External Monitoring System of the EC Development Aid Programmes
LOT 4 – Latin America 2004/097-402

Health Sector Report

External Monitoring Service
Monitoring Missions 2005 and 2006

Eptisa Consortium – Agriconsulting - LASO

Contents

(I) List of abbreviations

AIDCO Europe Aid Co-operation Office

B/L Budget Line

EC European Commission

ECLAC Economic Commission for Latin America and the Caribbean

GO General Objective

LF Logical Framework

M&E Monitoring and Evaluation

MERCOSUR Common Market of the South

NGO Non Governmental Organisations

ODM Millennium Development Objectives

OVI Objectively Verifiable Indicator

ROM Results Oriented Monitoring

SO Specific Objective

UNDP United Nations Development Programme

WHO World Health Organization

WB World Bank

1. Introduction

1.1 Report Objectives

This document was produced by the Latin American External Monitoring Service with the following objectives:

- To present the overall health situation in Latin America today and the framework of European cooperation in the health sector in the region.
- To provide an overview of the performance of health projects monitored during 2005 and 2006.
- To present the general conclusions of the external monitoring of health projects with a view to stimulating debate on the basis of the five criteria (quality of design, efficiency, effectiveness, impact and potential sustainability).
- To highlight lessons learned and make recommendations as input for future programmes.

1.2 Work Methodology

The work methodology used in the elaboration of this report included the following activities:

- Analysis of the sample of health projects monitored during 2005 and 2006 (17 in total) including different budget lines: Financial and Technical Cooperation, Economic Cooperation, Reproductive Health, Cofinancing with NGOs-PVD and Food Security (see list in appendix).
- Review of primary sources including project synopses (PS), monitoring reports (MR) and background conclusion sheets (BCS).
- Analysis of documents and studies on trends in European cooperation in the region and the overall situation of health in Latin America (see bibliography).

2. Overall Situation: Health in Latin America

Latin America has seen major changes over the last decade both in the demographic and epidemiological profile of the population as well as transformations in the management and funding of national health programmes.

As for developments with regard to the population, there has been a demographic shift with falling birth rates and stabilised death rates resulting in reduced growth in the population. This, coupled with longer life expectancy at birth for men and women, has changed the population's age structure and brought about a gradual increase in the percentage of middle aged persons.

As a result of the major demographic, social and economic changes, the epidemiological profile presents a double challenge for the Latin American region:

on the one hand, it must deal with traditional health-related problems such as contagious diseases and infections or mother and infant mortality; on the other hand, it faces new problems that have arisen as a result of development and changes in morbidity: the increase in chronic-degenerative, senile and mental diseases and HIV/AIDS, among others. This second set of problems is increasingly significant in terms of percentage with the result that HIV/AIDS in particular is putting an increasing strain on national health systems.

As regards health policies, reforms initiated in the 80s intended to ensure basic cover for all supported by participation by the private sector in the management of public financing and the provision of services (stepped up during the 90s) have led to a set of recent legislative changes that again grant the state a central role as service provider and regulator. The aim is the gradual integration of the various health subsystems (public, social security and private).

Main Health Problems

Although in differing degrees depending on the country, Latin American health authorities acknowledge that the high mother-infant mortality rate and the vector transmission of infectious diseases such as malaria, haemorrhagic and classical dengue fever, Chagas disease and Leshmaniasis are the main problems. Some are related to the deterioration of the public and private environment, others with eating habits but in general, all of them are directly related to the poor quality of life in certain regions and sectors of the population. Sexually transmitted and chronic transmittable diseases also give cause for concern.

The main health problems are the high maternal-infant death rate and the transmission of infectious diseases.

Chronic degenerative diseases (such as hypertension, diabetes, type II mellitus and chronic intoxications with pesticide) constitute a very significant second group of problems in the region, the impact of which is increasingly significant in Mexico, Brazil, Argentina and Colombia.

Healthcare Problems in Latin America

Most Latin American countries have no general public health cover, the exception being Brazil and the rest of the systems are segmented. The main problems presented by healthcare in Latin America are as follows:

The lack of equal access and the inefficiency of health systems are the two main obstacles to healthcare.

- **Institutional instability** of public health
- **Lack of equality**: Health problems do not affect the different sectors of society in the same way; the disparity in income, accessibility due to cultural or geographic reasons, gender, ethnic group and class are the determining factors of this inequality.

- **Inefficiency:** This is considered a problem of the first order in Costa Rica and Ecuador and a secondary one in Chile, Colombia and Peru. Among the associated problems are: limited installed capacity in certain regions, high execution costs, poor to management in certain territorial entities, weak monitoring and control processes, and systematic delays in the flow of resources.

- **Limited access** to health services. This is considered the main problem affecting Bolivia, Colombia, Guatemala, Panama, Paraguay and Peru.

The principal healthcare problems have various causes,

- Related with end-users' economic conditions. In this respect, general factors are highlighted such as poverty (Argentina, Bolivia, Brazil, Guatemala, Nicaragua, Panama and Peru), unemployment (Argentina) and poor basic sanitation (El Salvador, Paraguay). These barriers are related to the lack of financial resources to fund healthcare particularly in poor communities that have not been able to access schemes provided by insurance regimes.
- A second set of factors concerns the limited public budgets available for provision of human, technological and infrastructure resources for the institutional network of public healthcare services. The budgetary deficit is clearly the principal cause of healthcare problems in Brazil, Colombia, Costa Rica, Ecuador, Nicaragua and Peru. Poor healthcare provision in rural and peri-urban areas is significant in Bolivia, Colombia, Ecuador, Nicaragua, Panama and Paraguay.
- The lack of coordination between the systems that govern private and public healthcare systems (Uruguay, Chile)
- Existing healthcare models that are out of step with the changing epidemiological situation (Brazil, Uruguay),
- Shortcomings in patient reference and counter reference systems (Paraguay)
- Sociodemographic conditions typical of the population in the region such as high geographic distribution, particularly in rural areas, which results in inaccessibility to healthcare services due to the shortage of means of transport and communication (Bolivia, Brazil, Colombia, Ecuador, El Salvador and Peru).
- Cultural heterogeneity in itself represents a complex element in healthcare systems. In addition to entailing different customs, some of which are harmful to the population's health and different levels of health education and information, the lack of an intercultural approach to health is a major obstacle to success of healthcare systems.

End-user's lack of economic resources (demand) and the limited budgets available for provision of healthcare systems (supply) are two crucial factors in the limitation of healthcare.

National Health Programmes and Policies

There is a high degree of heterogeneity national health systems and policies in Latin America.

The specific characteristics of healthcare are determined by multiple factors among which the following are essential: the degree of development and pattern of socio-economic distribution, the predominant characteristics of the political and economic system, the regulatory framework of the healthcare system, the structure of the provision of services, the financial framework and the method of reimbursement of services provided, the administrative and clinical organisation of healthcare attention, the geographic distribution of healthcare and the geographic and financial coverage of public and private services. The impact of these factors, some of which change considerably over time and from one geographic area to another, produces a very noticeable heterogeneity in the characteristics and means of running healthcare services. Variation in the healthcare situation among populations and even within the same geographic area makes it practically impossible to define a "single model" of healthcare even for one specific country.

At the regional level, the healthcare sector presents a wide range of institutions and mechanisms for the funding, insurance, regulation and provision of healthcare services. These functions are usually coordinated by a fragmented public healthcare system, a social security system and the private sector. Depending on the country, the population participates not only as a beneficiary of the services but also as direct or indirect contributors.

There has been a generalised reduction in the budget assigned to the healthcare sector over the last decade.

Paradoxically, over the last decade, most countries in the region have seen a reduction in public expenditure assigned to the health sector despite formal adoption of the regional agenda for healthcare system reforms which is intended to increase the equality, efficiency and quality of services provided. So, coupled with the chronic lack of funding in the sector and demographic and epidemiological changes entailing increased healthcare costs, the increase in the public expenditure on health per capita has fallen as a percentage of the GNP from 3.1% (in USD) in 1990-1991 to 2.9% in 2002-2003. In most Latin American countries, expenditure on healthcare during the timeframe referred to was less than 40 dollars per capita (Bolivia, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay and Peru), it was between 60 and100 dollars in Venezuela and Colombia, between 100 and 200 in Brazil, Uruguay, Mexico and Chile and over 200 dollars in Argentina, Costa Rica and Panama.

The programmes in all Latin American countries include items of the national budget or non reimbursable contributions from international funds. However, a serious funding problem exists in almost all of them, i.e. the unequal distribution of resources destined for healthcare from one region to another.

The coordination of the programmes falls mainly to the national ministry of health which coordinates its performance with other social entities.

The 2005 report on the Progress of the Millennium Goals provides an overview of the healthcare

The 2005 report on the progress of the millennium goals provides an overview of the situation and points out that "few countries have succeeded in introducing adequate human resources policies and this is reflected in the persistence of chronic imbalances in their distribution, their concentration in urban areas, unbalanced growth in supply and demand, increased growth in the provision of education compared with the requirements of the work in healthcare, inadequacies in training, disorder in professionalization and the stagnation of public employment. In some countries, this has given rise to an exodus of healthcare professionals and growing emigration of qualified personnel to developed countries which has had a significant negative impact on Ecuador, Bolivia, Honduras and Peru".

Essential Challenges for Public Health in Latin America

The great number of possible approaches to public health and the functions and entities involved presents a major challenge to the healthcare sector and creates a high degree of heterogeneity between countries.

Even so and although it differs from one country to another, there is an overall consensus as regards the common denominators necessary for attainment of health-related Millennium Development Objectives. These are i) reduction in inequality where health is concerned, including inequality related to poverty, marginalization, gender, race or ethnicity and age; ii) progress in social healthcare cover; iii) increased cover of most critical healthcare provision; iv) increased levels of current public spending, investment in the sector and the quality of assignment of sector resources. It is also necessary to reorient healthcare services through the introduction of a new primary healthcare strategy that promotes active participation of all those who use the system, strengthening of the public health infrastructure and progress in the formulation and implementation of policies and inter-sector measures.

3. EC Healthcare Cooperation Policy

EC's General Framework for the Health Sector

As a consequence of the commitments made by the European Union and its member states regarding their contribution to the attainment of the Millennium Development Objectives (MDO) relating to Health and Poverty, the European Commission adopted the Communication "Health and poverty reduction in developing countries" in March 2002, the overall aim of which is to make poverty reduction a central objective of global development for the EU and the international community in the widest sense. The Communication recognizes and details the relationship between health and poverty, summarises the basic elements of a consistent development approach to improve health and well being and establish, for the first time, a single framework for community policy to guide the relative investment in health and the fight against AIDS in the context of overall European aid to developing countries.

The communication proposes four Global Objectives (GO):

(1) Improvement of health-related results, the fight against AIDS and population policies at national level, especially among the poorest.

(2) Maximize health services and minimise the potentially negative effects on healthcare of community aid in other sectors.

(3) Protection of the most vulnerable from poverty through support for equitable healthcare financial mechanisms and

(4) Investment in the development of tangible global public goods.

Consequently, in May 2002 the Council adopted a resolution to tackle health and poverty. The latter welcomes the above-mentioned communication, proposes a substantial increase in assistance for the health sector over the four subsequent years and reiterates the importance of health as a key factor in the strategy for poverty reduction and commitment to the MDOs.

As a practical addition to the aforementioned main lines in health, the EC has developed a Programming Guide to Health, AIDS and Population for use in delegations and a specific guide for the incorporation of HIV/AIDS in country strategies (January 2006).

From projects to a sector approach

Although EC support is channelled mainly through conventional health projects and programmes, the EC expressed its willingness to reinforce the approach of Sector or Budgetary Aid that increases appropriation on the part of receiving countries.

The two main EC budget lines related to the health sector are "Aid for policies and action concerning rights and sexual and reproductive health in developing countries" (21 02 07 03) and "Aid for poverty related diseases (HIV/AIDS, malaria

and tuberculosis) in developing countries" (21 02 07 02), both included in the sample covered by this report.

There are other lines which, although not specifically designed for the sector, assign funds directly or indirectly to health. Examples of this are: 21 02 03 "EC contribution to schemes concerning developing countries implemented by NGOs" and 21 02 01 concerning "Products mobilised within the framework of the Food Security Convention", also represented in the sample.

Specific EC framework for HIV/AIDS and Reproductive Health

The EC increasingly emphasizes the importance of the fight against "poverty pandemics": HIV/AIDS, Tuberculosis and Malaria, as well as the improvement of rights related to sexual and reproductive health.

The EC increases its investment and qualitatively profiles its HIV/AIDS and reproductive health intervention

From a quantitative point of view, investment in this sector has grown from 1% of the total EC aid to exceed 8% while from a qualitative perspective, the EC has gradually departed from its original approach centred on curative medicine and health infrastructure in favour of support for basic health services, development of programmes entirely designed to deal with HIV/AIDS and reproductive health and support reforms in the health and research sector. Since 2000, HIV/AIDS policy has been incorporated into a more strategic approach that incorporates malaria and tuberculosis as part of poverty reduction.

The most recent steps taken in the sector can be found in the Commission's working document of March 2005 "Principles for the EU's contribution to the Global Fund for the fight against HIV/AIDS, Tuberculosis and Malaria with a view to the processes of renewed provision of funds in 2006/2007" or the Communication of April 2005 "European Programme for action against HIV/AIDS, Malaria and Tuberculosis through external action".

Evolution of EC HIV/AIDS policy

To these purely bilateral initiatives is added the EC's contribution to the Global Fund for the Fight against AIDS, Tuberculosis and Malaria and an explicit commitment to seek greater coordination of policies both within the EU and with all other donors in general.

EC Cooperation Policy on Health in Latin America

The legal basis for development cooperation in Latin America can be found in Regulation 443/92 whereas its political framework is based on the conclusions of the summits held in Rio, 1999, Madrid, 2002, Guadalajara, 2004 and Vienna, 2006. In preparation of the Vienna summit, the Commission proposed a new strategy for the strategic relationship between the EU and Latin America in its communication of December 2005 "A stronger partnership between the European Union and Latin America".

General political and operational framework of the EC in Latin

The Commission sets forth four areas for priority action in its Latin American Regional Strategy Paper:

1. Support for relations between the European Union and Latin America by strengthening the collaboration of civil society networks.
2. Contribution to the reduction of inequality through selective action intended for underprivileged sectors of the population and to promote social cohesion.
3. Preparation, prevention and reconstruction in the face of natural disasters.
4. Observatory of EU - Latin America relations as a complementary action to support the strategic association.

Specific role of health in the 17 EC Latin American country strategy papers.

The specific objectives at national or sub-regional level are described in detail in the country and regional strategy papers adopted in 2002 and defined by the National Indicative Programmes 2002-2006. Latin America's heterogeneity both in the broadest sense and as regards the health sector in particular are evident in the European Commission's response, which varies very substantially, depending on the specific circumstances in each country. A review of the various country strategy papers and National Indicative Programmes (NIPs), drawn up for Latin American countries 2000-2006, reveals the following scenario as regards health:

a. In a certain number of countries, a significant contribution of the budget to the social sector including an explicit and very prominent place for health, as is the case in **Argentina, Brazil, Ecuador and Mexico.**
b. In another group of countries, health forms part of a wider objective of support for the modernization of the state and increased efficiency in the health system, as is the case in **Chile and Paraguay.**
c. Last, there is a group of Latin American Countries in which Health is not an EC cooperation priority for reasons ranging from the sufficient presence of other donors in the sector to the EC or receiving country's belief that prioritisation of other sectors due to the scarcity of resources would be more beneficial. This is the case for **Bolivia, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Peru, Uruguay and Venezuela**.

4. External Monitoring Results 2005 and 2006

4.1 Representativity of the External Monitoring exercise

After AIDCO geographic divisions took over the supervision and coordination of various contracts for monitoring services in 2002, the monitoring team for Latin America has visited 33 health projects. 17 projects were monitored during the period covered by this report, 2005 – 2006, and the 16 others were visited during the preceding three years.

Health projects in Latin America were financed under almost all budget lines **active** in the region (with the exception of the specific environment line). Health projects have been approved under the following budget headings: Human Rights, Drugs, Rehabilitation (REH), Financial and Technical Cooperation (FTC), Economic Cooperation (ECC), Health and Population (HEALTH), Food Security (FOOD) and Cofunding via NGOs (NGO-PVD).

Latin American health projects have been financed under almost all budget lines active in the region (with the exception of environment).

For the period covered by this report, the breakdown of the 17 projects per budget line is as follows:

- Financial and Technical Cooperation – 5 Projects[1]
- Economic Cooperation – 1 project
- Rehabilitation – 3 projects[2]
- Cofunding via NGOs – 4 projects
- Health and Population – 2 projects
- Fight against diseases of poverty (HIV/AIDS, Tuberculosis) – 1 project
- Food Security – 1 project

On the basis of the EC contribution, the **financial volume monitored** amounted to €134.77 million. The following table shows a breakdown of funds per country:

[1] The SOLEDUSA project in Panama in assigns over 50% of its budget to education.

[2] The PRRAC SALED project in Honduras also comprises an educational component.

Amount monitored per country (2005 – 2006)[3]

Ecuador	34,000,000 €
Bolivia	25,966,804 €
Peru*	17,492,591 €
Nicaragua	12,705,100 €
Guatemala	10,315,944 €
Brazil	1,357,889 €
Argentina*	579,758 €
Uruguay*	85,820 €

* Including the Urb-al project funds

Amount with over 50% of the budget for education

Honduras	23,100,000 €
Panama	8,500,000 €

EC funds are focused on the **Andean area,** with **support projects for sector reforms** with significant components in **water and sanitation**. Projects supporting the **reconstruction of Central America**, most of which are in their final stages, also account for a large part of the funds. The representativity of health projects in different budget lines is low. This poor representativity also applies to the **specific Health and Population line** which has gradually reduced the number of projects financed in the region as it was considered a greater priority to concentrate resources in African and Asian countries. When the analysis for 2005 and 2006 is summarised, the **geographic distribution** of health projects is as follows:

Taking account of all the monitoring exercises, it is clear that all countries in the region - except Costa Rica and Chile - have benefited from at least one health project.

- Argentina – 1 project
- Bolivia – 3 projects
- Brazil – 1 project
- Ecuador – 2 projects
- Guatemala – 3 projects
- Honduras – 1 project
- Nicaragua – 2 projects
- Panama – 1 project
- Peru – 2 projects
- Regional – 1 project

[3] By including both years, all projects eligible in accordance with the criteria established for the monitoring service have been included. The project financed under the Financial and Technical Cooperation Line in Argentina for 10 M€ was not included as it had not been running for six months at the time of the mission to Argentina in April 2006.

The classification in compliance with DAC codes for health-related sub-sectors is as follows:

- Health (includes various components), 12000
- Healthcare Policy and Administrative Management, 12110
- Basic Health, 12200
- Basic Health Care, 12220
- Infectious Diseases Control, 12250
- Health Education, 12261
- Reproductive Health Care, 13020
- STD control including HIV/AIDS, 13040

The following table summarizes the sub-sectors present in each country. Note that two sub-sectors have been included that do not belong to the health sector; In the case of the SOLEDUSA and PRRAC SALED projects in Panama and Honduras, respectively, it was considered more appropriate to assign them DAC Code "Educational Installations" on account of the percentage of their budget destined for education. The project "Boulevard: Recorridos de salud" was classified as Urban Development as it was financed within the framework of the Urb-al regional programme.

	AR	BO	BR	EC	GT	HN	NI	PN	PE	Reg.
Health				2			1			
Healthcare Policy		1							1	
Basic Health					2					
Basic Health Care					1				1	
Inf. Diseases Control							1			
Health Education		1								
Reproductive health		1			1					
STD control	1		1							
Educational facilities						1		1		
Urban Development										1

Analysis of the sample shows **some interesting trends**.

- The **Andean zone** receives a large part of the EC's financial efforts to support reform processes in Peru, Ecuador and Bolivia. The three projects AMARES, PASSE and PROHISABA devote resources to high vulnerability areas such as the Andean Trapeze in Peru, Potosí in Bolivia and the provinces of the central sierra Chimborazo, Bolivar and Cotopaxi in Ecuador.
- Almost all projects financed by the EC in this sector set out to alleviate problems related with the ***epidemiological gap*** - contagious and infectious diseases or the maternal and infant death rate - which affects the most vulnerable groups in the region and which are directly associated with unequal access to health services.

- **Central America** continues to prioritise the improvement of **primary healthcare** and improvement of coverage indexes, including improvements in healthcare models and the improvement of facilities and access to medicines.
- Projects **carried out by NGOs**, including those of Health and Population and the Fight against poverty related diseases lines, support **innovative processes** such as the generation of support and volunteer networks for people living with HIV/AIDS in Brazil, participative education for the exercise of rights related to health or the empowerment of women for the exercise of their sexual and reproductive rights. The sample also covers projects dealing with the provision of healthcare services, generally proposing improvements through pilot schemes.
- The health component of the **Food Security Support Programme** (PASA) in Peru was a precursor to budgetary support to the Ministry of Health, financing various lines of action over 10 years.
- The **Urb-al project aims to provide experience of cooperation through municipalities and the exchange of experience between European and Latin American municipalities** for the promotion of health.

Heterogeneity of the sample and general evaluations

Because the sample is limited to 17 projects, it was considered more effective to make a qualitative evaluation on the basis of the information contained in each monitoring report rather than draw overall conclusions on the basis of the quantitative scores given by monitors in Background Conclusion Sheets (BCS). Bearing in mind the nature of the projects (large projects supporting reform, small projects promoting the empowerment of citizenship, NGO projects), it was decided to break them down into subgroups with common characteristics:

Sub-Sectors	Projects
Support for reform processes	AMARES – Peru PROHISABA – Bolivia PASSE - Ecuador
Improvement of Primary Healthcare	FORSIMA - Nicaragua PRRAC Salud - Guatemala PRRAC SALED - Honduras PSIE – Ecuador NGO Medicus Mundi – Guatemala NGO CARE – Guatemala SOLEDUSA – Panama PASA - Peru
Education for the exercise of rights relating to health and promotion of health	NGO OIKOS – Bolivia NGO International Plan – Bolivia Urb –al – Regional
HIV/AIDS and other poverty related	NGO ICCO – Brazil

17 projects monitored during the 2005 and 2006 exercises. 16 have been assessed according to criteria

diseases	NGO F. Huésped – Argentina NGO ALISEI - Nicaragua

Another feature of EC health projects are their different methods of implementation. There are five types of project implementation method and this also makes it more difficult to make comparisons between projects.

Given the dynamics of different methods of implementation, conclusions will sometimes be drawn as regards these methods with comments on their strengths and weaknesses.

Methods of implementation	Projects
National Management	PROHISABA – Bolivia PASSE - Ecuador SOLEDUSA – Panama
Comanagement	AMARES – Peru PSIE – Ecuador
PRRAC – European Management	FORSIMA - Nicaragua PRRAC Salud - Guatemala PRRAC SALED - Honduras
NGO[1]	NGO Medicus Mundi – Guatemala NGO CARE – Guatemala NGO OIKOS – Bolivia NGO International Plan – Bolivia NGO ICCO – Brazil NGO F. Huésped – Argentina NGO ALISEI - Nicaragua
Municipalities[2]	Urb –al
Budgetary support for the Ministry of Health	PASA Peru

Finally, it is worth analysing different projects within the same country. Thus in Guatemala, where three health projects were under way during the period covered by the report and in Bolivia, where three projects are also operating, it is possible to make useful comparisons and thus present a number of lessons learned.

[1] The NGOs that have signed the subsidizing contract with the EC have been mentioned. In most cases the latter are not the executers.

[2] The implementing entities are the municipalities of Rosario and Montevideo, Citá de Torino, the local authority of Bilbao, the municipality of ATE and the Argentinean NGO, INPADES.

4.2 General Conclusions

The scores per criteria provide a very positive overview for PRRAC projects and an acceptable one for FTC projects. However, the results of NGO projects (also HEALTH line projects) are more heterogeneous.

The outlook is very positive for PRRAC projects and acceptable for FTC projects. NGO projects have heterogeneous results.

Country	B/L	Project	Relevance.	Efficiency	Effectiveness.	Imp.	Sustainability.
BOLIVIA	FTC	Support programme for hygiene and basic health (PROHISABA)	c	c	c	b	b
ECUADOR	FTC	Integrated Health Project in the Province of Esmeraldas (PSIE)	b	b	b	b	b
ECUADOR	FTC	Support programme for the health sector in Ecuador (PASSE)	b	b	b	b	b
PANAMA	FTC	Incorporation of new electrification technologies for health in marginalized areas (SOLEDUSA)	c	c	c	c	c
PERU	FTC	Health Sector Support Programme (AMARES)	b	b	b	b	b
GUATEMALA	REH	Expansion of a Primary Healthcare System	b	a	b	b	b
HONDURAS	REH	Strengthening the Health and Education Sector in Honduras (SALED)	b	b	a	a	a
NICARAGUA	REH	Rehabilitation project for primary healthcare services and strengthening of Silais de Managua (FORSIMA)	b	a	b	b	b
ARGENTINA	NGO-PVD	Integrated Programme to Promote Sexual and Reproductive Health and Prevention of HIV/AIDS among Poor Women, Adolescents and Youths in Greater Buenos Aires	b	b	c	c	b
BOLIVIA	NGO-PVD	Participative community education for the exercise of health-related rights in poor municipalities in the Departments of Oruro, Sucre, Tarija and Potosí, Bolivia.	b	b	b	b	c
BOLIVIA	NGO-PVD	Empowered women and adolescents in relation to sexual and reproductive rights	mn[3]	mn	mn	mn	mn
GUATEMALA	NGO-PVD	Implementation of a first level primary healthcare system in three districts, pilot scheme.	a	b	b	b	b
NICARAGUA	HEALTH	Strengthening and optimisation of national malaria and HIV/AIDS programmes in Nicaragua through an integrated approach prevention, diagnosis and treatment HALTED	b	d	d	d	c
GUATEMALA	HEALTH	Maternal Health Project	b	c	c	b	b
BRAZIL	HEALTH	Programme for setting up a network of buddy volunteer projects in Brazil	c	b	b	b	b
PERU	FOOD	Food Security Assistance Scheme Peru 'MIN SALUD'	b	b	c	c	b
URB-AL	EC	"Health Boulevard."	c	d	c	c	c

[3] A "Monitoring Note" is produced when, for various reasons, the project cannot be evaluated. This project was closed prematurely.

Evaluation by criteria shows that the weakest criteria are efficiency, effectiveness and impact.

The criteria shown to be weakest are efficiency, effectiveness and impact.

Summary of scores according to the monitoring parameters

	Quality of design	Efficiency	Effectiveness	Potential impact	Sustainability prospects
a	1	2	1	1	1
b	11	9	8	10	11
c	4	3	6	4	4
d	-	2	1	1	-
Total	16	16	16	16	16

The quality of design is good in 12 out of 16 projects.

The analysis of the information contained in the monitoring reports enables us to draw the following conclusions:

- First, **design is considered of good quality in** 12 of the 16 projects. This is mainly due to correct identification of the beneficiaries' needs and acceptable formulation of the Logical Framework (LF) in most cases. The intervention strategies chosen also scored well for these projects. Four (4) projects scored "c" due mainly to deficiencies in the intervention strategies selected for tackling the problems to be resolved and this is reflected in inconsistent LFs as assessed by the monitors.
- Second, very high scores were awarded for efficiency in 2 projects and **high scores** in 9. There were problems in 3 projects and 2 projects had serious shortcomings. It is worth noting that the 2 projects which were awarded an "a" in this criteria are both PRRAC projects. The efficiency of 11 projects which scored well is mainly due to the achievement of results[4] of the quality expected and in accordance with Objectively Verifiable Indicators (OVIs).

There were good scores for efficiency in 11 projects and problems or serious shortcomings in 5 of them.

- According to the information deriving from the sample, **effectiveness is the criterion that presents the** most problems: 6 projects were assessed with "c" and 1 with "d". Of the 16 projects, 7 do not succeed, or only partially succeed, in ensuring that the products and services generated by the projects reach all planned beneficiaries.[5] The achievement of the project purpose as defined in the LF is also usually partial. However, 9 projects have good prospects for attainment of PPs and will very probably

7 out of the 16 projects did not succeed in providing all beneficiaries with access to products and services introduced through the project.

[4] In the section on efficiency in the Background Conclusion Sheet (BCS), the achievement of results accounts for 40%. Three other criteria are assessed (availability of input, implementation of activities and contribution of the partners) and account for 20% in each case.

[5] In the section on effectiveness in the Background Conclusion Sheet (BCS), the probability of the Specific Objective being achieved accounts for 40% of the score. The percentage of the score specifically attributable to access to project services by the beneficiaries is 20% and use of these services by the beneficiaries is 30%.

attain their specific objective since 7 of the projects are in a very advanced stage of development.

- **11 of the 16 projects scored well in terms of prospects for impact.** This may initially appear to be at odds with the information yielded by the effectiveness criteria. However, the monitors have taken account of later action that can be taken from outside the project both by local authorities, national governments or other donors and which may contribute to the attainment of the General Objective.

Prospects for impact scored well in 11 of the 16 projects and poorly or with serious shortcomings in 5 cases.

The potential sustainability criteria, together with the quality of design received the highest scores. **12 of the 16 projects have good prospects for sustainability.**

12 of the 16 projects have good prediction for sustainability.

5. Conclusions per Criteria

5.1 Relevance and Quality of Design

Relevance

- In general, it is can be seen that health projects are highly **relevant**, which is mainly the result of correct identification of the needs of both final and intermediate beneficiaries. With the exception of the Urb-al project, the profile of the target population is highly vulnerable in the various countries of the region. In addition, except in the case of the Urb-al project (which channels funds both at the European and Latin American level), EC funds targeted at the alleviation of problems afflicting the most vulnerable populations and which are a consequence of the above mentioned epidemiological gap (infectious diseases, maternal and infant mortality).

EC funds through different budgetary lines prioritise the highly vulnerable populations of countries in the region.

- The EC **supports reform processes under way creating synergies with national efforts and other donors**. Naturally, the relevance of these projects depends on the quality of the reform processes undertaken by the different countries and although projects have some room for manoeuvre, often the referential framework is pre-established and little impact can be made on it as a project (the three projects supporting reform are the AMARES, PROHISABA and PASSE projects which operate at local, regional and central level).
- Projects implemented by **NGOs** are considered very relevant for two main reasons; **they concentrate their efforts on the most needy population and implement innovative strategies for** empowerment of the population and creation of the social fabric. Other NGO projects are pilot schemes and these are very valuable both for the country concerned and for replication by other countries in the region. For example, the "implementation of a primary healthcare project for first level healthcare" (NGOs Medicus Mundi Navarra) demonstrates good practice through the high quality of the way in which the work of identification and induction with the beneficiary population was performed.

NGO projects set up innovative strategies for empowerment of the population and the creation of social fabric.

Some examples of the origin of the proposals according to sub-sectors.

Sub Sectors	Origin	Examples Sample projects
Support for reform processes	Government request and consideration of the Action undertaken by other BM and BID entities	PROHISABA (Bolivia)
Improvement of Primary Healthcare	Arose as a result of a request made by the Health Authority of Esmeraldas	PSIE (Ecuador)
Education for the exercise of health-related rights	Collaboration between the International Plan and two	International Plan NGOs (Bolivia)

	Bolivian NGOs.	
HIV/AIDS and poverty-related diseases	Replicates the "Homobuddy" figure of the Schorder Foundation of Holland.	NGO ICCO (Brazil)

- However, 2 NGO projects included in the sample have serious problems and have been suspended or prematurely closed. ("Women and adolescents' empowerment on sexual and reproductive rights" - International Plan, Bolivia; "Reinforcement and optimisation of national malaria and HIV/AIDS programmes in Nicaragua through an integrated approach of prevention, diagnosis and treatment" Alisei, Nicaragua). As mentioned in the reports produced by the monitors, the artificial nature of the consortiums produced misunderstandings which led to the paralysis of activities.[6]

Design of the intervention strategy

- In general terms, **the quality of design of the intervention strategies is acceptable**. Both NGO projects and bilateral cooperation projects try to identify the most relevant problems to be resolved in conjunction with the beneficiary population.
- The **continuous efforts to update the strategies of the 3 PRRACs** are worthy of note. Despite lengthy start-up processes and methods of implementation (European management) with little or no local participation, the management teams made efforts to review the strategy, increase participation by all those involved in the various process and generate a degree of appropriation on the part of beneficiaries that was absent in the initial designs.

The PRRACs' continuous efforts to update intervention strategies are very positively assessed.

- Bilateral cooperation projects **supporting reform** wisely combine action to improve healthcare in highly vulnerable areas of the country with activities that support the ministry and this legitimises them at central level as an experimental laboratory with the potential for replication. However, this approach sometimes leads to complex designs that require extensive agreements between the numerous entities involved.

Projects supporting reform have complex strategies with interventions in various sectors and zones.

- Another aspect which sometimes caused **problems is the choice of geographic area covered.** This is usually the responsibility of the central health authorities and entails decisions that occasionally limit the impact of the intervention at a later date or undermine the efficiency of the project. In addition, in the Andean region, reaching the most needy population is often very costly and complicated due to the size of the areas and limited transport.
- In some cases, **NGO** projects are overoptimistic **as regards their capacities and the population they can cater to**. During

[6] As mentioned in the NGO thematic report produced by the monitoring system "the formation of **NGO consortiums** is a positive factor in theory but in practice is not always successful when it comes to carrying out action. The policy of promoting consortiums implemented by the EC seems to have more to do with the intention of distributing funds and reducing costs than a real desire to promote alliances and complementarity. As a result, many consortiums operate with a veneer of coordination but agree to distribute funding and work with segmented proposals and interventions".

implementation of the project, the number of beneficiaries is frequently revised downwards in order to match the resources available with needs.

- One key aspect is **consistency between the goals set and resources available** both in terms of funds and time. Monitors often comment that projects are "over ambitious". Incomplete or anachronistic identifications regularly oblige project teams to have to devote part of the first year to reviewing goals and analysing the situation. These unplanned activities take up project operating time. Almost all projects face this problem.
- Finally, key aspects of the design of the intervention strategy that are often not fully carried out are the **analyses of stakeholders' capacities and risks**.

Orientation of intervention strategies

As stated in the CEPAL report, the linchpin of the challenges faced by the Latin American health sector is provision of **universal basic cover**. However, this requires reforms in the way in which health systems are financed entailing major changes which some sectors of society find difficult to accept. It should be remembered that **only Brazil has a National Health System.** The rest of the countries have fragmented systems which is particularly detrimental for the poor population. In response to this resistance and encouraged by neoliberal approaches promoted by the WB and IDB during the 80s and 90s, countries implemented basic packages covering a number of minimum requirements to attend to maternal-infant health in particular. Some defend these packages as a first step towards the development of universal more comprehensive cover. The SIS, Comprehensive Health Insurance, in Peru and SUMI, Universal Maternal and Child Insurance, in Bolivia are working on these bases. However, both the SIS and the SUMI are financed to a large degree by foreign funds[7], which is testament to the fragile commitment of local authorities. In this context:

Brazil is the only country in the region to have a National Health System. The rest of the countries have fragmented or segmented systems which give rise to unequal access to services.

- Projects are sometimes envisaged by beneficiary countries more as aid activities that may provide a means of alleviating problems in the short term than as strategic interventions that bring about structural improvement in the sector (financing, management, institutionalisation, etc.). Efforts have been made to avoid this type of aid approach both by bilateral cooperation projects and NGOs due to the little added value they provide and their poor sustainability.
- In association with the above, **impact on public policy** is pursued by almost all projects. Some succeed in making contributions at local level, as in the case of the "Buddy Volunteers" project in Brazil, and others, such as the PRRAC, FORSIMA or PRRAC Health projects in Guatemala propose changes in policy of greater magnitude. However, the impact of activities that have an influence on policy depends on the political will of the moment.

[7]The health component of the Food Security Assistance Scheme has been funding the SIS over recent years.

- Another trend of increasing importance is the gradual adoption of "**facilitatory**" **approaches**. However, of the 17 projects in the sample, 13 are directly implemented or delegated projects and only 4 opt for facilitatory or partially facilitatory approaches. One project which has succeeded in adopting this approach in spite of difficulties is the AMARES project promoting participation by municipalities and health centre personnel through the presentation of initiatives to be financed by the project at a later date. In the local context of the AMARES project at least, it is clear that the facilitatory approach substantially contributes to improving appropriation by beneficiaries.

The AMARES project is an example of a project that provides support for reform. Its achievements can be seen through the appropriation generated by municipalities and health personnel.

Use of the Logical Framework

The quality of the logical frameworks of the 17 sample projects are of a generally acceptable quality. Continuous effort by the external monitoring system to stress the importance of the use of this tool is bearing fruit.

However, there are still shortcomings resulting from the afore-mentioned **incomplete and anachronistic identification processes.** As a result,

- Projects that have not carried out a good analysis of the problems usually have poorer LFs. There is also a relationship between poor LFs and the absence of a base line.
- On the other hand, it is still necessary to continue insisting on the improvement of basic assumptions and objectively verifiable indicators (OVIs).
- Sometimes, the results are defined more as outputs than outcomes in the strictest sense. That is to say, there is a gap between the generation of products or the production of services and their scope. Sometimes there are "x healthcare personnel trained in..." type results. However, it is not so much the training as the use that is made of it that matters. Projects like the PSIE project face this problem. This aspect relating to design directly affects considerations made on efficiency.
- It is important to highlight the **continuous improvements** that have been carried out by most projects, particularly the PRRAC projects, to adapt their respective logical frameworks to the environment in which they are operating and the changing needs of the population. However, a certain degree of confusion has been detected on the part of various implementing entities when it comes to updating the LF, it not being clear to what extent (Results) it is possible to update them without requesting authorization from the EC. Some confusion was also detected on the part of personnel from some delegations.

5.2 Efficiency

Rate of budgetary implementation

- However, the crucial factor for efficiency does not so much concern problems that implementing entities must face but their **capacity to respond** to them. Thus, projects such as AMARES, PSIE, PRRAC or the Medicus Mundi Navarra project are notable for their capacity to adapt and respond, by advancing funds (Medicus Mundi), recovering lost time or intensifying schedules (AMARES, PRRAC Guatemala).
- Most projects, both NGOs and bilateral cooperation, have **good administrative and financial management**.
- Close study of the information provided by monitors in the BCSs shows that all projects have encountered problems that affected their implementation. The most common causes are:
    - The late arrival of EC and/or national funds
    - Delays in POG/POA presentation
    - Delay in POG/POA approval
    - Delay in presentation of advance reports
    - Inefficient organisation and internal management
    - Coordination problems between various entities involved
    - The need for time to learn how to use the practical guide (both by implementing entities and delegation personnel)[8]
    - The need for an adaptation period to shift from co management to national management
    - Ineffective consortiums (NGOs) that hamper fluidity in decision making

The capacity to respond to problems is one of the characteristics shared by highly efficient projects.

Extent and quality of the results

- **Most of the projects achieve a significant percentage of the foreseen results** in terms of quantity.
- The challenge, however, concern their extent and quality. Sometimes, when projects are significantly delayed, quantity is given priority over quality which causes problems for effectiveness.

Internal monitoring and follow-up by delegations

Internal monitoring systems differ greatly from one project to another and in many cases it is not possible to speak of real quality-oriented systems but rather an administrative exercise to ensure accountability. In general, there is a shortage of good internal monitoring and follow-up systems (lack of solid base lines that make it possible to measure achievements and successes, well designed OVIs, integrated information systems, etc.). A significant problem encountered by various implementing units is the **lack of information** in some cases or the **unreliability of information** in others of the various health service information systems.

Most projects have to deal with unreliable information systems and poor quality of the records.

[8] The n+3 rule has also contributed to the fact that start-up times are reduced and staff being aware of the need to speed up contracting processes. However, the requirements of the guide itself and, more than the requirements, the interpretations or use that different delegations make of them is a source of tension between management teams and personal from delegations.

Projects often have to gather their own information and in fact many projects are working to improve the quality of public service information systems.

5.3 Effectiveness

Searching beneficiaries

- The projects are making real efforts to assess the exact number of beneficiaries. Some examples of this are shown in the following diagram. However, this is no easy task. It is especially the case for projects supporting reform since these interventions combine activities in specific geographic areas with others on a national scale. NGO projects, for their part, tend to overestimate what can be achieved with their capacities so it is not very reliable to assess their effectiveness in accordance with these estimates.

Some examples of the grouping of beneficiaries by sub-sectors

Sub Sectors	Beneficiaries	Implementing entity
Support for reform processes	In Potosí, 385,000 inhabitants. In Tarija 256,000 (health component). In water (84,000 in Potosí) and 36,000 in Tarija.	PROHISABA (Bolivia)
Improvement of Primary Healthcare	20,136 rural, indigenous population (Mam and Quiché) and mostly monolingual women. Revision downwards 17,000	NGO Medicus Mundi (Guatemala)
Education for the exercise of health-related rights	5 - 10 thousand people. 150 thousand radio audience 1,200 teachers. 24,000 students and 1,200 agents of change. Actual beneficiaries to date 11,555	NGO OIKOS (Bolivia)
HIV/AIDS and poverty-related diseases	300,000 people from Nicaraguan Mosquitia, Chinandega, MatagaB/La, Jinotega and León.	NGO Alisei (Nicaragua)

- In almost all cases, the population that benefits in the first instance from services made available through the projects are **intermediate beneficiaries**, i.e. healthcare personal. This explains why the exact number of end beneficiaries of the intervention within the target population is not known.
- On the other hand, while there are few projects within the sample that have adopted a facilitatory approach, the change of attitude among these intermediate beneficiaries when they are allowed to take decisions in their own interests and make their own proposals for improving the quality of their work is worthy of note. The AMARES project is a clear example of a facilitatory project which has succeeded in bringing about appropriation on the part of intermediate beneficiaries that has proven to be a worthwhile model. This project demonstrates the positive effect and connection

Most health projects work directly with intermediate beneficiaries: healthcare personnel. This entails a double challenge to attain the levels of effectiveness expected.

between the services provided for intermediate beneficiaries by the project and the target population.

Access to and quality of services from the perspective of the beneficiaries

- The evaluation of the **sample is on the whole positive**. Although effectiveness is the criteria for which scores were lowest, all strategic projects (with the exception of PROHISABA and including the PASA health component) scored well. The PRRAC and AMARES projects are examples of this, their work with municipalities exceeded the scope foreseen in terms of the number of beneficiaries.
- However, within the sample both are NGO, bilateral cooperation and food security projects which, for various reasons, have not reached the expected number of beneficiaries.
- The main reasons, in the case of NGOs, are organisational and internal management problems between the various organisations involved and excessive optimism as regards their capacities. In the case of bilateral cooperation projects, the main problems concern both weaknesses in management and coordination, as in the case of the project Urb-al "Boulevard: recorridos de salud" or shortcomings related to a lack of adequate planning (PROHISABA).
- One important aspect of social projects and health-related projects in particular is that, due to the lack of public service coverage, the role of **service providers** is adopted. Although efforts are made to avoid this as far as possible, especially in the case of bilateral cooperation projects, pressure to reach the beneficiary population and meet Specific Objectives means that **effectiveness becomes a greater priority than sustainability**.
- As regards the **probability of attaining SOs,** evaluations reveal very heterogeneous data. Besides the 6 projects that have serious problems in this respect, this rest of the projects have only partial probability of achieving SOs.
- The reasons why it is difficult to achieve SOs as presented in the various LF range from i) over-ambitious formulation, ii) confused formulation, iii) implementation problems or iv) influence of external factors that risk undermining their achievement. This applies especially to all bilateral cooperation projects with complex strategies where many players are involved and where, in spite of developing suitable strategies for appropriation by beneficiaries and the strengthening of institutions, project schedules often do not match up with institutional schedules and the time required for the processes undertaken maturing.

Evaluation of the attainment of SOs is very heterogeneous. Over-ambitious or confusing formulations, problems with implementation or the influence of external factors limit their attainment.

5.4 Prospects for Impact

Impact of the intervention on the direct environment.

- The results of monitoring as regards potential impact are positive in 10 of the 16 projects evaluated.
- **Efforts to minimise risk** through the periodic analysis and design of strategies for the participation and involvement of central and local authorities make a major contribution to the attainment of the GO and therefore attainment of the desired impact on the direct environment.
- These efforts were especially obvious in the case of the PRRAC projects. Aware of the limitations associated with their implementation models and the difficulties these meant for the fulfilment of basic assumptions, management teams implemented activities and strategies and entered into negotiations to generate the commitment and participation of local, regional and national entities involved. So, for example, in the case of FORSIMA, all basic assumptions seem to have been adequately met and progress with regard to the OG is already being achieved. The project is highly replicable with a potential demonstrative effect. The contribution of FORSIMA to the redefinition of the healthcare model, going beyond the curative to comprehensive preventive action is now a fact.
- The degree of dependency of NGO projects on external factors and their poor capacity to affect policies usually limits their impact.

Replica of the impact in other contexts

- **Systematisation of experience** is a generalized weakness of projects. Almost all monitoring reports identify pilot schemes, successful innovations and lessons learned that could be useful for future interventions. Yet very few projects make technical intervention validations and even more rarely systematise experiences.
- The sample contains numerous successful experiences which it would be very useful to bring together and systematise. In addition, the fact that many of the projects from the sample that scored well are in their final phase (PRRAC, AMARES, PSIE) could provide an opportunity to assess impact either per country, implementation method or sub-sectors. Among the NGO projects, one project that would certainly be worth studying in greater depth and possibly systematizing many of its experiences is the Medicus Mundi Navarra project.

Impact on public policy

- Pressure often arises due to the difference between the need to carry out activities and the agenda more political of the projects. Limited time and a certain lack of motivation often make it difficult for counterparts to fulfil the task. The new implementation method involving national management (i.e. implementation by the relevant national authorities) does not seem to be improving this particular aspect. On the contrary, postures are adopted

in line with the existing status quo which makes it impossible to bring about the necessary conditions for changes at the political level.

- Once again, the PRRAC, PSIE and AMARES projects are the exception with significant achievements particularly at regional and local level. PRRAC Health Guatemala, for example, developed various pilot schemes in coordination with the ministry that could be developed in other departments. Among these programmes is the women's health pilot scheme - community participation with a gender approach or the "*ventas sociales*" or rural pharmacies pilot schemes. The PSIE, for its part, reinforced the application of the National Health System Act - LOSNS. It promoted the training and operating method of the CPS (Provincial Health Councils) CCS (Cantoral Health Councils) CLS (Local Health Councils) and strengthened the End-User Committees that promote the Free Maternity Law, LMGAI. The framework agreement between the ministry of public health and the ministry of education has been consolidated at provincial level through joint action between the Provincial Health Department and the Provincial Education Department with a view to successfully implementing Schools Promoting Health.

Sectoral coordination with other entities and donors

Insufficient synergies and coordination of EC cooperation and coordination with the Member States of the European Union.

- Despite the need for effective coordination of aid between the EC and Member States being evident, synergies are still scarce (especially in the case of NGOs). In reality, the institutional structure of the EC itself offers very little scope for coordination on an operational level.
- However, sometimes coordination is successful with other donors as is the case of the AMARES project and the WB reform project. However, the AMARES project also encountered difficulties in coordinating with the PASA health component. While it is true that this coordination should have been facilitated by the Ministry of Health, a more proactive attitude on the part of the delegation would have been desirable.
- On the other hand, **it is not common to see coordination between bilateral cooperation and NGO projects**. Reasons often given for this lack of collaboration are that work is carried out in different areas or with different approaches. However, the exchange of experiences between projects from the same sector in the same country can always be enriching. This exchange could also be promoted by the delegations.
- Where **coordination with other donors** is concerned, it is worth mentioning that European cooperation takes consensual decisions that are in keeping with those of the IDB and the W.H.O. However, because of the limited scope of some projects, the primary causes of inequality in health such as financing or insurance processes for the populations concerned are not tackled, despite the fact that these problems are frequently acknowledged by both institutions.

Few projects have planned an impact evaluation. Several projects from the sample merit this type of assessment: namely, the PRRAC, PSIE and AMARES.

Evaluations of impact

The sample contains various projects that would benefit from an assessment of these characteristics. The PRRAC projects would be a good example, the 3 projects under way in Guatemala as well as the 3 projects supporting reform processes in the Andean zone.

5.5 Potential Sustainability

- The potential sustainability of the projects was found to be positive in 11 of the 16 projects monitored. Here, the aim is to make "predictions regarding the prospects for sustainability", although these are sometimes based on limited information and usually lack quantitative data that would provide a sound basis for analysis. They are therefore intellectually responsible and rigorous forecasts but based on ex-ante qualitative evaluations.
- Although **economic and financial sustainability** is considered to be the most important criteria in the BCS assessment system, it is the one that presents the most problems for all types of projects. Economic sustainability problems are related to the lack of commitment on the part of local, regional or national authorities or the incapacity of the beneficiaries to assume the costs involved.
- Most of the health **ministries have low budgets** largely aimed at covering personnel costs. There are few projects that succeed in obtaining explicit commitments from national authorities. Although in many countries in the region decentralization means powers are granted to local governments to designate funds to health, few municipalities make it a priority. Positive cases are the PSIE and AMARES projects whose work in the field of health promotion has been very notable.
- On the other hand, when agreements are made with the authorities, they are usually subject to future legislative elections and possible changes of personnel, another factor that threatens to undermine financial sustainability. In this type of context, in some cases the implementing entities at least try to secure solid agreements and minimise risks. One example of this is PRRAC FORSIMA which created an ad-hoc Committee for Change as a space for agreement and negotiation which made it possible to advance the processes undertaken.
- For their part, NGO projects working with innovative empowerment approaches face greater problems in guaranteeing sustainability once external funding ends.
- **Extent of appropriation by the beneficiaries.** Projects are aware of the crucial importance of appropriation of the activities undertaken by the project by both intermediate and end beneficiaries. Despite the fact that the number of projects to adopt facilitating approaches is still small, the majority develop appropriation strategies.

- In the health sector, where it is common to have to work with unmotivated health personnel, who are often poorly paid, and administrative personnel with few resources available to them, fostering appropriation is a challenge. In addition, projects supporting reform which propose changes to work dynamics and promote new models of service provision come up against aversion to change which makes improving appropriation exceedingly difficult.
- **Political support and interaction of the project with public policies.** The interaction of projects with public policies is constant both for NGO and bilateral cooperation projects. The challenge is to achieve an effective commitment on the part of the respective authorities. Often work at local level is more fluid and fruitful than at a regional or central scale. Problems associated with the very high turnover in healthcare staff at the highest level, both regional and central, make it impossible to establish commitments in the medium term.
- Project strategies are often in line with the **thrust of reform** of the sector undertaken by different ministries. The problem arises when governments change and priorities are no longer clear or when there is no explicit political agenda. Problems also arise when central government policies differ from local ones. All these political upheavals prevent proper overlapping of projects with national counterparts.
- **Strengthening Institutions** Projects supporting reform, as well as various NGO projects, work to strengthen the institutions with which they interact. The main weaknesses are usually the shortage and turnover of personnel in these institutions, their lack of clear objectives and very often the lack of resources available to them.[12]
- **Local participation and sociocultural aspects.** The sample covered by this report includes projects that have developed exemplary strategies for the development of local participation and interculturality, key factors for good sustainability prospects. Of the various barriers to access faced by the beneficiary population, the **cultural barrier** is perhaps the least prioritised. However, where there is awareness of its significance, the improvement of the effectiveness of services is very marked.[9]
- **Gender equality.** Although projects are aware of the fact that 50% of the population has a voice and the right to make decisions both within healthcare services and the beneficiary population, the small number of health projects developing explicit strategies with a gender approach and specific OVIs broken down by sex are conspicuous by their absence. One

The samples contain projects that have developed exemplary strategies to develop interculturality.

Few health projects have developed explicit gender strategies.

[12] One project which has achieved good institutional development is FORSIMA which has brought about a considerable degree of reinforcement of SILAIS in Managua.

[13] Projects such as the AMARES in Peru or the NGO Medicus Mundi in Guatemala are good examples of this. As indigenous women of childbearing age constitute one of the priority groups in highly vulnerable areas of intervention, action with intercultural approaches to bring services to this sector of the population have immediate and very clear results for the population. For its part, the OIKOS project in Bolivia has developed a very valuable strategy concerning the concept of health in the widest sense. The project encourages the presentation of proposals for improvement of health produced by the communities after working together with personnel from the project on issues related the right to health.

good example is provided by the Medicus Mundi and PRRAC projects in Guatemala. The first has specific subcomponents for men and women and has identified gender OVIs. The second has developed a very good strategy for participation by women in decision making within the water and sanitation component.

- **Environment** Few projects explicitly include of the environment as a cross-cutting issue in their designs. Only the PSIE and AMARES projects create and use the concept of Healthy Municipalities integrating the environmental dimension into the project.
- **Sustainability plans and exit strategies.** Most of the projects included in the sample did not have a sustainability plan or a handover or exit strategy when visited by the monitoring team.

Most of the projects did not have a sustainability plan or a handover or exit strategy when visited by the monitoring team.

The following table includes, by way of example, some of the strengths and weaknesses detected by the monitors.

Some examples of sustainability strengths and weaknesses.

Sub-Sectors	Strengths	Weaknesses
Support for reform processes	Statistics show growing levels of satisfaction among health system users in the case of projects facilitated with AMARES funding.	The project is not included in the institutional structures responsible for water, sanitation and health sectors and therefore does not contribute to the strengthening of their institutional and management capacity. (PROHISABA)
Improvement of Primary Healthcare	Degree of appropriation very effective: the community health agents are from the intervention areas, speak the same language and know the population (NGO Medicus Mundi)	Provincial health sector with budgetary problems due to the shortage of funds (PSIE)
Education for the exercise of health-related rights	Thanks to participative and horizontal methodology, the degree of beneficiary involvement is high. Communities not involved have expressed interested in participating (NGO OIKOS)	Political support in the area materialises only through limited municipal support (NGO OIKOS)
HIV/AIDS and poverty-related diseases	The process of participative planning has strengthened the communication process and capacity for analysis and represents an important space for integration for those involved (NGO ICCO)	The network of relationships and interests is complicated. There are client relationships which are difficult to break, dynamics of social control that impede and even prevent good project development. (F. Huésped)

General Recommendations per Criteria

To improve the quality of design

1. The sample of projects reveals that it would have been valuable to have incorporated more comprehensive **identification phases**. On the one hand, the need to carry out a detailed analysis of risk and opportunities as well as to produce a problem/objectives analysis with greater thoroughness is obvious in most projects. On the other hand, the familiarisation of the health personnel (indirect beneficiaries) and the target population with project proposals is slightly better among some NGO projects.

Improve the induction phases for project proposals with health personnel and the target population.

2. The successful experiences of "**facilitatory**" **projects** provides reason to believe that this approach is more relevant and sustainable than the conventional direct execution. However, this approach requires more time than direct execution so projects' **time dimension** would also have to be considered and the possibility of prioritising 3-year projects for NGOs and 5-year projects in the case of bilateral cooperation should be considered.

Promote the adoption of facilitatory approaches and open up the possibility for more lengthy projects.

3. It is necessary to carry out **intervention strategies** that have been discussed and agreed beforehand with civil society and healthcare personnel.

4. Given the relevance problems detected due to interventions covering too broad a **geographic area** taking account of the needs of the beneficiary population, it would be worthwhile reviewing intervention areas and the beneficiary population prior to beginning with the project implementation phase. This applies to both NGO and bilateral cooperation projects.

Review the relevance of geographic coverage and the choice of beneficiaries before beginning the implementation phase.

5. In general terms, stakeholder analysis should be strengthened in all projects. In the case of projects supporting health reform (FTC), reinforcement during the identification and design phase of this analysis is crucial in order to achieve the broadest possible basis for working together and agreement to support the modernization process under way.

6. Intervention strategies must continue to focus on **reducing the inequality gap in access to and use of health** services as well as in the improvement of their quality and effectiveness. However, it is necessary to introduce in design phase **plans for the sustainability** of services where commitments by local authorities are a priority from the start of the project implementation.

Sustainability plans should be designed from the outset, prioritizing commitment by local authorities

7. Projects frequently take on goals that are too ambitious given the resources available. This is particularly relevant for NGO projects but the problem was also detected in the case of bilateral projects with national

management. Goals should be **adjusted in accordance with the** human and financial resources, and time available.

8. There is gradual but clear improvement in the **Logical Frameworks** of health projects in the region. Still, it is necessary to continue insisting on the need to improve the designs of planning frameworks (improving the consistency and clarity of the intervention logic, including more effective OVIs with an increased capacity for assessing progress and performance, and the elaboration of detailed risk analysis, etc.)

9. The introduction of the **gender approach** in the design of health projects deserves greater attention. Few budgets include a reserve for gender experts with the result that not many projects incorporate the technical know-how required to pursue an intervention that promotes gender equality. Health projects and to a greater extent sexual and reproductive health, and HIV/AIDS projects require special attention in this regard. Work experience with men in the field of reproductive health is in its infancy. Promoting "masculinity workshops" that reflect upon the role of men is highly recommendable although not without difficulty given the prevailing chauvinist culture in the region.

Designate budget resources to hire experts in gender equality so as to be able to develop a comprehensive strategy with sex-specific OVIs.

In order to avoid certain efficiency problems

1. One of the problems affecting efficiency is the lack of a **clear definition of roles and responsibilities between implementing partners**. This has been detected in NGO projects in particular where European NGOs enter into a contract to subsidise but not intervene in the development of activities and sometimes the local partner delegates activities to other local entities. The network of entities involved requires clear definition of the scope of the obligations of each party.
2. In this context, it is particularly important to monitor the relevance and added value of the formation of **NGO consortiums.**
3. **As mentioned earlier, the quality of the results** depends in part on their being more clearly defined. It would, therefore, be highly recommendable to define key results in terms of processes rather than products.
4. It is necessary to insist on the design and use of **internal monitoring systems** centring on results and not merely the performance of activities. In spite of the difficulties faced by projects because of the lack of reliable registering systems, some are carrying out valuable case studies and controls that could prove very useful both for assessment of the impact of the intervention and for public health services.

The roles and responsibilities of implementing partners should be clearly defined, especially in the case of NGO projects.

Orient follow-up systems towards results and not the mere performance of activities.

To improve effectiveness

1. Working to promote access to and use of quality health services provided is the goal shared by all health projects. The most successful interventions in this respect are those that have a thorough knowledge of the target population and adopt an intercultural approach, operate as facilitators to healthcare professionals' own initiatives and work with both to increase access to services by the population.

2. EC delegations should **promote the exchange of good practices** achieved by some projects.

3. Focusing the design of the internal monitoring systems on the collective goal is essential to gradually measuring the degree of access to and satisfaction of services provided by the projects.

Promote exchange between delegations in order to spread good practice developed by successful projects.

Prospects for Impact

1. In order to ensure that the project contributes positively to the attainment of the GO, it is necessary to monitor **external factors thoroughly and coordinate with other entities and agents present in the intervention zones**.

2. The operability and efficiency of the various committees set up by projects varies considerably from one case to another as the role played by various delegations differs greatly in this respect. It is important that, with the backing of EC delegations, implementing entities adopt roles aimed at having a political impact on decisions made by local authorities (especially in the case of NGO projects) and to seeking commitments that guarantee a positive impact by projects.

3. Bearing in mind that the 3 PRRAC projects and 2 of the 3 FTC projects will be finalizing their activities in the near future, **evaluation of their impact** is recommended in order to analyse the contribution made by projects to reform processes and to analyse how various health projects present in the same country have contributed to improving primary healthcare. Guatemala or Bolivia might be two countries of special interest for this. The results of these evaluations could provide valuable input for future **programmes to support the sector**.

4. It is difficult to establish the connection between the EC contribution through the different cooperation projects and contributions to overall funds and the attainment of **Millennium Objectives** that are directly or indirectly related to health. However, it would be very useful to set up a monitoring forum with the participation of projects and delegations to serve as an observatory of same in the region.

Monitor external actors and coordinate with other parties and agents present in the intervention zones.

Carry out impact assessments in the hope that their outcomes can provide input for possible future programmes to support the sector.

Promote a joint effort by the institutions involved in the sector with a view to influencing policy and bringing about effective commitments that lead to financial sustainability.

Potential Sustainability

1. It is necessary to continue working toward free access to basic healthcare services for the most vulnerable population. However, the budgetary limitations and national priorities undermine attainment of this goal. In order to contribute to the **financial sustainability** of projects, a **combined effort is necessary by the institutions** of civil society, healthcare personnel, coordinated donors and, if possible, local entities.

2. The financial sustainability not of the projects but of the various healthcare systems has a political impact on the ministries of economy and finance and this can be very relevant in the framework of any sectoral support in the region.

Place the end and intermediate beneficiaries at the centre of the decision-making process related to their own development.

3. Appropriation **by** intermediate and end **beneficiaries by ensuring they are participants in decisions made relating to their own development**. In order to bring about this appropriation, effective coordination is recommended with local authorities and, if necessary, development of reinforcement strategies. Tension between the demands of healthcare professionals and the needs of the population are difficult to mitigate without dialogue or collaboration.

4. The achievement of **institutional strengthening** as well as the improvement of the management capacity of local entities is, in the first instance**, considered a strategic priority for ensuring sustainability**. This means designating specific funds for this purpose and producing more realistic schedules in accordance with needs in terms of the time and human resources required. Strengthening institutions not only means providing them with staff or training courses, it also means strengthening the institution itself, providing support **in the setting of its objectives, goals and vision after carrying out a management audit**, which is necessary in the majority of cases.

Consider institutional strengthening as a priority to ensure sustainability and designate funds to finance management audits.

5. The health sector and especially its **most highly qualified personnel are not usually very open to the introduction of changes and reforms**. This type of dynamic is difficult to manage for a cooperation project and demands clear and explicit stances on the part of the respective authorities.

6. Health and more specifically sexual and reproductive health projects are particularly gender sensitive. It is recommended therefore that the necessary means are provided to design and implement quality strategies which means **financial resources for hiring AT specialized in gender** and the identification of explicit goals in this field.

7. The environment is a crucial health factor. As in the case of gender, it is also necessary to have the necessary means to be able to **develop an explicit environmental impact or improvement strategy**. The deterioration of the intervention zones in which projects are implemented both by the inappropriate use of resources and the lack of a public strategy to deal with refuse demands an explicit response in this respect.

Bibliography

Overall Situation: Health in Latin America

" *Objetivos del Milenio. Una mirada desde América Latina y el Caribe. El Derecho a la salud y los ODM*"; United Nations; 2005.

"*Situación de salud en las Américas. Indicadores básicos de la salud";* Organización Panamericana de la Salud; 2005.

"*Políticas y programas de salud en América Latina. Problemas y propuestas*"; CEPAL; December 2005.

"*Transformaciones demográficas en América Latina y el Caribe y sus consecuencias para las políticas públicas del Panorama social de América Latina*"; CEPAL; 2004.

Political framework of European Cooperation for Health and Latin America

Communication "Health and the reduction of poverty in developing countries" 2002.

Council Resolution of 2002 on Health and other Matters.

Health Aids and Population Guide of the European Commission

Guide to the production of Country Strategy Papers and Health Sectors, AIDS and Population.

Strategic Regional Report for Latin America 2002-2006

Communication "A stronger partnership with Latin America" 2005

Regulation "Aid for Policies and Action related to Reproductive and Sexual Health in Developing Countries" 2003.

Regulation "Aid for Poverty-Related Diseases (HIV/AIDS, Malaria and Tuberculosis) in Developing Countries" 2003.

Declaration of Paris.

Monterrey Agreement.

Country Strategy Paper for Argentina (2000-2006)

Country Strategy Paper for Bolivia (2002-2006)

Country Strategy Paper for Brazil (2001-2006)

Strategy Paper for Chile (2002-2006)

Country Strategy Paper for Colombia (2002-2006)

Country Strategy Paper for Costa Rica (2002-2006)

Country Strategy Paper for Ecuador (2002-2006)

Country Strategy Paper for El Salvador (2002-2006)

Country Strategy Paper for Guatemala (2002-2006)

Country Strategy Paper for Honduras (2002-2006)

Country Strategy Paper for Mexico (2002-2006)

Country Strategy Paper for Nicaragua (2002-2006)

Country Strategy Paper for Panama (2002-2006)

Country Strategy Paper for Paraguay (2001-2006)

Country Strategy Paper for Peru (2002-2006)

Country Strategy Paper for Uruguay (2001-2006)

Country Strategy Paper for Venezuela (2001-2006)

Appendix

BOLIVIA	FTC	Support programme for hygiene and basic health (PROHISABA)
ECUADOR	FTC	Integrated Health Project in the Province of Esmeraldas (PSIE)
ECUADOR	FTC	Support programme for the health sector in Ecuador (PASSE)
PANAMA	FTC	Incorporation of new electrification technologies for health in marginalized areas (SOLEDUSA)
PERU	FTC	Health Sector Support Programme (AMARES)
GUATEMALA	REH	Expansion of a Primary Healthcare System
HONDURAS	REH	Strengthening the Health and Education Sector in Honduras (SALED)
NICARAGUA	REH	Rehabilitation project for primary healthcare services and strengthening of Silais de Managua (FORSIMA)
ARGENTINA	NGO-PVD	Integrated Programme to Promote Sexual and Reproductive Health and Prevention of HIV/AIDS among Poor Women, Adolescents and Youths in Greater Buenos Aires
BOLIVIA	NGO-PVD	Participative community education for the exercise of health-related rights in poor municipalities in the Departments of Oruro, Sucre, Tarija and Potosí, Bolivia.
BOLIVIA	NGO-PVD	Empowered women and adolescents in relation to sexual and reproductive rights
GUATEMALA	NGO-PVD	Implementation of a first level primary healthcare system in three districts, pilot scheme.
NICARAGUA	HEALTH	Strengthening and optimisation of national malaria and HIV/AIDS programmes in Nicaragua through an integrated approach prevention, diagnosis and treatment HALTED
GUATEMALA	HEALTH	Maternal Health Project
BRAZIL	HEALTH	Programme for setting up a network of buddy volunteer projects in Brazil
PERU	FOOD	Food Security Assistance Scheme Peru 'MIN SALUD'
URB-AL	EC	"Health Boulevard."