (Prindesa played a role in this at provincial level) – limited funds available to pay recurrent costs related to supervision (transport and DSA) – group supervision and in-service training of TBAs (instead of individual supervision visits)

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Motivation of staff	+ health staff motivation improved, due to improved working (training, supervision, monitoring) and housing conditions – VHWs and TBAs motivated by 'gratitude' of population, but de-motivated because of not being paid / and not having medicines (VHWs)	+ upgrading opportunities for murshedaat exist (to become a community midwife), which is important for their motivation	+ motivation improved by training and supervision – motivation still low because of bad working and housing conditions, and low salary + work of VHWs and TBAs very much appreciated by population, which contributes to their motivation
Supply of drugs and vaccines	+ regular supply of drugs – CSPS + improved info on drugs stock + no 'leakage' of essential drugs – not regular supply of drugs - PSP – vaccines supply not regular	– supply not yet regular + drug fund functional since early 2001 – but confusion about functioning of drug revolving fund	+ well structured drug management procedures exist – supply of drugs is very irregular – supply of vaccines is also irregular + supply of drugs for TB and lepra is regular
Therapeutic guidelines	+ therapeutic guidelines available	+ therapeutic protocols available for 20 diseases – protocols used (though no rational drug use prescription) – service protocols for diarrhoea and ARI not fully applied ± good functioning Quality Assurance Department (who defined criteria for curative protocols) has stopped functioning, which is a threat to the quality of care	+ therapeutic (MoH) guidelines available in HCs for most common illnesses, + therapeutic guidelines available for VHWs – hardly used, partly due to lack of medicines

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Accountability	+ adequate management procedures and tools at district level in place and regularly used + COGES (village health committee) in all CSPS actively involved in health management – COGES members do not represent full population of health area, but only those who live close to the CSPS + cost recovery system introduced: users fees for drugs, and partly for consults	+ Local Health Committees (LHC) installed + Cost recovery system introduced: users fees for consults and medicines + LHC can decide on use of recovered funds ± some doubts about use of recovered funds ± the fees system means that curative services are more lucrative than preventive, leading to sub centres also providing curative services in the evenings	+ management course for health staff (facilitated by Prindesa) – village health committee do not function
Health Information System	+ improved HIS + improved information on drugs stocks + HIS used for planning – limited use of reports at CSPS level – information collected at PSP level is not valued and not taken into account	+ well structured HIS – HIS not used for monitoring and evaluation	+ HIS data available (about curative and ante-natal consults, vaccine coverage, obstetric coverage and use of contraceptives) at health unit and district level – data hardly used for monitoring and evaluation

Effects on performance of health care system; based on observations of consultations; exit interviews and information from household surveys

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Curative care, including prescription Of drugs	– treatment guidelines not used + rational prescription of drugs, due to regular use of guidelines, DOTS-strategy for TB, continuous training, and availability and relative low price of essential drugs.	– no rational prescription of drugs, but prescription of drugs by trade name – cheap generic drugs from developing countries are seen as inferior by physicians and pharmacists	+ use of generic drugs commonly accepted
Ante natal care	Household survey (N=104 women) + 64 of 104 women attended at least once prenatal care	– health workers are lacking interpersonal and communication skills	NA (exit interviews only with 5 women)
Delivery care	+ increased number of women who deliver with assistance of health staff/TBA (40% in 1999) + emergency care improved, due to highly motivated staff, TBAs, availability of ambulance and radio, and 'soins a credit', and despite less specialized obstetric staff at CSPS	+ most deliveries assisted by a trained health worker + relationship to health workers good and their work appreciated to seek their help	+ most deliveries carried out with assistance of health staff or TBA – emergency care can only be given at health centre level; there are no means available to transport women to higher echelon
Nutritional and monitoring advice	+ routine weighing – grow curve not completed – very general – not personal – advice – WFP distributed food for malnourished children; use not monitored	+ growth monitoring at any visit to health centre – growth monitoring cards often not available/not adequately used – nutritional status and implications not explained to mother	No data available (exit interviews with limited number of women)
Vaccination services	– Services at defined days. During under five consultations, no advice was given on vaccination.	+ vaccination equipment, protocols and cards available – lacking interpersonal and communicating skills	– vaccines and vaccine cards not regular available

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Family planning services	No data available from exit interviews (too little cases) + slight increase of contraceptive prevalence rate	+ protocols for family planning strictly followed in all 21 observed cases	No data available (exit interviews with limited number of women)
IEC on AIDS-prevention, child care and FP	+ increased number of IEC on various topics, incl. AIDS and FP – IEC topics defined by central level, not based on locally identified needs	+ health centres equipped to give IEC at several occasions – home visits, for health education, is limited to risk families – decrease in number of IEC activities, because opportunities for IEC are not always used	– health centres very limited means for IEC – awareness increased; condom us low (household survey)
Showing respect for patients	+ relational skills improved (greeting, listening, communicating, respecting confidentiality)	± according to exit interviews: health personnel is responsive to clients' needs; observations give negative picture about communication skills of health workers + limited waiting time (hardly ever more than 30 minutes)	± according to exit interviews: health personnel is responsive to clients' needs; ± about one third of patients waited more than one hour (exit interviews, N=61)
Respecting autonomy of patients	– not taking into account patients priorities regarding treatment – taking into account women's priorities regarding family planning	No data available (observation of limited number of new users of family planning)	No data available (no observations done)
Adequate mechanisms for community participation	+ COGES functioning (community financing developed): managing drug revolving fund, and monitoring PASSPK project	+ Local health committees functioning (community financing developed) + LHC manage drug fund	– village health committees set up, but not functioning

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Fairness in terms of paying for health	– no systematic exemption policy defined ± ad hoc solutions found in case of people who cannot pay their drugs	+ exemption system developed – in principal risk families exempted from payment – exemption system does not function anymore: all clients have to pay for services and drugs – introduction of drug fund complicates giving drugs for free ± ad hoc exemption from fees for services and drugs (poor people)	(Very low fee for consultants and drugs exist) + general guidelines for exemption exist: poor people can get exemption when they show a 'atestado de pobreza' (to be procured from the local administration) ± ad hoc exemption from fees for services and drugs NB. fees very low, exemption rarely applied
Discrimination	+ no explicit signs of discrimination observed – gender inequality may lead to limited access for women and girls to health care services, in particular to family planning services	– all health centres require the husband's presence (read: approval) at the first visit for family planning – at times the HC insist on presence of husband even in follow-up visits	NA

Changes in health care behaviour by target populationEvaluation

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
	Household survey (N=104 women)	Household survey (N=120)	Household survey (N=101)
Utilization of health services	+ increased utilization preventive service: + 78 women had last delivery with TBA, 24 in CSPS; ± 64 women attended at least once prenatal care during last pregnancy – low utilization of curative services of CSPS : 39% of 104 women visited CSPS for last illness period	+ 87 % of women goes to health centre for child or self for various reasons + increased utilization of preventive services: + 84 % of 120 women visited health centres for ante-natal care during last pregnancy (non-users referred to bad experience with the services, go to private services or fear medicines) + 87 % of 120 women had TT vaccine (high TT % vaccine confirmed in observations) – low use of curative services – mothers do not take their children to public health centres when they are sick, due to a perceived or actual lack of a facility – public curative services are perceived as inferior, and only good as first line in treatment – mothers hardly go to a health centre for themselves; they use home treatments and (OTC) self-medication + curative sessions also take place in the evenings, on initiative of the local community	+ 95 women use nearest HC for curative and preventive services + 100 women visited health centres for ante-natal care during last pregnancy + 70 women had last delivery in a health unit with health personnel and 8 with TBA at home + for all 75 ill children the health centre was visited (in last month)

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Family Planning	– 28 of 72 women who want birth spacing actually use modern family planning ± according to half of the VHW increasing demand for family planning; use still low due to husbands resistance, lack of female staff at CSPS, and presence of local authority in the CSPS, which limits the health staff to express themselves freely	– 98 women do not want to become pregnant in the next two year: 48 % of them uses modern contraceptives. Others do not for various reasons, a.o. natural spacing (breastfeeding; menstruation not yet returned), non approval of husband, perceived side-effects, or religious objections + 27 of 31 (84%) contraceptive users obtained contraceptives from health centres	– 40 of 101 women do not want to become pregnant in the next two years. 21 of them used any method to prevent pregnancy. 17 of the 21 use a modern contraceptive, which they got through the health centre.
Perceived quality of care	Household survey (N=188 men and women) + 97 % is positive about quality of care, due to various factors		No data available
Percentage of children vaccinated	-vaccination coverage low (household survey) + vaccination coverage increased from 20% in 1997 to 40% in 1999 (health statistics)	Household survey (N= 120) + 93% of youngest children had BCG, DPT/polio 1-3 varied from 97-87 %, measles 84 % + all mothers positive about vaccination	Household survey (N=101) + major part of children are vaccinated – except for BCG (92 %) , a high percentage not completely vaccinated for their age, varying from 81-14%. – 7 recently born children not vaccinated at all, due to lack of vaccines
Nutrition	No data available	+ breast feeding is a common practice + local weaning food given after 4 months No data available	+ breast feeding is a common practice + local weaning food given after 4 months Household survey (N=101) + AIDS (100) and condom (75) awareness high
Condom use	No data available		– condom use low: 5 persons possessed a condom at the moment of the interview.

Changes in key indicators

Evaluation component	PASSPK – Burkina Faso	Hodeidah – Yemen	Angoche – Mozambique
Maternal mortality	National Health Statistics + improved from 342 per 100.000 life births in 1997 to 94 in 1999	Data at national level vary substantially	NA
Total Fertility Rate (reproductive age: 15-49 years)	National Health Statistics remained similar: 6.9 in 1993; 6.8 in 1998-99	1994 Census – Hodeidah governate: 5.88 1997 DHS - Coastal region: 5.81 1997 DHS – whole country: 6.48	National data: FR changed from 6 in 1990 to 5 in 1998
Child mortality (< 5 years)	National Health Statistics – deteriorated from 187 per 1000 in 1993 to 219 in 1998-99 (Unicef 1999: 199)	1994 Census report IMR for Hodeidah is 107.9 compared with 163 for the year 1986 (Unicef 1999: 119)	National data: slight improvement from 238/1000 in 1990 to 213/1000 in 1998 (Unicef 1999: 203)

Abbreviation List

ABBEF	Association Burkinabé pour le Bien Être Familial (Burkinabe association for family welfare)
ADB	African Development Bank
AHO	Aden Health Office
ARI	Acute respiratory infections
BCG	Bacille Calmette-Guérin
CAMEG	La Centrale d'Achat de Medicaments Essentiels Génériques (Central agency of generic essential drugs purchase)
CFA	Communauté Financière Africain (French financial community)
CMAM	Central de Medicamentos e Artigos Médicos (Central agency for drugs and medical supplies)
COGES	Comité de gestion (Management Committee)
CSPS	Centre de santé et de promotion sociale (Health and social promotion centre)
CRS-code	Creditor reporting system
Daly	Disability adjusted life years
DHS	Demographic and health surveys
DGIS	Directoraat-Generaal Internationale Samenwerking (Directorate General International Co-operation)
DOTS	Directly observed treatment with short course therapy
DPT	Diphtheria-pertussis-tetanus
DVL	Directie Voorlichting (Information Service of the Ministry of Foreign Affairs)
EDM	Essential Drugs Management (Programme of WHO)
ENSP	École Nationale de la Santé Publique (National School of Public Health)
FGD	Focus group discussions
FNUAP	Fonds des Nations Unies pour la Population (United Nations Population Fund)
GDP	Gross domestic product
GTZ	Gesellschaft fur Technische Zusammenarbeit (German Technical Co-operation)

HHO	Hodeidah Health Office
HIS	Health information system
HNP	Health, nutrition and population
HNI	Health Net International
ICN	International Conference on Nutrition
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross (and Red Crescent Movement)
IEC	Information education communication
INE	Instituto Nacional de Estadística (National Statistical Institute)
IOB	Inspectie Ontwikkelingssamenwerking en Beleidsevaluatie (Policy and Operations Evaluation Department)
IOV	Inspectie Ontwikkelingssamenwerking te Velde (Operation Review Unit)
LDC	Least developed country
LCH	Local health committee
MCH/FP	Mother and child health/family planning
MIDAS	Management Inhoudelijk Documentair Activiteiten Systeem (Management and Information System of the Ministry of Foreign Affairs)
MFO	Medefinancieringsorganisatie (Co-financing Organisation)
NDP	National drug policy
NGO	Non-governmental Organisation
NIC	Nederlandse Inkoop Centrale (Dutch Agency for purchase of goods)
NSL	Nederlandse Stichting Leprabestrijding (Netherlands Leprosy Control Society)
NTLCP	National Tuberculosis and Leprosy Control Programme
OPV	Oral poliomyelitis vaccine
ORS	Oral rehydration salts
PASSK	Projet d'Appui au développement de Soins de Santé Primaires dans la Région Sanitaire de Kaya (Support for primary health care in the Kaya sanitary region project)
PATA	Pooling Agreement on Technical Assistance
PHC	Primary health care
PNLT	Programme National de Lutte contre la Tuberculose (National tuberculosis control programme)

PSI	Population Service International
PSP	Poste de Santé Primaire (Primary health post)
RLA	Regeling Laag Frequente Aandoeningen (Arrangement for diseases occuring with low frequency)
RNE	Royal Netherlands Embassy
SGS	Societé General de Ségurance (General quality control company)
TBA	Traditional birth attendant
TT	Tetanus toxoïd
UN	United Nations
UNAIDS	United Nations Programme on Acquired Immune Deficiency Syndrome
UNDP	United Nation Development Programme
UNFPA	United Nation Population Fund
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VHW	Village health worker
WHO	World Health Organisation
WOZ	West Oost Zuid (West East South)
YEMDAP	Yemen Drug Action Programme
YER	Yemeni rial

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