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Special report

EU financial support for health systems in selected partner countries

Broad strategic objectives followed but interventions affected by coordination and sustainability issues

EUROPEAN
COURT
OF AUDITORS

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Executive summary

I The EU's support for health in partner countries contributes to the main EU development policy goal of reducing and, ultimately, eradicating extreme poverty. In line with the international approach to health, in particular with the United Nations Sustainable Development Goal 3, the EU provides funding to its partner countries' health systems through bilateral and regional programmes and global health initiatives. This support amounted to over €3 billion in each of the two previous programming periods (2007-2013 and 2014-2020), and to over €2 billion at the beginning of 2024 for the current period (2021-2027).

II Our objective was to assess the EU's financial support for health in partner countries in these three programming periods. Our conclusion was that the Commission allocated funding according to its broad priorities. However, the methodology of allocation was affected by shortcomings. The effectiveness of projects was hampered by issues of coordination and sustainability, and monitoring did not provide a full picture of the Commission's activities in the health sector.

III We found that the amount of EU funding for health support remained relatively constant during the reviewed programming periods. However, bilateral assistance to partner countries has decreased, while support through global health initiatives has increased substantially. The Commission's ranking of partner countries according to their health systems' needs has had little effect on bilateral funding, mainly because the principle of ownership requires programming to be based on policy choices agreed with partner governments. The allocation of support to individual global health initiatives was not based on a set of specific and quantifiable criteria and the process has not been sufficiently documented.

IV We examined a sample of projects in selected partner countries (Burundi, Democratic Republic of the Congo and Zimbabwe). These focused on, among other things, the provision of free healthcare , the organisation of training for health professionals, the provision of medicines and equipment, and reconstructing health centres. We found that the EU supported different health interventions which were in line with countries' needs. However, there was insufficient coordination at the district level, which led to shortcomings in the distribution of equipment and medicines. Furthermore, the costs of interventions in the health sector were impacted by the cascading structure of implementation. This increased the costs of projects' implementation. In addition, the visibility of EU funding among targeted populations was low.

V The Commission's monitoring of its health spending has relied on a small number of high-level indicators which gave only a partial picture of EU health actions and were calculated in a way that results cannot be attributed solely to EU funding. In the case of bilateral assistance, results are not shared satisfactorily with the in-country EU delegations, and the data collected by project implementers for their reporting was sometimes not made available or turned out to be unreliable.

VI The Commission is engaged in the governance of global health initiatives to ensure they are better aligned and thus end fragmentation. However, further efforts are needed to achieve these goals and rationalise the international approach to global health challenges.

VII The sustainability of health projects and programmes is at risk due to the lack of clear transition and exit strategies and the inadequate maintenance of equipment.

VIII On the basis of these conclusions, we recommend that the Commission:

- better matches countries' needs and the allocation of health funding;
- sets clear criteria for the funding of global health initiatives and improves documentation of the allocation process;
- improves needs analysis and the coordination of distribution of equipment and medicines;
- analyses reasonableness of management costs;
- avoids overlaps and ensures synergies between the global health initiatives supported;
- identifies indicators to monitor in a comprehensive manner the EU support for the health sector;
- takes action to promote the sustainability of the health systems;
- increases the importance of maintenance of equipment delivered by projects.

Introduction

Importance of improving health to address poverty

01 The EU's support for health in partner countries contributes to the main EU development policy goal of reducing and, ultimately, eradicating extreme poverty[1]. Poverty can be both a cause and a consequence of insufficient health coverage. In general, as the economy of a country improves, the health of its citizens improves. But the opposite is also true – improving the health of citizens can result directly in economic growth[2].

02 The World Health Organization (WHO) defines health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'[3]. The WHO includes enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being. It identifies unequal development in the promotion of health and control of diseases, especially communicable diseases, as a common danger. Half of the world's population does not have access to the health services it needs[4], and about 100 million people fall into extreme poverty each year because of excessive health costs[5].

03 In 2000 the United Nations agreed on eight Millennium Development Goals (MDGs) to be achieved by 2015[6]. Three of the goals were directly linked to health: reduce child mortality (MDG4), improve maternal health (MDG5), and combat HIV/AIDS, malaria and other diseases (MDG6).

04 Subsequently, in 2015, under the UN 2030 Agenda for Sustainable Development[7], the international community set 17 Sustainable Development Goals (SDGs) to be achieved by 2030. SDG3 relates to ensuring healthy lives and promoting well-being for

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1 Article 208 (1) of the Treaty on the Functioning of the European Union.

2 Growing importance of health in the economy, Collins, Francis S., Outlook on the Global Agenda 2015, World Economic Forum, 2015.

3 Constitution of the World Health Organization.

4 Monitoring universal health coverage, Health and demography, World Health Organization.

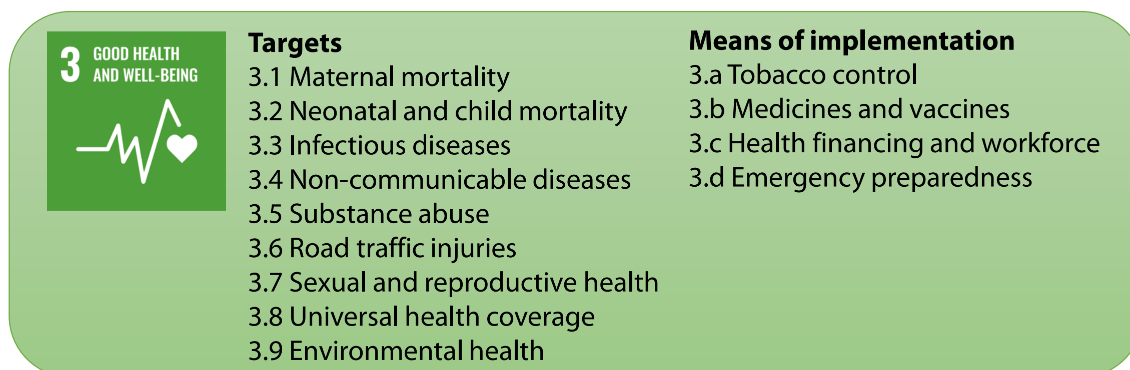
5 Health and demography, European Commission – DG International Partnerships.

6 2000-2015, Millennium Development Goals, Dag Hammarskjöld Library, United Nations.

7 Transforming our world: the 2030 Agenda for Sustainable Development, United Nations.

all at all ages. It has nine associated targets, all of them linked to reducing major health challenges by 2030 (see ***Figure 1***).

Figure 1 – SDG3 health and well-being targets



Source: ECA, based on WHO.

05 In its 2023 special report on the SDGs, the WHO spoke positively of the advances that have been made on improving global health in recent years, but underlined the insufficiency of progress in areas such as maternal mortality and the expansion of universal health coverage. The COVID-19 pandemic slowed progress towards SDG3 (see ***Box 1***). The WHO therefore called for long-standing healthcare shortcomings to be addressed through investment in health systems to help countries recover and build resilience against future health threats.

Box 1

Effects of COVID-19 on health aid

The WHO's 2023 special report on the SDGs pointed to a deterioration in universal health coverage in developing countries and disruptions in the delivery of essential health services (e.g. vaccination campaigns) due to the COVID-19 pandemic. It concluded that the pandemic had slowed progress towards SDG3.

The report stated further that, in 2021, COVID-19 control represented the largest share of global official development financial assistance for basic health ($9.6 billion, of which $6.3 billion was for vaccine donations).

Regarding EU actions against the effect of COVID-19, the Commission allocated over €440 million in 2020, and over €1.27 billion so far for the programming period 2021-2027.

06 Although international concern over the faltering progress towards universal health coverage is growing [8], there is a chronic shortage of financial, human and material resources to deal with the health needs of the steadily increasing population of developing countries. According to the latest African Union data (2021), only two African countries – South Africa and Cabo Verde – have met the Abuja Declaration target of allocating at least 15 % of their national budgets each year to the health sector[9]. International aid in developing countries aims to improve local health systems and to strengthen health services sustainably so that they meet local needs and are accessible to all, particularly those living in poverty.

07 According to the WHO, a health system consists of 'all organizations, people and actions whose primary intent is to promote, restore or maintain health'[10]. This refers to the structures that need to be in place to support the goals of improving health and health equity while removing financial barriers to health care. The WHO has laid out six building blocks that make up a health system: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance. The WHO emphasises the concept of 'health systems strengthening' (HSS), which it defines as 'improving these building blocks and managing their interactions in ways that achieve more equitable and sustained improvements in all health services and health outcomes'. HSS is dependent on technical knowledge and political will[11].

08 Traditionally, HSS activities have focused to a large extent on reducing 'input constraints' – supporting health systems by supplying material resources such as mosquito nets, contraceptives or medicines. However, these activities per se cannot accomplish comprehensive objectives, such as improving policies, legislation, organisational structures or delivery systems to allow the more effective use of resources[12].

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[8] Universal health coverage - Key facts, WHO, 2023.

[9] Africa Scorecard on Domestic Financing for Health, African Union.

[10] Everybody's business. Strengthening health systems to improve health outcomes, WHO, 2007.

[11] Health systems strengthening, Unlimit Health.

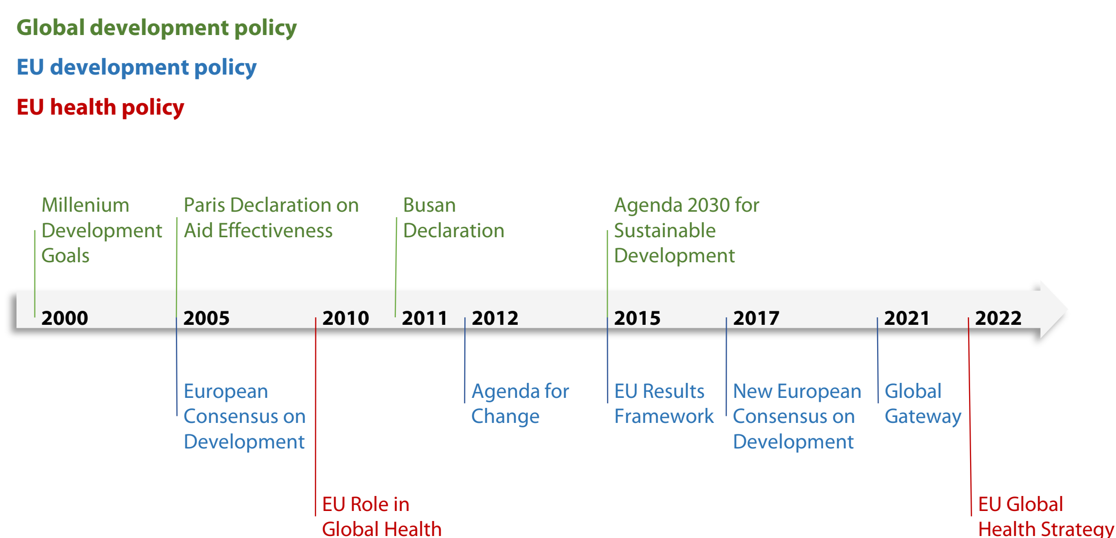
[12] Why differentiating between health system support and health systems strengthening is needed, Chee, G. et al., The International journal of health planning and management, 28(1), 85-9, 2013.

The EU response to health challenges in partner countries

09 The EU's health support in partner countries is underpinned by Article 168(3) of the Treaty on the Functioning of the European Union, which states that 'the Union and the member states shall foster cooperation with third countries and the competent international organisations in the sphere of public health'.

10 The EU's current health aid policy and objectives were developed through multiple policy documents during recent budgetary cycles. The relevant global[13] and EU policies and strategies are shown in ***Figure 2*** and ***Annex I***.

Figure 2 – Timeline: global and EU health aid policies and strategies



Source: ECA, based on information from DG INTPA.

11 In 2005, the European Parliament, the Council and the Commission adopted the 'European Consensus on Development', which reiterated the EU´s commitment to meeting internationally agreed development objectives (i.e. the MDGs). This policy was made applicable in 2017 for the SDGs.

[13] Millenium Development Goals, Paris Declaration, Busan Declaration and Agenda 2030 for Sustainable Development.

12 In 2010, the Commission adopted a communication on the EU's role in global health[14], a statement of the EU's policy on health aid that has influenced two successive multiannual financial frameworks (2014-2020 and 2021-2027). The associated Council conclusions[15] called on the Commission and the member states to act together by prioritising support for HSS in partner countries. In November 2022, the Commission adopted a new strategy on global health[16], in which it reaffirmed the commitment to SDGs and the European Consensus on Development.

13 *Table 1* shows how much has been spent on health aid programmes under Commission management during the last three programming periods. This area of EU financial support is managed mostly by the Directorate-General for International Partnerships (DG INTPA).

Table 1 – Evolution of EU health aid by Commission department (payments in million euros)

European Commission department in charge	2007-2013	2014-2020	2021-2027 (January 2024)	% of total since 2007
DG INTPA (ex DEVCO)	2 887	2 812	2 244	86.5 %
DG NEAR (excluding IPA instruments)	400	429	193	11.2 %
Others (Service for Foreign Policy Instruments, DG ECHO, DG SANTE and DG REFORM)	55	153	7	2.3 %
TOTAL	**3 342**	**3 394**	**2 444**	**100 %**

Source: ECA, based on data extracted by DG INTPA from OPSYS in January 2024.

14 EU funding for health aid consists of a geographic pillar (actions implemented under country and regional programmes) and a thematic pillar (actions tackling worldwide issues). The geographic and thematic pillars require multiannual indicative programmes (MIPs) to be drawn up, setting priorities and objectives for a seven-year period to address the challenges identified.

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[14] COM(2010) 128.

[15] Council conclusions of 10 May 2010, EU Role in Global Health.

[16] COM(2022) 675.

15 The legislation establishing the European Development Fund (EDF), the Development Cooperation Instrument (DCI) and the Neighbourhood, Development and International Cooperation Instrument[17] (NDICI-Global Europe) instruments included a 'geographic pillar' with financial envelopes that can be used to provide EU bilateral health aid to specific partner countries and regions. The geographic pillar primarily finances the implementation of programmes and projects that strengthen health systems in partner countries. The EU delegations implement these projects mainly through non-governmental organisations, implementing agencies of EU member states or international organisations such as UN agencies.

16 Using the same instruments, the Commission also allocates health funding through the thematic pillar, mostly to global health initiatives (GHIs). These combine the efforts of stakeholders from around the world to tackle global health challenges. GHIs mobilise, manage and distribute funds to support the implementation of health programmes in low- and middle-income countries. The two biggest GHIs supported by the Commission are the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and the Global Alliance for Vaccines and Immunization (GAVI).

17 The thematic pillar under the NDICI-Global Europe is composed of four thematic programmes:

- Human rights and democracy;
- Civil society organisations;
- Peace, stability and conflict prevention;
- Global challenges.

18 NDICI-Global Europe does not specify how much is earmarked for health. Within the 'Global Challenges' multiannual indicative programme (MIP), priority area 1 (People) has an indicative budget of €1 835 million (28.8 % of the total thematic pillar of NDICI, or 50 % of the 'Global Challenges' MIP) and includes health among other priorities.

[17] Regulation (EU) 2021/947.

Audit scope and approach

19 We assessed the EU's financial support for health systems in partner countries to answer the following questions:

- Did the Commission establish clear objectives for its financial support for health, and select interventions consistent with the objectives?
- Has EU financial support for strengthening health systems achieved the expected results?
- Has the Commission taken sustainability into consideration at all stages of its interventions?

20 The audit focused on DG INTPA's financial support for the health sector in partner countries during the 2014-2020 programming period. We also took account of the 2007-2013 period (for our assessment of sustainability) and the start of the 2021-2027 NDICI programme (data were extracted until January 2024). We focused on global and country allocations.

21 Our work included an analysis of documents provided by the Commission (DG INTPA and EU delegations) on the EU's health aid strategies, the definition of objectives and indicators and the distribution of funding during the respective programming periods.

22 We held several meetings with DG INTPA in Brussels. We also visited the Geneva headquarters of the Global Fund to obtain detailed information about the role and scope of its interventions in partner countries.

23 In addition, we selected three countries – Burundi, Democratic Republic of the Congo (DRC) and Zimbabwe – for an in-depth analysis of EU health support in the field. Our selection criteria were the materiality of financial support for health, the EU's strategic health priorities, the evolution of financial support over time, and the volume of assistance from the Global Fund. We reviewed each selected country's national health strategy and programming documents and examined a sample of 17 of their biggest EU-funded bilateral health programmes and projects (see ***Annex II***).

24 During visits to Burundi and Zimbabwe we interviewed local authorities, the EU delegations, other donors, project implementers, non-governmental organisations and final beneficiaries. Our audit of programmes in the DRC was performed through a desk review.

25 According to the Commission, health has become a priority sector, shifting from being a policy to being an EU strategy. We decided to do this audit given the importance of global health in the EU development agenda as well as the materiality of EU financial support. We expect this report to contribute towards improving the way in which EU support for health is managed, and to contribute to the debate on the allocation of EU support in this area in the future.

Observations

The EU has established broad priorities for health aid, but the allocation of funding is affected by shortcomings

26 We analysed the priorities of the EU's health aid strategies and DG INTPA's funding for health programmes. We assessed whether both overall funding and the sample of interventions we selected for audit were aligned with the above strategic objectives.

27 The 2005 European Consensus on Development required the Commission to draw up criteria for participation in GHIs and contributions to them. Hence we examined the process for allocating funding to GHIs.

Policy documents set broad parameters for the allocation of funding which have remained constant over programming periods

28 The Commission's 2010 communication on the EU's role in global health, and the corresponding Council conclusions (conclusion #5), stated the need for the EU and its member states to prioritise their support for strengthening health systems in partner countries. The focus was intended to ensure that the main components of systems – health workforce, access to medicines, infrastructure and logistics, and decentralised management – are effective enough to deliver basic, equitable and quality healthcare for all, particularly in fragile countries (see ***Annex I***). This objective was to be achieved through bilateral channels, as well as through participation in global initiatives and international fora. The communication also proposes that the EU should support stronger leadership by the WHO, work to increase the effectiveness of the UN system, ensure coherence between relevant EU policies, and support research, information exchange and collective expertise in global health.

29 The EU's 2022 Global Health Strategy focuses on three interlinked priorities (see ***Annex I***):

- Deliver better health and well-being for people at all stages of life.
- Strengthen health systems and advance universal health coverage.
- Prevent and combat health threats, including pandemics, applying a 'one health' approach.

30 The Commission's main policy documents provided a general framework for the provision of financial support for health, without specifying any operational objectives. The Commission's health support corresponded to the stated priorities. It contributed to MDGs 4, 5 and 6 and later to SDG 3 – mainly through bilateral programmes and support for GHIs, such as the Global Fund, GAVI or the United Nations Population Fund (UNFPA) Supplies Partnership. However, financial support for the key priority of strengthening health systems (see paragraph ***28***), which comes from the geographic pillar (see paragraph ***15***), has been reduced over time.

31 Until 2020, the Commission committed funds to health assistance mainly through EDF and DCI. Since 2021, development cooperation has been implemented through NDICI-Global Europe.

32 Details of DG INTPA's funding are presented in ***Table 2***. Total amounts have remained relatively constant, however, they have declined in real terms.

Table 2 – Evolution of DG INTPA's health aid payments by funding instrument, in million euros

EU funding instrument	2007-2013	2014-2020	2021-2027 (January 2024)
Neighbourhood, Development and International Cooperation Instrument (NDICI-Global Europe)			2 244
European Development Fund (EDF)	1 256	1 850	
Development Cooperation Instrument (DCI)	1 566	943	
Others	65	19	
Grand total	2 887	2 812	2 244

Source: ECA, based on DG INTPA data.

The Commission's ranking of partner countries according to their health needs has had little effect on the allocation of bilateral funding

33 As the 2010 communication on the EU's role in global health focused on prioritising and increasing support for fragile countries (see paragraph ***28***), DG INTPA prepared a list of countries most in need to inform allocation decisions. A new list followed in 2020.

34 In 2010, the Commission ranked partner countries using five indicators: countries' need for health assistance, public financial capacity, willingness to spend health aid in a proper way, amount of aid received, and past performance on health. The 2020 list was drawn up using a new methodology based on three international indices: the human development index, the human capital index and progress towards SDG3. Due to this methodological change, as well as the evolving situation on the ground, the country rankings in the two lists differ substantially (see ***Table 3***).

Table 3 – Evolution of health prioritisation and financing for partner countries most in need in 2010

INTPA ranking 2010	INTPA ranking 2020	Partner country	Commitments 2007-2013 (in million euros)	Health as a priority in NIP 2007-2013	Commitments 2014-2020 (in million euros)	Health as a priority in NIP 2014-2020	Commitments 2021-2027 (in million euros)	Health as a priority in NIP 2021-2027
1	26	Tanzania	0.018	✗	0	✗	0	✗
2	32	Zambia	68	✓	2.3	✗	12.3	✓
3	13	Afghanistan	198	✓	172.5	✓	65.3	✓
4	5	Mozambique	24	✓	0	✗	4	✗(*)
5	33	Central African Republic	0	✗	7.4	✓	34	✓
6	2	Sierra Leone	24.2	✓	0	✗	0	✗
7	3	Niger	0	✓	11.8	✓	1	✗
8	6	Liberia	63.5	✓	0	✗	0	✗
9	28	Sudan	0	✗	0	✗	26	✓
10	29	Zimbabwe	39	✓	132.6	✓	32.8	✓
11	14	Burundi	30.1	✓	120.4	✓	58.7	✓
12	4	Mali	0	✓	1.2	✗	0	✓
13	41	Senegal	0	✓	0	✗	22.3	✗(*)
14	9	Nigeria	85	✓	78.5	✓	52.2	✓
15	43	Rwanda	0	✗	0	✗	30.1	✗(*)
16	20	Gambia	0	✗	2.8	✗	0	✗
17	7	Guinea	29.5	✓	23	✓	10.3	✓
18	18	Madagascar	31.9	✓	0	✗	32.5	✓
19	1	Chad	10	✓	1.2	✗	0	✗
20	38	Comoros	0	✗	0	✗	0	✗

Purple cells = countries where health is not a priority sector in the 2014-2020 NIP.

Yellow cells = countries where health is not a priority sector in the 2021-2027 MIP.

(*) Senegal, Rwanda, Mozambique and Niger do not include health as a priority area in their MIPs for 2021-2027 but do receive allocations from the regional 'sub-Saharan Africa' MIP.

Source: ECA, based on DG INTPA data.

35 There was little correlation between the rankings of partner countries and the bilateral financial allocation for the health sector (see ***Table 3***). Tanzania, top-ranked country in the 2010 list, received very little support in 2007-2013. Sierra Leone was highly ranked in both lists but only received support in 2007-2013. Mozambique also received little support despite being high on the two lists. In all three countries, health was not one of the priorities for EU funding. The health sectors were supported to some extent from regional envelopes. On the other hand, Zimbabwe and Burundi received relatively high levels of health aid although they were lower on both priority lists. The most highly funded countries in the 2014-2020 period were the DRC, Afghanistan, Zimbabwe, Ethiopia and Burundi. In the current programming period (2021-2027) the top five recipients of Commission funding for the health sector have been DRC, Afghanistan, Burundi, Nigeria and Ethiopia.

36 The reasons for these discrepancies mainly lie in the 'programming principles'[18], in particular the principle of ownership set out in Article 13(1)(a) of Regulation(EU) 2021/947, which requires programming to be based on a policy dialogue with partner governments. Accordingly, sector-specific support should depend on each partner country's priorities. Other reasons were the limitations in the number of priority areas to be included in national indicative programmes (a maximum of three priority areas as of MFF 2014-2020). Other pressing needs – mainly economic – can get in the way of attention to health needs: for example Chad, top of the 2020 list (see ***Table 3***), has governance, human development (other than health) and the Green Deal as multiannual priorities. The Commission's analysis therefore gave guidance for starting programming negotiations but was not a decisive factor in the allocation of funding.

37 For the same reasons, the number of country MIPs with health as a priority sector decreased from 48 in the 2007-2013 programming period to 17 in 2014-2020. Under NDICI-Global Europe (2021-2027), health is a priority area for 27 out of a total of 86 country MIPs (i.e. 59 country MIPs do not prioritise health in this way). A full list of countries that have prioritised health during the last three programming periods is given in ***Annex III***.

[18] Special report 14/2023.

The methodology used for allocations from the thematic pillar is not formalised and not adequately documented

38 Besides geographic allocations (by country or region) the EU supports health through thematic funding (see paragraph *16*) which finances GHIs. EU spending on GHIs in the three audited MFFs has increased substantially (see *Table 4*). In recent years the COVID-19 pandemic enhanced this trend. In addition, since the 2014-2020 MFF, more EU support has been given through GHIs than directly, as bilateral assistance, to partner countries. The two main initiatives supported by the Commission are the Global Fund and GAVI (see paragraph *16* and *Annex IV*). The European Commission has supported the Global Fund since its launch in 2002 and GAVI since 2003, three years after its launch in 2000.

Table 4 – Evolution of Commission payments to GHIs, in million euros

Global Heath Initiative (GHI)	2007-2013	2014-2020	2021-2027 (until January 2024)	Grand Total (2007 – January 2024)
The Global Fund	585	853	1 017	2 455
GAVI	20	285	510	815
WHO-UHC Partnership	22	150	37	209
Pandemic Fund			227	227
UNFPA Supplies Partnership	48	50	45	143
Global Financing Facility (IBRD)		24		24
UNAIDS – Joint United Nations Programme on HIV/AIDS	2			2
Total GHIs	677	1 362	1 836	3 875
Total bilateral aid (countries listed in Annex III)	1 308	990	136	2 435
Total DG INTPA health aid	2 887	2 812	2 244	7 944
% Total GHIs/Total DG INTPA health aid	23.4 %	48.4 %	81.8 %	48.7 %
% Total bilateral aid/Total DG INTPA health aid	45.3 %	35.2 %	6.1 %	30.7 %

Source: DG INTPA´s dashboard and extraction of data from CRIS/OPSYS database, based on health DAC codes.

39 Neither the NDICI-Global Europe Regulation nor the corresponding thematic MIP specifies the EU funding allocated for each GHI. According to the Commission, GHIs were selected for funding after a review of evaluations, funding gaps, budget availability, progress towards the SDG targets, and indicators reported by the GHIs, as

well as an assessment of DG INTPA's influence in the GHI governance bodies and strategic considerations. However, we found that the process was not sufficiently documented. Although the Commission used quantitative and qualitative elements, the methodology was not based on a formal, pre-defined set of specific and quantifiable criteria.

EU funding has contributed to the functioning of health systems but its effectiveness has been hampered by coordination issues

40 We examined the relevance and effectiveness of EU health aid interventions in three partner countries selected for in-depth analysis, coordination between donors, project implementers and government institutions, the costs of managing interventions, the visibility of EU funding and monitoring arrangements. We examined whether the Commission has identified and prioritised relevant interventions to ensure that they are consistent with national health policy and civil society expectations and are in line with funding allocation. We examined whether interventions are coordinated with other donors and contribute to the implementation of the strategy and objectives, and whether the results of the interventions can be verified.

The EU supported a range of health interventions that were in line with the selected countries' needs

41 We found some divergence in the type of interventions funded by the EU in the three countries we selected for in-depth analysis. In Burundi during the 2014-2020 period, the EU support was used for, among other things, free healthcare for pregnant women and children under five. Additional projects that were supposed to strengthen the health system in areas of surgical capacity at the district level, digitalisation or mental health, have allocated only a small percentage of funds to these activities. In the provinces of Bururi, Makamba and Gitega, out of nearly €9 million allocated by the EU, 28 % was allocated to running costs and human resources.

42 The Commission has supported the health system in Zimbabwe through consecutive multi-donor funds. The Health Development Fund (HDF), in place during 2016-2022, spent over one third of its budget on the procurement of essential medicines and nutrition products (see ***Figure 3***).

43 Support for the health sector has been a priority of the EU's bilateral aid to the DRC in the last three programming periods, during which the country has been a top beneficiary of EU health aid. The bilateral programmes and projects which the EU has implemented in the DRC have focused on:

- the reconstruction of hospitals and health centres;
- the establishment of agencies to manage the operating and care costs of health structures;
- improving the supply of quality medicines;
- strengthening health authorities.

44 We consider that all these interventions were broadly pertinent to the countries' needs.

Coordination efforts and distribution systems at district level are inadequate

45 In the selected countries efforts were made to improve coordination and to strengthen distribution systems. In the course of our analysis we observed that national coordination efforts often concentrate only on countrywide strategies and allocation by region. However, coordination is also necessary at the lower level of districts and clinics to ensure that they receive what is really needed. Our visits to rural health clinics demonstrated the importance of improving the analysis of needs and the distribution of medicines, as we found empty shelves in most clinics' pharmacies (see paragraph ***47***).

46 In Zimbabwe, the evaluators[19] have found that projects were not addressing underlying problems exhaustively which led to the duplication of interventions. In both Burundi and Zimbabwe, we ourselves came across instances of funding going to underused equipment (see ***Box 2***).

[19] The End-Line Evaluation of the Health Development Fund (HDF) Programme, AAN Associates, 2021.

Box 2

Underused equipment in Burundi and Zimbabwe

In Burundi we visited a hospital and found that, although two new EU-funded incubators were in use, three other new incubators (supplied by a different donor) were not. The new EU-funded incubators would not be needed if those received previously from other donors were functional.

At a district hospital in Zimbabwe, we found that two boxes containing brand-new ultra-freezers had been standing in the corridor for over half a year because the hospital had no use for them. The beneficiary could not clarify the origin of these items, and it was not possible to establish the source of financing for the equipment. If the hospital's needs had been better analysed the donor community's money could have been spent more effectively.

47 In Zimbabwe's HDF project, the largest budget line is for medical products and vaccines (see ***Figure 3***). Despite multi-donor investment, the availability of medicines has been limited, as we observed during our on-the-spot visits (see ***Picture 1***). We found that some basic medicines had been out of stock for several months. We also came across instances where unexpired medicines had been thrown out.

48 The final evaluation of the PASS project in Burundi recommended reinforcement of the capacities linked to the management of pharmaceutical products. The 2021 annual report from the Ministry of Health confirms a stock-outs or shortages of medicines as main hurdles.

49 Finally, regarding DRC, the mid-term evaluation of PRO DS (published on 17 January 2022), the largest health project for 2014-2020, found that three objectives relating to the supply of essential medicines were only partially achieved because of the ineffective reorganisation of the Federation of Purchasing Centres of Medicines and the Directorate General of Health Care Organisation and Management.

Picture 1 – Some medicines in a Zimbabwean clinic we visited were permanently out of stock

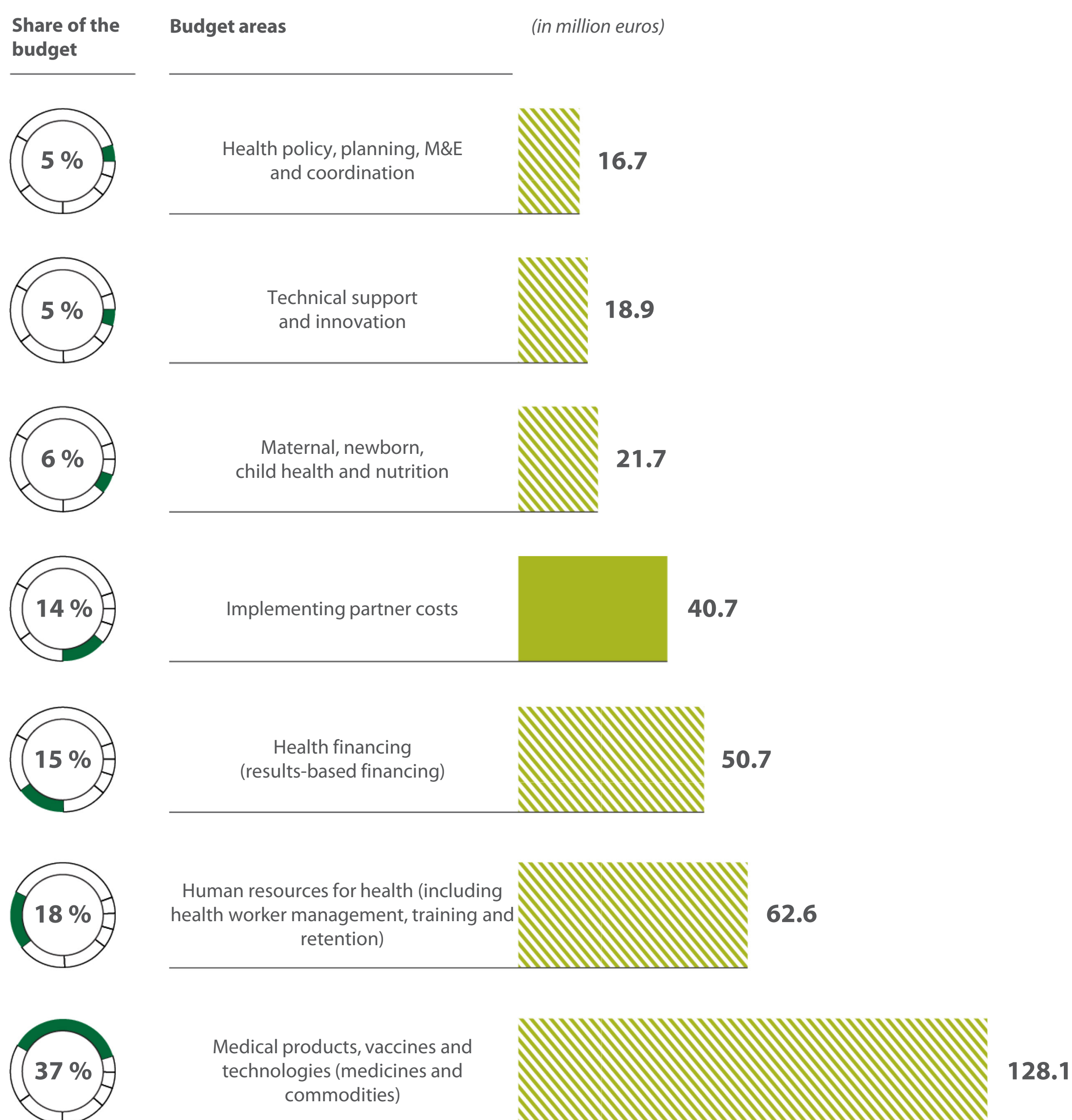
Source: ECA.

The cascading structure of implementation has an impact on costs

50 Costs of interventions in the health sector are impacted by a cascading structure of implementation. Projects are often led by implementing partners which hire subcontractors. All these actors collect management fees which reduce the amount of money available for final beneficiaries.

51 In Zimbabwe, the Commission contributed to multi-donor funds. There were two implementing partners for the HDF project, which ran from 2016 to 2020. The implementing partners charged 7 % of the budget for management costs and an additional 7 % for headquarters management costs – a total of 14 % of the entire budget. This meant the total management costs were higher than some allocations by intervention heading. ***Figure 3*** shows that implementing partners' costs were nearly double the amount allocated to maternal, newborn and child health and nutrition.

Figure 3 – Health Development Fund budget (EU + other donors) in Zimbabwe (2016-2022)



Source: ECA.

52 We found that projects in Burundi under the common name "Twiteho Amagara", funded directly by the EU had operating costs above 30 %. The projects were implemented by five consortia and in all 18 provinces of Burundi. The total amount given to the consortia was €45 million, out of which nearly a third (€14 million) covered operating costs.

Coordination of different funding streams is complex

53 The Commission uses two distinct funding streams – geographic funding and global initiatives – to support the same geographic territories. Moreover, in recent years, GHIs have expanded their scope horizontally to include HSS. There is therefore a risk of overlap between the Commission's actions and those of GHIs, and a risk that synergies, both between the Commission's and GHIs' fields of intervention, as well as between the GHIs themselves, is not strengthened.

54 The Global Fund requires a clear mechanism in each beneficiary country for the coordination of joint efforts to access and utilise financing. Because of problems with stakeholder representation (in particular that of local communities) in national coordination arrangements, this often necessitates the creation of a separate country coordination mechanism. We found that this mechanism increases the administrative burden for the partner country. For example, due to this complexity, Burundian officials told us of their interest in merging the country coordination mechanism into the Health and Development Partnership Framework, which is the overall coordination structure managed by the Ministry of Health.

55 The Commission is engaged in the governance bodies of GHIs, as well as in steering and implementing the 2023 Lusaka Agenda, which provides a coordination forum on the future of GHIs. The Lusaka Agenda identified several key requirements necessary to improve the contribution of GHIs to protecting lives and improving the health of people globally. These include a stronger contribution to primary health care, a catalytic role supporting domestically financed health services, joint approaches to achieving health equity, strategic and operational coherence of GHI's governance models, and coordination of research and development with regional manufacturing. Implementing effectively the agenda will be key to ensuring coordination in the approach of donors, GHIs and national governments to strengthening health systems in partner countries.

The visibility of EU-funded actions on the ground is low, in particular when funds are pooled with other donors

56 The visibility of EU actions is essential to strengthen the EU's role in the world. The Commission has produced several guidelines focusing specifically on external actions[20]. Recipients of EU funding have obligations that are intended to ensure the visibility of the EU. The rules also cover co-branding – a requirement in most cases to display the EU emblem at least as prominently as other logos.

57 Our visits revealed that the visibility of EU-funded actions is insufficient. The most common problem is that beneficiaries are aware of the project or the implementers but not that the funding was provided by the EU.

58 Project implementers are usually much more visible than donors, and are generally felt by beneficiaries to be those providing funding. For example, in Burundi we came across instances of the EU flag being displayed with no accompanying text identifying the European Union (see ***Picture 2***), which is not in line with the guidelines (see paragraph ***56***). This is problematic because local populations do not always associate the flag with the EU. In other instances, only the implementer's logo was displayed.

[20] Communicating and raising EU visibility: Guidance for external actions, European Commission.

Picture 2 – Logo of EU flag without any text identifying the European Union

Source: ECA.

59 In the case of multi-donor funds, beneficiaries usually do not know the identity of all the donors but are only familiar with the name of the fund. Despite the requirement that EU support be advertised at least as prominently as that of other contributors, final beneficiaries will only recognise the implementing partner. This is detrimental to the objective of raising awareness of the EU's external policies and global action.

Broad performance indicators and data weaknesses hinder measurement of EU health aid achievements

60 The EU results framework used by the Commission includes a small number of health indicators for measuring the achievement of strategic objectives (five indicators until 2017, two since then). These indicators (see ***Table 5***) are meant to measure specific EU support. In practice, however, they show the outcome of assistance from the entire community of donors and provide only a partial picture of the EU's intervention in the health sector.

Table 5 – Evolution of health indicators in the EU results framework

2015-2017	from 2018
Number of one-year-olds immunised with EU support	Number of one-year-olds immunised with EU support
Number of women using any method of contraception with EU support	Number of women of reproductive age using modern contraception methods with EU support
Number of births attended by skilled health personnel with EU support	-
Number of people with advanced HIV infection receiving antiretroviral therapy with EU support	-
Number of insecticide-treated bed-nets distributed with EU support	-

Source: EU International Cooperation and Development Results Framework (EURF) (2015), revised EURF (2018), Global Europe Performance Monitoring System containing a revised Global Europe Results Framework (2022).

61 Similarly, the performance indicators used by global health initiatives are often not attributable solely to their actions, but reflect the joint action of all donors and the governments of beneficiary countries (e.g. the Global Fund's key performance indicator on mortality rates).

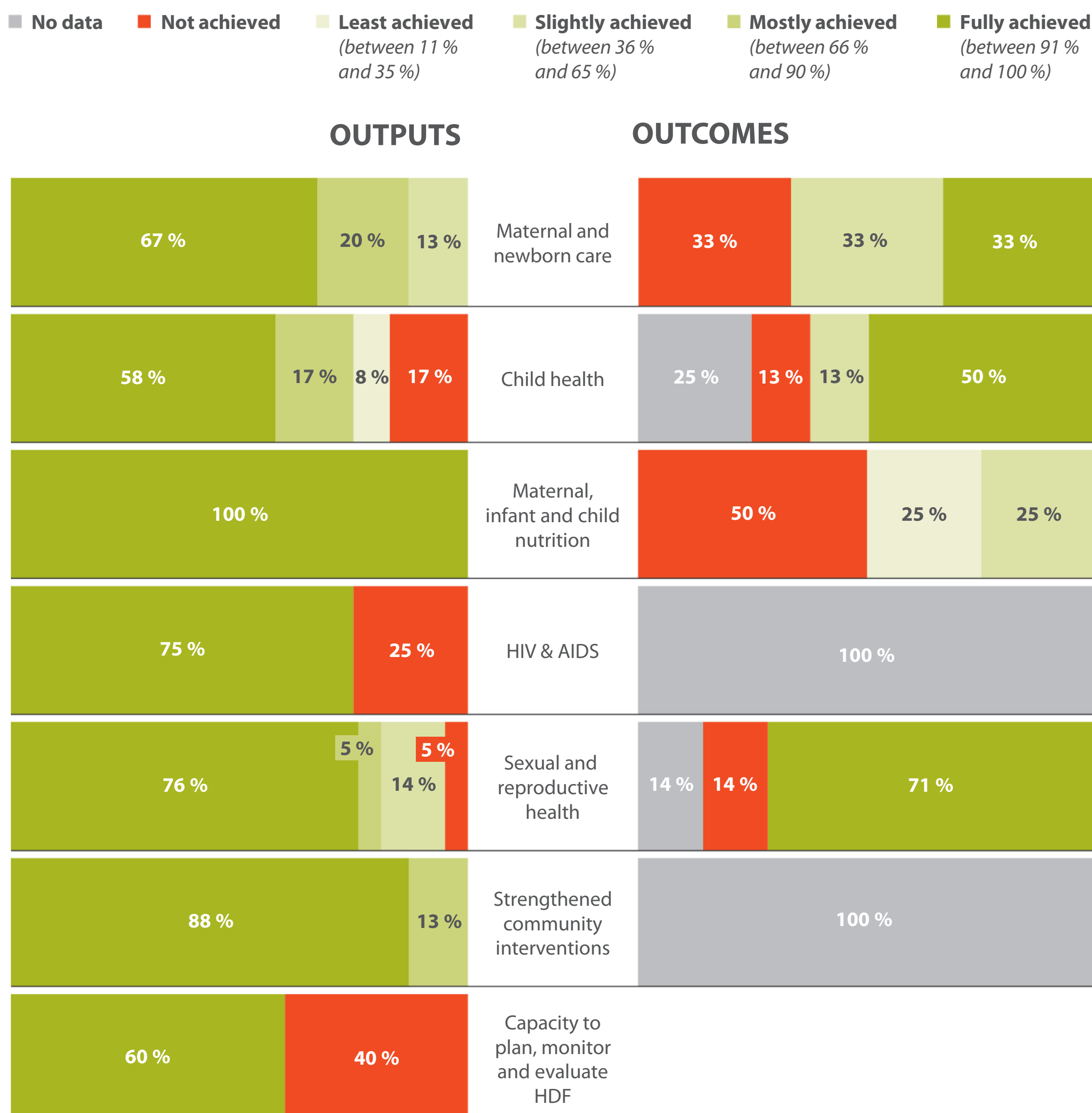
62 The outputs generated by pooled funds are not sufficiently communicated to the EU delegations. For example, the delegation in Zimbabwe did not receive quarterly implementation reports but only annual progress reports with insufficient information on the use of funds.

63 As explained above (see paragraphs ***60*** and ***61***) it is difficult to isolate the impact of EU intervention from other donors' support and other exogenous factors. In Burundi, the available evaluations estimate that outcomes and results were partially achieved[21].

[21] *Evaluation du programme d'appui au système de santé (PASS) au Burundi*, IBF, 2021; Interim evaluation report of the programme Twiteho Amagara, Proman, 2022; and other non-public evaluations.

64 According to the final evaluation, the Health Development Fund in Zimbabwe targeted 24 outcomes and 69 outputs. The indicators show that most outputs were achieved, but less progress was reported on the achievement of outcomes (see *Figure 4*).

Figure 4 – Health Development Fund in Zimbabwe: outputs and outcomes



Source: ECA, based on the end-line evaluation of the Health Development Fund in Zimbabwe.

65 In the DRC, the mid-term evaluation of PRO DS, the largest health project for 2014-2020, showed that three out of 10 expected results were essentially achieved in full (e.g. rationalisation of the functioning of a reference hospital and health centres), and five were partly achieved (e.g. strengthening the regulatory role of the central health administration). Progress towards two results was far below what was expected (e.g. the establishment of human resources adapted to operational levels and administrative functions).

66 During our audit visits, we found that some data collected for reporting was unavailable or unreliable. In Burundi, several indicators were used to monitor maternal health. However, some reported values were clearly impossible to achieve. For example, the indicator for assisted births was sometimes as high as 125 %. The Commission has explained that this is attributable to outdated population statistics.

Sustainability of projects is at risk

67 Poor sustainability is an inherent risk in development aid projects. Aid is temporary, the time horizon for interventions is short, and the availability of funds fluctuates, all of which can have a negative impact on the continuation of projects in the recipient countries. We examined whether sustainability was taken into consideration at all stages of the interventions, i.e. from planning, through implementation, to monitoring.

Beneficiary governments lack transition or exit strategies and commitment, and have limited budgetary resources

68 Funded projects are time-bound and rarely self-sufficient after the end of funding. Donors therefore need to work with local and national authorities to ensure that results are not lost. At the same time, it is important that donor funding is matched by adequate absorption capacity and is not used by governments to replace national spending. It is also important that recipient countries have health financing strategies to mitigate the effects of the end of donor contributions.

69 We found no clear transition and exit strategy in the three countries we analysed in depth (see ***Box 3***), which implies challenges to the sustainability of operations once EU support is withdrawn, also considering the limited budgetary resources of the countries.

Box 3

Health systems remain dependent on international aid

In Burundi, EU intervention in the health sector was initially transitional, to ease the move from emergency support to regular health services. Burundi is still very dependent on external donors and the aid barely maintains the system in place. The Commission recognises that although work involving political and sectoral dialogue as well as technical assistance to the government is ongoing, stronger efforts are needed to prepare a transition/exit strategy. So far, there are no concrete plans for doing this, although talks among the donors are ongoing.

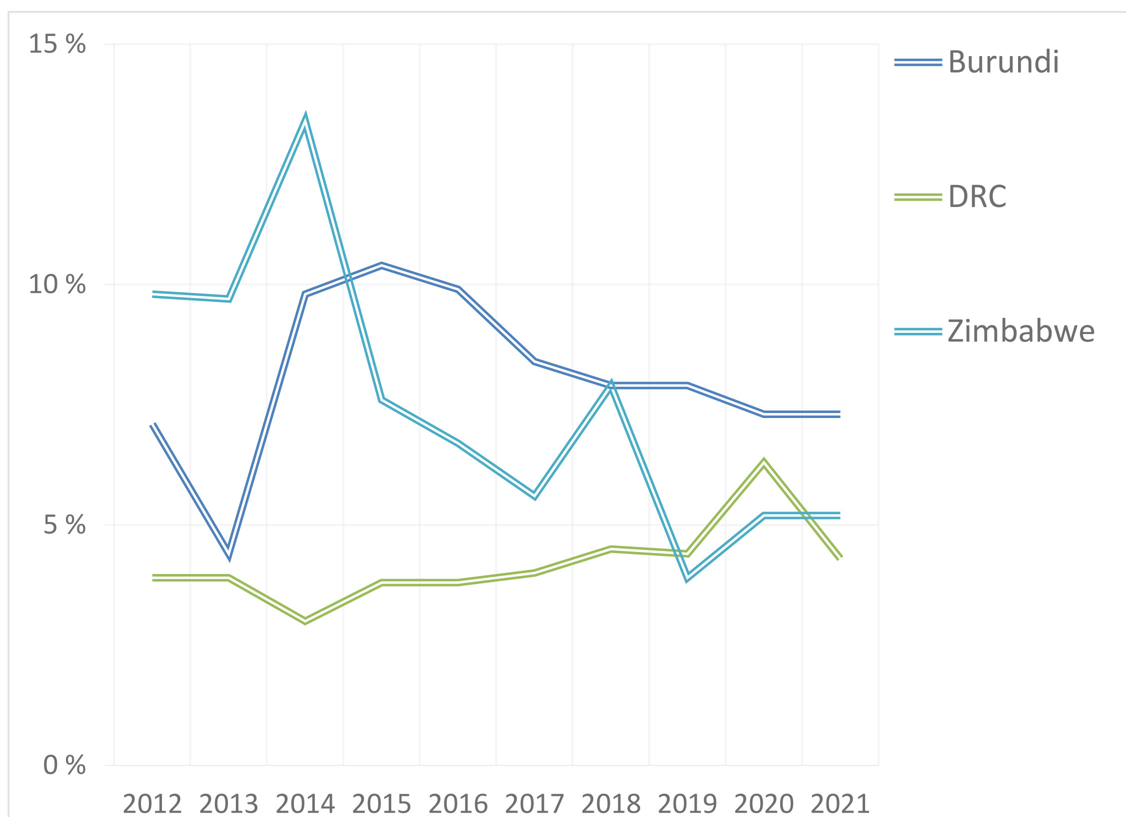
In Zimbabwe, the HDF project assigned a considerable amount of funding to human resources needs, such as the payment of retention allowances, performance bonuses and other staff costs. The partners assumed that the government would take over the financing of community health workers at the end of the HDF after the donors' funding was scaled down in the follow-up Health Resilience Fund, but no government support has materialised for salaries and assimilated costs.

The mid-term evaluation of the largest EU programme for health in the DRC in the 2014-2020 period highlighted challenges relating to sustainability, and advocated for the development of an exit strategy involving all stakeholders.

70 Exit strategies often require the creation of fiscal space to allow for sufficient national health financing. The health budgets of our three selected countries have not yet achieved the threshold of 15 % of the overall budget pledged in the Abuja Declaration of 2001 (see paragraph ***06*** and ***Figure 5***)[22].

[22] Africa Scorecard on Domestic Financing, African Union.

Figure 5 – Health budget as % of GDP in audited countries



Source: ECA, based on Africa Scorecard on Domestic Financing for Health.

Equipment is not always adequately maintained

71 When donors finance or deliver equipment, they often assume that the recipients will take good care of it and provide the necessary maintenance and consumables. However, this often entails additional costs: telephones require a line subscription, cars need regular maintenance and spare parts, and printers need paper and toner cartridges. Those additional costs may only be a fraction of the value of the equipment, and yet sometimes they can become an unsurmountable barrier to its effective use.

72 The issue of maintenance has been identified in many evaluations. We found that the process of equipment selection and maintenance did not sufficiently take into consideration whether the necessary services, skills and spare parts were available in the recipient country. The joint evaluation of the first two performance-based financing projects in Burundi noted issues with the maintenance of equipment.

73 During our project visits we found cases of unused (see ***Box 4***), damaged (see ***Picture 3***) or underused equipment financed directly or indirectly with EU funds. We consider that causes for these cases related to absent or insufficient needs assessment and poor choice of equipment.

Picture 3 – Haematology analyser in a laboratory in Burundi broken for over 16 months

Source: ECA.

Box 4

Non-operational PHEOC in Burundi

Public health emergency operations centres (PHEOCs) coordinate all activities relating to public health emergencies. EU funding of €800 000 was used to set up a PHEOC in Burundi, and it was inaugurated on 20 April 2021[23]. At the time of our audit visit, over two years later, the computers were still not physically connected, the telephones were not working, and other IT equipment had never been used. The centre's management explained that it was not operational because the Ministry of Health had been unable to reach agreement with a telephone company.

[23] WHO report *Inauguration officielle du Centre des Opérations d'Urgences de Santé Publique*.

Conclusions and recommendations

74 Overall, we found that the Commission allocated funding in line with its broad priorities, but the methodology of allocation was affected by shortcomings. The effectiveness of interventions was hampered by issues of coordination and sustainability.

75 Main EU policy documents set the broad parameters for the allocation of funding, without specifying operational objectives. Payments for health support have remained relatively constant over the last three programming periods. However, the funding of bilateral cooperation with partner countries, has decreased, while the funding of support for global health initiatives has increased substantially also due to the COVID-19 response (paragraphs ***28***-***32***).

76 The Commission has ranked partner countries according to their health systems' needs, but this assessment has had little effect on bilateral funding, mainly due to the programming principles (paragraphs ***33***-***37***).

Recommendation 1 – Better match countries' needs and the allocation of health funding

In preparation of the next MFF, the Commission, in dialogue with beneficiary countries, should explore how to better match the ranking of partner countries' needs with the geographic allocation of EU health aid and, if possible, based on the legal basis of the next MFF, rebalance the allocation of funding between global initiatives, regional, and bilateral support to countries.

Target implementation date: in time for the next MFF

77 The allocation of support to individual global health initiatives through thematic programmes was based on quantitative and qualitative elements. However, this was not based on a formalised pre-defined set of specific and quantifiable criteria and the process was not sufficiently documented (paragraphs ***38***-***39***).

Recommendation 2 – Set clear criteria for the funding of global health initiatives and improve documentation of the allocation process

The Commission should set clear, specific and, where applicable, quantifiable criteria for funding global health initiatives and improve the documentation of the process, including an analysis of the added value of the Commission's involvement in these initiatives.

Target implementation date: 2025

78 The examined projects delivered a range of outputs – from the reimbursement of medical visits, through medicines to hospital buildings. However, insufficient coordination at district level led to shortcomings in the distribution of equipment and medicines (paragraphs *40*-*49*).

Recommendation 3 – Improve needs analysis and coordination of the distribution of equipment and medicines

The Commission should liaise with relevant actors at an appropriate level to improve coordination of distribution of equipment and medicines. The Commission should work with partner countries to increase their capacity for needs analysis, planning and coordination.

Target implementation date: 2025

79 The costs of interventions in the health sector were impacted by a cascading structure of implementation. This increased the costs of projects' implementation and reduced the amounts available for final beneficiaries (paragraphs *50*-*52*).

Recommendation 4 – Analyse reasonableness of management costs

The Commission should strengthen its analysis of the reasonableness of budgeted management costs, in particular that relating to a cascading structure of implementation.

Target implementation date: 2025

80 The Commission is engaged in the governance bodies of global health initiatives and in the steering and implementation of the Lusaka Agenda. This is to ensure better alignment of those initiatives, end fragmentation, and rationalise their architecture (paragraphs *53*-*55*).

Recommendation 5 – Avoid overlaps and ensure synergies between the supported global health initiatives

The Commission should take further action to avoid overlaps and ensure synergies between the supported global health initiatives.

Target implementation date: 2025

81 The visibility of EU funding among targeted populations was low (paragraphs *56*-*59*). The Commission uses a limited number of high-level indicators related to health. We found that these indicators gave only a partial picture of the multiple EU health actions. Furthermore, they were calculated in a way that de facto measured the joint effort of different actors and was not attributable solely to EU funding. This prevented the Commission from fully measuring the results achieved by the EU funding in the health sector against strategic objectives. Moreover, the results of bilateral interventions implemented by multi-donor funds were not sufficiently communicated to the EU delegations. The data collected by project implementers for reporting was sometimes unavailable or unreliable (paragraphs *60*-*66*).

Recommendation 6 – Identify indicators to monitor EU support for the health sector in a comprehensive manner

In preparation of the next MFF, the Commission should identify indicators for the health sector which monitor in a comprehensive manner the effects of EU interventions, in line with aid effectiveness principles. As regards multi-donor funds, the Commission should assess the feasibility of applying a proportional method for reporting the results of EU interventions.

Target implementation date: in time for the next MFF, by 2027 at the latest

82 There were no clear transition and exit strategies in place after the scaling down of donor funding for the government to continue the financing of the projects. This might jeopardise the sustainability of systems once EU support is withdrawn (paragraphs *67*-*70*).

Recommendation 7 – Take action to promote the sustainability of health systems

The Commission should further examine with all relevant actors involved in supported partner countries how to ensure sustainability of the health systems. The discussion should further address health financing, including domestic revenue mobilisation and clear and realistic transition and exit strategies. Exit strategies should cover the future planned financing of relevant parts of the health systems.

Target implementation date: 2025

83 The sustainability of EU interventions is at risk also due to inadequate maintenance of the equipment provided (paragraphs *71*-*73*).

Recommendation 8 – Give increased importance to equipment maintenance

The Commission should:

(a) include maintenance aspect in the procurement of equipment, i.e. taking into consideration if the necessary services, skills and spare parts are available at country level and how this could be established if needed;

(b) take actions in order to contribute to awareness raising and behaviour change in relation to maintenance, to help establish a culture and routine of maintenance among stakeholders.

Target implementation date: 2025

This report was adopted by Chamber III, headed by Mrs Bettina Jakobsen, Member of the Court of Auditors, in Luxembourg at its meeting of 9 July 2024.

For the Court of Auditors

Tony Murphy
President

Annexes

Annex I – Objectives of EU health aid strategies since 2005

Strategic document	Health aid objectives
2005 European Consensus on Development	— Seeking to meet the UN MDGs relating to health: MDG4 on reducing child mortality, MDG5 on improving maternal health, MDG6 on combating HIV/AIDS, malaria and other diseases. — Addressing the exceptional human resource crisis facing health providers. — Fair financing for health. — **Health systems strengthening (HSS)** to promote better health outcomes. — Continue to contribute to **global initiatives**; in this regard paragraph 108 of document 2006/C 46/01 states that 'The Commission will draw up criteria for Community participation in global funds and contributions to them.'
2010 Commission communication on the EU Role in Global Health (and accompanying staff working documents)	— EU leadership to coordinate global initiatives on health, involve stakeholders at partner country level. — Universal health coverage (**UHC**): o **Priority for fragile countries** through bilateral channels (list of fragile countries) and through participation in global health initiatives (promote adaptation of existing GHIs). o Concentration on support for **HSS**. o Funding one national health budget and one monitoring process as the preferred framework for providing EU support. o Channelling 2/3 of official development assistance (ODA) for health through partner country-owned development programmes and 80 % using partner countries' procurement and public financing management systems. — Ensuring coherence with other policies to promote UHC. — Investing in health research for all.

Strategic document	Health aid objectives
2011 Commission communication on an Agenda for Change (Council conclusions of 2012)	— Use its range of aid instruments, notably 'sector reform contracts'. — Develop and strengthen health systems (HSS). — Reduce inequalities in access to health services. — Increase protection against global health threats. — Promote policy coherence. — Council conclusions 'Support to social inclusion and human development [health, education and social protection] will continue through at least **20 %** of EU aid' and 'The EU will remain engaged in fragile states…'.
2017 European Consensus on Development	— Seeking to meet the **UN SDGs** relating to health. — The EU and its member states will promote UHC. — Support to build strong, good quality and **resilient health systems (i.e. HSS)**. The EU and its member states will support developing countries in health workforce training, recruitment, deployment, continuous professional development, etc. — Preventing and combating communicable diseases such as HIV/AIDS, tuberculosis, malaria and hepatitis. — Taking action to address global threats (epidemics or antimicrobial resistance). — Work towards reducing child and maternal mortality, promote mental health and address the growing burden of non-communicable diseases in partner countries. — Promote innovation in health tech. — The EU reiterates its commitment to allocating at least 20 % of its ODA to social inclusion and human development.
2022 EU global health strategy	— Deliver better health and well-being for people at all stages of life (SDG3 on healthy lives, SDG5 on gender quality, SDG10 on reducing inequality within and among countries). This mentions **HSS**, measures to combat HIV and support for **GHIs**. — **Strengthen health systems (HSS)** and advance UHC. This includes digitalisation, innovation technology and addressing workforce shortages. — Prevent and combat health threats, including pandemics, applying a 'one health' approach. Including support for the Pandemic Fund, manufacturing capacity, etc. — Reiterates the EU's commitment to allocating at least 20 % of its ODA to human development and social inclusion under the NDICI.

Annex II – List of audited programmes and projects

Burundi

Name	MFF	Reference	EU support (commitments in million euro)
Programme d'appui au système de santé (PASS) à travers l'outil du financement basé sur la performance (FBP) – Phase 2	2014-2020	FED/2019/413-660 (CL)	27.8
TWITEHO AMAGARA - Bujumbura Mairie, Bujumbura rural, Muramvya, Rumonge et Kirundo	2014-2020	FED/2019/405-241 (EC)	9.4
TWITEHO AMAGARA - Cankuzo, Ruyigi, Rutana, Mwaro	2014-2020	FED/2019/405-314 (EC)	9.3
TWITEHO AMAGARA - Ngozi, Kayanza, Cibitoke	2014-2020	FED/2019/405-306 (EC)	8.9
TWITEHO AMAGARA - Bururi, Makamba, Gitega	2014-2020	FED/2019/405-304 (CL)	8.1
TWITEHO AMAGARA - Karuzi, Muyinga, Bubanza et santé mentale à Ngozi	2014-2020	FED/2019/405-311 (CL)	7.5

Democratic Republic of the Congo

Name	MFF	Reference	EU support (commitments in million euro)
Programme d'appui au plan national de développement sanitaire (PA PNDS).	2007-2013	FED/ 2009/21511	53.8
Projet d'accélération des progrès vers les OMD 4 et 5 (PAP OMD 4 - 5)	2007-2013	FED/2012/023-801 (EC)	40
Programme de renforcement de l'Offre et Développement de l'accès aux Soins de Santé en RDC (PRODS)	2014-2020	FED/2016/038-165 (EC)	217
Unis pour la santé et l'éducation	2021-2027	NDICI AFRICA/2021/043-305 (EC)	30
Unis pour la santé, phase 2	2021-2027	NDICI AFRICA/2022/043-891 (CA)	35

Name	MFF	Reference	EU support (commitments in million euro)
Unis pour la santé, phase 3	2021-2027	NDICI AFRICA/2023/045-313 (EC) (JAD.1258480)	9

Zimbabwe

Name	MFF	Reference	EU support (commitments in million euro)
Health Development Fund (Improving access to basic health services to all Zimbabweans)	2014-2020	FED/2015/368-364 (CL)	62.6
Improving access to basic health services to all Zimbabweans II	2014-2020	FED/2020/415-680 (EC)	42.5
Health Resilience Fund (HRF)	2021-2027	NDICI AFRICA/2022/438- 583 (EC)	41.0
Improving access to basic health services to all Zimbabweans II_UNICEF	2014-2020	FED/2020/415-231 (CA)	35.9
Contribution to Health Transition Fund IV	2014-2020	FED/2015/356-385 (CA)	12.0

Annex III – Partner countries where health is a priority sector identified in their national indicative programmes (NIPs) / multiannual indicative programmes (MIPs)

	MFF 2007-2013	MFF 2014-2020	MFF 2021-2027
Afghanistan	•	•	•
Algeria	•		
Angola	•		
Bangladesh	•		
Belize		•	
Burkina Faso	•	•	
Burundi	•	•	•
Central African Rep.		•	•
Chad	•		
Congo	•		
DRC	•	•	•
Côte d'Ivoire	•		
Cuba			•
Dominica	•		
Egypt	•		•
Ethiopia		•	•
Ghana	•		
Grenada		•	
Guinea Bissau	•	•	•
Guinea Conakry	•	•	•
India	•		
Iran			•
Jamaica	•		
Kenya			•
Lao PDR			•
Lebanon			•
Liberia	•		
Libya	•	•	•
Madagascar	•		•
Mali	•		•
Mauritania	•	•	•
Moldova	•		
Morocco	•	•	•
Mozambique	•		
Myanmar	•		
Namibia	•		
Niger	•		
Nigeria	•	•	•
Palestine			•
Peru	•		
Philippines	•		
Saint Lucia	•		
Saint Vincent and the Grenadines	•		
São Tomé and Príncipe	•		
Senegal	•		
Sierra Leone	•		
South Africa	•		
South Sudan	•	•	•
Sudan			•
Swaziland	•		
Syria	•		
Tajikistan	•	•	•
East Timor	•		
Togo	•		
Tunisia			•
Uzbekistan	•		
Vietnam	•		
Uganda			•
Yemen	•		
Zambia	•		•
Zimbabwe	•	•	•
TOTAL countries	**48**	**17**	**27**

Annex IV – Allocations from the thematic pillar of NDICI-Global Europe (January 2024)

Health programmes	Commitments (EUR)
Contribution to the Global Fund	**1 064 503 222**
Contribution to GAVI	**525 000 000**
Contribution to the Pandemic Fund	**427 000 000**
Contribution to the United Nations Population Fund (UNFPA)	**45 000 000**
Contribution Agreement for the Acceleration Human Development (HDX) Programme – polio component	275 000 000
Others	12 517 500
Grand total	**2 349 020 722**

Note: Rows in bold refer to allocations to GHIs (Global Fund, GAVI including COVAX facility for COVID-19 vaccines, UNFPA and Pandemic Fund).

Abbreviations

DCI: Development Cooperation Instrument

DG ECHO: Directorate-General for European Civil Protection and Humanitarian Aid Operations

DG INTPA: Directorate-General for International Partnerships

DG NEAR: Directorate-General for Neighbourhood and Enlargement Negotiations

EDF: European Development Fund

GAVI: Global Alliance for Vaccines and Immunisation

GHI: Global health initiative

HDF: Health Development Fund

HSS: Health systems strengthening

IPA: Instrument for Pre-accession Assistance

MDG: Millenium Development Goal

MIP: Multiannual indicative programme

MFF: Multiannual financial framework

NDICI: Neighbourhood, Development and International Cooperation Instrument

NIP: National indicative programme

ODA: Official development assistance

PASS: *Programme d'appui au système de santé* (Burundi health support programme)

PHEOC: Public health emergency operations centre

SDG: Sustainable Development Goal

UHC: Universal health coverage

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

WHO: World Health Organization

Glossary

EU delegation: Diplomatic representation of the EU in a non-EU country or at a multilateral or international organisation.

European Development Fund: EU fund, managed by the Commission outside the general budget, that provides development aid to the African, Caribbean and Pacific States, and to overseas countries and territories that are associated with the EU through member states.

Impact: Wider long-term consequences of a completed project or programme, such as socio-economic benefits for the population as a whole.

Impact indicator: A measurable variable providing information on the human, financial, physical, administrative and regulatory means used to implement a project or programme.

Millennium Development Goals: Global targets to reduce poverty and its manifestations by 2015. Set by world leaders and major development institutions at the UN Millennium Summit in September 2000.

Official development assistance: Government aid designed to promote the economic development and welfare of developing countries.

One health approach: an integrated, unifying approach that aims to sustainably balance and optimise the health of people, animals and ecosystems.

Outcome: Immediate or longer-term, intended or unintended, change brought about by a project, such as the benefits resulting from a better-trained workforce.

Output: Something produced or achieved by a project, such as delivery of a training course or construction of a road.

Output indicator: Measurable variable providing information for assessing a project’s products or achievements.

Result: Immediate effect of a project or programme upon its completion, such as the improved employability of course participants or improved accessibility following the construction of a new road.

Sustainability: Ability of a project or system to continue for as long as required because it is sufficiently well established and either financially self-sufficient or sufficiently well-funded.

Sustainable Development Goals: 17 goals set in the United Nations 2030 Agenda for Sustainable Development to stimulate action by all countries in areas of critical importance for humanity and the planet.

Replies of the Commission

https://www.eca.europa.eu/en/publications/sr-2024-18

Timeline

https://www.eca.europa.eu/en/publications/sr-2024-18

Audit team

The ECA's special reports set out the results of its audits of EU policies and programmes, or of management-related topics from specific budgetary areas. The ECA selects and designs these audit tasks to be of maximum impact by considering the risks to performance or compliance, the level of income or spending involved, forthcoming developments and political and public interest.

This performance audit was carried out by Audit Chamber III – External action, security and justice, headed by ECA Member Bettina Jakobsen. The audit was initially led by ECA Members Baudilio Tomé Muguruza and Hannu Takkula.

The audit was finalised by ECA Member George-Marius Hyzler, supported by Pietro Puricella, Principal Manager; Piotr Zych, Head of Task; Alfonso Calles Sánchez and Piotr Senator, Auditors. Alexandra Damir-Binzaru provided graphical support.

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We audited the EU's financial support for health systems in partner countries over three programming periods. We carried out a documentary analysis and we examined projects in Burundi, Democratic Republic of the Congo and Zimbabwe. We conclude that the Commission allocated funding according to its broad priorities. However, the methodology of allocation was affected by shortcomings. The effectiveness of projects was hampered by issues of coordination, sustainability and monitoring. The cascading structure of implementation increased the projects' costs whilst the visibility of EU funding amongst targeted populations was limited. We issue recommendations on allocation and criteria of funding, coordination, reasonableness of management costs, synergies, monitoring, sustainability and maintenance of equipment delivered by projects.

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